

ЕКСПЕРИМЕНТАЛЬНІ ТА ПРИКЛАДНІ ДОСЛІДЖЕННЯ

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EVALUATION OF A PSYCHOSOCIAL INTERVENTION TO ENHANCE RESILIENCE AND DECREASE PSYCHOLOGICAL DISTRESS IN UNACCOMPANIED ASYLUM-SEEKING MINORS

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A – Study design; B – Data collection; C – Statistical analysis; D – Manuscript Preparation; E – Funds Collection.

Relevance of research: This research contributes to understanding of vulnerability and resilience among unaccompanied asylum-seeking minors (UAMs) in forced migration to Europe and presents the findings of a pilot group intervention to enhance resilience and decrease psychological distress in UAMs.

Purpose of research: The purpose of the research was to evaluate the effectiveness of a group-based psychosocial intervention (Taking Part, TP) to enhance resilience and decrease psychological distress in UAMs following resettlement in the UK. An increasing number of UAMs have been

forced to migrate alone to seek asylum in UK and are known to experience psychological distress. Many of them are considered to need individual clinic-based therapy; however, helping them to build resilience could offset this need.

Methods: *A pragmatic randomised controlled trial was employed to evaluate the effectiveness of the TP psychosocial intervention. The participants (n=30), aged 15 to 17 years, were randomly assigned to one of the two conditions: experimental (n=15) and wait-list control (n=15) groups. The experimental group received 14 hours of TP intervention to enhance resilience-building skills, while the wait-list control group received standard support services provided by a refugee agency. Measures of resilience and psychological distress were administered pre- and post-intervention to both groups. Data analyses comprised of a combination of descriptive and inferential statistics, and intervention fidelity outcomes.*

Results: *Analyses indicated that the experimental group had significantly higher resilience scores (i.e., increases in optimistic thinking, reduction in pessimistic thinking) and lower scores in psychological distress (i.e., reduction in depressive symptoms) post-intervention than did the wait-list control group.*

Conclusions: *These findings suggest that psychosocial intervention may be useful to enhance resilience and decrease psychological distress in UAMs.*

Keywords: *unaccompanied; asylum-seeking minors; resilience; psychological distress*

**Оцінка психосоціального втручання для підвищення
резильєнтності та зменшення психологічного дистресу у
неповнолітніх без супроводу, які знаходяться у пошуку**

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Актуальність дослідження: представлене дослідження сприяє розумінню вразливості та резильєнтності серед неповнолітніх, які не мають притулку у примусовій міграції до Європи та представляють результати втручання пілотної групи для підвищення резильєнтності та зменшення психологічного дистресу.

Мета дослідження: метою дослідження було оцінити ефективність групового психосоціального втручання (за участю, ТП) для підвищення стійкості та зменшення психологічних страждань в неповнолітніх, які не мають притулку після переселення у Великобританії.

Методи: вибірка ($n = 30$) представлена від 15 до 17 років, були випадковим чином віднесені до однієї з двох груп: експериментальна ($n = 15$) та контрольна ($n = 15$) груп. Експериментальна група отримала 14 годин інтервенцій для підвищення навичок резильєнтності. Вимірювання резильєнтності та психологічного дистресу вводили до та після інтервенцій обох груп.

Результати: Аналізи показали, що експериментальна група мала значно більші високі показники резильєнтності (тобто збільшення оптимістичного мислення, зменшення песимістичного мислення) та зниження психологічного дистресу (тобто зменшення депресивних симптомів) після інтервенції.

Висновки: Психосоціальна інтервенція сприяла підвищенню резильєнтності та зменшенню психологічного дистресу у неповнолітніх без супроводу, які знаходяться у пошуку притулку

Ключові слова: особи без супроводу; неповнолітні особи без притулку; резильєнтність; психологічний дистрес.

Introduction

The number of unaccompanied minors (UAMs) who have overcome great odds to seek asylum alone in the UK has become an increasingly global problem with profound psychological consequences (Bradby et al., 2019; Mohamed and Thomas, 2017; Home Office, 2015; Refugee Council, 2014). These minors have been forced into migration to seek asylum alone because of war, political instability, religious and ethnic persecutions, violence, terrorism, natural disasters, and extreme poverty (Blackmore et al., 2020; Bradby et al., 2019; Mohamed and Thomas, 2017; Crawley, 2011; Groark et al., 2011).

The most widely used definition of UAMs in the UK 'is a person under 18, applying for asylum on his or her own right, who is separated from both parents and is not being cared for by an adult who by law has responsibility to do so' (Home Office, 2015, p. 63). This population is characterised as vulnerable to psychological distress due to the likelihood of them experiencing multiple adverse life events during forced migration and resettlement (Blackmore et al., 2020; Bradby et al., 2019; Vervilet et al., 2014; Thommessen et al., 2013; Crawley, 2011; Clarke, 2011; Sirriyeh, 2011; Groark et al., 2010). These children and young people may have witnessed or become victims of violence, been forcibly recruited as child soldiers and/or exposed to elevated risks of rape, torture, and substance abuse (Blackmore et al., 2020; Bradby et al., 2019; Fazel, et al., 2012; Chase et al., 2008). Forced migration of minors causes disruption in multiple life domains and impacts on education and psychosocial development (Blackmore et al., 2020; Bradby et al., 2019; Wade, 2011; Groark et al., 2010; Papadopoulos, 2010; Chase et al., 2008). This trajectory has deleterious impact on the health and psychological wellbeing of UAMs; existing literature has documented high prevalence rates of psychological distress (depression, anxiety) and somatic complaints among UAMs (Blackmore et al., 2020; Bradby et al., 2019; Mohamed and Thomas, 2017).

Few interventions exist to address psychological distress in UAMs following resettlement. To date, those that have been trailed to ameliorate psychological distress in UAMs are traditional Western trauma-focused treatments for PTSD and depression, including Cognitive Behavioral Therapy (CBT), Narrative Exposure Therapy (NET), Eye Movement Desensitization and Reprocessing (EMDR), and Testimonial Psychotherapy (Blackmore et al., 2020; Mitra and Hodes, 2019; Ehnholt and Yule, 2006). Despite an array of treatment modalities, the uptake of trauma-focused mental health services by UAMs remains low (Dura-Vila et al., 2012; Sanchez-Cao et al., 2012; De Anstiss et al., 2009; Michaelson and Sclare, 2009). This is likely to reflect challenges such as cultural differences in help-seeking behaviour, language barriers, as well as structural difficulties which impact on the ability to register and access specialist mental health services (Sanchez-Cao et al., 2012; Michelson and Sclare, 2009; De Anstiss et al., 2009). Given the experience of multiple trauma and loss, and the need for psychosocial support to facilitate the integration of UAMs in the host community of resettlement, it is important that the scope of interventions be broadened beyond clinical models targeting trauma-focused treatments for PTSD and depression (Bradby et al., 2019; Mitra and Hodes, 2019; Sleijpen et al., 2017; Mohamed and Thomas, 2017).

Increasing numbers of researchers have evaluated the effectiveness of psychosocial interventions that are conducted outside of clinical environments to enhance resilience and reduce psychological distress in asylum-seeking and refugee children and adolescents (Bradby et al., 2019; Mitra and Hodes, 2019; Sleijpen et al., 2017; Mohamed and Thomas, 2017). These interventions have incorporated several psychosocial modalities including social support, psychoeducation, cognitive behavioral therapy, relaxation techniques, and resilience building skills (Bradby et al., 2019; Mitra and Hodes, 2019; Mohamed and Thomas, 2017; Groark et al, 2010). Psychosocial interventions to promote resilience in children and

adolescents have focused on teaching cognitive and behavioral skills that aid the habitual use of accurate and flexible thinking patterns which can optimise resilience (Reivich et al, 2011; Luthar, 2008; Masten and Powell, 2003). These resilience promotion programmes, for example, the Penn Resilience Programme (PRP) and the UK Resilience Programme (UKRP), target school age children and adolescents and train them in cognitive and behavioral skills that help them become more aware of their habitual way of explaining (explanatory style) their experiences of life events. This positive psychology model, underpinned by the socio-cognitive theory of reformulated learned helplessness and Albert Ellis's ABC model (Ellis, 1962) promote the idea that optimistic thinking and explanatory style can be learned. Despite the importance of the therapeutic role of resilience in helping people deal with psychological distress, the evidence base for feasible and effective resilience enhancement interventions for UAMs is limited.

The purpose of this study was to evaluate the effectiveness of a group-based psychosocial intervention (TP) to enhance resilience and decrease psychological distress in unaccompanied asylum-seeking minors (UAMs) following resettlement in the UK. Three psychosocial modalities were incorporated in the intervention: cognitive behavioral therapy, psychoeducation, and social problem-solving skills. The TP intervention comprised seven structured sessions (2 hours per session), which were delivered over a 7-week period. The design drew upon the theory of reformulated learned helplessness, which proposed that individuals who face an adversity and have pessimistic appraisals are prone to feelings of helplessness (Seligman et al., 1984; Abramson et al., 1978). The theory posits that it is not the experience of adversity that triggers the emotional distress but the beliefs and interpretation of the event (Ellis, 1962; Beck, 1967). This theory suggests that supporting an individual to identify and examine negative beliefs about an adversity can provide a buffer against anxiety and depression (Reivich et al., 2011; Seligman, 1991; Abramson et al., 1989).

It was hypothesized that: 1) UAMs who attended the 7-week resilience intervention (TP) would have improved explanatory styles (Reivich et al., 2011, Seligman et al., 1984; Abramson et al., 1978) and a reduction in depressive symptoms (measured by Beck Depression Inventory II, Beck et al., 1996) compared to those in the wait-list (standard care) control group; and 2) the effectiveness of the TP intervention will be maintained or improved for the intervention group compared to the wait-list control group at 4-Month follow-up.

Methodology of research

The evaluation of the TP resilience building intervention used a pragmatic randomised controlled trial, with a pre-test and post-test experimental design. The study gained ethical approval (Ethics Reference Number: 5993) from the research and ethics committee of Cardiff Metropolitan University.

Sample

The participants (n = 30) were unaccompanied asylum-seeking and refugee minors between the ages of 15 and 17 years. They were recruited based on referrals from community support-based participation group for asylum seeking and refugee minors in Cardiff, Wales. The inclusion criteria comprised the following: participants could speak, read, or comprehend conversational English, unaccompanied asylum-seekers, or refugees between the ages of 15 and 17 years, and were receiving independent issue-based advocacy and support from the refugee agency that ran the participation group. Unaccompanied asylum-seeking and refugee minors with learning disabilities or involved with Child and Adolescent Mental Health Services (CAMHS), as well as accompanied asylum-seeking and refugee minors below the age of 15 years were excluded.

The demographic characteristics of the participants consisted of 18 girls (60%) and 12 boys (40%) from 8 different. The participants were randomly allocated (single-blinded randomisation) to one of the two conditions: TP intervention group (n=15) and the wait-list control group (n=15). The intervention group received 14 hours of

instruction in the TP resilience building Programme over seven weeks. The wait-list control group received the standard support services provided by a refugee agency.

Measures

The outcome measures were collected using two anonymous self-report questionnaires: Children's Attributional Style Questionnaire Revised (CASQ-R, Kaslow and Nolen-Hocksema, 1991) and Beck Depression Inventory II (BDI-II, Beck et al., 1996).

The revised Children's Attributional Style Questionnaire (CASQ-R) is a 24 forced-choice item, self-report measure that assesses the attributional or explanatory styles of children on three dimensions: internality, stability, and globality (Kaslow and Nolen-Hocksema, 1991). Internal consistency reliabilities ranging from 0.4 to 0.7 have been reported for the composite CASQ-R (Lau et al., 2006). Test-retest reliabilities over a six-month follow-up period ranging from 0.5 to 0.8 have been reported for the composite scores of CASQ-R (Sankaranarayanan and Cycil, 2014; Lau et al., 2006; Kaslow and Nolen-Hocksema, 1991).

The 21-item BDI-II instrument measures the existence and severity of the symptoms of depression. Respondents rate the severity of depressive symptoms based on their experiences over the previous 2 weeks on a 4-point scale for each item, ranging from 0 to 3. Each of the 21 items corresponds to a symptom of depression on the cognitive, affective, and somatic sub-scales, and is summed to give a single score, ranging from 0 – 63. BDI-II has shown strong reliability and validity across a variety of study populations and has been used by persons over 13 years of age for more than two decades to identify and assess depressive symptoms (Hobkirk et al., 2015; Dare et al., 2015; Meffert et al., 2014). The test scores have shown good internal consistency with a Cronbach's coefficient alpha of 0.8 (Meffert et al., 2014). The construct validity of BDI-II has been established and the instrument is able to differentiate depressed from non-depressed patients (Hobkirk et al., 2015; Dare et al., 2015; Meffert et al., 2014).

The TP resilience building intervention

The TP intervention included seven training sessions, which were delivery in two hours per session over a seven-week period. The first three sessions have cognitive skills components and are based on socio-cognitive theories of coping with mental health issues such as depression and anxiety, and other empirically validated works in the field of positive psychology. These cognitive skills components train asylum seeking and refugee minors to recognise and challenge negative beliefs about resettlement in the host country by considering alternative explanations that enhance resilience building. Resilience concepts and cognitive skills to identify and examine negative beliefs are also presented. The following four sessions consist of social problem-solving skills components which introduce asylum-seeking and refugee minors to a variety of resilience building strategies including assertiveness, conflict negotiation and decision-making techniques that they can use to buffer the challenges of resettlement-related stressors. All sessions are administered through hypothetical examples (scenarios), role-plays, small group discussions and plenaries, which illustrate concepts and teach skills.

The first session, Introduction to TP Intervention, is devoted to introducing the participants to the overall resilience building training programme, establishing rapport, laying ground rules, and building group cohesion. It provides brief information on the purpose of the training and how the sessions are structured. Two different sets of baseline questionnaires (pre-test), the Beck Depression Inventory-II (BDI-II, Beck et al., 1996) and the Revised Children's Attributional Style Questionnaire (CASQ-R, Kaslow and Nolen-Hocksema, 1991) are administered to the participants for completion. The questionnaires will be re-administered to the participants for completion at the end of the training for the purpose of evaluation (post-test and at follow-up).

Session 2 (Cognitive Skills Foundation) lays the foundation of the cognitive skills component of the TP intervention. This session

helps participants to recognise the relationship between thoughts (beliefs) and activating events. The focus is on recognising patterns of thinking that can hinder resilience in asylum seeking and refugee minors in the period of resettlement. In the first half of the session participants are introduced to the concepts of values and signature strengths (Peterson and Seligman, 2004), followed by Albert Ellis' ABC (Adversity, Belief, Consequence) model as a skill for interpreting and responding positively to activating events. Participants are encouraged to talk about their strengths and describe how they have used these strengths in their life events, especially in the resettlement phase of integration in the host community. In the final section of session two participants learn to use the ABC model (Ellis, 1962) to recognise the link between an activating event, beliefs (thoughts), and consequences (emotions/feelings and behaviors) of the beliefs.

Session three (Emotions and Behaviours) focuses on the patterns of thinking and explanatory style that can either foster resilience and coping abilities or hinder them. Using a scenario, the participants practice exploring how patterns of negative thinking and explanatory style of activating events can lead to negative feelings and actions. The activities in this session require participants to distinguish activating events, thoughts, and consequences and to recognise the link between thoughts and consequences (emotions/feelings and behaviours). After practicing the activities in this session, the participants would have now learned the essential ABC skill. They would understand the link between activating events, thinking errors, feelings, and actions, and how to apply this skill to generate alternative explanatory style. This would enable them to effectively respond to the adverse circumstances they may encounter as they integrate in the host community of resettlement.

Session four (Let us communicate) is the first in the communication and relationship skills that introduces the participants to behaviourally oriented techniques to help them strengthen their relationships and manage difficult emotions or stressful situations in

the host community of resettlement. This session and the following sessions focus on applying the basic cognitive skills learned in the first half of TP intervention to the interpersonal domain. It introduces basic communication skills (verbal and non-verbal) to participants to establish the foundation for strengthening relationships and successful conflict negotiation. Participants learn active listening skills and body language techniques for understanding and communicating with someone who is angry. Participants use role-play (listening in pairs) to illustrate active listening and discuss the consequences of speaking to a good or bad listener as well as the thoughts/beliefs that promote or hinder active listening.

Session 5 (Let us assert ourselves) helps participants gain an understanding of the differences between aggressive, passive, and assertive behaviour and communication styles, and to learn and practice assertive communication skills using body language and “I” statements. The communication skills that are learned in this session enable participants to develop self-confidence in communicating with other people assertively and to build and maintain good relationship with others that is devoid of a domineering or a submissive disposition. The session provides practical tools that help participants to challenge thoughts/beliefs that inhibit positive communication and good relationships. This session also introduces participants to assertive behaviour and communication styles.

Session 6 (Conflict Negotiation) introduces participants to the concept of conflict negotiation. Skits are used to illustrate the two main approaches to conflict negotiation: win – lose and win – win approaches. Participants practice the skills of a ‘win-win’ negotiation as a technique to handle conflict in a non-violent manner. The participants discuss the four types of conflict: Intrapersonal; Interpersonal; Intragroup; Intergroup and relate these to their personal experiences. In the final section of this session, participants learn and practice negotiation skills to resolve conflict successfully.

Session 7 (Decision-making and Friendship) introduces participant to decision-making skills and how to apply these skills in

important life events such as career, education, employment, finance, leisure/recreation, friendship, sexual reproductive health, drug/substance use, etc. The challenges of resettlement-related stressors such as the uncertainty of the asylum-seeking process can make decision making very difficult for UAMs. The first skit of the session helps participants to recognize the effects of peer pressure and personal values on decision-making. It also introduces the participants to the three different types of decision-making: Proactive, Reactive, and Inactive. The participants practice the decision-making skills with scenarios offered by the facilitator. In the final section of the session participants apply the decision-making skills to important events in their lives, for example, making and maintaining friendship.

Procedure

The TP intervention was evaluated using two conditions, pre-test and post-test design, and single-blinded randomisation via computer-generated random numbers. The participants of the study ($n = 30$), aged 15 to 17 years, were randomly allocated to one of the two conditions: TP intervention group ($n = 15$) and control group ($n = 15$). The intervention group received 14 hours of instruction in the TP resilience building Programme over seven weeks. The wait-list control group received the usual social support services provided by a refugee agency.

The intervention was delivered by the researcher, as the main facilitator, and assisted by a co-facilitator. The researcher was a qualified children and young people practitioner and has experience in working with youth in community and residential settings. The co-facilitator was a qualified youth worker with significant experience working with asylum-seeking and refugee adolescents. The intervention was delivered in face-to-face group-based sessions and was conducted in a local church building that is used as a community hub to support refugees and asylum-seekers. Outcome measures were administered at baseline and completion of the trial (Time 1 and Time 2). The intervention monitoring tools (attendance register

and session feedback questionnaire) were completed by the participants during each session of the intervention.

Data analysis

A combination of descriptive and inferential statistics was used to analyse the data. Parametric statistical tests (t-test and analysis of covariance) were performed to compare baseline characteristics and to analyse the effectiveness of the TP intervention. The baseline characteristics of the TP intervention group and the wait-list control group were compared using the independent samples t-test. Analysis of covariance (ANCOVA) was used to detect differences in the outcome measures between the intervention group and the wait-list control group. The effect sizes of the TP intervention were computed and presented as eta squared (η^2). An effect size of $>.01$ is considered as small, $>.06$ is considered medium, and $>.14$ is considered large (Berger et al., 2012).

Results

Table 1 shows the sample characteristics of the study. At baseline the sample consisted of 12 boys (40%) and 18 girls (60%) between the ages of 15 and 17 years. There was no significant difference in the mean age between the participants in the Wait-list control group (mean age: 16.26) and those in the TP intervention group (mean age: 16.33). Twenty participants (66.7%) were asylum-seekers, while ten participants (33.3%) have been granted refugee status.

Table 1

Demographic characteristics of participants at baseline

Variable	Intervention (n=15) Mean (SD)	Wait-list Control (n=15) Mean (SD)
Gender		
Male	6	6
Female	9	9
Region of origin		
Africa	4	5
Middle East	5	4
South East Asia	4	3
Eastern Europe	2	3
Legal Status		
Asylum-seeker	13	7
Refugee	2	8
Religion		
Muslim	2	11
Christian	11	1
None declared	2	3
Mean age: years (SD)	16.33 (0.72)	16.26 (0.70) $t(28) = -0.26, ns$

Notes: Significance levels for age between groups was determined using independent samples t -test.

Baseline data for explanatory style scores across the TP intervention and wait-list control groups on the dimensions of the CASQ-R, and depressive symptoms are presented in Table 2. At baseline, there was no significant difference in mean scores of composite positive (CP) between the TP intervention group and the wait-list control group ($t(28) = 1.79, p = .084$, two-tailed). There was a significant difference between the intervention group and wait-list control group on the pre-test composite negative (CN) scores of CASQ-R as revealed by the independent samples t -test, $t(28) = 2.168, p = 0.039$. The baseline depressive symptom scores for the

participants ranged from 21 to 33, which is indicative of symptoms of clinical depression. Independent samples *t*-test found no significant difference between the TP intervention group and the wait-list control group on baseline depressive symptoms scores, $t(28) = 1.543$, $p = 0.134$ (two-tailed).

Table 2.

Pre-test (time 1) to post-test (time 2) and pre-test to 4-Month follow (time 3) scores for explanatory style and depressive symptoms for the TP intervention group and the control group

Variable	Condition	Intervention Mean(SD)	Control Mean(SD)	Statistic	Partial η^2
CP	Pre-test	5.47 (0.64)	4.93 (0.96)	$t(28) = 1.79$ ns	0.90
	Post-test	9.13 (0.74)	4.87(0.63)	$f(1,27) = 248.17^*$	
	Follow-up	9.9 (0.8)	5.2 (0.9)	$f(1,27) = 190.66^*$	
CN	Pre-test	8.47 (0.52)	8.00 (0.65)	$t(28) = 2.168^*$	0.70
	Post-test	6.40 (0.63)	8.40 (0.63)	$f(1,27) = 62.55^*$	
	Follow-up	5.7 (1.2)	9.5 (0.9)	$f(1,27) = 84.025^*$	
Depress	Pre-test	31.53 (1.25)	30.33 (2.74)	$t(28) = 1.543$ ns	0.96
	Post-test	20.87 (0.9)	30.27 (1.98)	$f(1,27) = 615.55^*$	
	Follow-up	18.3 (1.8)	28.3 (2.3)	$f(1,27) = 250.17^*$	

Notes: significance levels for pre-test scores at baseline were determined using independent samples *t*-test. ANCOVA was performed on CP and CN scores at 4-Month follow-up, as well on depressive symptoms scores at 4-Month follow-up, ns = not significant, * $p < 0.05$.

Effectiveness of the TP Intervention

Table 2 provides the mean scores of the post-test explanatory style for the TP intervention and wait-list control groups on the composite positive (CP) and composite negative (CN) dimensions of CASQ-R, as well as significant changes as determined by ANCOVA, and the effect sizes. Preliminary ANCOVA checks were conducted and found no violation of the assumptions of normality, linearity, homogeneity of variance and of regression slopes. Consistent with hypothesis 1, there was a significant post-test improvement in the optimistic explanatory style for the TP intervention group compared to the wait-list control group, $f(1, 27) = 248.17$, $P < 0.05$. The effect size of the TP intervention for the composite positive events on CASQ-R was 0.09. There was also a significant reduction in pessimistic explanatory style for the TP intervention group compared to the control group, $f(1, 27) = 62.55$, $p < 0.05$. The effect size of the TP intervention for the composite negative events on CASQ-R was 0.70. Participants in the TP intervention group reported significantly fewer depressive symptoms compared to the wait-list control group, $f(1, 27) = 615.55$, $P < 0.05$. The effect size of the TP intervention for depressive symptoms on BDI-II was 0.96.

The post-test (time 3) mean scores for explanatory style, depressive symptoms, as well as significant changes as determined by ANCOVA are shown in Table 2. At 4-Month follow-up, there was no attrition among participants who completed the pre- to post-test (time 3) evaluation of the TP intervention. Consistent with hypothesis 2, there was a significantly greater improvement in the optimistic explanatory style of participants in the TP intervention group than participants in the wait-list control group, $f(1, 27) = 190.66$, $p < 0.05$. The effect size associated with this analysis was 0.88. ANCOVA also revealed a statistically significant reduction in pessimistic explanatory style for the TP intervention group compared to the wait-list control group, $f(1, 27) = 84.025$, $p < 0.05$. The effect

size of the TP intervention in reducing pessimistic explanatory style was 0.76. Similarly, a significant reduction in the depressive symptom for the TP intervention group compared to the wait-list control group was reported at 4-Month follow-up, $f(1, 27) = 250.17$, $p < 0.05$. The effect size associated with the analysis of the depressive symptom was 0.90.

Intervention fidelity

The intervention fidelity data revealed consistently high mean scores across the four indicators (content, presentation, timing, and attendance) of the TP implementation. The mean scores and standard deviation for the four indicators of the implementation fidelity were: content 33.3333 (1.79947), presentation 34.4000 (2.06328), timing 30.3333 (2.41030), and attendance 14.0000 (0.00000). The average score for attendance was 14 hours (2 hours per session, over a period of seven weeks). The attendance indicator was outstanding since there was no drop-out among the TP intervention group.

Discussion

The results show that the TP group-based psychosocial intervention is feasible and effective in enhancing resilience and reducing psychological distress in UAMs. The intervention was delivered within a community setting used by UAMs, the resources required were relatively few and the attrition rate was zero. The participants who received the resilience building intervention reported statistically significant increase in optimistic thinking, reduction in pessimistic thinking, and reduction in depressive symptoms compared with the wait-list control group, suggesting the effectiveness of the TP intervention. The effect sizes were moderate for the optimistic explanatory style, pessimistic explanatory style, and depressive symptoms. It is important to note however that although the results are significant, the sample was relatively small. The trial needs to be repeated with much larger sample, now that the feasibility of the intervention has been assessed.

This pilot suggests that UAMs can be supported to adopt resilient thinking by engaging in interventions that help them change

how they think about the challenges and adversities of forced migration, displacement, and resettlement. Optimistic explanatory style or resilient thinking style is a proxy indicator of resilience, and as such the results contribute to the growing evidence that resilient thinking patterns can be learned by children, adolescents, and adults (Challen et al, 2014; Reivich et al, 2011; Brunwasser et al., 2009; Luthar, 2008). This is particularly significant for the wellbeing of UAMs facing the challenges of resettlement and may lead to longer term benefits, including improved integration in the host community (Bradby et al., 2019; Mohamed and Thomas, 2017; Sleijpen et al, 2017; Weine et al., 2014; Groark et al., 2010; Ni Raghallaigh and Gilligan, 2010).

Although research has provided evidence for the therapeutic role of resilience in helping people deal with stress and adversity (Luthar, 2008; Masten and Reed, 2002), the importance of the thinking process in the development and enhancement of resilience has been given minimal attention (Reivich et al, 2011; Luthar, 2008; Masten and Powell, 2003). However, recent resilience promotion programmes for children and adolescents have focused on teaching cognitive and behavioral skills that aid the habitual use of accurate and flexible thinking patterns which can optimise resilience. These resilience promotion programmes, for example, the Penn Resilience Programme (PRP) and the UK Resilience Programme (UKRP), target school age children and adolescents and train them in cognitive and behavioral skills that help them become more aware of their habitual way of explaining (explanatory style) their experiences of life events. This positive psychology model, underpinned by the socio-cognitive theory of reformulated learned helplessness and Albert Ellis's ABC model (Ellis, 1962) promote the idea that optimistic thinking and explanatory style can be learned. The results of this TP evaluation study lend support to the view that optimistic explanatory style can be learned and can enhance resilience. This approach can empower asylum-seeking and refugee minors to

maintain an optimistic perspective when they encounter situations of stress and adversity that typically create feelings of helplessness.

Regarding the effectiveness of the TP intervention in reducing depressive symptoms, significant improvement in the reduction of depressive symptom scores was observed in the TP intervention group compared with the wait-list control group. Participants in the wait-list control group also reported improvement in the reduction of depressive symptom scores over the same period; this may be attributed to the wait-list engagement in other support services. Post intervention, the mean scores on the BDI-II remained high for both the TP intervention group and the wait-list control group, indicating that most of the participants continued to experience mild to moderate depressive symptoms. This highlights that the intervention does not replace the need for continued mental health support in UAMs.

There are a few methodological limitations of this trial that must be acknowledged. A key limitation was the potential sampling bias in the recruitment of the participants in terms of gender and religious identity. The total sample ($n=30$) of the evaluation comprised of more females than males, and most of them were predominantly Christians. Although this potential sampling bias was a limitation, the design of this study used single-blinded randomisation to reduce such bias, as well as the ANCOVA statistical technique to control for pre-existing differences between the intervention and wait-list control groups. The single-blinded randomisation adopted in this study is an excellent tool designed to reduce or eliminate bias in randomised controlled trials (Field, 2013).

Another methodological limitation relates to the outcome measures of the TP intervention. Resilience itself is never directly measured, so it was inferred based on the measurement of the explanatory style of the participants of the TP intervention. A self-report questionnaire (CASQ-R) was used to measure explanatory style, but the psychometric properties and cut-off scores for this instrument have not been established for the population of asylum-

seeking and refugee minors. Although positive results were reported for resilient enhancement among participants of the TP intervention based on improvement in their explanatory style, these results cannot be assumed to generalise to other domains that are involved in resilience processes such as self-efficacy, competence, or coping skills, which are all individual-level assets that are used to infer resilience (Luthar, 2008).

The limitations mentioned above call for caution in the interpretations made or the conclusions drawn from the results of this research. Despite these limitations, the results have profound implications for practice, service development, policy, and research. The findings of the research contribute to the growing body of knowledge that psychosocial interventions with asylum-seeking and refugee minors have the potential to enhance the resilience of these minors which could promote their wellbeing and better integration in the host community (Bradby et al., 2019; Mohamed and Thomas, 2017; Sleijpen et al, 2017; Weine et al., 2014b; Fazel et al., 2012; McCarthy and Marks, 2010; Rutter, 2006; Miller and Rasco, 2004). Also, the successful and effective delivery of the TP intervention in a community-based setting supports the literature which suggests that psychosocial interventions can offer an alternative to the traditional clinic-based services for meeting the psychosocial needs of asylum-seeking and refugee minors in the host community of resettlement (Bradby et al., 2019; Mohamed and Thomas, 2017; Sleijpen et al, 2017; Papadopoulos, 2010; Miller and Rasmussen, 2010; Miller and Rasco, 2004). This psychosocial model of service delivery takes account of a wide range of the social needs of asylum-seeking and refugee minors which are not provided by the clinic-based services. This is precisely because the social dimensions of resettlement-related challenges are largely outside the scope of clinic-based services. Moreover, group-based psychosocial intervention for UAMs has the additional advantage of saving costs, especially within the tightly budgeted National Health Service (NHS). This type of intervention, if delivered in a timely fashion (i.e., before behaviour

and thinking patterns are too entrenched), could save costs of delivering one-to-one clinic-based therapy to UAMs further down the line.

Conclusions

This research has presented evidence about the feasibility and effectiveness of the Taking Part psychosocial intervention in enhancing resilience and reducing psychological distress in UAMs following resettlement in the UK. The findings strongly resonate with those emphasised by researchers in the broad field of resilience-based intervention studies (see, for example, Tol et al., 2013; Luthar, 2008; Luthar and Cicchetti, 2000) that suggest that interventions should not only be directed at the reduction of negative outcomes or influences (vulnerability factors) but also toward the promotion of positive adaptation or competence (resilience factors). The manualised format of the group intervention also makes effective psychosocial help and resilience enhancement strategies available to asylum-seeking and refugee minors in the UK and potentially other resettlement countries for a much wider audience of refugees.

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