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Social anxiety among unaccompanied minor refugees in Norway.The association with pre-migration trauma and post-migration acculturation related factors

Toril Jore[a,*], Brit Oppedal[b], Guido Biele[b]

[a] Psycho-social work, University of Oslo, Norway
[b] Norwegian Institute of Public Health, Department of Child Health and Development, Norway

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ABSTRACT

Objective: Unaccompanied refugee minors (URMs), are at high risk for mental health problems, yet there is a lack of knowledge about social anxiety among these youths. The aim of this study was to investigate symptoms of social anxiety among URMs resettled in Norway, and the combined effects of pre-migration traumatic events, post-migration acculturation related factors (perceived discrimination and culture competence in relation both to the heritage and majority cultures) and demographic background variables, over and above the effect of concurrent depressive symptoms.

Methods: Cross-sectional self-report questionnaire data were collected from 557 URMs from 31 different countries, mainly from Afghanistan (49,6%), Somalia (11,1%), and Iraq (7,0%). Results: The findings from structural equation model (SEM) showed that the effect of pre-migration traumatic events on social anxiety was non-significant ($\beta = 0.001$, $p = .09$), while perceived discrimination and majority culture competence had unique effects on social anxiety ($\beta = 0.39$, $p < .001$ and $\beta = -0.12$, $p = .008$, respectively) over and above depressive symptoms ($\beta = 0.30$, $p < .001$).

Conclusions: The findings show that factors of the current socio-cultural developmental context rather than pre-migration war-related traumatic events the youths experienced before migration accounts for variation in social anxiety. Potential practical implications of the findings for social workers, educational staff and clinicians are discussed.

1. Introduction

Unaccompanied refugee minors (URMs) refer to children under the age of 18 who migrate without parents or other legal guardians, and who are granted residence permit in their country of destination. URMs have been exposed to more potentially traumatizing events than accompanied refugees who migrate with their parents [6]. The pre-migration traumatic experiences among URMs involve death or persecution of family members, forced recruitment, personal persecution, witnessing violence and experiencing war [23,26]. The risk factors associated with war, flight and subsequent acculturation in the resettlement country, makes URMs an especially vulnerable group regarding mental health problems, such as symptoms of post-traumatic stress, depression and anxiety [32].

Previous research on the mental health of URMs have mainly focused on the development and levels of post-traumatic stress disorder (PTSD), depression and to some degree general anxiety disorder (GAD) [14,22,28]. However, we lack knowledge regarding other, *specific* types of anxiety problems among them. Hence, the overall aim of the present study is to get research-based information about social anxiety, which has increasing incidence and prevalence rates throughout adolescence, the ages when the majority of URMs migrate [8]. This is particularly important, since anxiety disorders are the most undertreated mental health problems in adolescents [54].

1.1. Social anxiety among refugee children

While there is scarce information about social anxiety among refugee youths, findings from general populations have demonstrated comorbidity with depression [16], other anxiety disorders [33], and post-traumatic stress disorder (PTSD) [39].

Social anxiety is related to impairment in peer relationships [37].

* Corresponding author.
E-mail address: toriljore@gmail.com (T. Jore).

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URMs are particularly dependent upon positive interpersonal relationships in the resettlement process, not only to gain friendships and support, but also to be able to learn about the culture of the new society. One of the main elements of social anxiety is fear of other people's negative evaluations of oneself, which may cause withdrawal and socially avoidant behavior [21]. Social anxiety is also associated with poor academic and vocational achievements [56,59], as well as with school avoidance, specifically during adolescence [54]. Thus, social anxiety may interfere with the URMs ability to establish and maintain the social networks necessary for a positive adaptation and integration into a new society.

As with other anxiety and internalizing disorders, social anxiety symptoms and disorders are usually higher among girls than boys [36]. However, previous studies have shown inconsistencies in traditional gender differences in mental health problems among migrant and refugee youth [1,47,49]. Information about gender variation in social anxiety among URMs can further elucidate this issue.

Because of the acculturative stress recently arrived refugees encounter, levels of mental health problems are expected to be high in the years following resettlement, with a subsequent reduction, a pattern that is also observed among URMs [30,58].

1.2. Unaccompanied minor refugees in a Norwegian context

URMs who are resettled in municipalities are normally granted residence permit for three years, with the possibility to apply for a permanent residence permit after this period of time given that they fulfill some demands set by the government. After the refugee-crisis in 2015 the Norwegian Government started using temporary leave to remain in the country until the age of majority. This practice, however, does not involve any of the youths in this study. As part of the integration process, The Directorate of Diversity and Integration make decisions about where each refugee is to resettle. The refugees have to live in this particular municipality the first five years to keep their rights for financial support.

When resettled in a municipality, local authorities oversee the adolescents developmental and psychosocial needs. Living arrangements are organized in various ways, but the most common is that URMs are resettled in group-homes with staff available 24/7 until they turn 18 years old. They are entitled to education and healthcare in line with ethnic Norwegian citizens [19].

1.3. Acculturation risk and protective factors

When URMs are granted residence in their country of destination, they can start planning their new life and future. This transition involves a process where the adolescents have to adjust to the new majority culture while at the same time making decisions about how to relate to and preserve their heritage culture, also called the *acculturation* process [10]. This involves, among other things, learning a new language, understanding a new set of cultural codes and values, and getting to know the religious system of the new society.

Recently there has been an increase in acculturation research on immigrant and refugee youth, involving the concepts of culture competence on majority and heritage culture [31,48]. Culture competence refers to children's cultural resources and involves knowledge and skills about verbal and non-verbal communication and patterns of interpersonal behavior, and the values underlying these [44]. The perception of oneself as being successful, mastering and coping are empirically and theoretically linked to positive mental health outcomes [4].

Previous studies have demonstrated significant associations between higher levels of majority and heritage culture competence (MCC and HCC, respectively) on the one hand, and lower levels of depression. Moreover, youth who reported themselves high on both HCC and MCC also reported lower levels of perceived discrimination, and subsequently with lower levels of depression. In other words, the ameliorating association between culture competence and symptoms of depression was mediated through lower levels of perceived discrimination [44,45].

Individuals develop culture competence through interpersonal relationships in academic and non-academic social settings, with people from their own and from the majority culture. The lack of education and thereby little exposure to academic language that many URMs have experienced [63] probably affect their perceived level of culture competence, particularly in the language dimension. Factors such as age, developmental stage, contextual demands, and comparison group can also impact the individuals' reports on culture competence ([4,20]; [64]; [55]).

In contrast, perceived ethnic discrimination is consistently found to be associated with higher levels of depression and other health problems [12,35]. Studies of URMs have found that the development and maintenance of mental health problems among them, is directly related to experiences of discrimination as an acculturative risk in their everyday life [15,32,42]. Keles et al. [32] found that both general daily hassles that all youth may experience such as conflicts with peers- and acculturation specific daily hassles, idiosyncratic to immigrant-background youths, such as ethnic identity crisis have unique individual effects on depressive symptoms, above and beyond the impact of war-related trauma. However, we do not know how acculturation-related resources like MCC and HCC, and risk factors like discrimination, impact on the level of social anxiety among URMs. To promote resilience and good mental health among them, we need knowledge about how various mental health outcomes are related to the process of acculturation. On a theoretical level, such information can contribute new knowledge regarding the relationship between social anxiety and acculturation specific variables. On a practical level, the study may provide useful insights for practitioners working with URMs, to broaden the perspective in how to understand their life situation, as well as providing adequate interventions when necessary.

1.4. Aims of present study

The overall aim of the present study is to get information about social anxiety in refugee and acculturation context among URMs in Norway. More specifically, we estimate a structural equation model (SEM) based on the assumptions that:

- there is variation in social anxiety among URMs associated with gender, age, and length of stay in Norway.
- there is variation in social anxiety associated with pre-migration traumatic events, ongoing perceived discrimination, and culture competence.

Because previous studies have demonstrated an association of depression with social anxiety [45], and of depression with discrimination, majority culture competence and heritage culture competence, we include depression as a covariate in the multi-variate analyses.

2. Method

2.1. Participants

The study was approved by the Regional Committee for Medical and Health Research Ethics and by the Norwegian Data Inspectorate and participation was conditioned on written consent. If the participants were younger than 16 years, additional consent was collected from their legal guardians. The population base for the project was 4051 children and youths who were granted asylum in Norway between 2000 and 2010, and who were 13 years or older when their applications were approved. The Norwegian Directorate of Immigration provided information about gender, country of origin, birth date and year, and year and place of resettlement for the whole group.

To obtain a sample with varied post migration experiences, and based on available economic resources, all unaccompanied refugee youth that could be located in 41 rural and urban municipalities in the five regions of the country, i.e. 1206 (out of 16) 85, were invited to partake in the study. Invitation letters were sent to their homes and in cases when they were less than 16 years, also to their legal guardians. When possible, local refugee or child protection service agents gave additional information about the study and explained what their participation involved. Only 47 youth (3.9%) actively declined to partake, however 218 (18.0%) youth who initially confirmed their participation did not show up on the day of data collection. The final study sample of 948 participants represented 78.4% of the final sampling frame and 22.5% of the total unaccompanied refugee population. The sample is representative of the total population in terms of country of origin, gender, age, and length of stay in Norway (For a detailed description of the sample and sampling procedures, see [32]).

Recruitment to the project and Wave 1 data collection was carried out from the end of 2006 throughout 2011. Wave 2 data were collected one year later, i.e. between 2007 and 2012. Because the funding came to a halt, not all youth that had been recruited for Wave 1 could be followed up at Wave 2. Thus, Wave 2 included 557 participants (61% of the original sample, 82.4% boys). There were not significant differences between Wave 2 participants and non-participants in demographic characteristics [32]. Sixty-two participants originated in Somalia (11.1%), 276 in Afghanistan (49.6%), 39 in Iraq (7.0%), and 139 in other countries (25.0%). The category “other countries” includes 28 different countries. The average length of stay in Norway at the Wave 2 data collection was 4.6 years (SD = 2.40).

2.2. Procedures

The research team, together with local resettlement authorities, assisted in providing information and explaining the participants the purpose of the project. The youths gathered in groups of 5–15 participants in their local communities, in a place that was familiar to them. The research team supported the participants by explaining difficult questions, according to a standardized protocol. While 15% wanted a translator, who could read the questions to them in their mother tongue at Wave 1, none of the participants took advantage of this offer at Wave 2. The questionnaire took from 1.5 to 2 h to complete. The participants received a gift certificate of around 12.50 € [45].

2.3. Measurements

All measures were translated by standard back- translation procedures.

2.3.1. Symptoms of social anxiety

Social anxiety symptoms were assessed by the 12-item short version of the “Social Anxiety Scale for Adolescents - Revised” (SAS-A) [37]. SAS-A is a modified version of the “Social Anxiety Scale for Children-Revised” (SASC-R), with verbal adjustments to make it fit for adolescents [37], and includes one dimension of social anxiety involving questions measuring *Fear of negative evaluation* “I worry that others make fun of me”, *Social avoidance and distress,* “I feel shy around people I don't know”, and *Social avoidance and distress with new social situations or unfamiliar peers,* “I am quiet when I'm with a group of people”. The participants checked how often they experienced each statement on a Likert-scale from 1 (never) to 5 (always).

The Cronbach's Alpha for the SAS-A scale was 0.86.

2.3.2. Depressive symptoms (depression)

Depression symptoms were assessed by the 20-items' Center for Epidemiological Studies Depression Scale, CES-D for adolescents [51]. Participants checked how often during the last week they experienced symptoms like “I felt my life was a failure” from 0 (rarely/never) to 3 (most of the time/all the time) The Cronbach's Alfa was 0.87.

2.3.3. Pre-migration trauma

The participants were asked to indicate which pre-migration traumatic events they had experienced before arriving in Norway. The checklist included eight different dramatic events involving family, illness, war-experience, and physical violence in addition to an open-ended question about other events as suggested by Bean, Derluyn, Eurelings-Bontekoe, Broekaert, and Spinhoven [7].

2.3.4. Discrimination

Perceived discrimination was assessed by 5 statements indicating different degrees of cultural victimization [9]. The participants checked how much they agreed to each statement like “I feel like people from other cultures don't accept me” on a Likert-type scale from 1 (totally disagree) to 4 (totally agree). The Cronbach's Alpha was 0.75.

2.3.5. Culture competence

Culture competence was assessed with the 18 items of *The Youth Culture Competence Scale* (YCCS) which taps knowledge and skills of verbal and non-verbal communication and patterns of interpersonal behavior. The scale is bi-dimensional with 9 parallel items for heritage and majority culture competence (HCC and MCC respectively). Each dimension involves one verbal and one non-verbal behavioral sub-dimension. The scale is based in theories of self-perceived self-efficacy and competence [4] which are consistent predictors of reduced levels of depression and anxiety [3]. The two-dimension latent factor structure has been validated in a study involving three different samples of youth with refugee and immigrant background in Norway and the United States [46].

The participants checked how competent they perceived themselves on a four-point scale from 1 (very difficult) to 4 (very easy). Sample items for the behavioral dimension of the MCC and the HCC included “How easy is it for you to hang out with Norwegian peers?” and “How easy is it for you to know how to behave when visiting friends and families from your culture?” The Cronbach's Alpha was 0.88 and 0.81 for MCC and HCC respectively.

2.3.6. Gender

Gender was self-reported and coded 1(boys) and 2 (girls).

2.3.7. Length of stay

NDI provided information about the participants date of arrival in Norway. We subtracted this date from the date of the Wave 2 data collection to assess length of stay.

2.3.8. Age

Information about the participants` birthdate was also provided by NDI. The participants' age was calculated by subtracting their birthdate from the date of Wave 2 collection.

2.4. Statistical analyses

Descriptive analyses were carried out in SPSS Statistics, version 25. We calculated mean sum scores for the depression and acculturation indices, and a sum score for the 8 trauma items to inform about mean and standard deviation.

We used the R [50] packages mice [60] and lavaan [53] to impute missing data and estimate a structural equation model (SEM) with six latent variables: social anxiety depression, discrimination, MCC, HCC and traumatic events, which were informed by items from the respective scales. The structural model regressed social anxiety on the other latent variables and on age, gender, duration of stay. Assuming that the data were missing at random we imputed 50 data sets. The imputation model included all variables used in the structural equation model. All SEM-fits converged successfully, and we report results

Table 1
Descriptive statistics, reliability and correlations for all included variables.

	1	2	3	4	5	6	7	8	9
1. SAS -	–	0.05	-0.09*	-0.13**	0.08	0.38**	-0.20**	−0.17**	0.45**
df		552	530	540	489	538	513	508	538
p		*0.*21	0.05	0.001	0.09	0.001	0.001	0.001	0.001
2. Gender		–	−0.12**	0.03	-0.14**	-0.04	0.22**	-0.03	0.09*
df			556	567	497	547	525	519	549
p			.004	.47	.002	.34	.001	.55	.05
3. Age			–	80**	.12**	-.07	.05	.06	-.08
df				549	481	525	503	497	527
p				.001	.01	.11	.30	.22	.05
4. Length of stay		-		–	.04	.07	.13**	.04	-.18**
df					488	535	514	508	537
p					.39	.11	.002	.37	.001
5. Trauma					–	.13**	.04	-.03	.15**
df						482	479	475	485
p						.004	.41	.53	.001
6. Discrimination						–	-.05	-.15**	.27**
df							506	509	532
p							.001	.27	.001
7.MCC							–	.16**	.22**
df								512	507
p								.001	.001
8. HCC								–	-.21**
df									503
p									.001
9. Depression									–
M	2.35	-	20.10	4.63	2.84	1.79	2.73	3.20	2.,23
SD	.70	-	2.59	2.39	1.70	.64	.57	.50	9.56
α	.86	-	-	-	-	.75	.88	.88	.87

Note. Statistical significance: $^{*}p < .05$, $^{**}p < .005$, two-tailed significance test. SAS = Social anxiety symptoms, CC = Culture Competence. Mean and standard deviations for continuous variables. α = Cronbach's alpha. *df* = degrees of freedom.

pooled over the analysis of the 50 imputed data sets.

3. Results

Table 1 shows correlations, degrees of freedom and *p*-values between all included variables, means and standard deviations, and Cronbach's Alpha for the scales.

It can be seen that the mean level of perceived social anxiety was slightly below the midpoint (three) of the social anxiety scale ($M = 2.35$, $SD = 0.70$). The analyses did not show significant gender differences in level of reported social anxiety symptoms. There were small but significant bivariate correlations between social anxiety and age, and between social anxiety and length of stay.

3.1. Associations with pre-migration traumatic events, and acculturation related factors

Seventy-nine percent of the participants reported having experienced at least one traumatic event before migrating, and half of the participants (50.9%) reported having experienced three or more such events. Table 2 shows that pre-migration traumatic events did not correlate significantly with social anxiety.

The URMs who reported higher scores on social anxiety, also reported having experienced more discrimination. Higher HCC and MCC was associated with lower levels of social anxiety (Table 1). All correlations between social anxiety and the included variables were small to moderate, ranging from $r = 0.14$ to $r = 0.43$. The strongest correlation was between social anxiety and discrimination.

3.2. The structural equation model

To examine the multivariate associations between the main study variables and social anxiety, we estimated a structural equation model (c.f. Fig. 1). The fit indices were RMSEA 0.43 (0.41, 0.46), CFI = 0.944, and TIL = 0.947, which indicates an acceptable fit. The supplementary table shows the factor loadings. The SEM regressed social anxiety on the latent traits, depression, discrimination, trauma, heritage, and majority culture competence, as well as on gender, age, and duration of stay in Norway.

Table 2 which shows the coefficients from the regression model in the SEM analysis confirms that none of the demographic variables were strongly associated with social anxiety.

Of the acculturation-related variables, perceived discrimination had the strongest association with social anxiety. MCC and HCC were

Table 2
Regression coefficients from the SEM model.

Predictor	Standardized beta	Standard error	95% CI	*p*
Gender	0.07	0.05	[0.01, 0.14]	0.16
Stay in years	-0.17	0.09	[− 0.28, 0.05]	0.09
Age	0.08	0.09	[−0.03, 0.19]	0.38
Depression (latent)	0.30	0.05	[0.24, 0.36]	< 0.001
Discrimination (latent)	0.39	0.05	[0.32, 0.45]	< 0.001
Pre-migration trauma	0.01	0.05	[−0.05, 0.07]	0.86
Majority CC (latent)	-0.12	0.04	[−0.18, 0.07]	0.008
Heritage CC (latent)	−0.02	0.05	[−0.08, 0.04]	0.62

Note. Latent social anxiety estimated with SEM measurement model, see Supplementary Table 1 for details.CC = culture competence.

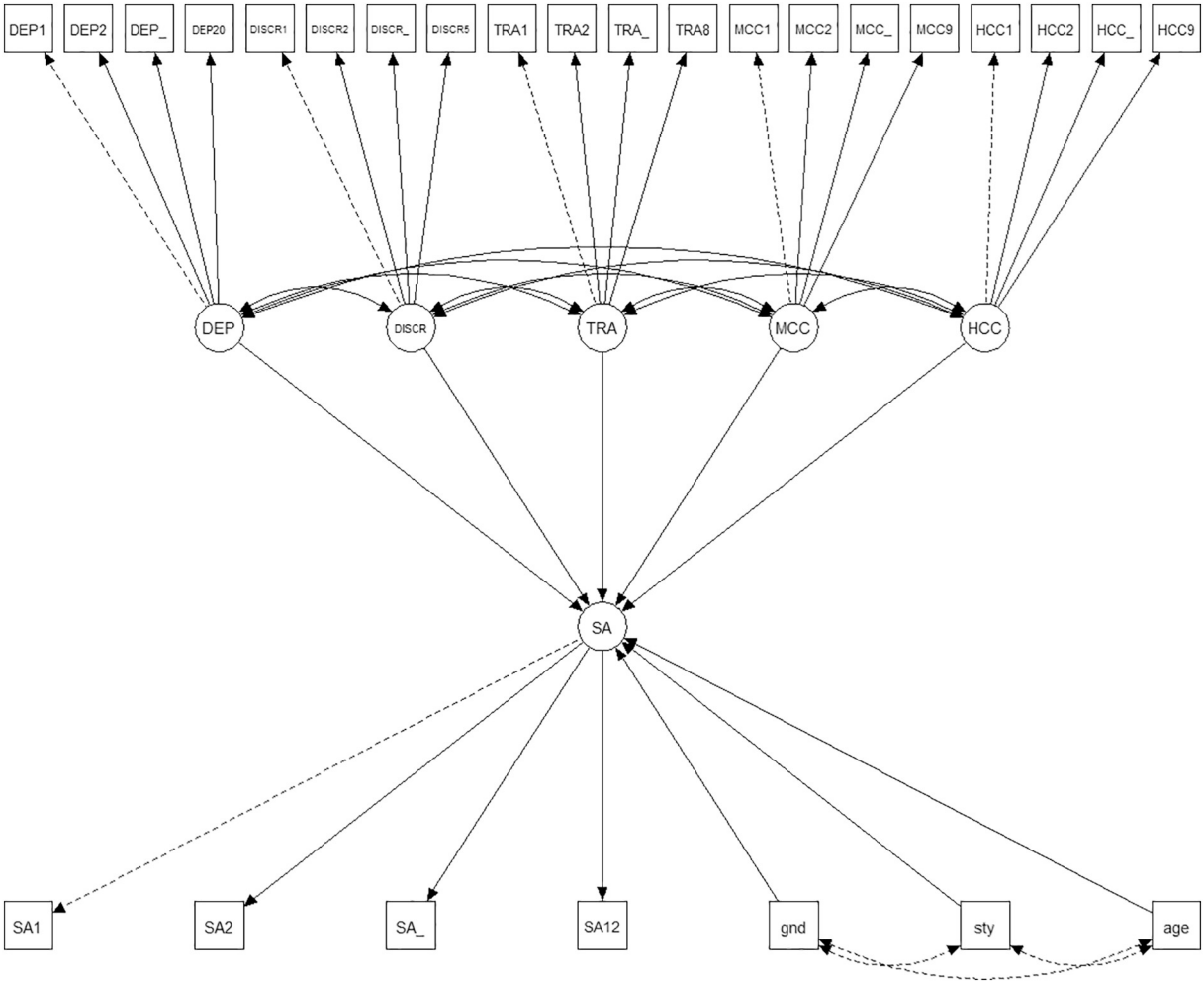

Fig. 1. Note: The Structural Equation Model Incorporating Six Latent Variables, in which social anxiety (SA) was regressed on the latent variables of depression (DEP), discrimination (DISCR), traumatic events (TRA), majority and heritage culture competence (MCC and HCC), and on gender (gnd), length of stay (STY) and age. SA 1- SA_: Social anxiety indicatiors; DEP 1–20: depression indicators; DISCR 1–5: discrimination indicators; TRA 1–8: indicators of traumatic events; MCC 1–9: indicators of majority culture competence; HCC 1–9; indicators of heritage culture comptencen.

negatively associated with social anxiety, whereby the association with of majority culture competence was somewhat stronger.

Notably, the associations of discrimination and depression with social anxiety were about equally strong ($\beta = 0.39$, $p < .001$ and $\beta = 0.30$, $p < .001$, respectively).

4. Discussion

The overall aim of the present study was to get information about social anxiety in refugee and acculturation context among unaccompanied refugees in Norway. The results show that refugees who experience high levels of discrimination experience higher levels of social anxiety. Furthermore, higher levels of MCC are related to lower levels of social anxiety. Notably, the levels of social anxiety do not differ significantly with gender, though a significant effect might materialize with larger samples. The findings add to previous research focusing on depression among URMs by confirming that URMs are similarly vulnerable to developing social anxiety when facing acculturation related stressors such as discrimination. However, individuals who perceive themselves to be culturally competent have lower risk for social anxiety [32,45].

4.1. The level of social anxiety among unaccompanied refugees

Information about social anxiety among URMs is highly relevant for teachers, social workers and others who work with these youths. Social anxiety symptoms may manifest as school refusal, social withdrawal or as hostility towards the new social environment. How these youths are met and interpreted may be of great importance regarding their mental health and ability to adjust to the new society.

The present study included a shortened version of the SAS-A scale with 12 items. Most previous studies on social anxiety among adolescents, however, are based on the full SAS-A scale with 18 items which prevents us from directly comparing the reported levels of SA between the groups [25,40,57].

4.2. The role of gender, age, and length of stay

There was no significant gender difference in the reported levels of social anxiety. A review by Fazel, Reed, Panter-Brick, and Stein [18] on protective and risk factors for immigrant and refugee children, did not find gender as a consistent predictor of internalizing symptoms such as anxiety and depression. The lack of presumed gender differences in depression symptoms has also been found in studies comparing ethnic Norwegian adolescents and immigrant youth [17,43]. One can speculate if such findings imply that unaccompanied refugees and other

immigrant background boys internalize problems to a greater extent than adolescent boys with non-immigrant background. An alternative explanation may be that when individuals are exposed to an accumulation of traumatic events and daily hassles, their gender-based coping resources are undermined. Alternatively, gender effects to indeed exist, but the sample sizes of previous studies were too small to detect statistically significant effects.

In the initial multivariate analytical models, there was a significant relationship between length of stay and social anxiety. However, this effect was reduced and was almost zero in the last model when depression was included. If this is due to multi-collinearity between symptoms of depression and social anxiety, and length of stay, this implies that the presumed increased level of distress after cross-cultural transition due to acculturation stress that decreases over time [11,38], may not be valid in this group. An alternative explanation may be that the association between length of stay and social anxiety is mediated by depression, i.e. longer stay is associated with less symptoms of depression, that again is associated with fewer symptoms of anxiety [5]. More studies are needed to disentangle the effect of the passage of time on social anxiety among URMs.

4.3. Pre-migration trauma, perceived discrimination and culture competence

Adverse life events and traumatic experiences are associated with higher levels of emotional disorders [2,34], including social anxiety disorder [29]. In our analyses, however, experienced pre-migration traumatic events did not have a unique effect on social anxiety. The participants in this study had an average length of stay of 4,6 years. One can argue that the course of time between the experienced traumatic events and the data-collection may result in less reported traumatic experiences and hereunder a lack of associations with social anxiety. Collimore, Carleton, Hofmann, and Asmundson [13] suggest a shared vulnerability model to explain the co-occurrence of PTSD and social anxiety disorder. They suggest fear of negative evaluations as one of these vulnerability factors. Our study does not include separated results on the subscales of SAS-A. Future studies may examine if there are differentiated associations between the various social anxiety sub-scales and pre-migration traumatic events.

Discrimination was a consistent predictor of social anxiety in all models. According to Rapee and Heimbergs [52] model of the maintenance of social anxiety, the mental representation a socially anxious individual has when encountering a situation is based upon long-term memory, internal, − and external cues. The individual's attentional recourses are allocated simultaneously to his or her internal representation and any perceived threat in the environment (e.g., someone laughing). These experiences, in addition to the characteristics of adolescents` development, especially with the cognitive progress in perspective-taking, self-awareness, metacognition, and self-reflection [65] give reason to believe that a socially anxious individual more easily interprets ques. from the surroundings as discriminating. However, the literature shows that both immigrants and refugees are more exposed to overt discrimination based on their cultural and ethnic background than members of the host society [62]. The positive correlation between discrimination and social anxiety symptoms may as well be a product of real discriminating actions and attitudes from the environment, that enhances the fear of negative evaluations, which in turn leads to avoidant behavior.

Experiences with ethnic based discrimination apparently had a stronger association with social anxiety than pre-migration cumulative traumatic exposure. It may be that the majority of the participants had overcome the mental reactions to trauma that has been shown in studies involving URMs with shorter stay in the destination countries over the years [32]. It is a common finding that ongoing post-migration stressors have stronger associations with mental health than pre-migration trauma [41] Perceived discrimination is a consistent predictor of negative health outcomes, including both mental and physical health [24,61] One likely explanation of these relations may be that ethnic based discrimination has a profound, belittling impact on the victim's sense of who s/he is, and of being of less value than the others. The health costs of ethnic discrimination imply that preventing discrimination should have highest priority in multicultural societies. Acculturation hassles may have the extra implication of being associated with their status as immigrants or ethnic minorities.

Culture competence within both the majority and heritage cultural domains showed a negative relationship with social anxiety. The correlation values are considered small, and only MCC remained significant in the multivariate analyses. This may reflect an effect of the ability to master a new set of values, a new language and knowing how to behave in situations involving peers from the majority society. One can argue that greater feeling of mastery in this domain may reduce the anxiety attached to fear of negative evaluations in potentially social-evaluative situations. Clinicians and social workers supporting URMs should take this acculturation resource into consideration in assessment and decisions about interventions for them. Supporting the development of MCC appears to promote reduction in both social anxiety and depression among them.

Altogether, the acculturation variables accounted for 18% of the variance in social anxiety, implying that the acculturation context plays an important part in the development or maintenance of symptoms of social anxiety.

4.4. Limitations

The cross-sectional design of this study limits the possibility to draw clear causal conclusions based on the results. Future longitudinal studies can provide information about this. This study is based on self-report questionnaires, which may inflate the common method variance. Procedures such as reports from teachers, employees in group-homes and significant others in the everyday life of the URMs, might have given additional objective information about the study variables. However, the information asked about in the questionnaires involve personal experiences attached to both resources and challenges. Previous studies have shown that children and youth report more precisely about their affective problems, than teachers and professional caretakers [6].

It should also be taken into account that this study only include data on pre-migration traumatic events. We know that many URMs experience traumatic events during their flight to the country of destination and after arrival. However, in a recent study by Jensen, Skar, Adersson and Skogbrott Birkeland [27] trauma after arrival in the country of destination was not found to predict the sustainment of mental health symptoms.

Unfortunately, none of the ethnic group in this study are big enough to be analyzed separately in regard to differences in culture competence. This, however, would be an important next step in future research.

It may also be noted that the effects of culture competence may overlap with other psychological constructs such as IQ, cognitive and social skills [45]. This should be taken into consideration when interpreting the results.

4.5. Conclusions and future studies

The study provides new and important knowledge about social anxiety among URMs and extends on previous knowledge about predictors of symptoms of PTSD and depression among them. The findings show that factors of the current socio-cultural developmental context rather than pre-migration war-related traumatic events the youths experienced before migration account for variation in social anxiety. The findings give direction to future research to get additional information about social anxiety among these youths, particularly what regards

stability and change in such symptoms. Nevertheless, the accumulation of findings confirming the importance of acculturation-related resources and risk factors, imply that interventions to enhance culture competence and coping with discrimination are warranted and should be developed and implemented.

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