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Internalizing and Externalizing Symptoms among Unaccompanied Refugee and Italian Adolescents

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## **Internalizing and Externalizing Symptoms among Unaccompanied Refugee and Italian Adolescents**

### **Abstract:**

This study investigated the prevalence of emotional and behavioural symptoms in unaccompanied refugee adolescents living in Italy; an area which remains under-researched despite the relatively high number of asylum seekers registered in Italy compared to other industrialised countries. The Child Behaviour Checklist (CBCL) for 6-18 year-olds was completed by a social worker or parent for each of the 120 participating adolescents; sixty male unaccompanied refugee adolescents and sixty male native Italian adolescents. The paper presents findings that illustrate high levels of emotional and behavioural problems in unaccompanied refugee youth living in Italy. On all components of the CBCL, unaccompanied refugee adolescents were found to present with significantly more problems, as reported by social workers, compared to the Italian group of adolescents. In the light of these results, the importance of interventions and culturally sensitive therapeutic

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**Keywords:** Unaccompanied Refugee Adolescents; Internalizing and Externalizing Problems; Psychological Adjustment; Adolescence.

### ***1. Introduction***

In the first half of 2011, a significant increase in individuals requesting refugee status was reported compared to the same period in 2010. In total, a 20 percent increase was found in the forty-four industrialised countries examined, with Italy being the fourth largest recipient of asylum seekers in 2011 (UNHCR, 2011). Approximately half of all asylum-seeking individuals are children (Bhabha & Young, 1999; UNHCR, 2012), and many of these children are unaccompanied.

Unaccompanied minors have typically been forced to flee their home country to escape armed conflicts and human rights violations (Halvorsen, 2002), and have been found to suffer more from psychiatric disorders and depressive symptoms, compared to accompanied refugee children (Wiese & Burhorst, 2007). Hence, family support during hardship pre-migration, the journey to safety and family support whilst in the host country seems to be a protective factor (Derluyn & Broekaert, 2007; Macksoud & Aber, 1996). Consequently, unaccompanied minors are frequently referred to as the most vulnerable of all refugee groups (e.g. Halvorsen, 2002; Mels, Derluyn, Broekaert & Rosseel, 2010), as they experience increased danger compared to accompanied refugee children and youth, yet, are also considered to be highly resilient (Betancourt & Khan, 2008) because of the adversity these young individuals survive.

In the UK, Hodes, Jagdev, Chandra and Cunniff (2008) found 73.1% of unaccompanied females and 61.5% of unaccompanied males, compared to 35.3% of accompanied girls and 14.3% of accompanied boys to be at high risk of developing post-traumatic-stress-disorder. Correspondingly, Derluyn and Broekaert (2007) conducted a study in which social workers or foster parents and unaccompanied minors in Belgium

completed a range of questionnaires (the *CBCL*, the *Strengths and Difficulties Questionnaire*, the *Stressful Life Events Scale*, the *Hopkins Symptom Checklist-37* for Adolescents, and the *Reaction of Adolescents to Traumatic Stress Questionnaire*). The results demonstrated that unaccompanied minors presented with depression, anxiety and post-traumatic stress symptoms more frequently than accompanied refugee children.

Similarly, Wiese and Burhorst (2007) reported a significant difference between the number of traumatic events, such as having experienced physical violence, exposure to life-threatening events, or having survived torture, maltreatment or prison, experienced by unaccompanied in comparison to accompanied minors in the Netherlands.

Derluyn, Broekaert and Schuyten (2008) argue that research has led to contradictory results in regards to whether or not migrant children experience greater risk of emotional and behavioural problems compared to native European children. In support of this claim, Davies and McKelvey (1998) found non-intact family background, lower socioeconomic status, school setting and male gender to be stronger predictors of poor outcomes than migrant status on the *Child Behaviour Checklist* and *Youth Self Report*, compared to native youth in Australia. The migrant sample, however, comprised participants from more than twenty different countries and forty-four percent reported being refugees, yet subgroups were not tested.

Derluyn and colleagues (2008) found that migrant children in Belgium reported significantly more traumatic experiences, problems with peers, and higher avoidance scores compared to the native Belgian sample, whereas Belgian youth showed significantly higher levels of anxiety, hyperactivity, and higher scores on the externalising subscale. Derluyn and colleagues' (2008) sample included children from 93 different countries from Central

Africa, Asia and Eastern Europe. As individuals from Asia and Africa are more likely to have been forced to flee their home country, and to have experienced traumatising events during the journey than European individuals, combining data from migrants and refugee participants may have the effect of diminishing the differences between refugee and Belgian youth. Indeed, 28.6% of the migrant sample reported experiencing war in the home country, and 58% were unaccompanied refugee minors. The differences in cultural background and reason for migration between unaccompanied refugee minors and migrants from Eastern Europe are likely to influence responses to mental health measures, and it would therefore be helpful if a distinction could be made between migrants and refugees when comparing such groups to European samples in future research. Although Derluyn and colleagues' (2008) results illustrate remarkable resilience in the unaccompanied refugee minors, the influence of cultural stigma related to mental distress and differences in perceptions of traumatic experiences between the migrants and unaccompanied refugee minors may have influenced their responses.

The present study investigated the emotional and behavioural problems in unaccompanied refugee youth and ethnic Italian adolescents in Rome, through questionnaires distributed to adolescents' caregivers. Despite the fact that Italy receives relatively many asylum seekers compared to other industrialised countries (UNHCR, 2011), there is a lack of research investigating the mental health of unaccompanied refugees in Italy. The aim of this study was to shed light on this area, and to create increased focus on the importance of interventions tailored specifically to this group.

## ***2. Methodology***

### ***2.1 Participants and Procedure***

Sixty male unaccompanied refugee adolescents (mean age=17.17; SD=.38) and sixty male native Italian adolescents (mean age=17.14; SD=.35) formed the sample. The mean age of the unaccompanied refugee adolescents at the time of their arrival to Italy was 14.9 years (SD=1.28). At the time of data collection, the unaccompanied refugee adolescents had been living in a refugee center in Rome for a mean of 2.5 years (SD=1.6). The length of their residence in Italy ranged from 1-3 years, with a mode of 2 years. The unaccompanied refugee sample was from Guinea-Bissau (n=16), Afghanistan (n=15) and Bangladesh (n=29). Before categorizing the unaccompanied refugee adolescents as one single group, a series of preliminary analyses were conducted. Chi-square tests explored the main demographic characteristics: age (17 vs. 18 years old), time in Italy (0-6, 7-12, 13-36 months), and length of residence in the refugee center (0-6, 7-12, 13-36 months). No significant differences were found for these three variables [ $\chi^2(1)=.33, p=.56$ ;  $\chi^2(2)=5.51, p=.07$ ;  $\chi^2(2)=3.63, p=.16$ ; respectively].

Twelve social workers (four males and eight females) were identified as professional non-parental caregivers. In this context, the social workers were classified as non-parental caregivers because their role required them to care for five specific unaccompanied refugee adolescents, whom they spent time with on a daily basis; enabling close relationships to develop. For the purpose of this study, each social worker completed the CBCL for the unaccompanied refugee adolescents he or she cared for. The social workers had worked in child/adolescent education for an average of 9 years (SD = .86), in the specific refugee

centre for an average of 6.3 years ( $SD = 1.22$ ), and had known the unaccompanied refugee adolescents for an average of 2 years ( $SD=.39$ ) at the time of data collection. Participation was preceded by an informed-consent procedure which required active consent from the participating youth and social workers. The aim of the study was explained to social workers before they were asked to complete the questionnaire.

Italian adolescents' questionnaires were filled in by one of their parents (25 fathers and 35 mothers). Parental educational level was in line with the Italian national rate; 35% primary, 34% secondary, 31% academic degree. Both groups were informed that participation was voluntary and responses confidential. This study and the related survey were reviewed and approved by the Ethics Commission at the Department of Developmental and Social Psychology of Sapienza University of Rome.

## ***2.2 Measure***

The *Child Behaviour Checklist* for 6-18 year-olds (CBCL/6-18; Achenbach & Rescorla, 2001) was completed by a social worker or parent for each of the adolescents. This questionnaire is among the most widely used parent/caregiver report measures of youth emotional and behavioural problems in clinical and research settings (Althoff, Ayer, Rettew, & Hudziak; 2010, Seligman, Ollendick, Langley & Baldacci; 2004), and contains 118 problem items covering behavioural, emotional, and social experiences over the past six months. Respondents are asked to rate the occurrence of problems on a 3-point scale. The measure can be scored on eight syndrome scales: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent



Behaviour and Aggressive Behaviour. The Internalizing scale can be derived from the first three syndrome scales (in the present study Cronbach's  $\alpha = .86$ ), and the Externalizing scale from the last two (in the present study Cronbach's  $\alpha = .85$ ). The Total Problems scale was determined by summing the individual item scores (in the present study Cronbach's  $\alpha = .84$ ). Thus, 55 of the items are summed to yield six DSM-oriented scales: Affective Problems, Anxiety Problems, Somatic Problems, Attention Deficit/Hyperactivity Problems, Oppositional Defiant Problems, and Conduct Problems. Good test-retest reliability, cross-informant agreement, and success in discriminating between referred and non-referred adolescents have been demonstrated for the CBCL (Achenbach & Rescorla, 2001; Frigerio et al., 2004).

### **3. Results**

#### **3.1 Differences between the unaccompanied refugees and Italian adolescents**

As a preliminary analysis, we conducted MANOVA on the CBCL/6-18 dimensions, considering nationality as independent variables. This MANOVA did not lead to a main effect for nationality (Wilks's  $\Lambda = 0.99$ ;  $F(15, 44) = 1.41$ ;  $p = .18$ ). When comparing unaccompanied refugees and Italian adolescents, however, MANOVA revealed a main effect for nationality (Wilks's  $\Lambda = 0.11$ ;  $F(15, 104) = 51.94$ ;  $\eta^2 = 0.88$ ;  $p < .001$ ). Moreover, the univariate tests (ANOVA) revealed that the two groups differed on all subscales of the CBCL/6-18. More specifically, unaccompanied refugee adolescents obtained higher scores than Italian adolescents, as reported in Table 1.

-----*Insert Table 1 here*-----

### 3.2 Internalized and Externalized Problems

As reported by Garnefsky, Kraay and van Etten (2005), a distinction was made between four categories of problems: (1) Internalizing-problem group (IP) for adolescents who scored above the 80<sup>th</sup> percentile of the Internalizing scale and below the 60<sup>th</sup> percentile on the Externalizing scale; (2) Externalizing-problem group (EP) when adolescents scored above the 80<sup>th</sup> percentile on the Externalizing scale and below the 60<sup>th</sup> percentile on the Internalizing scale; (3) Internalizing-and-Externalizing-problem group (IEP) for the adolescents who scored above the 80<sup>th</sup> percentile on both scales; and lastly, (4) Low-problem-group (LP) when adolescents scored below the 60<sup>th</sup> percentile on both scales. The decision to include a cut-off score at the 80<sup>th</sup> percentile was based on research by Garnefsky and colleagues (2005), who illustrated that this is the most accurate cut-off point for discriminating between referred and non-referred adolescents in a normative sample, when seeking to minimize false negatives and false positives. The 60<sup>th</sup> percentile cut-off point score was added in the present study to minimize the number of false classifications further.

According to these criteria, adolescents who scored between the 60<sup>th</sup> and the 80<sup>th</sup> percentile on either the Internalizing or the Externalizing scale were excluded to ensure that margin scores were not wrongly classified (Garnefsky, Kraay & van Etten, 2005; Tambelli, Laghi, Odorisio, & Notari, 2012). Accordingly, eight adolescents (five unaccompanied refugees and three Italian adolescents) were not classified because one or both of their problem scores fell between the 60<sup>th</sup> percentile and 80<sup>th</sup> percentile.

On the basis of caregivers' responses to the CBCL, adolescents were assigned as follows: Internalizing Problems only ( $N=9$ ; 8 %), Externalizing Problems only ( $N=27$ ; 24.1 %), both Internalizing and Externalizing Problems ( $N=18$ ; 16.1 %), neither Internalizing nor Externalizing Problems ( $N=58$ ; 51.8 %). Using chi-square test, we examined whether there were any significant differences amongst the two groups.

Unaccompanied refugees were more likely to be classified with Internalizing and Externalizing problems than native Italian adolescents ( $\chi^2(3)=27.78, p<.001$ ). Specifically, 81.5% of the unaccompanied refugees, showed both Internalizing and Externalizing problems, compared to 18.5% of the Italian adolescents ( $R=2.5$ ). Similarly, 72.2 % of the refugee adolescents were classified as having Externalizing Problems, compared to 27.8 % of the Italian adolescents ( $R=2.0$ ). Lastly, Italian adolescents were more likely to be classified without problems (74.1 % vs. 25.9 % of unaccompanied refugee adolescents;  $R=2.4$ ).

#### ***4. Discussion***

The aim of the present study was to explore the prevalence of emotional and behavioural problems in a sample of unaccompanied refugee adolescents living in Italy, and to create an increased awareness of the need to offer interventions and support to unaccompanied refugee youth. The results of this study found significant differences in Internalizing and Externalizing problems between unaccompanied refugee adolescents and native Italian adolescents; on all components of the CBCL, unaccompanied refugees were found to have significantly more problems than the Italian group.

These findings highlight the importance of offering appropriate interventions to unaccompanied refugees. Screening at reception is necessary, however, longer lasting interventions and enduring access to mental health services is equally important, especially in the light of research findings showing that difficulties associated with being a refugee tend to persist for years or even decades after arrival to the host-country (Barenbaum, Ruchkin & Schwab-Stone, 2004; Bean, Eurelings-Bontekoe & Spinhoven, 2007; Sack et al., 1993).

Efforts to minimize the barriers to mental healthcare for refugees, such as language barriers or cultural stigmas and prejudices against mental health services, need to be considered. Likewise, an increased focus on interventions that are culturally sensitive and easy to access is necessary, and lastly, a variety of help systems should be offered; ranging from short-term to longer term and from outpatient care to residential care (Derluyn & Broekaert, 2007, Hopkins & Hill, 2010, Huemer et al., 2009). The individual needs of unaccompanied refugee minors should therefore be considered when determining how best to intervene. Groups of unaccompanied refugee minors are highly diverse and individual experiences, cultural backgrounds and belief systems influence the way in which psychological distress and interventions are perceived by the individual.

One of the limitations of the present study is that it relied solely on parental / caregivers' reports and moreover, that social workers and parents had different relationships with the respective adolescents who participated. Davies and McKelvey (1998) found adolescents' scores on the Youth Self Report Measure to be higher than parental responses on the CBCL, which corresponds with previous findings indicating that parents tend to underestimate symptoms in their children (Almqvist & Brandell-Forsberg,

1997). Consequently, parents may have been less aware of, or willing to report, emotional and behavioral problems in their children compared to social workers, who, through their professional training, role as caregivers rather than parents, or mere expectations about the unaccompanied refugee adolescents' behavior, may have been more prone to report emotional and behavioral problems than the native Italian parents.

### *5. Concluding remarks*

Although resilience, strengths and coping strategies were not incorporated or explored in the present study, shifting the predominant focus from symptoms only, to resilience and coping mechanisms in unaccompanied refugee children and adolescents is an important task for future research (Betancourt & Khan, 2008; Bronstein & Montgomery, 2011). Integrating self-report measures and qualitative methodologies into research seeking to understand and facilitate adaptation in host societies for refugee youth, would enable researchers to gain a broader understanding of risk and resilience factors, and to thereby inform both theory and practice. We are currently working on a program of studies enquiring into which factors facilitate and hinder refugee children and adolescents' positive adjustment in European host societies. These studies involve qualitative methodologies and self reports measures about resilience and coping strategies.

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Table 1.

*Mean score on the CBCL/6-18 subscales for Unaccompanied Refugee and Italian adolescents*

	Unaccompanied Refugee Adolescents (N=60)		Italian Adolescents (N=60)		F <sub>1,118</sub>	Eta squared
	M	SD	M	SD		
Withdrawn	8.43	5.32	5.95	4.72	7.32*	.05
Somatic complaints	3.73	2.52	1.10	0.67	74.46**	.38
Anxious/depressed	5.33	3.70	1.83	0.80	17.42*	.13
Social Problems	3.28	2.57	1.70	1.76	15.33*	.11
Thought Problems	8.37	2.91	0.55	0.77	240.21**	.67
Attention Problems	7.50	3.87	2.87	1.80	69.59**	.37
Delinquent Behaviour	9.70	4.89	2.77	2.87	89.69**	.43
Aggressive Behaviour	10.45	5.65	3.15	3.56	71.71**	.38
Internalizing Problems	17.50	10.51	9.45	7.72	22.86*	.16
Externalizing problems	20.15	9.74	5.92	4.19	91.26**	.43
Total Problems score	39.22	14.01	17.60	5.09	36.43**	.24
DSM-oriented scales						
Affective problems	3.47	2.76	2.07	2.15	9.57*	.07
Anxiety Problems	3.37	2.64	1.80	1.93	13.80*	.10
Somatic Problems	1.63	1.70	0.55	0.98	18.32*	.13
Attention Deficit/Hyperactivity	5.32	2.61	1.70	2.05	71.28**	.38
Oppositional Defiant Problems	4.72	2.74	1.32	1.61	68.75**	.37
Conduct Problems	5.07	3.76	1.60	2.33	36.86*	.24

*Note.* \*p<.05; \*\*p<.01