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Mental distress in unaccompanied refugee minors: a cross-sectional study

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Summary

Background. Evidence from a growing number of studies indicates that unaccompanied refugee minors (URMs) have a higher prevalence or severity of mental distress than the general population, and this is generally attributed to the presence of traumatic events. In this observational study, we compared 40 male URMs with 22 male minors living with a family (FLMs) in Friuli Venezia Giulia region.

Methods. Study participants were administered validated psychodiagnostic tests: Childhood Traumatic Events Scale; Early Recognition Inventory for the retrospective assessment of the Onset of schizophrenia Checklist (ERIraos-CL) and Youth Self Report 11/18 (YSR). URMs achieved higher scores in ERIraos-CL non-psychotic symptoms in the previous 6 months (M-W = 2.849, p = 0.004). Similarly, the YSR score on the "social withdrawal" scale was significantly higher in the URMs than in FLMs (p = 0.013). The higher YSR scores in URMs were independent of the severity of traumatic events, except for the somatic disconfort scale, that did not differ between groups after controlling for trauma score.

Conclusions. In our study, significant differences between URMs and FLMs in mental distress were identified. Traumatic events in URMs were associated with increased somatization and internalizing symptoms and difficulties at the social level.

Key words: refugee, minors, distress, social withdrawal, trauma

Introduction

Migration in adolescence can represent a stressful event that threatens personal identity and can therefore be a risk factor for the development of mental distress. Unaccompanied refugee minors (URMs) are minors who are abroad without an accompanying person who is entitled to legal custody [1]. According to the growing volume of studies published in the literature, there is evidence that young immigrants in general, and unaccompanied minors in particular, undergo various traumatic events both at their place of origin and during their journey. Several studies have found a risk of post-traumatic stress disorder (PTSD), depression or anxiety disorders in this particular category of subjects. When compared with local adolescents and accompanied minors, URMs must have experienced more traumatic experiences; moreover, separation from a significant person may in itself be an independent risk factor for the development of PTSD [2-6].

The importance of trauma was highlighted by Mollica et al. already in the late 90s [7,8]. They reported also a dose-effect relationship between the number of traumatic events and the development of PTSD. The symptomatology seems

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to fade over the years in relation to the amelioration of social conditions and resilience of these children, as confirmed by the study conducted by Montgomery in 2010 after a 9-year follow-up on arrival in the host country [9]. At the same time, it has been seen that in the first years after migration most URMs do not show any noteworthy improvement in their state of mental health [10].

Huemer et al. (2009) concluded that unaccompanied minors represent an extremely vulnerable group suffering from psychiatric morbidity more than the general population [11]. This has also been confirmed by other studies that have shown that URMs have a higher prevalence or severity in psychopathology than the general population or groups of accompanied minors [12-15].

The main objective of this study was to compare the prevalence of mental distress in a group of URMs with that of a group of minors resident in the region and living in a family (FLMs); a secondary objective was to explore whether traumatic events in URMs' life were associated with a worsening of some aspects of psychopathology.

Materials and methods

In this study, we compared a group of male URMs aged between 14 and 18, who were living in a residential educational facility (the "Civiform") located in Cividale, with a group of Italian or foreign males of the same age range who were living permanently in the region with families and who attended professional training courses offered by the "Civiform" institute. Cividale is a small town with 11,204 inhabitants located in Friuli Venezia Giulia, a North-Eastern Italian region bordering Austria and Slovenia.

Participants were recruited voluntarily after the presentation of the study project. The choice to include only males was based on the observation that the large majority of the URMs arriving in our region are male.

Participants were asked to undertake an individual anamnestic interview, in the presence of a cultural mediator if necessary, and a psychometric test evaluation. Recruitment and data collection were carried out from 1 December 2018 to 30 June 2019.

Inclusion criteria were to be an adolescent living or studying at the Civiform institute and to receive written informed consent from the parents/legal guardian. Exclusion criteria were mild/severe intellectual disability or a medical condition that could affect mental status.

The following psychodiagnostic tests were administered to each group:

- *Childhood Traumatic Events Scale* [16] is a self-report questionnaire which includes items investigating six types of traumatic events occurring before the age of 17 years: death of a family member or close friend, separation or divorce of parents, traumatic sexual experiences, experiences of non-sexual violence, serious illness or physical trauma, other unspecified trauma. Subjects were asked to rate the traumatic intensity of each event on a scale from 0 to 7 (0 = non-exposure; 1 = not at all traumatic; 4 = moderately traumatic; 7 = extremely traumatic). Moreover, the subject had to report whether in the traumatic events were involved other people;
- ERIraos-CL (*Early Recognition Inventory for the retrospective assessment of the Onset of schizophrenia - Checklist*) [17] is a structured interview consisting of 17 items: the first 13 items investigate non-psychotic symptoms in the last 6 months (social withdrawal, depression, lack of energy, nervousness, suspiciousness); items 14 to 17 investigate specific psychotic symptoms in the lifetime (hallucinatory or thought disorders);
- *Youth Self Report 11-18* [18], a questionnaire used for adolescents between 11 and 18 years of age, composed of 112 items, grouped in eight syndromic subscales: "withdrawal", "anxiety", "somatic complaints", "social problems", "attention problems", "thought problems", "deviant behavior/non-observance of the rules", "aggressive behavior". The Withdrawal, Somatic Complaints, Anxiety/Depression subscales form the Internalizing Scale, and the Deviant Behavior, Aggressive Behavior form the Externalizing Scale. The YSR scores were reported as standardized t-scores, that have a mean of 50 and a standard deviation of 10.

Statistical analysis

The scale scores were compared between URMs and FLM using Mann-Whitney test, because the assumption of normality of the distribution of variables and/or homoscedasticity did not hold. Chi-square test or Fisher's exact test were used to compare categorical variables between groups. Multiple Poisson regression models were used to compare the scores between the two groups after controlling for the trauma score.

All statistical analyses were conducted using IBM SPSS,

Table I. Age and country of birth of URMs and FLMs.

			URM	FLM
Mean age, (SD)			16.6 (0.5)	17.0 (1.4)
Country of birth	Afghanistan	N (%)	3 (7.5)	0
	Albania	N (%)	7 (17.5)	0
	Other European country	N (%)	0	1 (4.5)
	Bangladesh	N (%)	3 (7.5)	1 (4.5)
	Kosovo	N (%)	7 (17.5)	1 (4.5)
	Italy	N (%)	0	18 (81.8)
	South-American country	N (%)	0	1 (4.5)
	Pakistan	N (%)	20 (50.0)	0
Total		N (%)	40 (100.0)	22 (100.0)

Table II. *Childhood Traumatic Events Scale*. Frequency of traumatic events.

	URM		FLM	
	N	%	N	%
Death of a family member or close friend	24	60.0%	14	63.6%
Separation or divorce of parents*	5	12.5%	10	45.5%
Traumatic sexual experience	1	2.5%	0	0.0%
Violence-aggression**	13	32.5%	3	13.6%
Serious illness or physical trauma	6	15.0%	2	9.1%
Other unspecified trauma	10	25.0%	7	31.8%

** p = 0.006; ** p = 0.081.*

version 25 (SPSS Inc., Chicago, IL, USA). The significance level was set at 0.05.

Results

Participants included 40 URMs and 22 FLMs male minors (Tab. I). The age distribution was similar in the two groups (M-W test = -1.386, p = 0.166). The large majority (65%) of URMs were from Pakistan, Bangladesh or Afghanistan, and the remaining 35% from Albania or Kosovo. On the contrary, 18/22 (81.8%) of FLMs were Italian and the other four from Bangladesh, South America or Europe.

Most participants experienced at least one trauma (URMs: N = 31, 77.5%, FLMs: N = 20, 90.2%) as detected using to the Childhood Traumatic Events Scale (Tab. II). No significant differences between the two groups were found concerning the experience of bereavement, sexual violence, diseases and/or serious injuries or other unspecified traumas. With regard to physical aggression, 13/40 (32.5%) of URMs *vs* 3/22 (13.6%) of FLM reported that they had suffered an assault in their lives (Fisher's exact test, p = 0.081), and 11/13 (84.6%) URMs and 2/3 FLM considered this experience highly traumatic. Still, the FLMs had higher scores on the separation scale, which may be related with some degree of sufferance (M-W test = -2.723, p = 0.006).

Overall, there were no significant differences in the total trauma score (the sum of ratings of the severity of the different traumas experienced), however trauma sharing was more frequent among FLM (50% *vs* 22.6%, chi-square test = 4.1, p = 0.043).

As to ERIraos-CL, significant differences between groups were found concerning non-psychotic symptoms, that were more common among URMs (M-W = 2.849, p = 0.004, Fig. 1), while specific psychotic symptoms (perception/perplexity, paranoid ideas, interference of thought, hallucinations) had a similar frequency in URMs and FLMs. The differences between the groups in non-psychotic symptoms remained after controlling for the trauma exposure.

Lastly, concerning the Youth Self Report questionnaire (YSR), the total score and the subscales scores measuring aggressive and deviant behaviours (externalizing

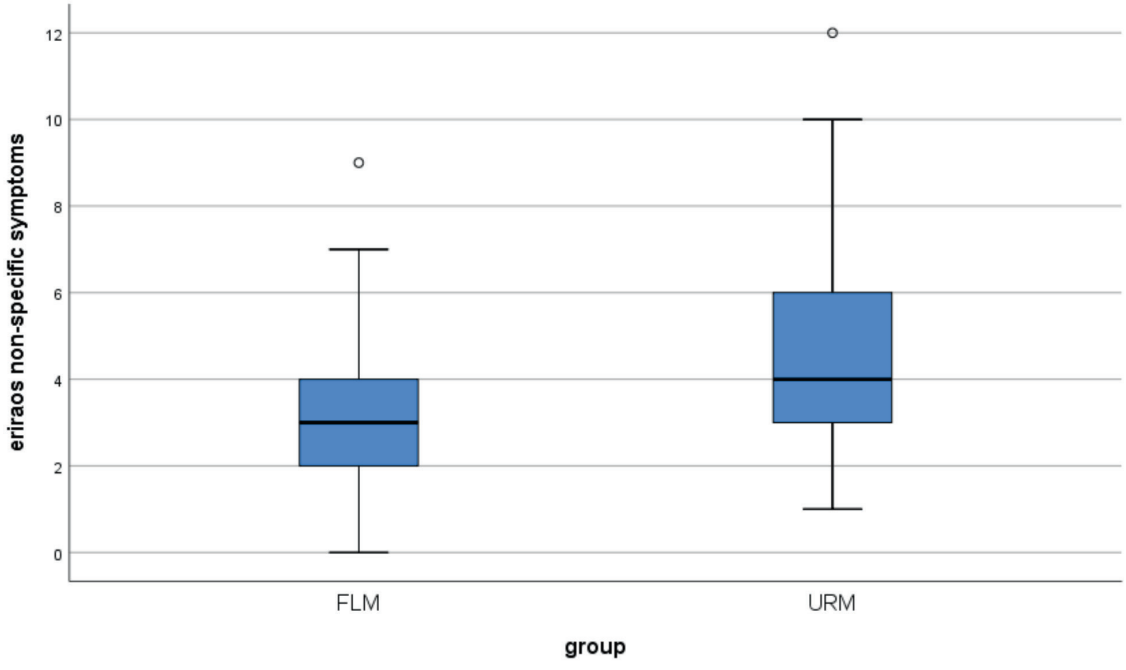

Figure 1.
ERIraos-CL non-psychotic symptom score in the last 6 months.

Table III. *Youth Self Report* questionnaire.

	URM		FLS		p
	Mean	Standard deviation	Mean	Standard deviation	
Anxiety	60.3	8.2	60.3	9.7	0.802
Withdrawal	64.3	8.1	59.0	9.9	0.013
Somatic complaints	55.3	6.4	58.5	7.8	0.026
Social problems	56.1	7.2	57.2	6.4	0.566
Thought problems	54.2	6.8	57.1	7.9	0.062
Attention problems	54.1	8.2	55.9	7.7	0.058
Internalization	60.3	8.5	59.5	9.7	0.632
Deviant behaviour	54.2	6.3	59.1	7.2	0.003
Aggressive behaviour	54.2	8.5	58.0	9.5	0.015
Externalization	48.8	10.8	57.1	10.3	0.003
Total	45.9	9.6	51.8	10.0	0.015

scale) and somatic complaints were significantly higher in the FLM group (Tab. III). Apart from somatic complaints, they remained significant after controlling for the trauma score. On the contrary, the withdrawal scale score was higher in the URMs group (M-W test = 2.472, p = 0.013), even after controlling for trauma score.

In a secondary analysis focused on URMs and comparing individuals with and without traumas, minors experiencing at least one trauma had significantly higher scores on internalization (M-W test = 2.161, p = 0.031) and social problems (M-W test = 2.373, p = 0.018) compared with those who did not experience a trauma.

Discussion

Several studies on the URMs have shown that these subjects show a greater mental distress than immigrants living in families and native children [14,19,20]. These studies generally focus on traumatic events occurring during the migratory journey, which probably explains the beginning of a clinically significant psychopathology, in particular PTSD. The literature agrees with the hypothesis that unaccompanied minors tend to suffer more from specific symptoms attributable to some common mental disorders: post-traumatic stress disorder, major depressive disorder and anxiety disorders. In our study we analysed symptomatic dimensions rather than fully diagnosed disorders, because we selected apparently healthy young people who were not receiving psychiatric treatment at the time.

Considering the trauma scale, the presence of "non-sexual physical violence/aggression" in the URMs group was unfortunately frequent (one third of subjects) and corresponded to a load of high traumatic intensity. URMs who have suffered assaults claimed that the event was often attributable to their own life context, such as family wars over property, and this has happened several times. It was often presented as a reason to choose migration. Otherwise, in the control group this type of trauma was not frequent and was mostly caused by dynamics that are not culturally explainable or acceptable.

Our results indicate that a traumatic experience is not necessarily correlated with mental distress. The between-group differences in non-psychotic symptoms was independent from previous traumatic events. As for YSR scores, withdrawal remained more compromised in the URMs group even after controlling for the trauma score.

Comparing our results with the literature, on the one hand our results are in line with it, due to the high scores of URMs in non-psychotic symptoms, on the other hand the importance of the traumatic event in the genesis of mental suffering was not always confirmed. It is interesting to note that in the group of URMs the traumatic event seemed to affect only the dimension of somatic complaints. This means that if a URM has suffered a trauma, it transmits the discomfort on a somatic rather than psychological level. This evidence is confirmed by the literature that analyses the relevance of traumatic experiences on somatization processes [21].

Note that the secondary analysis conducted only on the group of URMs seems to make the overall picture more complicated. In this group the presence of a trauma produced changes in the expressiveness of mental suffering, favouring a greater frequency of internalizing symptoms together with difficulties at the social level.

In conclusion, we have found that URMs show a higher presence of non-psychotic symptoms than controls. The presence of trauma in minor refugees seems to favour some symptomatologic expressions, such as withdrawal, somatization, a greater presence of internalizing symptoms and social difficulties. On the contrary, at least in this sample, the presence of deviant and antisocial symptoms was not confirmed. This seems to be a relevant data also in terms of treatments and is somehow in contrast with the scenario of social danger of the migrant that is often proposed.

We are aware that this study has many limitations: the sample size is low; there was a selection bias (voluntary recruitment; only one recruitment centre that cannot represent the general population); it is a cross-sectional and not prospective study; a recall bias was possible (especially related to traumatic events); there were linguistic and cultural barriers (even if the help of the cultural mediator was possible). In addition, the group chosen as a comparison did not prove to be symptoms free, but rather showed a certain degree of mental suffering: it is possible that the comparison with a group of minors living in nonseparated families would have produced different results.

Despite these limitations, this study may have the merit of

exploring an increasingly important issue for mental health services in our territory, namely the request for assistance to young immigrants without a social support network. It becomes essential to focus on preventive interventions to be implemented in favour of this population, whose fragility emerges from our research and is confirmed by a growing international scientific literature. In fact, it is important to recognize the discomfort of adolescents when it still expresses itself with subthreshold symptoms, before it turns into a real psychopathology.

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