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Abuses, resilience, behavioural problems and post-traumatic stress symptoms among unaccompanied migrant minors: an Italian cross-sectional exploratory study

Nadużycia, rezyliencja, problemy behawioralne i objawy zespołu stresu pourazowego u małoletnich imigrantów bez opieki: przekrojowe badanie rozpoznawcze przeprowadzone we Włoszech

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Abstract

The aims of this study were to explore the type and prevalence of pre-/peri-migratory trauma experiences in unaccompanied minors and the prevalence of mental health problems and resilience. The study included 19 unaccompanied migrant minors aged 16–17 years coming from Egypt, Albania, Senegal, Bangladesh, Gambia, Morocco and Mali. The participants completed self-report questionnaires on emotional and behavioural problems, post-traumatic stress symptoms, abuse and resilience. All the unaccompanied migrant minors in our study were physically and psychologically abused at least once in their life and more than half were sexually abused before or during their migration. The most frequent abuses were: being hit with an object, being punished at school and at home with torture and infliction of pain, being forced to do something dangerous, being insulted, undergoing theft or damage of personal objects, being forced to look at sexual photos or videos and being sexually abused. The scores on post-traumatic stress, depression, anxiety and dissociation are above the clinical cut-off point. Mean scores in the scales of resilience are generally in line with normative data. These scores show that despite their traumatic pre-migratory and peri-migratory experiences of abuse and the clinical psychopathological effects, the minors interviewed proved to have good sources of resilience. Immigration policies however should be based not only on admittance to emergency refuge centres but also on assessing the subjects and providing them with psychological support for the traumas experienced in order to achieve a successful integration process in the host society.

Keywords: unaccompanied migrant minors, behavioural problem, post-traumatic stress, violence, abuse, resilience

Streszczenie

Celem badania była analiza rodzajów i częstości występowania przed- i okołomigracyjnych doświadczeń traumatycznych u małoletnich imigrantów bez opieki oraz występowania u nich zaburzeń zdrowia psychicznego i rezyliencji. Badaniem objęto 19 małoletnich imigrantów bez opieki w wieku 16–17 lat pochodzących z Egiptu, Albanii, Senegalu, Bangladeszu, Gambii, Maroka i Mali. Uczestnicy badania samodzielnie wypełnili kwestionariusze dotyczące problemów emocjonalnych i behawioralnych, objawów zespołu stresu pourazowego, nadużyć i rezyliencji. Wszyscy nieletni imigranci bez opieki uczestniczący w badaniu co najmniej raz w życiu doświadczyli znęcania fizycznego lub psychicznego, a ponad połowa była wykorzystywana seksualnie przed lub w trakcie migracji. Najczęstsze nadużycia obejmowały bicie przedmiotem, karanie w szkole i w domu z wykorzystaniem tortur i zadawania bólu, zmuszanie do wykonywania niebezpiecznych czynności, obrażanie, kradzież lub zniszczenia mienia, zmuszanie do oglądania fotografii lub filmów o treści erotycznej oraz wykorzystywanie seksualne. Wyniki dotyczące stresu pourazowego, depresji, lęku i dysocjacji znajdują się powyżej klinicznego punktu odcięcia. Średnie wyniki w skali rezyliencji pokrywają się na ogół z danymi normatywnymi. Wyniki te pokazują, że pomimo traumatycznych przed- i okołomigracyjnych doświadczeń związanych z nadużyciem i oddziaływaniem psychopatologicznym ankietowana młodzież wykazała dobrą rezyliencję. Polityka imigracyjna powinna opierać się nie tylko na przyjmowaniu imigrantów do ośrodków dla uchodźców, ale również na ich ocenie i udzieleniu im psychologicznego wsparcia w radzeniu sobie z traumatycznymi doświadczeniami w celu osiągnięcia udanego procesu integracji w przyjmującym społeczeństwie.

Słowa kluczowe: małoletni imigranci bez opieki, problemy behawioralne, zespół stresu pourazowego, przemoc, nadużycia, rezyliencja

INTRODUCTION

In the last year, the number of unaccompanied migrant minors (UMs) hosted by Western countries has risen as a result of political and economic instability in non- European countries. In 2015, the number of first time asylum-seekers applying for international protection in the Member States of the European Union (EU) was 1,255,600, which is double that of 2014 (UNHCR, 2014–2015). A significant number of children travel unaccompanied or have been separated from their families while on the move. Last year, 25,000 unaccompanied children arrived in Europe. Some of these minors were separated from their families during long, dangerous journeys, others were sent alone by desperate parents who entrusted them to traffickers and smugglers, while the third group included orphan minors. Before leaving their home countries, many of these children had endured trauma, poverty, and lack of education while others have suffered hardship and danger during their travels. As a result of these experiences, this population is most vulnerable within the asylum-seeker communities (UNHCR, 2015).

A few studies investigating the mental health of UMs have found that they are at greater risk of developing mental health problems than their accompanied peers (Bean *et al.*, 2007) and that they have high levels of post-traumatic anxiety and depressive symptoms, behavioural and emotional disorders, as well as altered prosocial capacities. Post-traumatic stress disorders (PTSD) occur following various traumatic experiences, manifested in multiple chronic ways (Kisiel *et al.*, 2014). UMs appear to have experienced a range of unfortunate, hostile events, including forced migration, violence, stressful resettlement and the loss of primary caregivers (Derluyn and Broekaert, 2007; Heptinstall *et al.*, 2004).

The study by Derluyn and Broekaert (2007), for example, analysed young refugees living in Belgium. This study showed that almost half of the unaccompanied refugee adolescents had severe or very severe symptoms of anxiety, depression and post-traumatic stress. Other research assessed mental health and behavioural problems among UMs (Sanchez-Cao *et al.*, 2013) and also showed that UMs had a high level of emotional symptoms, especially the signs of post-traumatic stress. The support from the family could be an important protective factor but this is lacking in unaccompanied foreign minors. In the case of unaccompanied foreign minors, numerous risk processes against which, however, minors can defend themselves by using personal resources related to the construct of resilience, should be taken into account. Resilience is regarded as a process through which individuals are able to use resources (individual, relational or other) that enable them to adapt to situations considered to place them at risk (Daigneault *et al.*, 2013; Longobardi *et al.*, 2016). Protection factors act as bounce-back factors from the negative outcomes of the traumas experienced. Emotional, behavioural and peer group problems as well as hyperactivity and attention deficit can be manifested in the post-migration stage during which the process of integration in cultural contexts different from their own becomes of primary importance.

The data we obtained underlines the impact on the mental health of UMs. However, to our knowledge, there are still no research studies that investigate whether the minors suffered abuse during their journey. Furthermore, only few studies have been conducted on the resilience of individuals exposed to high levels of anxiety, depression and stress, which could attenuate the impact of such stressful events (Keles *et al.*, 2016). It is necessary to further increase investment in research concerning mental health in this population, because studies on this topic report that UMs may have more mental health problems than accompanied refugee children (Derluyn, 2004; Derluyn and Broekaert, 2007).

AIM OF THE STUDY

The aim of the present study was to investigate the type and prevalence of pre-migratory and peri-migratory (physical, psychological and sexual) abuses, perform a global psychopathological screening highlighting the emotional symptoms, behavioural problems, peer problems, anxiety, depression, post-traumatic stress, anger, sexual concerns and the specific strength and personal resilience among UMs.

MATERIAL AND METHODS

Participants

The sample included 19 UMs (18 males and one female), although at the beginning of the study there were 23. Participants were young adolescents aged 16–17 years, who arrived in Italy between 2013 and 2015 from seven different countries: Egypt (n = 5, 26.3%) Albania (n = 5, 26.3%), Senegal (n = 3, 15.8%), Bangladesh (n = 2, 10.5%), Gambia (n = 2, 10.5%), Morocco (n = 1, 5.3%), Mali (n = 1, 5.3%).

Procedure

The present study is based on the data obtained from interviews in UMs' rehabilitation centres in four different cities of Northern Italy. The residents of four small scale centres (which on average have 20 resident UMs each) were invited to participate in an initial information meeting and the centre's head coordinator and the legal guardians of each minor were given information letters and consent forms. Unfortunately, it was not possible to cover the wages for translators and, whenever possible, the participants were given the questionnaires in their mother tongue and when this was not possible, we decided to provide the questionnaires in a familiar and readable language: English, French, Italian and Arabic. Although the questionnaires were self-report, each interviewee was always supported by a social worker.

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Measures

Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997; Tobia *et al.*, 2011). The SDQ is a well-validated behavioural screening questionnaire. It consists of 25 items, and five subscales, which are: Conduct Problems, Hyperactivity, Emotional Symptoms, Peer Problems and Prosocial Behavior. The items are evaluated on a three-point Likert scale (0 = not true, 1 = partially true, 2 = absolutely true).

The internal consistency, Cronbach alpha coefficient, of the self-report SDQ is 0.80 (Goodman, 2001). Reliability for this study was adequate, with Cronbach's alpha values equal to 0.69, 0.77, 0.71, 0.67 and 0.74 respectively for Conduct Problems, Hyperactivity, Emotional Symptoms, Peer Problems and Prosocial Behavior subscales.

Trauma Symptom Checklist for Children (TSCC; Briere, 1996). Symptoms of post-traumatic stress were measured by this questionnaire, which considers six domains of trauma symptoms (Anxiety, Depression, Anger, Post-Traumatic Stress, Dissociation, and Sexual Concerns) and consists of 44 items evaluated on a four-point Likert scale (from 0 = never to 3 = almost always). The instrument also has two validity scales: Hypo-response and Hyper-response.

	M	*SD*	Range
CYRM			
Individual	3.42	0.75	1.50–4.27
Individual: Personal Skills	3.39	0.93	1–4.80
Individual: Peer Support	3.45	0.80	2–5
Individual: Social Skills	3.45	1.01	1.25–5
Relationship with Caregivers	3.59	0.72	2.29–4.71
Caregiver: Physical Caregiving	3.68	1.26	1.50–5
Caregiver: Psychological Caregiving	3.56	0.73	2.20–4.60
Context	3.44	0.62	2.20–4.30
Context: Spiritual	3.36	1.08	1.33–5
Context: Education	3.58	1.02	2–5
Context: Cultural	3.43	0.71	2.20–4.80
SDQ			
Emotional Symptoms	4.26	1.73	1–9
Conduct Problems	2.78	1.99	0–9
Hyperactivity	3.33	1.78	0–7
Peer Problems	3.61	1.20	2–6
Prosocial Behavior	8.29	1.53	5–10
Total Difficulties	14.06	4.35	5–25
TSCC			
Hypo-response	45.37	7.57	37–61
Hyper-response	60.16	17.42	47–97
Anxiety	59.26	13.15	41–88
Depression	58.63	8.16	48–79
Anger	48.63	8.14	36–64
Post-Traumatic Stress	59.47	9.57	45–81
Dissociation	56.58	11.77	37–81
Sexual Concerns	48.00	10.95	36–87

Tab. 1. Descriptive statistics: means, standard deviations and range of CYRM, SDQ and TSCC

The TSCC has high overall reliability (α = 0.97) and internal validity (α = 0.87) (Briere, 1996). Reliability for this study was adequate, with Cronbach's alpha values equal to 0.78, 0.73, 0.77, 0.67, 0.84, and 0.79, respectively, for Anxiety, Depression, Anger, Post-traumatic Stress, Dissociation, and Sexual Concerns.

ISPCAN Child Abuse Screening Tool Child Institution Version (ICAST-CI; Zolotor *et al.*, 2009). This is an internationally recognised screening instrument designed to identify cases of institutional violence. The ICAST-CI consists of 44 items and contains response modalities that enable the frequency of the episodes of violence to be investigated along with the perpetrators. In this study we asked participants to answer questions related to the migratory journey and the centres. In the study, the three subscales showed good internal consistency (physical abuse: α = 0.74; psychological abuse: α = 0.78; sexual abuse: α = 0.75).

The Child and Youth Resilience Measure (CYRM; Liebenberg *et al.*, 2012). Resilience was measured by the CYRM-28, which is a self-report instrument validated originally with a purposeful sample of 1,451 youths growing up facing diverse forms of adversity in 11 countries. The CYRM-28 consists of 28 items evaluated on a five-point Likert-type scale from 1 = not at all to 5 = a lot and has three subscales. For this sample study, the internal consistency of the three subscales is good: Individual Capacities/Resources (α = 0.79), Relationships with Primary Caregivers (α = 0.82) and Contextual Factors (α = 0.77).

Compliance with ethical standards

Individual informed consent to take part in the research was collected from participants, along with a written consent describing the nature and objectives of the study according to the ethical code of the Italian Association for Psychology (AIP) and with adherence to the requirements of privacy requested by Italian law (Law DL-196/2003). Regarding the ethical standards for research, the study referred to the latest version of the Declaration of Helsinki.

Data analysis

Given the aims of the study, we reported the participants' responses to questionnaire items and analysed the resulting data in order to describe the dimensions studied. We also reported the incidence of the three types of abuse measured by ICAST-CI. These analyses were performed with the statistical program IBM SPSS v. 22 for Windows.

RESULTS

Descriptive statistics

As shown in Tab. 1, we performed a descriptive analysis (means, standard deviation and range) in our total sample of 19 UMs. Concerning resilience, which was investigated

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using the CYRM, it was observed that the mean scores on the three dimensions investigated (Individual, Relationship with Caregivers and Context) ranged from 3.42 (for Individual capacities/resources) to 3.59 (for Relationship with Caregivers).

Referring to behavioural problems, by comparing the results obtained with the cut off score for the normal, borderline and clinical range as indicated by Goodman (1997) for the SDQ questionnaire, we found that the mean scores of all the scales were in the normal range except for the peer problems subscale which was in the borderline range.

In relation to the TSCC (Tab. 1), we found mean scores diverged by more than one standard deviation from the mean of the Italian population (even if they were not abnormal) on the scales for Dissociation (M = 56.58, SD = 11.77), Post-Traumatic Stress (M = 59.47, SD = 9.57), Depression (M = 58.63, SD = 8.16), Anxiety (M = 59.26, SD = 13.15), Hyper-response (M = 60.16, SD = 17.42), while the scores on the other scales were in line with ethnic Italian youth: Sexual Concerns (M = 48.00, SD = 10.95), Anger (M = 48.63, SD = 8.14), Hypo-response (M = 45.37, SD = 7.57).

Considering ICAST-CI (Tab. 2), for each of the three scales (physical, psychological, sexual) we calculated the incidence corresponding to having undergone, at least once during the migration period, at least one of the experiences described in the scale. We found that all participants declared that they had been physically and psychologically abused (incidence = 100% for both). On the sexual abuse scale, almost half of our total sample declared that they had been abused (52.6%). Overall, the most common forms of abuse included being hit with an object, being punished with torture and infliction of pain, being forced to do something dangerous, being insulted, undergoing theft or damage of personal objects, being forced to look at sexual photos or videos and being sexually abused.

DISCUSSION

This phenomenological and psychopathological investigation analysed the pre-migratory and peri-migratory experiences of 19 UMs that migrated to Italy, highlighting their psychological well-being and sources of resilience. We investigated the type and prevalence of physical, psychological and sexual abuses as well as performed a global psychopathological screening highlighting emotional symptoms, conduct problems, peer problems, anxiety, depression, post-traumatic stress, anger, sexual concerns as well as individual strengths and personal resilience.

Regarding the descriptive analysis of resilience, we observed that the children's mean scores obtained on the three subscales (Individual, Caregivers, Context) were on average lower than the mean scores of the normative sample (Liebenberg *et al.*, 2012). However, the mean values on all the scales deviate from the normative scores by less than one standard deviation, suggesting that the UMs presented adequate levels of resilience. The only exception was the mean score of the cluster Context: Spiritual (religion as a point of strength) which is higher for the UMs. Presumably the fact of trusting in God is a protective factor for these UMs. Since their resilience was similar to normative data as regards the other clusters related to the three subscales (personal skills, peer support, social skills, education, culture, physical and psychological caregiving), it is possible that young refugee minors experiencing anguish and violence called on God to help them, something they still do now as protection in everyday problems. Previous research (Sleijpen *et al.*, 2016) has shown that religion can be a strong source of resilience for UMs. In the study by Ní Raghallaigh and Gilligan (2010), for example, young children described religion as particularly important to them. They spoke enthusiastically about God and about relying on him for support. Faith may function as a guide in coping with life, a facilitator in accepting and understanding adversities, a source of practical support (some may address the mosque's Imams or have a religious relationship with God). It acts as continuity of their past, as a distraction, but also as strength to help them through difficult periods and achieve a minimum sense of control over their life (Sleijpen *et al.*, 2016).

Concerning behavioural problems, none of the scores were in the abnormal range, but compared to the provisional banding of SDQ scores (Goodman, 1997), the total difficulties score was in the normal range but tending to borderline. This is probably due to the peer problems scores, which are in the borderline range.

Observing trauma symptoms, we measured high, though not abnormal, scores in the Dissociation scale, Post-Traumatic Stress scale, Depression scale and Anxiety scale. These results corresponded to extensive scientific literature (Baddoura and Merhi, 2015; Bean *et al.*, 2007; Bronstein *et al.*, 2012; Derluyn and Broekaert, 2007; Derluyn *et al.*, 2008; Vervliet *et al.*, 2014).

The results revealed that all participants were physically and psychologically abused, at least once during the pre-migratory and peri-migratory periods and almost half of our sample were also sexually abused. Few studies focus on the descriptive analysis of specific abuses, even though this method could increase the quality of the study on cause and effect relationships, between life events and psychopathological impacts. Although we know that some factors (such as personality, type of traumatic experience) can influence the trauma's effects, our results, in line with other research (Vervliet *et al.*, 2014) suggest that UMs' experiences are marked by multiple traumas, including the separation from their parents. This aspect is particularly important because the multiplicity of traumas can have an extremely damaging effect on mental and physical health. The 19 UMs interviewed generally seemed to show good resilience but the high level of distress symptoms and the high incidence of abuse highlighted the need for clinical attention to this population.

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	Many times	Sometimes	Never
Physical abuse			
Slapped you with a hand on your face or head as punishment?	36.08	36.08	26.3
Slapped you with a hand on your arm or hand?	10.5	47.4	42.1
Twisted your ear as punishment?	0	57.9	42.1
Pulled your hair as punishment?	0	36.8	63.2
Hit you by throwing an object at you?	5.3	62.2	15.8
Hit you with a closed fist?	15.8	52.6	31.6
Kicked you?	15.8	63.2	21.1
Crushed your fingers or hands as punishment?	5.3	26.3	68.4
Washed your mouth with something like soap or put something like pepper in your mouth?	0	15.8	84.2
Made you stand/kneel in a way that hurts to punish you?	10.5	47.4	42.1
Made you stay outside in the cold or heat to punish you?	5.3	26.3	68.4
Burnt you as punishment?	0	5.3	94.7
Put you into hot or cold water as punishment?	0	10.5	84.2
Took your food away from you as punishment?	5.3	26.3	68.4
Forced you to do something that was dangerous?	0	42.1	57.9
Choked you?	0	21.1	78.9
Tied you up with a rope or belt?	0	21.1	78.9
Tried to cut you purposefully with a sharp object?	0	36.8	63.2
Psychological abuse			
Swore at you?	21.1	52.6	26.3
Shouted at you to embarrass or humiliate you?	15.8	36.8	47.4
Called you rude or hurtful names?	5.3	26.3	68.4
Purposely made you feel stupid or foolish?	5.3	42.1	52.6
Referred to your skin colour/gender/religion or culture in a hurtful way?	5.3	36.8	57.9
Referred to any health problems you might have in a hurtful way?	5.3	21.1	73.7
Stopped you from being with other children to make you feel bad or lonely?	5.3	31.6	63.2
Tried to embarrass you because you were an orphan or without a parent?	0	21.1	78.9
Embarrassed you because you were poor or unable to buy things?	10.5	36.8	52.6
Stole or broke or ruined your belongings?	0	57.9	42.1
Threatened you with bad marks that you didn't deserve?	0	42.1	57.9
Sexual abuse			
Touched your body in a sexual way or in a way that made you uncomfortable? By "sexual way" we mean touching you on your genitals or breasts	0	15.8	84.2
Showed you pictures, magazines, or movies of people or children doing sexual things?	0	26.3	73.7
Made you take your clothes off when it was not for a medical reason?	0	21.1	78.9
Did anyone make you have sex with them?	0	26.3	73.7
Did anyone make you touch their private parts when you didn't want to?	0	5.3	94.7
Did anyone at school (work) give you money/gifts to do sexual things?	0	10.5	89.5
Did anyone involve you in making sexual pictures or videos?	0	0	100
Did anyone kiss you when you didn't want to be kissed?	0	21.1	78.9

Tab. 2. Experiences of abuse and punishments suffered by UMs

It is likely that the prevalence of these traumatic experiences influenced the level of current clinical problems such as depression, anxiety, dissociation and post-traumatic stress symptoms, even though the subjects seemed to have an adequate resilience level. The migration journey is therefore dangerous for physical safety (risk of drowning at sea, violence, torture, etc.), but it is also a mental health risk factor in UMs.

Our study is far from being exhaustive, considering the small sample, not representative of the total population of UMs coming to Europe in the last two years. This study has significant limitations also due to the sample characteristics and the communication problems that limited the validity of data collection. Minors may have misled interviewers on their age and personal information, once in Europe, to take advantage of immigration policies (UNHCR, 2014). Therefore the youths interviewed were selected by the health tutors of each centre as suitable participants for our project, excluding psychiatric minors or those with a more serious and acute symptomatology.

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CONCLUSIONS

Our findings appear to be interesting and also unexpected. The most positive results concern the levels of resilience in our samples, despite their pre-migratory and peri-migratory experiences of abuse. Future studies with comparative samples could be performed to highlight the psychopathological effects of early separation from primary caregivers and migration to another country.

UMs are the most vulnerable part of the migrant population, needing extra attention due to their age. Since there is no protection before and during their journey, it is important to establish a protection service for children and adolescents in the countries of arrival, to take responsibility for them. In the near future, it is essential to increase research on the migration experiences of UMs in order to analyse this phenomenon in greater detail and implement focused interventions, supporting and encouraging them to hope for a better future.

Conflict of interest

The authors do not have any financial or personal connections with other persons or organizations, which might negatively affect the content of this publication and/or claim authorship rights to this publication.

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