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Complex PTSD and Forced Migration of Children and Adolescents from Latin America

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ABSTRACT

In order to provide culturally competent care to children and adolescents that have been subject to forced migration, clinicians must first understand the unique trauma these individuals experienced. Victims of forced migration frequently experience trauma pre-displacement, typically resulting from the same factors that led to the forced migration. They then often experience trauma during the migration itself and post-migration as they settle in a new environment, sometimes without their families if they are unaccompanied minors. An increased risk of developing complex PTSD (C-PTSD) correlates with the number of adverse childhood experiences (ACEs) such as those experienced by children and adolescents that experience forced migration. Understanding the nuances of these traumas and their specific manifestations for the individual child or adolescent is critical for effective behavioral health support. Trauma signature (TSIG) analysis offers clinicians a method to understand the relationship between traumatic events and the physical and psychological consequences to best support these victims.

Keywords: Complex trauma; C-ptsd; Forced migration; Forced displacement; Unaccompanied minors

1.Introduction

Forced migration (also

called forced displacement) is an involuntary or coerced movement “as a result of persecution, conflict, generalized violence or human rights violations”^[1].

As of 2022, the number of people displaced by force exceeds 100 million, meaning 1 out of every 78 people on the planet have been involuntarily relocated. Forty-one percent of displaced people are children ^[2]. In the United States, the bulk of forced migration comes from Latin America and the Caribbean. In 2021, the number of displaced Venezuelans grew by more than half a million and the socio-political crisis in Nicaragua caused 100,000 additional people to seek asylum ^[2]. The migration of children specifically is driven by desperate conditions for many children in their home countries. UNICEF estimates that “6.3 million migrant children in the region are facing life-threatening situations and multiple forms of violence” (UNICEF) ^[3]. Some of those children remain in place, others migrate within their home countries and become an Internally Displaced Person (IDP). Only a fraction of the children facing desperate conditions reach the United States and a fraction of those are unaccompanied minors.

In the 12 months ending on February 29, 2021, the U.S. Customs and Border Protection (CBP) encountered 29,792 unaccompanied children and single minors along the Southwest Border. Of the total, 2,942 of these were under the age of 12 years old and 26,850 are aged 13-17 years old” ^[4].

The statistics from the CBP don’t indicate how many unaccompanied minors actually reach or attempt to reach the United States from Latin America. The numbers from the U.S.

Customs and Border Protection only reflect the unaccompanied minors that are encountered by CBP. Minors that evade detection, that are somehow diverted during the migration, or who reach a destination outside of the United States are not counted.

However, the numbers do indicate that, starting in April 2020, there has been an increase in encounters of unaccompanied children from Central America at the Southwest Border ^[5].

2.What Happens to the Children and Adolescents Who Experience Forced Migration?

The potentially traumatizing experiences of displaced minors often begin before the migration. The children have often been traumatized by the factors driving migration – violence, poverty, and disease. During the chaos of a forced displacement, minors may become separated from their families and exposed to additional dangers, including forced recruitment, abduction, human trafficking, exploitation, sexual violence, and rape. For many children, detention at the border, housing in a refugee camp, or institutional care may span many years, effectively depriving them of the love and family so crucial to their healthy emotional development. Children who are relocated to the United State face new pressures, including learning a new language, adjusting to school, learning cultural norms, adjusting to the

family's loss of status, and – for unaccompanied minors – dealing with a loss of family [6-8]. The series of traumatic experiences in three parts (before migration, during migration, and relocation after migration) has been labeled Trilateral Migration Trauma [9].

The prevalence of mental health disorders in children and adolescent refugees vary dramatically from one study to the next. Studies found incidences of PTSD in those living in refugee camps that range from 0-87 percent and anxiety at depression from 9.5 to 95.5 percent [10]. The variability in these studies speaks to the need for more research to understand the full extent of the psychological implications of forced migration. It also highlights the differences in both the experiences and cultures of these populations, emphasizing the importance of taking both into account when dealing with those subjected to forced migration. The research does, however, consistently find maladjustment problems amongst children living in refugee camps [11]. A UNICEF report during the peak of civil war in Colombia found that up to 80% of internally displaced children “show fear, cry, have nightmares, wet their beds, do not concentrate, have memory problems or are more dependent on adults” [12].

3.The Potentially Traumatizing Experiences of Forced Child Migrants from Latin America

Each child migrant has a unique story. The traditions, cultures, and values vary between the countries and regions of origin. The potentially traumatizing events experienced before, during, and after migration also vary, but a common thread is that individual children often experience multiple potentially traumatic events and different types of events. For diagnosis and treatment of individual patients with culturally sensitive interventions, it is necessary to understand the experience of each group and of individuals within that group [13].

Daily Hardships: A study of 363 Sierra Leonean youth found that daily stressors were the primary intermediate factor through which war exposure connects to psychological distress [14]. Daily hardships include domestic violence, housing insecurity, food and water shortages, family disintegration, and decreased or no access to core services [10]. For example, estimates of wasting (low weight to height ratio) in children under five in Venezuela have skyrocketed from 3.2% in 2009 to 15.5% of children by 2017 [15,16].

Prolonged exposure to violence: In war, children may witness violence from the conflict itself. However, there are many other bi-products of conflict that are potentially traumatizing. Children may have to deal with the death of family members, the physical separation from family or friends, and physical, sexual or psychological harm. They may also participate in the violence themselves if they are forced to inflict harm on others [10]. Even

more, prolonged exposure to violence is not limited to actual war zones. In the Northern Triangle of Central America (NTCA), composed of Honduras, Salvador, and Guatemala, the homicide rate is higher than in most regions experiencing actual civil war or armed conflict ^[17]. Gangs use violence, including sexual violence, and terror in the day-to-day lives of citizens.

Lack of a “normal” baseline experience: PTSD was conceived in the context of American soldiers who went from a relatively stable life to a war zone, and then return to relative normality. For many of the children who are forced migrants, they have no baseline “normal” experience. Their entire childhood may have been subject to violence from gangs or warring factions ^[8]. Indeed, there are unique challenges associated with treating populations who have only ever experienced negative circumstances in their lives ^[18].

Family separation: Unlike a traumatic event that a child experiences but then returns to a supportive family, many of the displaced children experienced prolonged separation from family (and some may be permanently severed from their families). Little is known about the health outcomes of unaccompanied minors compared to adolescents and children who were displaced together with their families, but it is clear that unaccompanied minors experience more violence and a greater number of potentially traumatic events ^[13].

Repeatedly experiencing a loss of safety:

the migration was undertaken to seek safety. Often, the reality of the new environment is, once again, vulnerability to violence ^[18,19].

4.The Traumatic Impact of Human-made Trauma versus Natural Disaster

There is some evidence that human-made disaster has more traumatizing potential than natural disaster ^[20]. In the case of forced displacement from Latin America the two factors often mix. Natural disaster and the COVID-19 pandemic may have depleted economic resources in the location of origin, while violence by gangs and criminal syndicates may have created an additional layer of traumatic events ^[21].

5.The Dosage Effect of Repeated Traumatic Events in the Development of C-PTSD

PTSD is usually the result of one or more impersonal, traumatic events (such as war, natural disaster, or a car accident).

Complex PTSD (C-PTSD) is associated with more frequent, more diverse, and more numerous traumatic experiences in childhood ^[22]. C-PTSD in adults is typically a result of traumatic interactions experienced as a child during critical developmental stages, especially between the child and a parent or other caregiver. These traumatic events can interfere in the child’s development of the internal working model of self ^[23].

Repeated adverse childhood experiences

(ACEs) have more impact than single or isolated experiences. The “dosage effect” is apparent even in cases where the episodes are less severe than what is typically experienced by forced migrants from Latin America and the Caribbean. A longitudinal British civil service-based cohort study (N = 7,870, 69.5% male), found that the risk of problematic drinking increased as the number of adverse childhood experiences increased [24].

Forced migrants from Latin America and the Caribbean can experience a large number of ACEs, including episodes of extreme violence. This is especially true for unaccompanied minors.

6.The Cumulative Impact on Children: The Trauma Signature

The displacement trajectory for displaced persons creates a “trauma signature.” Borrowing and generalizing from a description of internal displacement in Colombia [25], we can describe a sequence of stages: (1) pre-displacement (threats and vulnerability), (2) expulsion/migration (separation from family, more danger, and more vulnerability), (3) initial adaptation to relocation, (4) resettlement (typically, a protracted process for forced migrants).

7.Trauma Signature Analysis

Trauma signature (TSIG) analysis seeks to understand the relationship between exposure

to traumatic events (natural disaster, wars, famine, and other extreme events) and the physical and psychological consequences. The goal is to provide guidance for effective mental health and psychosocial support [26].

The rationale of understanding the trauma signature is that behavioral health support that is tailored to meet the defining features of the event will be more effective. Each forced migration has a novel pattern of traumatizing exposure. Understanding these exposures can help us predict the mental health consequences. Specific analysis of the unique series of traumatic events will determine the shape and prevalence of the mental health consequences [27].

8.Culturally Sensitive Treatment

Displaced minors, especially adolescents, often split off the formative years of their development as they try and fit into a different culture. The result can be feelings of disconnectedness and disorientation. They will often be alienated by a trauma narrative that explains their experience in political and psycho-educational terms. In treatment, they need to build an integrated identity by creating connections between the world that they left, the new culture they live in now, and their own private experiences [28].

Therapy needs to factor in the culture and belief system of the client. For example, depending on the culture and the individual’s

belief system, religion can be a source of resilience, or it can actually be an obstacle to seeking or fully utilizing mental health treatment [29]. While the belief systems of displaced persons from Latin American and the Caribbean will be more familiar to culturally sensitive Western-trained clinicians and clinicians from Latin America than in other parts of the world, the clinician needs to be attuned to the cultural nuances and the unique experiences of the individual client.

Trauma Systems Therapy for Refugees (TST-R) is one approach that seeks to incorporate support from multiple sources through a four-tiered approach and places importance on including culture in the process of healing [30]. The first tier focuses on parent and community support. The second tier incorporates skills-based groups. The third and fourth tier consist of individual therapy and family support respectively. Each tier is mediated by a cultural broker who shares not only the language but also the culture of the refugee. In this way, the process of healing reaches beyond the therapy session and is done entirely in the context of their culture. This approach shows much promise in effectively helping refugees heal from trauma, but much more research is needed to demonstrate the effectiveness of the approach on a large scale [31].

9. Conclusions

Mental health professionals have been acutely aware of the ramifications of experiencing repeated traumatic events in childhood, including the potential for intergenerational transmission of the traumas. Researchers have been contributing systematically to the evidence and theoretical base for trauma and crisis intervention for refugees and asylum seekers since the later part of the 20th century [32,33].

Clinicians should work to understand the unique trauma signature of children entering therapy and to understand the trauma signature of adults who experienced forced migration from Latin America as a child or adolescent.

Effective assessment and care requires the therapist to be alert to the early childhood experiences and the impact of those experiences on the child. Understanding the adverse childhood experiences of each individual can help the clinician tailor therapy to the individual and help the therapist provide culturally sensitive care.

Conflict of Interest

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References

1. UNHCR, 2015. UNHCR Global Trends – Forced Displacement in 2014. UNHCR. <https://www.unhcr.org/556725e69.html>.
2. UNHCR, 2022. Global Trends Forced Displacement in 2021. UNHCR. <https://www.unhcr.org/62a9d1494/global-trends-report-2021>.
3. United Nations International Children’s Emergency Fund (UNICEF). (n.d.) *Migrant and Refugee Children in Latin America and the Caribbean*. UNICEF Latin America and the Caribbean. <https://www.unicef.org/lac/en/migrant-and-refugee-children-latin-america-and-caribbean>.
4. US Customs and Border Protection, 2021. CBP Announces February 2021 Operational Update. US Customs and Border Protection. <https://www.cbp.gov/newsroom/national-media-release/cbp-announces-february-2021-operational-update>.
5. US Customs and Border Protection, 2021. Southwest Land Border Encounters. US Customs and Border Protection. <https://www.cbp.gov/newsroom/stats/southwest-land-border-encounters>.
6. Fazel, M., Stein, A., 2002. The mental health of refugee children. *Archives of Disease in Childhood*. 87, 366–370.
7. DeHoff, L., Hatzichristou, C., Mayes, F., et al., 2017. International collaboration on psychosocial support for refugee children in Greece. *Communique*. 48(4), 1-9.
8. Kaplin, D., Parente, K., Santacroce, F.A., 2019. A review of the use of trauma systems therapy to treat refugee children, adolescents and families. *Journal of Infant, Child and Adolescent Psychotherapy*. 18(4), 417-431.
9. Clauss-Ehlers, C.S., 2019. Forced Migration among Latinx Children and their Families: Introducing Trilateral Migration Trauma as a Concept to Reflect a Forced Migratory Experience. *Journal of Infant, Child, and Adolescent Psychotherapy*. 18(4), 330-342.
DOI: <https://doi.org/10.1080/15289168.2019.1686742>
10. Newnham, E.A., Kashyap, S., Tearne, J., et al., 2018. Child mental health in the context of war: An overview of risk factors and interventions for refugee and war-affected youth. *Mental Health of Refugee and Conflict-affected Populations*. 37-63.
11. Vossoughi, N., Jackson, Y., Gusler, S., et al., 2016. Mental health outcomes for youth living in refugee camps: A review. *Trauma, Violence, & Abuse*. 1524838016673602.
DOI: <https://doi.org/10.1177/1524838016673602>
12. Quiroz, N., 2002. Children first...organisation and recovery in Latin America. *Forced Migration Review*. 15, 12-13.
13. Uribe Guajardo, M.G., Slewa-Younan, S., Santalucia, Y., et al., 2016. Important considerations when providing mental health first aid to Iraqi refugees in Australia: a Delphi study. *International Journal of Mental Health Systems*. 10, 54.
DOI: <https://doi.org/10.1186/s13033-016-0087-1>
14. Newnham, E.A., Pearson, R.M., Stein, A., et al., 2015. Youth mental health after civil war: the importance of daily stressors. *The British Journal of Psychiatry*. 206(2), 116-121.
15. United Nations International Children’s Emergency Fund (UNICEF), 2018. In Venezuela, prevalence of malnutrition among children grows as economic crisis deepens: UNICEF urges coordinated national action to reach children most in need. UNICEF. <https://www.unicef.org/press-releases/venezuela-prevalence-malnutrition-among-children-grows-economic-crisis-deepens>.
16. United Nations International Children’s Emergency Fund (UNICEF), 2021. Child Migration. UNICEF. <https://data.unicef.org/topic/child-migration-and-displacement/migration/>.
17. International Crisis Group, 2017. Mafia of the poor: Gang violence and extortion in Central America. *Latin America & Caribbean*. 62.
18. Sapountzis, I., 2022. Reflections on Trauma Systems Therapy for Refugees (TST-R): A commentary on Dr. Franco’s paper. *Journal of Infant, Child, and Adolescent Psychotherapy*.
19. Franco, F., 2022. Recognizing and treating complex post-traumatic stress disorder in refugee children. *Journal of Infant, Child, and Adolescent Psychotherapy*.
DOI: <https://doi.org/10.1080/15289168.2022.2094674>
20. Myles, P., Swenshon, S., Haase, K., et al., 2018. A comparative analysis of psychological trauma experienced by children and young adults in two scenarios: evacuation after a natural disaster vs forced migration to escape armed conflict. *Public Health*. 158, 163-175.
DOI: <https://doi.org/10.1016/j.puhe.2018.03.012>
21. Mitchell, S.M., Pizzi, E., 2021. Natural Disasters, Forced Migration, and Conflict: The Importance of Government Policy Responses. *International Studies Review*. 23(3), 580-604.
22. Ocean, S.E., 2020. Family Environment and Attach-

- ment in Relation to Complex Trauma and C-PTSD. Graduate Student Theses, Dissertations, & Professional Papers. 11656. <https://scholarworks.umt.edu/etd/11656>.
- 23.Schore, A.N., 2003. Affect dysregulation and disorders of the self. Norton & Company.
- 24.Leung, J.P., Britton, A., Bell, S., 2016. Adverse Childhood Experiences and Alcohol Consumption in Midlife and Early Old-Age. *Alcohol and Alcoholism*. 51(3), 331–338.
DOI: <https://doi.org/10.1093/alcac/agv125>
- 25.Shultz, J.M., Garfin, D.R., Espinel, Z., et al., 2014. Internally displaced “victims of armed conflict” in Colombia: the trajectory and trauma signature of forced migration. *Current Psychiatry Reports*. 16, 475.
DOI: <https://doi.org/10.1007/s11920-014-0475-7>
- 26.Shultz, J.M., Neria, Y., 2013. Trauma signature analysis: State of the art and evolving future directions. *Disaster health*. 1(1), 4–8.
DOI: <https://doi.org/10.4161/dish.24011>
- 27.Kessler, R.C., McLaughlin, K.A., Koenen, K.C., et al., 2012. The importance of secondary trauma exposure for post-disaster mental disorder. *Epidemiology and Psychiatric Sciences*. 21(1), 35-45.
DOI: <https://doi.org/10.1017/s2045796011000758>
- 28.Bragin, M., 2019. Myth, Memory, and Meaning: Understanding and Treating Adolescents Experiencing Forced Migration. *Journal of Infant, Child, and Adolescent Psychotherapy*. 18(4), 319-329.
DOI: <https://doi.org/10.1080/15289168.2019.1691892>
- 29.Hinton, D.E., Patel, A., 2018. Culturally Sensitive CBT for Refugees: Key Dimensions. N. Morina, A. Nickerson (eds.), *Mental Health of Refugee and Conflict-Affected Populations*. Springer Nature.
DOI: https://doi.org/10.1007/978-3-319-97046-2_10
- 30.Ellis, B., Miller, A., Baldwin, H., et al., 2011. New directions in refugee mental health services: Overcoming barriers to engagement. *Journal of Child and Adolescent Trauma*. 4, 69-85.
- 31.Soltan, F., Uphoff, E., Newson, R., et al., 2020. Community-based interventions for improving mental health in refugee children and adolescents in high-income countries. *The Cochrane Database of Systematic Reviews*. 6.
DOI: <https://doi.org/10.1002/14651858.CD013657>
- 32.Apfel, R.J., Simon, B., (Eds), 1996. *Minefields in Their Hearts: The Mental health of Children in War and Communal Violence*. Yale University Press.
- 33.Garbarino, J., Kostelny, K., Dubrow, N., 1991. What children can tell us about living in danger. *American Psychologist*. 46(4), 376–383.
DOI: <https://doi.org/10.1037/0003-066X.46.4.376>