

# Culture and Migration: Psychological Trauma in Children and Adolescents

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Elizabeth Batista-Pinto Wiese<sup>1,2</sup>

## Abstract

Important development in the knowledge of migration, forced migration and asylum-seeking, its association with psychological trauma in childhood and adolescence, as well as in the intergenerational legacies of trauma in the family, have occurred in recent years. Trauma must be considered within a culture, because it is the cultural context that shapes the life experiences including the ones that are considered traumatic. Certainly migration has an impact on the family and a massive interference in the child's psychological development and mental health, which can be severe if related to acculturative stress or traumatic states. Young infants can develop insecure, ambivalent, or disorganized attachment; their lack of basic trust in their surroundings can result in negative effects in their exploratory behavior and autonomy, which may be reflected in disorganized behavior. Older children and adolescents may present increased externalized aggressive behavior and/or internalized anxiety and depressive behavior. Therefore, the models for trauma treatment in childhood must integrate the individual's actual psychological development with elements of the original and host cultures, including societal belief systems, community, neighborhood, family, and individual aspects. The way these elements interrelate and the risk and protective factors related to the child's resilience and psychological resources to overcome primary or secondary traumas must also be taken into account, are discussed in depth in this article.

## Keywords

culture, migration, psychotrauma, trauma, childhood

“...despite the tears of trauma, children's souls are full of hope.”

(Lewis & Ippen, 2004, p. 41)

Every year, thousands of migrant and refugee families seek mental health treatment in countries of the European Union. Many of these families, from different origins and cultural backgrounds, are victims of war, ethnic conflicts, economic disasters, political caprices, or international migratory movements, coming to Western Europe in search for a better present and future. The condition of being a migrant is often burdensome, especially in the case of forced migration of asylum seekers and refugees, and the combined effects of these experiences can result in problematic consequences for the mental health of parents and children, bringing extra complexity to their psychological condition, and having negative effects on parents–children interaction (Wiese & Burhorst, 2004, 2007).

This article aims at scrutinizing some aspects of the relationship between culture, migration, acculturative stress, and psychological trauma in childhood and adolescence. First, social and psychological aspects related to voluntary and forced migration are considered, discussing the specific consequences they bring to parenting and filiation. Second, acculturation and assimilation processes related to migration are discussed, focusing on the way they can be affected by

traumatic experiences, which can be associated especially with forced migration, leading eventually to the development of Posttraumatic stress disorders in children and adolescents. Finally, some relevant aspects of the psychological assessment and treatment of these disorders in migrant and refugee children and adolescents are discussed.

## Culture and Migration

Migration<sup>1</sup> is a sociological event which takes place in a historical and political context. The reasons for migration vary, and in general, when someone moves to live in another country, he or she faces economic, linguistic, administrative and legal difficulties, and often social exclusion.

The migrant has left his original place, where he built the first and fundamental cultural and psychological identifications, moving to another place, in search of a better life. As

<sup>1</sup>Roosevelt Academy, International Honors College of Utrecht University, Middelburg, the Netherlands

<sup>2</sup>Institute of Psychology, University of Sao Paulo, Brazil

### Corresponding Author:

Elizabeth Batista-Pinto Wiese, Noorwegenlaan 9, 4318 CB, Brouwershaven, the Netherlands  
Email: [e.wiese@roac.nl](mailto:e.wiese@roac.nl)

a consequence, he or she can suffer the loss of the primordial world of his existence, to face a long, and frequently difficult process of acculturation to the new culture. Thus migration can be seen as a courageous and complex act, which affects the person's life, bringing many changes in the family history and in the individual cultural identity.

Before discussing the development of cultural identity, especially in children and adolescents, some basic questions will be reviewed: What is culture? How does culture influence the person's psychological functioning? How is culture transmitted?

To answer the first question—What is culture?—we adopted the definition from Bates and Flog (1990): "Culture is a system of shared beliefs, values, customs, behaviors, and artifacts that members of a society use to cope with one another and with their world, and that are transmitted from generation to generation" (p. 466).

In reply to the second question—How does culture influence the person's psychological functioning?—we point to the ideas of Droždek (2007) that "culture impacts the regulation and expression of emotions, sets limits of tolerance of specific and strong emotions, and provides lay theories and strategies about handling emotions" (p. 7).

Adding to these ideas, Lewis and Ippen (2004) explained that culture provides the "... psychic structure for relationships among members of a social group while simultaneously helping them to make meaning of the physical world" (p. 13). Besides, culture also provides a *cultural envelope* around the person, which is a collective identity that can bring magical and powerful components of the group, assuring, since early childhood, the maintenance, countenance, inscription, and transmission of basic cultural elements, through the child's interaction with the parents and other attachment and role-model figures, modeling the child's cultural-identity development.

Therefore migration, with its profound influences on family history, can cause ruptures in the external cultural framework which, as consequence, can also cause ruptures in the internal psychological cultural framework of the person (Devereux, 1970; Nathan, 1986), affecting his or her psychological and cultural identity. Due to the mutual influence between cultural and psychological structures, after migration the person's reference systems and categories used to understand the world and the relationships are no longer the same, determining profound individual identity changes, and even modification in the cultural transmission from parents to children.

To discuss the third proposed question—How is culture transmitted?—one must understand that culture is transmitted to the new generation in the day-to-day interactions with adults and other children who dispose of a complex cognitive, emotional, social, and behavior structure, which will determine an *explicit and implicit knowledge*, common to all individuals of a given group. This structural cultural knowledge is transmitted from one generation to another, throughout the processes of parenting and filiation, also called transgenerational transmission.

Parenting, or the complex process of becoming a parent of a specific child, is based on the recognition of the child as the bearer of a psychic heritage, which holds the parent's culture, conscious dilemmas, and unconscious conflicts that can exist in the family line: the transgenerational mandate. This mandate has as metaphorical paradigm—*The Tree of Life*—a transgenerational transmission which tends to be a family myth that defines the axis of the life mandate imposed on the descendant (Lebovici, 1996, 1998). This heritage is transmitted to the child through the care and the daily parent-child interactions, being the child's reality built on his or her first relationships with the caretakers.

In the parents-child interaction real and fantasmatic exchanges happen, and complex and reciprocal identifications are produced, in which the experience modifies the symbolic and vice-versa. These early interactions are constituted (Stern, 1985, 1995) by series of operational acts (care techniques), corporal and sensorial acts (mother-infant physical contact), language acts (words said to the child), and psychic acts (consisting of maternal representations). This circle of influences is quickly expanded to the father and other attachment figures for the child.

To mirror the parenting process, explained above, comes the filiation process, of being a son or daughter of specific parents. This part of our identity is also developed through the child-parents interactions, in which the child progressively acquires his or her psychological and cultural structuring. These two structures—psychological and cultural—are developed concomitantly, and although they are independent, they maintain permanent exchanges with one another. The bond these developmental processes establish in childhood, linking psychological and cultural elements, is kept vivid and operational throughout the person's existence, due to the permanent exchanges between the individual and his or her cultural environment (Nathan, 1986).

Therefore, to bring a child into the world is, for migrant parents, an important step in their own migratory history. Pregnancy and birth periods are, for example, especially vulnerable ones for these parents, as they are mostly affected by the migration plans in their minds (reasons, conditions, experiences, feelings, hopes). Other important elements that influence the adjustment to the culture are the following: The number of years spent in the new country; the cultural differences between the country of origin and the new one; the social, educational, and economic conditions; and the support (or lack of support) from the partner, family, and community.

Through their child, the migrant parents will possibly have more opportunities for contact with the host society, its culture, and demands. This exposure places them in a paradox: A process of being *parents among parents* in a new cultural and social group that possibly has different values and practices related to educating and raising children than those of their original culture (Sayad, 1999). As a consequence, migrant parents can be torn from their original group values. Then they also have the challenge of adjusting to the host society,

which often expects them to behave the same way as the other members of that society. This expectation in the case of occidental Western societies in general includes the challenge of raising the children in a culture with predominantly individualistic cultural values, which can bring extra conflicts when they come from cultures of predominantly collective values.

Therefore, migration brings important modifications in the psychological and cultural developmental processes of children, adolescents, and adults, affecting the individual's cultural identity. In general, after some time, migrants do not maintain their original culture in its totality, as they bring mainly local or regional variants, which include a selection and mixture of cultural elements (Berting, 2009). Besides, in case of migration, the parents exposed to a new culture in the acculturation process, can lose their confidence in the external social and cultural framework, and may feel that the outside world is no longer safe, and even develop a certain degree of confusion in the way they perceive the world (Moro & Nathan, 1995); as a consequence, these parents may transmit their kaleidoscopic perception to the child, generating anguish and insecurity.

Therefore, it can be stated that the parents' migration brings an extra vulnerability factor for the child, because its being *in between* different cultures, frequently with conflictive values and beliefs, may result in difficulties in the cultural identity development, which can bring an acculturative stress or be traumatic to children and adolescents, with extra risks for their psychological development.

### The Migrant Child's Acculturation Process

After migration, the person's psychological adjustment to environmental and cultural changes has the tendency to take place progressively. This adjustment process has the aim to move to a less conflicting position in between the culture of origin and the new culture.

Acculturation can be defined as a prolonged contact between individuals or groups of different cultures and the resulting change, such as the adoption of certain aspects of either or both cultures (Sam & Berry, 2006). The acculturation process occurs after migration or even after a temporary stay in another country, when people need to make adjustments to the culture of the host country. So it presumes an interactive process of change, which involves both the migrant and the host society.

For some people, the acculturation process can be smooth and quick, whereas for others it can take very long and imply struggling with stress, eventually even leading to the development of health problems. These individual differences in the acculturation process seem to be related to demographic factors, like age, intrapersonal factors, as personality and attitudes, and interpersonal factors, like social and cultural contexts (Wiese & Burhorst, 2007).

For Berry (2005), the different strategies for acculturation have the following components: Attitudes and behaviors. Attitudes are related to the person's opinions and beliefs, whereas

behaviors refer to the daily life practices. As these two components often do not harmonize, individuals often experience a discrepancy between their opinions/beliefs about, and their behaviors toward life events.

Berry (2005), in 1970, proposed descriptors for the adjustment process of migrants to a new country, its culture and social life, including fundamental acculturation processes, which have several layers and phases: Integration, assimilation, separation, and marginalization. Integration is a strategy that implies the maintenance of the original culture, whereas in parallel, interacting with the host culture. Assimilation is the complete adoption of the host culture, without the maintenance of the original cultural identity. Separation implies in holding on strongly to the original culture, rejecting the host culture. Marginalization defines the position of having no possibility to keep the original culture, but, at the same time, not developing the cultural identity of the host culture. These strategies are important, as they contributed a great deal to the research of adjustment processes in immigrants (Ward, 1997).

For the migrant, acculturation can be a mourning process, because it can imply a loss of what is familiar, such as language, home, relationships, places, and weather. The acculturation process for children and adolescents, in general, is much more rapid than for adults, and can lead to a strong integration to the host society, incorporating practices and values of the new group.

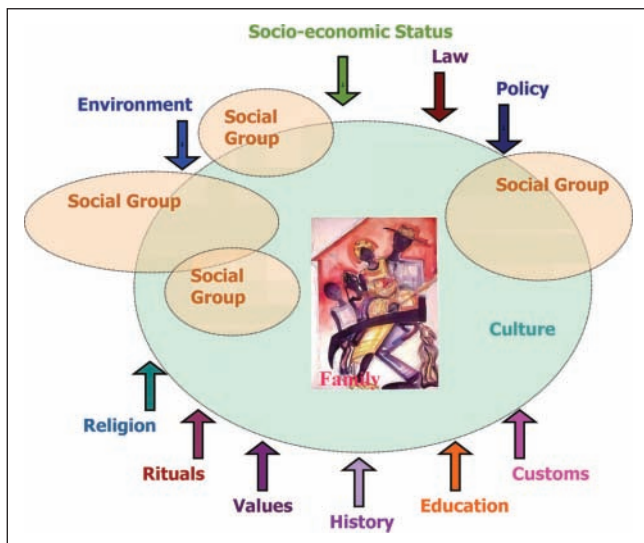
In the integration process, the perceived difference between the original and the host culture, termed as cultural distance, seems to interfere in the cultural adjustment process (Shupe, 2007), but its effects in children can have great variability. In this particular aspect, it seems that the parent's attitudes toward the host culture are also very important, and can favor or make more difficult the development of the new cultural identity for the child and adolescent (Sam & Berry, 2006).

Besides cultural distance, also social factors and personality characteristics seem to influence how individuals cope with the stressors in their environment (Taylor, 2009). The culture learning theory places emphasis in the learning experience of living in a new country, rather than in the adjustment to it (Furnham & Bochner, 1986). This theory implies that social skills are basic elements in the adjustment of a host culture, and consequently social support systems are vital in the acculturation process.

Cohen and Wills (1985) also emphasized social support as an important element to buffer the negative effects of stress. In addition, social support can also have an effect in alleviating the physiological damaging of stressful experiences (Cohen & Wills, 1985), and existing stress can be exacerbated by lack of social support (Taylor, 2009).

Figure 1, illustrates graphically some influences on the acculturation process.

Acculturation is, in general, a long and difficult adjustment, which often leads to (and frequently aims to achieve) some form of assimilation to the new culture, in a process that can take even several generations. This process has many phases, characterized by different levels of integration in the



**Figure 1.** Elements that influence the cultural identity

culture—including bi and multiculturalism—in several aspects of the cultural and social life. Eventually, if the acculturation process leads to a complete assimilation of a new generation, it includes the establishment of a new cultural identity (presupposing the loss the original culture of the parents), with its ethnic identification, values, language, beliefs, and practices.

The acculturation process to a new culture, which is mostly done by the first and second generations, involves complex interactions in several dimensions: Affective, cognitive, social, and cultural. It can bring many difficulties and psychological suffering to parents and children, but can also give opportunity to develop new coping strategies and creative solutions, as well as foster resilience.

In the different aspects of the acculturation process parents frequently have more difficulties in, for example, mastering the new language, presenting a strong accent while speaking it, and maintaining their original eating habits and customs, as well as many other aspects which show their strong relationship with the culture of origin. Children that are born in the host country or migrated very young, frequently speak the language without accent, and closely identify with the host culture, which can eventually lead to rejecting aspects of their parents' original culture.

It must be emphasized that the acculturation process ideally should include democratic participation, with equal opportunities and rights, and the acceptance of cultural diversity in an atmosphere of mutual respect and tolerance (Hollands, 2001). Unfortunately, even in Western Europe, this is not always the case (Wiese & Burhorst, 2007).

The acculturation process turns out to be even more complex when the forced exile of refugees is considered. Mestheneos and Ioannidi (2002), in a study carried out in fifteen member states of the European Union, by the European Council on

Refugees and Exiles (ECRE) Task Force on Integration, proposed that integration should be measured using objective indicators to compare the refugees' position with that of the dominant majority, including access to jobs, education, housing, political representation, and participation. These authors outlined the obstacles for refugee integration: long delays in the legal asylum-seeking procedure before obtaining refugee status; loss of social status as they have to learn the local language and have to be re-qualified or have to learn new social and professional skills; the lack of consideration of cultural differences and different forms of racism and assumptions of superiority; dealing with welfare state systems with either very bureaucratic or inflexible procedures, overgenerosity or enforced dependence; living in shared houses or marginal neighborhoods; and barriers in finding permanent employment in jobs commensurate with their abilities and training.

If acculturation, with its doubts and conflicts, is a very complex process for adults, its implications are even more complicated for children and adolescents, because the fact that they are in a period of intense change in their psychological development makes them more vulnerable (than adults) to the influences of the external environment, especially when exposed (primarily or secondarily via parents) to stressful or traumatic experiences. Therefore, during this process, children can quite often have their development positively or negatively affected in different levels and aspects, with important consequences for their future. Besides that, children from migrant parents have the difficult challenge to build a bridge between the former family culture and the host culture, and to develop a new cultural identity, with bicultural or multicultural influences.

It is, therefore, not easy to measure the impact of life events like migration on the psychological functioning of individuals, especially children. The consequences of the harsh change of environment that exile brings can manifest itself a long time after the event and affect the entire family. The migrant child has to develop cognitively, culturally, socially, and emotionally in a transcultural situation. The child must build a cultural structure in the separation between two worlds of different natures, one related to its family culture—the world of affection—and another, to the outside world—the world of rationality and pragmatism. This frequently results in many conflicts in the interaction with the environment (Moro, de La Noë, & Mouchenik, 2004). To these children, migration can be a knot in the family history that constitutes a source of phantoms, which are built in the mirror of the parents' phantoms, frequently rich and creative but also often psychologically disturbed (Wiese, 2007).

To better explain how culture may influence the child's reactions to extreme stress, Aptekar and Stöcklin (1997), described the following paths: (a) Mediating the child's responses to the stressful experiences, that range from a benign reaction to the development of Posttraumatic stress disorder—PTSD; (b) Being used by the child as a means to cope with stress, as the knowledge of situations can help to transform circumstances into opportunities; (c) Giving conditions that,

unfortunately, can predispose to stigmatization of children in specific difficult circumstances.

Baum (1990) defined stress as a “negative experience that is associated to threat, harm or demand” (p. 660), explaining that this emotional experience is “accompanied by predictable biochemical, physiological, cognitive, and behavioral changes that are directed either toward altering the stressful event or accommodating to its effects” (p. 653). When stress is prolonged, it turns into chronic stress, which can severely affect mental and physical health. Chronic stress also includes perceived threats, harm, or demands and the organism’s responses to them, which persist mostly because the stressor remains. This can be the case in the event of migration and acculturation difficulties.

Therefore, one possible consequence of the difficulties brought by migration, is the development of acculturative stress, which is defined as “one kind of stress, that in which the stressors are identified as having their source in the process of acculturation” (Berry, Kim, Minde, & Mok, 1987, p. 492). This term, acculturative stress, was initially proposed by LeVine (1963), as part of the culture-adjustment process after moving to a different country, and starting to live in a new cultural context, where many stressors can be experienced, resulting from cultural, social, and psychological changes (Berry et al., 1987).

Another risk related to acculturation is the development of a Posttraumatic stress disorder —PTSD. This possibility will be considered in the acculturation process, especially in case of forced migration, great cultural distance, severe discrimination experiences, lack of professional and social support, and other difficulties. It is important, in that case, to take into account that “the cultural context phenomenologically shapes the lived experience of both children’s development and their experience of trauma. The meaning of trauma is often culture specific” (Lewis & Ippen, 2004, p. 14).

Thus, migration, either voluntary or forced, independent of its motivation, can be understood as a potentially stressful and even eventually traumatic event, specially for children and adolescents, inducing a long and necessary process of defensive, adaptive, or structuring modifications, which lead to acculturation and identity changes, through bi or multicultural influences.

## Migration Related Trauma in Childhood and Adolescence

The migration process, especially in the initial phases which include leaving the country of origin and starting the acculturation process in a host country, can have the status of a severe psychological wound, a trauma, for some parents and children (Moro, 2005). Trauma can result in a break in the psychological protector shield against negative stimuli, exposing the frequently vulnerable child and putting at risk his mental health. This trauma, is mostly not developed in a single isolated experience but by repeated occurrences that often happen in a close

intrafamilial setting, in primary or secondary traumatization (in this last case, when the parents are traumatized).

There are strong predictors of trauma: (a) The exposure to an extreme traumatic stressing event, to the person and/or his or her family, being the following the most frequent: Threat to, witnessing or learning about forced separation from family, unexpected violent death, life-threatening events, physical violence or serious harm or injury to physical integrity (for example: inappropriate sexual experiences considering the age); (b) The psychological distress related to the traumatic situation, considering the severity, duration, and proximity of the experience. The trauma is long-lasting when there is a human stressor imposing the situation. Other variables such as personality variables, preexisting mental disorders, and family and social support must also be considered.

The trauma that is discussed here is of a specific type, based mostly on the minority status of a group of people, and on legacies of intergenerational ethnic and/or cultural conflicts related to migration, which can even present more severe characteristics and consequences in the case of the forced migration (as war, genocide, rape, racism, and discrimination) of refugees.

Within this approach, taking into account voluntary and forced migration experiences and their consequences for a psychological trauma in children, there are two important concepts that we must consider: vulnerability and risk of psychopathology in a critical period. Vulnerability is a state of least resistance to harm and aggression. To illustrate this vulnerability, Anthony, Chiland, and Koupernic (1982) took the image of three dolls: One of glass, the second of plastic, and the third of steel. If dropped, the doll made of glass will probably break, the second, of plastic, will be damaged with a scar, and it is possible that the third, of steel, will remain unaffected. Therefore, the doll that is dropped will break or be harmed with more or less facility depending on the material it is made of.

This metaphor for the concept of intrinsic vulnerability will take into account that the damage depends on the kind of surface on which the doll is dropped, which is a metaphor for the concept of environment. The damage to the doll is also related to the force applied when dropped. These are related to the circumstances of the fall, as for example, the aggression that was involved in the situation and the exposure to harm. Taking this image as a metaphor for trauma vulnerability, it can be understood that the psychological symptoms and disorders after the exposure of traumatic events depend on the interaction of three categories of factors: The intrinsic vulnerability of the child, the social and family environment, and the circumstances related to the situation. To these can be added the possibilities of treatment that the child has at his disposal following the trauma, and how the specific family culture considers the events and deals with their consequences (Moro, 2005).

This notion of vulnerability can be better conceived when we think that the child is part of a complex, interactive family system. The child’s interactive system consists of the nuclear

family, and frequently also of the extended family and its culture, as well elements of the outside world such as school and health care, in a dynamic process which can bring favorable or unfavorable influences to the child's psychological development. The rupture of one element of that system can effect changes in the whole interaction process, and lead to changes in the child's functioning and his psychological development.

The second concept mentioned above applied to trauma in children, is the critical period of psychopathological risk, which has practical consequences on prevention and intervention. This concept refers to the level of psychopathological risk in the different periods of human development, proposing that the effects of trauma can influence the child's development in such a way as to increase the risk of psychological disorders, not only in childhood but also later, in adolescence or adulthood.

In the case of a child of migrants, a vulnerability can be determined when the psychological functioning is such that minimal internal or external variations can lead to large dysfunctions, and often suffering, blockages, inhibitions or reduced development of his psychological resources and potentials (Moro, 2005). This notion of vulnerability is mainly clinical, therefore it is very complex and difficult to quantify, because it allows for varied modes of expression which can have multiple causes. This fragile condition is often manifested as real or latent sensitivities and weaknesses with variable traits.

Besides the traumatic experiences that can be associated mostly with forced migration, also in voluntary migration, the transcultural situation in which the child of migrant parents grows up, having to structure a cultural identity built on a split between two different worlds, can bring more insecurity and fragility. To grow up, this child must create several splittings (Moro, 2005): on the topographical level—within versus without—(for example, between family and school relationships); on the temporal level—before versus after (the event of migration); on the spatial level—there versus here (at home, in the treatment setting and with friends); and, on the ontological level—the same versus the other (contexts with same or different religion, habits, and clothes). These splittings are necessary to enable the child to move around in two different cultural worlds, in a transcultural situation, and to adjust to the double reference universe he is exposed to, but they can also be sources of inhibitions and anxieties, as they can be structured and become mechanisms for psychological functioning, in a form of ego-splitting, with severe consequences for mental health.

Therefore, in their cultural and psychological structuring, children of migrants may build mechanisms of cleavages to deal with their unstable contexts. These mechanisms determine the specific vulnerabilities of these children. In that theoretical frame, Moro (2005) named them as *the exposed children*.

The psychological functioning of being an *exposed child* can be accompanied by a denial of the filiation, meaning the denial of being the son or daughter of his or her parents. As a consequence of this mechanism, the child of migrants, raised

in a new country and under the influence of a different culture, can be perceived as a *foreigner* within the family, by the parents for example, or by the extended family; (Moro & Nathan, 1995). This means that his or her behaviors, ideas, opinions, habits, attitudes, and expressions, for example, can be different from what the family would expect or recognize as part of their cultural background. To explain this *foreignness* of the child, the family or even the child him- or herself, can create fantasies, representations from cultural myths or legends which can persist and be transmitted to other generations (Moro & Nathan, 1995).

Besides the child's direct exposure to traumatic experiences, it is also important to consider the risk of secondary trauma—when the parents are traumatized—because trauma can affect the attachment basis, bringing direct consequences to the child's life and development.

In infant mental health, the clinical treatment of mothers and babies indicates that babies of traumatized mothers seem to perceive, directly or indirectly, their mother's traumas, as they leave strong traces in their interactions (Wiese, 2007). This mechanism of a secondary trauma can affect the child's psychological developmental processes and influence his future as adolescent and adult. A consequence of the parents' trauma can be the development of a disturbed affective parent-child communication. In these cases, the parents often are unable to deal with the child's needs, and can behave in a frightened/anxious way toward the child.

Therefore, it can happen that after the exposure to traumatic events, the child may show heterogeneous and complex manifestations and symptoms. Thus, the same circumstances and situations can have many different effects in infants (Lebovici, 1989). Yet, in the etiology of trauma, it is also necessary to consider the child's psychological development at the moment of the traumatic experience, when several affective impressions were encoded. For the migrant child, these vulnerabilities can determine lower resistance to traumas, in comparison with children who are raised within their own parents' culture.

In the case of forced migration of refugees, several studies (Anderson, 2001; Farwell, 2001; Lie, Lavik & Laake, 2001; Lustig et al., 2004; Maloney, 2000), investigated how these children cope with their new situation, showing consequences of the adaptation to the new society, including depressive symptoms. Maloney (2000) discussed in a transatlantic workshop about unaccompanied asylum-seeker children, comparing policies and practices in North America and Europe, with several child-friendly practices and recommendations. Anderson (2001) described a qualitative research about the social situation of refugee children, based in many interviews, carried out by the German Youth Institute between 1997 and 2000, concluding that these children live in a state of constant uncertainty with regard to future and life planning, which increases psychological pressure in their daily lives. Farwell (2001) did an ethnographic research, based in interviews with key informants, about 33 youth recently repatriated to Sudan, describing the sources

of traumas and coping strategies, and suggesting the need of planned interventions to provide psychological support to that population. Lie and colleagues (2001), in a study conducted in the Psychosocial Centre for Refugees, in Norway, showed that the exposure to life-threatening events, physical violence, and forced separation from the family are strong predictors of psychological distress. Lustig and colleagues (2004), made a broad literature review of studies conducted between 1990 and 2003, addressing the mental health of refugee children and adolescents, concluding that this group of young people suffers from significant conflict-related exposures, including preflight stress and stress in resettlement, and associated traumas.

Research done in relocation countries, using psychological tests, indicated an increased level of psychological distress among migrant children (Lavik, Christie, Solberg, & Varvin, 1996; Mollica et al., 1993; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993; Vrana & Lauterbach, 1994). Other research showed that the children's self-regulating ability depended largely on the emotional state of their caretakers (parents mostly), therefore, the asylum-seeking children and adolescents without caretakers may have a greater risk of psychiatric disorder following trauma exposure (Loughry & Flouri, 2001; Lustig et al., 2004; Sourander, 1998).

In a study conducted in the United Kingdom with refugee children, Fazel and Stein (2003) showed that more than one quarter of them suffered from a significant psychological disorder and this incidence was three times more frequent than in English children. In another study on 129 asylum-seeking and refugee children and adolescents referred to a mental health facility in the Netherlands, Wiese and Burhorst (2004, 2007) also reported significant physical and psychological traumatic experiences in 26% of the children and adolescents with families, and in 68% of the unaccompanied minors. Sexual abuse had a high frequency in unaccompanied minors, especially for girls (67% compared with boys 14%). The results of that study indicated that unaccompanied minors had a statistically significant higher frequency of symptoms and psychiatric disorders, than asylum-seeking children who were with their families, indicating the presence of the mother and/or the father as an important protective factor to children against stress reactions in adverse situations.

The above mentioned studies emphasized the relationship between traumatic exposure and psychological symptoms in refugee children, as well as the need for early diagnosis and treatment to avoid long-term effects of trauma. Also emphasized was the highlighting of the high vulnerability of asylum-seeking children and adolescents.

Epidemiological studies (Nemeroff et al., 2003) also showed the importance of preventing the psychological effects of trauma in children, because individuals who had traumatic experiences in childhood are more vulnerable to the development of PTSD in adulthood. Therefore early detection and intervention in children's trauma can also help to prevent psychological disorders later in life.

## Effects of Posttraumatic stress disorder—PTSD in Children and Adolescents

Before the 1950s, there was very little investigation of the psychological effects of traumatic events in children and adolescents, being Spencer Eth and Robert Pynoos pioneers in the field (Beall, 1997). Since that time the field has expanded enormously, with publication of researches investigating the different psychological effects of PTSD. In children, the reaction of traumatic experiences often includes nightmares, concentration difficulties, irritability, and hypervigilance. The symptoms can also be psychosomatic, such as headaches, stomachaches, and other pains, as well as enuresis. Affective difficulties are often found: Frequent crying and depression, withdrawal behavior, and isolation which can be manifested by avoiding contacts with the peer group and not wanting to attend school. Other findings are changes in self-perception, in the relationship to others and in the interpretation of the social context, fear of being left alone, changes of eating and sleeping habits, regression to underdeveloped behaviors, and increase of aggressive behavior (Wiese & Burhorst, 2004, 2007).

Very young children can lose their trust in the caregivers and develop an attachment disorder, with its consequences for emotional and social functioning. Frequently, their exploratory behavior is reduced and they show less autonomy. Their symptoms can include irritability and anger, search behavior for the missing person (in case of separation), lack of age-appropriate interest, and change in appetite and/or in sleeping patterns, sadness and emotional withdrawal (Hinshaw-Fuselier, Heller, Parton, Robinson, & Boris, 2004). It is possible that children under age eight do not have the traditional symptoms of PTSD as a consequence of trauma, and present other signs of stress, such as disorganized behavior, increased aggressive behavior, or anxious/depressive behavior.

Trauma can affect the child's and the adolescent's readiness to learn and bring mechanisms of hypervigilance, constriction of exploration, misattribution of hostile intention to others. The excess preoccupation can affect attention and concentration processes that are fundamental in the learning development, having important consequences in school performance (Lieberman & Horn, 2004).

## Assessment and Treatment of Acculturative Stress and PTSD in Migrant Children and Adolescents

The diagnosis and treatment process of acculturative stress and PTSD related to migration in children and adolescents include the family system, taking into account the family's cultural background and favoring its integration with elements of the host culture.

As the children in treatment come from diverse cultural backgrounds, there is also a concern about the language; it can be very important to have interpreters or bicultural therapists participating as mediators in mental health treatment. Although the child and the parents can appear to have enough knowledge of the local language, their memories and feelings related to important events in their lives may be encoded and better processed in their native language (Lewis & Ippen, 2004).

It is also important that health care professionals familiarize themselves with the cultural background of their clients, in such a way that the differences in language or in cultural background between the professional and the client are not obstacles to the effectiveness of the trauma treatment. The consideration of the cultural meanings of the symptoms and disorders the child presents is also fundamental in the treatment, as well as the family's cultural values and how they can affect the response to the treatment. The health care professional must also be attentive to the identification of cultural or environmental elements in the client, especially those that can cause resistance to the psychological treatment, and those that can foster the treatment and show positive elements of resilience.

In order to do that it is necessary to develop individual treatment strategies, within the specific therapeutic approach. This way, therapeutic strategies are built, aiming to approach the child and to help him or her to transform the vulnerability into strength and to diminish the risk factors for later psychiatric disorders, favoring the social and emotional development process as well as the participation in the host society.

Culture can also become a protective factor for parents. It gives them strength and a sense of direction in their roles as parents, and in the case of psychological or psychiatric disorders, culture can provide an envelope to support parent-child interactions, especially in critical periods. The psychological treatment can also provide a model to parents and children, to help them in building a strong bridge between their two referential worlds, mastering the transcultural risk. For the child of migrants, any therapeutic approach that does not take into account the family's cultural background only contributes to reinforce the splitting he/she built between the two worlds of reference, contributing to marginalization.

In the psychological assessment and treatment of traumatized children, the following considerations (inspired in the general recommendations of the American Psychiatric Association, 2004, for the treatment of adults with PTSD, and adapted by the author of the present article) will be followed: To screen for recent and remote exposure to traumatic events, and to secondary trauma; To investigate the response of the child and of the parents to each traumatic event, as well as the nature of the event itself; To consider the limitations in making a diagnosis, related to the age of the child and to the complexity of the associated circumstances (for example, dissociation may prevent patients from recalling their trauma; young children do not express trauma directly and tend to project it); To collect

as much as possible the full history of all salient traumas (age and duration of the traumas) and factors or interventions that may have intensified or mitigated the traumatic response.

The mental health assessment phase of migrants may include medical and/or psychiatric assessment, anamnesis, psychological assessment (cognition, neuropsychological development, and personality), creative observation and assessment, and family-system assessment. On average, the assessment evaluation takes place in the first 3 months, and should be followed by 3-monthly follow-up evaluations.

Several specialized psychological tests and instruments were developed to identify posttraumatic stress reactions in children (Finch & Daugherty, 1993; Yule & Udwin, 1991). Among some of these scales and inventories are: The Children's Stress Reaction Index (Frederick & Pynoos, 1988); Revised Impact Events Scale (Horowitz, Wilner, & Alvarez, 1979), the Children's Post-Traumatic Stress Disorder Inventory (Saigh, 1989), and also a semistructured interview guide (Pynoos & Eth, 1986).

In the case of young children (under age 4), the assessment of the parents-child interaction is very important and can be done, for example, by the application of the Interaction Assessment Procedure—IAP (Batista Pinto, 2001, 2007; Wiese, 2006, 2007), a special videorecording technique that aims at a detailed assessment of the mother-child and father-child interaction. For the infant's diagnosis, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood—DC: 0-3R (2005) is strongly advised.

The Sandplay, as a nonverbal method (Boik & Goodwin, 2000; Kalff, 2003; Wiese, 2007), also seems to be a very appropriate psychological tool to use with migrants, both in the assessment and in treatment, providing a very safe situation for the projection of traumas and conflicts, as well as their elaboration.

After the diagnostic phase, a treatment plan is established. Different treatment modalities are proposed to the family (including for example, play therapy, art therapy, psychomotor therapy, parent counseling, and others). Several modalities of psychotherapeutic treatment—individual, parents/child, group or family—can be offered in different phases, and they can be effective in various possible approaches: play therapy (Cattanach, 1994; Klapper, Plummer, & Harmon, 2004), attachment therapy (Brisch, 2002); family ethnopsychotherapy (Moro, de La Noë, & Mouchenik, 2004); sandplay therapy (Boik & Goodwin, 2000; Wiese, 2007) and others. The choice of a specific treatment is preferably decided by a multidisciplinary team, considering the specializations and specific theoretical approach of the psychotherapists, and matched with the needs, issues and feelings of the child and the parents. For some children and adolescents, there can be a need of intensive psychiatric care, in-patient or day-clinic treatment, which can also include a special school, adjusted to the child's learning possibilities and actual resources.



## Final Considerations

Several authors have written guidelines (Nader, 1994; National Center for PTSD, 2006) for the therapist's attitude towards the client. Inspired by these, as well as based on clinical experience with traumatized clients, some principles and guidelines are suggested by the present author for psychotherapists who work with traumatized children and adolescents, to foster resilience and overcome their trauma: be able to talk about the traumatic events; provide means to express the experiences and feelings related to the trauma; support the client in positive strategies to cope with anxiety, anger, and other stress reactions/symptoms; be consistent and predictable in your relationship with the client in view of his or her vulnerability; be affectionate and take into account the context and the culture of the client's background; discuss what is expected in the client's behavior in different situations and contexts; answer the questions and explain what is needed; look for signs of reenactment, dissociation, avoidance, and reactivity; empower the client to avoid retraumatization; talk to the client about choices giving him or her some sense of control of his or her own life; ask for help and supervision if necessary. Most of all, therapists should be aware that children, in their need to reestablish their connection with the different cultural worlds they are exposed to and the variety of persons involved in their lives, can have an extended process of healing that continues long after the treatment ends.

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## Note

1. In this text we chose to use the word *migration* in its broader meaning: to move to live in another country of which the person is not a native.

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