In-depth material:
Targeted support by specialised professionals for unaccompanied children with development issues

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1.1 Introduction

Module 1 of the Alternative Family Care manual says that most unaccompanied children have a lot of resilience, and have generally had a happy childhood with sufficiently safe relationships and secure attachments. Most unaccompanied children develop well in Europe as long as they have basic safety, good support and understanding, and an adequate social network.

This in-depth material describes the ways to support unaccompanied children with development issues. These children need extra support for their personal development. The material deals with a number of problematic attachment and psychological problems that may put the development of young unaccompanied children at risk. These include trauma, depression, suicidal behaviour and inappropriate behaviour. Ways to offer specific psychological assistance to refugees are also discussed.

Several issues are addressed from a variety of angles, influenced by experiences in different European countries. This helps professionals to choose the approach which is the most suitable in their particular situation.

The material was developed primarily for specialised professionals. It offers targeted training for those interested in supporting unaccompanied children with personal development issues, such as therapists, psychologists, behavioural scientists and other practitioners responsible for treatment.

1.2 Problematic attachment

This section discusses the theory of attachment, different views on attachment from an intercultural perspective, and opportunities for screening and treatment of problematic attachment.

1.2.1 Theory of attachment

Attachment is a lasting emotional bond that a child develops with the caregiver based on acquired experiences with that person (Bowlby, 1980).

Attachment theorists say that children are born with the ability to attach themselves to their primary caregivers. Whenever the child experiences situations where there is danger – hunger, cold, fear, illness or any other form of stress – they show attachment behaviour and seek the protective presence of a caregiving adult. The corresponding behaviour may be quite diverse: crying, thrashing about and other ways to attract attention. When caregivers deal with this well, the child will experience others and the outside world as safe (Savenije, van Lawick & Reijmers, 2008).

By becoming attached to an adult, the child develops a mental image of human beings in general. This can be an image of availability and willingness, when the child is securely attached, or of inaccessibility and rejection, in cases of disorganised attachment. Attachment theory calls this the internal working model of the attachment. This model contains expectations about others and about the child themselves. The working model is changeable: positive experiences with carers can change a disorganised model into a secure model. And a person can develop different patterns towards different people (Fonagy, 1991).

Four attachment patterns have been identified:

1. Secure: children who are securely attached will seek contact with and proximity to their attachment figure when they feel distressed (Ainsworth, 1979). When reunited with their caregiver, they will feel easily comforted and will return to exploration. Securely attached children have recurrently experienced that their caregiver is available and responsive.
2. Insecure-ambivalent: these children often have experienced that their caregiver is inconsistently available and responsive. They maximise their attachment behaviour and

display a combination of excessive proximity-seeking and ambivalent reactions upon reunion (Ainsworth, 1979). They do not feel easily comforted.

3. Insecure-avoidant: these children have generally experienced that their caregiver is unavailable or even rejecting. They will not seek contact with their caregiver, but will instead minimise their attachment behaviour and avoid proximity (Ainsworth, 1979).
4. Insecure- disorganised: these children have experienced unpredictable, frightening caregiving. They do not have a consistent, organised attachment strategy to deal with stressful situations.

Under normal circumstances, children develop the first attachment relationships when they are between 6 and 12 months old. This generally involves several caregivers, especially in extended family cultures. The tendency of a child to attach cannot be postponed if the circumstances of the upbringing are bad (Juffer, 2010). Children who are neglected or maltreated also attach to their caregivers, but generally have an insecure, qualitatively worse relationship with them (Cyr, Euser, Bakermans-Kranenburg & van IJzendoorn, 2010).

A child who is attached to one or more carers learns to distinguish between themselves and others. The child thus develops the ability to mentalise (Fonagy, Gergely, Jurist & Target, 2002). Mentalisation means reflecting on your own and someone else's behaviour and feelings. Especially children with severe attachment problems turn out to be mentalising poorly (Allen, Fonagy & Bateman, 2008). These children therefore are much more sensitive to developing psychopathology later in life (de Wolff, Dekker-van der Sande, Sterkenburg & Thoomes-Vreugdenhil, 2015).

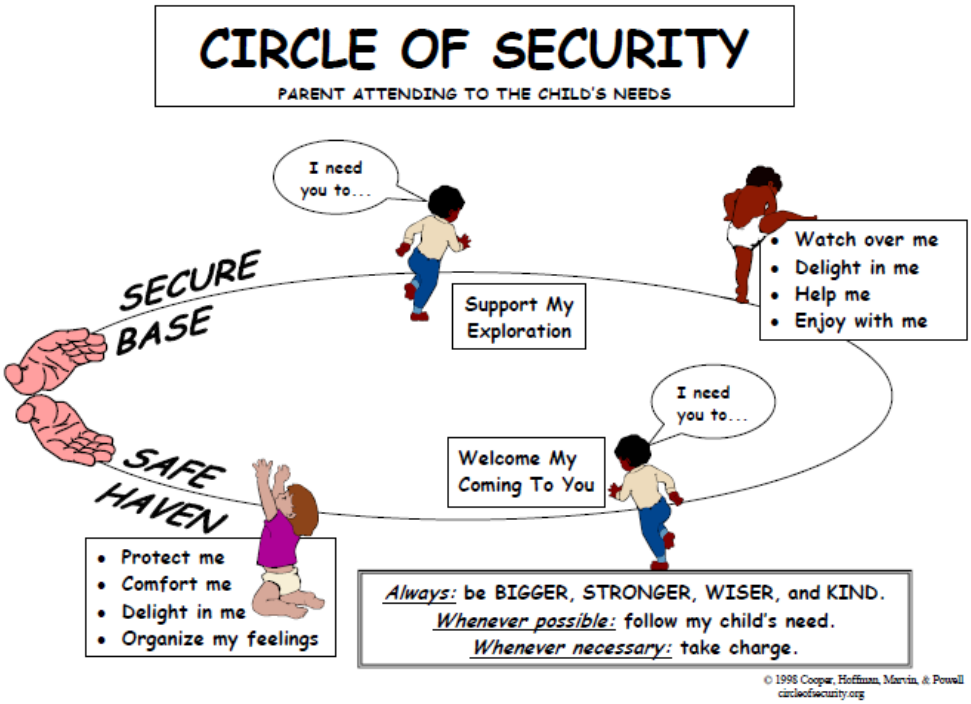
There are three basic needs for developing secure attachment (Juffer, 2010):

1. Reacting in a sensitive and predictable way to the child. The upbringer is receptive to the signals of the child, understands these signals and responds to them in a predictable way, quickly and adequately. The child learns from this that the caregiver is available as a safe operating base A safe operating base is created while stimulating the self-confidence of the child by having fun together but also by offering structure and setting boundaries. Safety is offered by comforting a child who is grieving and reassuring a child who is experiencing fear, anger or other emotions. See Circle of Security below.
2. Continuity in the presence of the attachment figures. The number of adults taking care of the child is preferably not too big and does not change too often. It has been estimated that the maximum number of adults that children can get attached to is around six (van IJzendoorn, 2008). Too many breakdowns in attachment adversely affect the possibility of experiencing secure attachment.
3. Mentalisation by the caregiver. This means that the caregiver is aware of the feelings and thoughts of the child, recognises them and takes this into consideration in their own behaviour towards the child. A caregiver who mentalises puts themselves clearly in the perspective of the child. Mentalisation is, for example, identifying what the child does,

thinks and feels (de Wolff, Dekker-van der Sande, Sterkenburg & Thoomes-Vreugdenhil, 2015).

Good example: Circle of Security

The behaviour of children shows if they trust the caregiver to mention the signals they are giving and to react to them in a direct and adequate way when necessary (secure attachment). Children show their attachment by contacting their caregivers when they feel frightened, sad, insecure or ill. Concerning the attachment behaviour of the child, it is important that the child wants to be connected to the safe operating base that the caregiver provides. This secure base offers the child an operating base for exploring and a safe base to return to in case of emergency (Juffer, 2010). This is shown in the Circle of Security below.



The effects of attachment

Juffer, Professor of Adoption Studies at Leiden University (2010): “Research shows that children who were securely attached in early childhood develop better, socially and emotionally, than children who were insecurely attached to their caregivers at a young age. A meta-analysis (Fearon et al., 2010) of 69 studies with a total of 5947 researched children showed a significant connection between insecure attachment and externalising behavioural problems (such as aggressive behaviour). Children who are insecurely attached show more externalising problems than securely attached children”.

3.2.2 Attachment from an intercultural perspective

Attachment has been studied in several ways and views on the universal value of attachment and parental sensitivity vary. Two of them are explained below.

Crittenden and Claussen (2003) say that the behaviour described for securely attached children is exactly the behaviour that fits our Western society and culture. We want children who can communicate their intentions and ideas in an open and direct way. So secure attachment becomes the standard for psychological health. In this way, the theory has moved away from its origin, namely dealing with danger and stress. Dealing with danger requires all kinds of behaviour. In a totalitarian society, open communication about feelings, ideas and intentions is life-threatening.

Van IJzendoorn (2008) concluded in a cross-cultural study on attachment that patterns of attachment are context-sensitive. They adapt in a flexible way to the specific habitat the child is born into and has to survive in. There is evidence that secure attachment occurs most frequently in all cultures around the world and that disorganised attachment concerns a minority of children. Most studies reveal the same connection between secure attachment and parental sensitivity. Attachment behaviour can be specific to the cultural context (for example, to reach for the hand of the mother instead of searching for closeness as a sign of secure attachment), but patterns of attachment can be described in the same way for different cultures. Parents and experts from diverse cultures judge secure attachment the same way, and when parents describe their ideal child they express a preference for secure attachment.

1.2.3 Screening and treatment of problematic attachment

Screening for problematic attachment

Problematic attachment can manifest itself in different ways, therefore many people find it difficult to recognise. The most visible signs are behavioural and/or emotional problems. The symptoms a child shows depend on many factors, including past experiences and the temperament and resilience of the child. Underneath the visible symptoms is often the fear of losing their caregiver or being rejected by others. The child has developed strategies that previously helped them to protect themselves and sometimes even to survive. But these strategies now increase the risk of developmental and social problems. Generally speaking, they are not confident that the other person, or that person's love, is there for them and will always be there[1].

Screening instruments

[1] Retrieved from www.basictrust.com

The list *Signals of Disturbed Attachment Behaviour* (Boris & Zeanah, 2005)[2] screens children on many of the elements in the Circle of Security mentioned above: affection, wanting comfort, trusting others, asking for help, cooperation, exploratory behaviour, controlling behaviour, reactions to reunification and return, and reactions to strangers.
This list is recommended in the *Directive on problematic attachment for the Dutch youth care system,* as well as the *Attachment Insecurity Screening Inventory* (AISI) and the *Emotional Availability Scales (EAS).*

Good practice:
Nidos mostly uses the list *Signals of Disturbed Attachment Behaviour* to assess the level of attachment behaviour in young children living in reception families.

Classification diagnostics
DSM-5 classifies attachment disorders as trauma and stress related disorders. DSM-5 distinguishes between two different attachment disorders:

1. Reactive or inhibited attachment disorder (RAD):
   no or very little attachment behaviour.
2. Disinhibited social engagement or attachment disorder (DSED):
   uncritical in search for attachment figures.

Treatment of problematic attachment
There is no consensual definition or assessment strategy, nor are there established guidelines for treatment. The scientific basis for attachment theory is limited, both in terms of its ability to predict future behaviours and, especially, with regard to its use as the underpinning theory for therapeutic intervention with children experiencing conduct problems (Barth, Crea, John, Thoburn & Quinton, 2005). Furthermore, within an attachment approach in foster care, the focus lies exclusively on the understanding of the behaviour of the foster child. This is attractive for foster parents, because it offers an explanation of the behaviours and specific needs of the foster children (Herbert & Wookey, 2007). It is, however, important to find a balance between understanding and showing empathy for the child's problems and effectively reacting to the behavioural problems, a balance that can be found in the non-violent resistance approach.

If a foster child's problems are framed too much within their history, foster parents might fail to do something about these behaviours, either because of compassion for the foster child or because of the assumption that they cannot do anything about it. Moreover, how to treat the disorder and restore attachment security is inadequately described by any attachment theory. Until a few years ago, even prominent researchers were convinced that the first years of life (some explicitly mentioned the first six years) determine the development of attachment. This pessimistic, almost fatalistic, vision made it useless to seek

[2] The list can be found on: http://richtlijnenjeugdhulp.nl/problematische-gehechtheid/signalering-en-diagnostiek/conclusies-en-stappenplan/

treatment because there was nothing to be done. Furthermore, in foster care it has long been thought that foster parents should not become too attached to their foster children, because foster care was seen as a temporary intervention, and this would complicate the return home. But now we know that:

- every child forms an attachment; not being attached is impossible;
- attachment security cannot be taken with, because attachment involves a unique bond between a caregiver and a child;
- children can have different attachment figures;
- there is no age limit for the onset of secure attachment, but the older the child, the more time and the more work it takes. Indeed, meta-analytic findings suggest that foster children show impressive although incomplete catch-up after their placement (cf. disorganised attachment in maltreated and institutionalised children = 73-93%, in foster children = 31%, normative = 15% - (van den Dries, Juffer, van IJzendoorn & Bakermans-Kranenburg, 2009).

Interventions

Interventions should acknowledge the origin of the problems but focus on current interpersonal interactions. The most important challenge is to come up with an intervention that focuses both on the bond between the child and the caregiver (warmth/sensitivity) and the behavioural problems (contingency/predictability).

In the Netherlands, there are a number of proven effective interventions aimed at improving attachment. Most interventions focus on the interaction between the child and the upbringer, and work on skills such as sensitive upbringing behaviour. A well substantiated preventive intervention is Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD). There are also several acknowledged interventions for treating attachment disorders. Some interventions address the interaction between child and upbringer, and work on parenting skills, such as the Basic Trust method and the Parent-Child Interaction Therapy (PCIT). There are also interventions aimed at treating the child, such as Integrative Therapy for Attachment and Behaviour (ITGG)). They are all explained below.

Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline(VIPP-SD) is a behaviour intervention for parents with children aged 1-3. The programme aims at preventing or reducing behavioural problems by strengthening parenting skills. It focuses on positive interaction and sensitive discipline strategies. This is done during six home visits and by giving feedback on video recordings of interactions between parent and child.

The Basic Trust method is a short-term intervention for children aged 2-5 with behavioural and/or emotional problems. It can also help their caregivers if there are problems within the attachment relationship. In eight sessions of Video Home Training (VHT), the focus is on

reducing the child's problems. This method is also used for older foster and adopted children, in residential care settings, and by Nidos in reception families.

Parent-Child Interaction Therapy (PCIT) is a protocolised treatment programme for children aged 2-7 with behaviour disorders and their parents. By improving parenting skills, the intervention aims to reduce the child's behavioural problems and the parents' stress.

Integrative Therapy for Attachment and Behaviour (ITGG) is a psychotherapeutic intervention for children up to the age of 18 with multiple disabilities and severe attachment and behavioural problems. It is used in situations where other interventions for providing support in daily life have not been effective. The programme involves three hours a week in the child's daily environment and consists of three phases: building up an attachment relationship, behavioural therapy, and generalisation in the daily environment. ITTG may be needed for up to a year.

Good practise:
In Belgium and the Netherlands, residential youth care workers are increasingly adopting the New Authority approach developed by Omer, professor of psychology in Tel Aviv. Minor-Ndako's experience with this method is very positive (see box below).

Non-violent resistance (NVR), New Authority and the Anchoring function
If adults (parents, foster parents, upbringers, teachers) are confronted with the problematic behaviour of children and young people, it often provokes feelings of impotence and helplessness. There is much debate on the best ways of coping with this, fluctuating between tough (traditional authority) and soft (liberal) styles of upbringing.

Non-violent resistance (NVR)
In order to empower parents in these situations, professor Haim Omer and his team in Israel developed a short-term intervention programme, inspired by the ideas of non-violent resistance (Mahatma Gandhi & Martin Luther King). In this programme, parents are trained in four areas of interventions: training to avoid processes of escalation; learning how to actively resist problematic behaviour; stimulating positive interactions (for instance, by making gestures of reconciliation) and mobilising the parents' network. In this way, helplessness and powerlessness may decrease and parents can resist this kind of behaviour.

New Authority
Omer and his team developed more preventive ways to deal with violent or destructive behaviour in their theory of the New Authority, based on presence, self-control (*'only you can control yourself'*), persistence (*'you don't have to win, you just have to persist'*),

transparency, cooperation and involving a supporting network (*'it takes a whole village to raise a child'*). New Authority stands for vigilant care, 'keeping your finger on the pulse'. This means that adults adjust their care to the degree of concern for the child or young person. It has three levels and is dynamic.

An open dialogue is the first level and is characterised by spontaneous and honest conversations based on trust and interest. Adults can show that they trust the child to prevent themselves from danger and to talk about unpleasant incidents. The child can trust the adult to react in the right way and protect them if necessary. This open dialogue can be stimulated by expressing active and sincere interest in the social environment of the child by asking questions. The adult takes responsibility by keeping their finger on the pulse and being alert to signs of danger.
At the appearance of a sign of danger, parental presence will be raised (the second level). This is explicitly announced: 'Based on what has happened the last few months, we have decided that we should know who you are going out with, where you will be and when you will come home. From now on, we will ask about these things when you go out' (Omer 2011, p. 59). The transition from a heart-to-heart conversation to these specific questions is not usually a smooth one. That is why there are several guidelines for having these conversations in a de-escalating way. The changing attitude of an adult is difficult for a young person to deal with but it reflects the responsibility that is being taken.
Vigilant care can be upgraded to a third level, the level of one-sided action.

When adults think that the development of a young person is at risk, there is open non-violent resistance to any harmful action or relationship. This is an effort that takes patience and persistence in cooperation with a supporting network for the parents/ foster parents/teachers. The goal of non-violent resistance is ending the destructive behaviour of the child without this leading to escalation (Omer, 2007). A toolkit of different methods that can be used has been developed, including the announcement, text messaging, recovery measures, reconciliation gestures, telephone support and network meetings,
Non-violent resistance is more than a collection of techniques. It is a coordinated set of interventions resulting from a vision of mutual strengthening (Huybrechts, 2013).

The Anchoring function
According to Omer (2013), the characteristics of the New Authority correspond with the conditions for safe attachment. He uses the metaphor "the anchoring function" to add a dimension of authority to the acknowledged functions of safe haven and secure base that are seen as core to a secure parent-child bond.

In the New Authority, the adult keeps "clinging" to the child: I am here and I will stay here, whatever you do, and you have the freedom to move around, but when you are in dangerous waters, I will stop you. Even a small anchor can stop a big vessel. Make sure you

have a firm anchor (network) and a strong cable that fits the needs of the child (vigilant care). This image can also be used to describe the child's later processes of internalisation: when the ship is big enough and sails away, they take the anchor on board, where it remains and can always be used later if necessary (Thys, 2013).
Parents who fulfil an anchoring function offer the child a secure relational frame, while also manifesting a stabilising and legitimate kind of authority.

More information can be found on: www.newauthority.net

1.3 Psychological issues

This section explains the most common psychological problems seen in unaccompanied children and possibilities for treatment. But first, different perspectives and solutions for health problems in general will be discussed.

1.3.1 Ideas about health from an intercultural perspective

In many cultures it is not customary to make a distinction between psychological and physical causes of ill-health. On top of that, mental illness is considered a kind of madness and something to be ashamed of that damages the family honour. So in these cultures, symptoms someone may be experiencing are not likely to be diagnosed as the result of anything other than a physical complaint.

As described in module 1 of the Alternative Family Care manual, emotional symptoms are sometimes explained as the result of supernatural forces. Children, for example, say that they were caused by a djinn or the evil eye, or that they are the victim of black magic. This is quite common, but children are ashamed to talk about it. They feel that explaining psychological symptoms as something supernatural will not be understood by many Western social workers or will at least seem strange.

The conviction that 'something' (that we cannot directly observe) influences human beings does, however, occur in many religions and societies. For example, believing in the angel, the devil, God, Allah, Jehovah, evil spirits, karma, faith, energetic powers and extraterrestrial creatures.
All over the world, people confronted with illness, suffering or problems search for explanations for their emergence and suitable treatment. Orlemans, Eelen and Hermans call this the 'personal illness and treatment theory' (2007). In this theory, there are differences and resemblances within the same society but also between different societies. Different people within one society may have completely different illness and treatment theories. One person can attribute their symptoms to a disturbance within themselves, whilst another person with the same cultural background attributes the same symptoms to a disturbance outside themselves.

Communication problems can occur when the social worker approaches (psychological) illness and treatment from their own point of view, without exploring that of the child. Especially when these views are very different. The child can get the feeling that the social worker does not understand them or become convinced that the social worker cannot help them anyway (Kleinman, 2005). It is therefore important to talk to the child about what they think is the cause of the disorder, and to look together for a way to treat it. Some children know about certain treatments from their country of origin, such as herbs and plants, or find strength and healing in their religion. By visiting holy sites, for example, or by praying and wearing amulets. These options can be taken into account as part of the treatment. It is not, however, advisable to agree to extreme treatments such as exorcism and certain purification rituals that may include a form of violence.

Good practice:
Nidos does not allow young Eritrean children in the Netherlands to expel evil spirits with violence. A priest is called instead to expel them by praying. This is accepted by the children without any problems.

If the child has a severe emotional disorder which affects their daily life, treatment from a transcultural psychologist is a logical step. Their experience and knowledge of different cultures enables them to assess to what extent the child has a strong belief in a certain phenomenon or if there really is a psychiatric problem. The psychologist will respond appropriately to ideas from another culture and set suitable treatment in motion.

An example:
A Dutch guardian was worried about an Eritrean girl with very severe trauma symptoms who did not want to talk to a psychologist. The guardian called a priest and explained the situation. She then took the girl to the priest, who expelled evil spirits by praying and also advised the girl to talk to a psychologist. The girl happily told the guardian that she was now ready to see a psychologist.

1.3.2 Post-traumatic symptoms

A trauma is a radical, unexpected, acute or repeated life-threatening or shocking experience that overwhelms the individual and makes him/her powerless and helpless for a longer or shorter period of time (Decraemer, 2010).

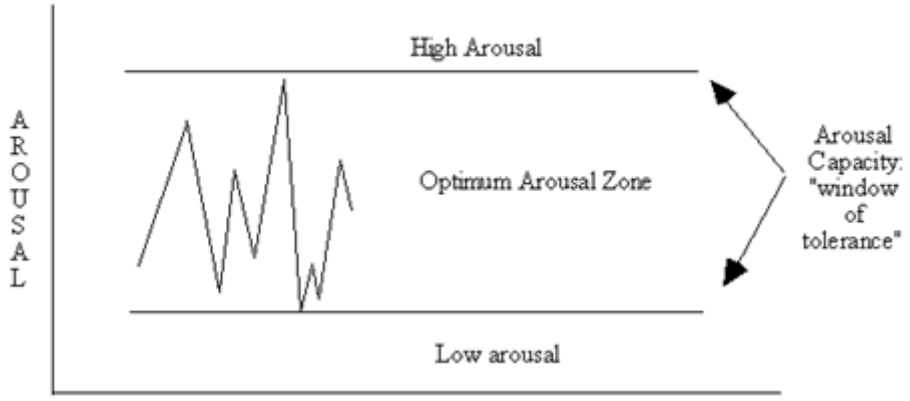
The traumatising nature of an emotionally shocking experience is determined by factors such as the assessment and interpretation of the danger of the experience by the individual involved, and not by objective features of the situation.

Chronic stress and traumatisation

During the first period after arrival, unaccompanied children definitely have to deal with stress caused by the procedure, uncertainty about the future, disorientation, as well as missing and worrying about their family. Many were traumatised before and/or during the journey. As a result, many unaccompanied children have to deal with 'chronic stress', which can considerably affect their functioning. The brain may lose the ability to concentrate and regulate emotions, so children may be flooded with emotions, thoughts and relived experiences, which reduces their capacity for remembering and storing information. Some stress in daily life is necessary and good for learning, but too much stress is unhealthy.

Theory about stress and trauma

The stress zone tolerated by the amygdala (in the brain) is sometimes called the 'window of tolerance'. If the stress remains within these levels, the brain can handle the stress well. A child (or adult) can experience the emotions, bodily sensations, and thoughts that belong to an experience without the defence system having to become active. Because the child remains within the 'window of tolerance', they can process that experience effectively. With traumatic experiences, if the stress level is no longer tolerable and too much danger threatens, the defence system is activated. To divert the danger, the body may bring itself into a state of heightened or hyperarousal. In a state of hyperarousal, threatening danger is met with a direct reaction – heartbeat and muscle tension increases, the child is attentive and alert, the senses become hypersensitive, everything is focused on the threatening danger, as dopamine and noradrenaline are released. It is a situation where active defence against danger is used, such as fight, flight, or 'active' freeze. If the brain assesses that active defence is actually hindering survival and will not be able to avert the danger, it proceeds to passive defence where the body prepares itself for very serious injury, a kind of shock situation, in which as much energy as possible is saved. The body moves to a state of lowered or hypoarousal and the brain temporarily loses the ability to assess danger, and the ability to think and solve problems has been switched off. A situation of hypo-arousal is accompanied with slower heartbeat and superficial slow breathing, reduced blood circulation and hypothermia. A stream of opiates is released, reducing pain and causing a kind of rest. Passive survival states include submission or 'passive' freeze (paralysis). Both defence systems, hyperarousal and hypo-arousal, are also observed in animals (Struik, 2011).



Due to traumas and chronic stress, the 'window of tolerance' of unaccompanied children is often very small. They enter a state of hyperarousal or hypo-arousal faster, or remain in it longer. In hyperarousal, they are constantly alert, easily alarmed, react in an agitated manner, quick to anger, or react fearfully to specific triggers. In lowered or hypo-arousal, specific triggers make them stiffen or stare ahead and they are very passive. To process traumas, the 'window of tolerance' must be sufficiently large, or the limit will be quickly reached again and this requires effective emotion-regulating skills.

Trauma treatment

Giving *psycho-education* about the functioning of the human stress system and how that works for a chronically stressed unaccompanied child is a good support option and can be part of treatment.

The goal of psycho-education in cases of post-traumatic stress is to frame and reduce the symptoms. Framing is how the symptoms are related to the terrible events and are worsened by sudden and radical uprooting, confrontation with the strangeness of the host country and uncertainty about their own faith and that of those they are missing and have left behind. It is important to understand that traumatic reactions are normal reactions to abnormal situations.

Tool: Psycho-education about post-traumatic symptoms

After a traumatic experience, a child may develop psychological symptoms. They feel depressed and **tired,** and tend to fret and worry. The child may notice this immediately after the shocking experience. But they may only discover later that the experience has had a big impact on them. Thinking about the horrible experience often causes so much pain, sorrow or fear that they would rather avoid these memories.

The consequence is that the memories keep forcing themselves on them, accompanied by the fear they experienced at the time. These **flashbacks** are so intense that it seems as if they are experiencing them again. The child may have recurring nightmares in which the

experience flashes through their mind like a film. If they see or hear something related to the shocking experience, this evokes very strong emotions. They feel the **tension** and panic in their body, their heart beats faster and they get headaches.

A child suffering from Post-Traumatic Stress Disorder Syndrome (PTSD) is irritable. They feel tense and **restless**, and always on the alert. They may have sleeping problems and difficulties concentrating. Other people often notice that they are fearful and easily irritated. The confrontation with what happened is often so painful that they want to avoid it. They avoid situations related to the painful experience and try not to think about it. It is as if their emotions are dulled, they feel listless and don't want to do anything. They would rather forget what has happened and get on with their life. Maybe they are scared what will happen if they allow memories to pop into their minds.

Such a traumatic experience may have a negative effect on the way the child thinks about themselves, other people and the world. They may suffer from feelings of shame and **guilt** and have less confidence in other people. They feel lonely and insecure; have the idea that they are not safe, that a bad experience is about to happen. The child's self-image and self-confidence are affected[3].

Trauma treatment in practice

Unaccompanied children often refuse to talk about their traumatic experiences or depressive feelings. There are many different reasons/explanations for this. One explanation is that talking about negative feelings is not customary in the child's culture. Sometimes the child's negative experiences can even damage the family honour, for example if a child was raped. Another explanation is that for some children coping means looking forward instead of looking back: their focus is on the future. Talking about bad experiences makes no sense to them. This attitude doesn't fit with the traditional dominant idea of Western trauma treatment, which is partly based on reframing the negative experiences and fears by talking about them.

Trauma treatment options

There are several options for treating trauma directly or indirectly. One of these options is working with *narrating experiences.* Narrating experiences helps people to gain control over feelings and events. This can be done by talking, writing stories, reading literature and poems on the subject, drawing and making music. White (2005) suggests that it is better to focus first on the story of resilience, on how people cope with difficulties and the values that are lost due to trauma (what is important for you?) than to immediately approach the child's trauma, physical pain and difficulties in the past, which reduces them to being exclusively victims. He calls this the development of subordinate storylines.

Working with *metaphors* and *visualisation* will also help to express the unspeakable, the unsaid and the ambivalent. Giving the child or young person the opportunity to see and read a story gives them the opportunity to be an observer. This might enable them to reflect on

[3] Retrieved from www.interapy.nl

their own story, and a confusing story can become clear or new meanings can be created within the symbolic space of the metaphor. Memories become vague and less painful and it leads to better understanding and more distance from the events at the same time. It is, however, advisable to do this under the guidance of a specialised social worker.

The last important part of the treatment of post-traumatic stress is stimulating future prospects, which is a crucial developmental task for adolescents. Not all authors share this opinion. Jongedijk (2010) recommends not emphasising the future too much in contact with a traumatised client.

Borra (2002) also emphasises the importance of narrating experiences and stimulating future prospects in the treatment of traumatised refugee children. At the same time he underlines the importance of the "actualisation of loyalties". This enables the client to be loyal to essential attachment figures. That is even possible if these people are dead, missing or out of reach. It is about remembering and positioning themselves in their relationships with these people, thus empowering and motivating the client to put themselves at the centre.

Protocols have also been developed for working directly with specific elements of a traumatic event, for example EMDR and NET to prevent persistent flashbacks and nightmares, and to reprocess experiences that have been lodged 'in the brain'.

NET (Narrative Exposure Therapy), developed for traumatised refugees, seems to be very effective for children in refugee camps. Specific to this method is that not only traumatic experiences are recalled but also beautiful and important experiences in the life of that person. People talk about all the stressful events they have experienced, in chronological order from birth until the present moment. This way, a timeline is created in which negative experiences are marked with stones and beautiful experiences with flowers[4]. People who are able to tell a cohesive story about their traumatic experiences benefit the most from the e*xposure*, which proves that creating a meaningful story also supports recovery.

NET aims to construct a cohesive autobiographical representation of traumatic events within the context of a story of the person's whole life [5].

Trauma treatment using EMDR (Eye Movement Desensitisation and Reprocessing)
In practice, EMDR appears to be effective treatment for traumatised child refugees, even when there are still uncertainties regarding living situation and residence permit. In EMDR, internal focus is on the experience of the traumatic memory, while external diverting stimuli ensure that the trauma is integrated. It is not necessary to describe the traumatic experiences completely or to re-experience them fully. The information processing system is

[4] Retrieved from Centrum ' 45, trauma expertise centrum in the Netherlands.
[5] Retrieved from psychotraumanet ttps://psychotraumanet.org/en/search/node/NET.

affected by the treatment, resulting in a fading out of the traumatic memory, where the person will be able to think of the event without becoming emotionally affected. The accompanying pictures become hazy and increasingly fade away. In addition, cognitive restructuring may occur because new insights are connected with the event and it is no longer experienced as quite so threatening. Negative blocking by traumas can be removed by EMDR with positive results often already noticeable after a few treatments.

Risks of (post)trauma debriefing

Debriefing is care given directly after traumatic events, taking into account the facts and thoughts about the event, allowing emotions to be expressed (emotional ventilation) and giving information about stress reactions. A number of randomised studies showed that this kind of care given after the traumatic event generally has no positive effect and sometimes even a damaging effect on the development of PTSD symptoms (Jongedijk. 2010). This author suggests that natural processing of the trauma can be influenced in a negative way because of the stress that information on post-traumatic stress reactions can provoke. The author gives advice for care after traumatic events that is often based on stimulating social support, social activities and relaxation, meeting the person's needs, inquiring about thoughts and feelings, discussing unrealistic thoughts and feelings, and stimulating peer support contact and talking about the events with others (Jongedijk, 2010).

Presence approach

Beenakker-Schelee (2011) argues in favour of a presence approach (Baart, 2004) as a starting point for social workers working with refugees with PTSD. This approach is based on a positive, patient, attentive and non-demanding presence.

1.3.3 Depression

Depression is quite common in unaccompanied children, mostly the result of chronic stress and trauma. Symptoms can be: lack of appetite, apathy, sadness, negative thoughts about the future, thinking about death, not enjoying themselves and a lack of self esteem. Depression easily goes unnoticed because most of the time it imposes internalising behaviour and is therefore not as obvious as, for example, behavioural problems. It is often experienced as difficult by others in the child's environment.

Tips: What helps in cases of depression

It is important to support depressed and dejected children by keeping them active with a regular daily routine and making sure they have an appropriate day and night cycle. Depression can influence mood, thoughts and the body. It is important to find the right balance between burden and capacity to cope by reducing stressors and increasing capacity with the introduction of (enjoyable) everyday activities. This will turn the downward spiral back into an upward one. Being active and doing physical exercise and sports will also have a positive effect on their mood.

1.3.4 Suicidal behaviour and non-suicidal self-harm

Unaccompanied children, most of them living in large reception centres, regularly express a wish to end their life and this makes many care workers feel powerless. Knowledge and understanding of these suicidal thoughts contributes to being able to handle this. Thoughts of suicide often arise as a reaction to problems that seem impossible to solve and, although many people do not actually want to die, they do not want to carry on living their life in such difficult circumstances. As they no longer see acceptable options for the future, thinking of suicide is a form of self-protection: they are protected against even greater disaster, having to live with the idea of a dreadful future, with unbearable feelings of loneliness, or having to live without any feelings. The thoughts may be compulsive and hard to suppress or stop. Worrying continuously, especially during the night when everything seems worse, may result in exhaustion and that may be another reason to think about suicide. In French, worrying is called 'torturer l'esprit', torturing the spirit or, in other words, self-torture. The function of worrying is to protect a person against future disaster but if this becomes too much, then this self-defence can be self-torture. Thoughts of suicide are often accompanied by depression, where everything is experienced through negative thoughts that may become seriously distorted. Much support and treatment may be required to counter these distorted thoughts (Kerkhof & Spijker, 2012).

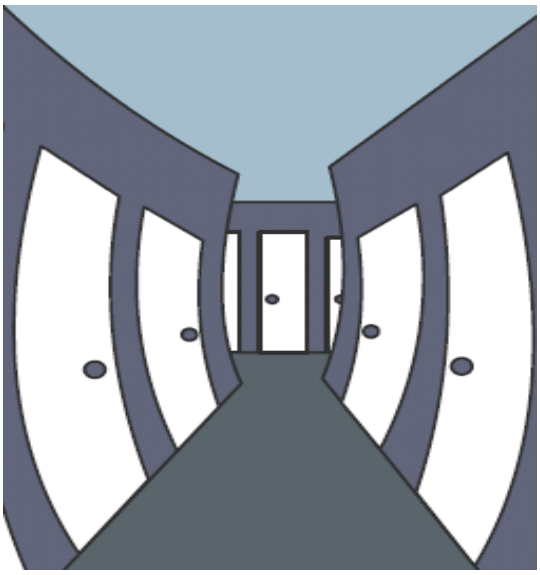
Suicidal process

Before a child actually commits suicide, they have often gone through a long suicidal process. The process, which always precedes suicide, starts with vague suicidal thoughts: "I'd rather not live any longer". These thoughts become more concrete and compelling and may evolve into a detailed suicide plan: "How and when will I do it?" The problem here is that only part of the suicidal process is visible to the person's environment. Suicidal behaviour - actual suicide and attempts at suicide - can be observed but thoughts and plans mostly cannot. Talking to the young person can make the boundary between visible and invisible smaller. In fact, conversations can make plans and thoughts visible. In this way, it becomes easier to intervene and give suicidal young people more support (Van Heeringen, 2001).

People with suicidal thoughts do not always make plans and not all people with plans carry them out. The suicidal process is reversible, and stoppable, but some plans may lead unintentionally to death.

Good example: metaphor for the suicidal process; an ever-narrowing road

Several metaphors are used to indicate the suicidal process: a trap, a tunnel or this ever-narrowing road. The further a person goes along the road (in the narrow part), the less solutions (doors = ways out) you see.



More than 70% of the people who commit suicide have sent out signals beforehand. But most of the process takes place without others in the person's environment noticing or recognising the signals. Underlying signs may reveal that young people have problems and suicidal intent.
It is important to react to the signals and to make suicide a subject of discussion. All young people send out one or more signals of suicidal thoughts at a certain moment. This does not necessarily mean the worst. The risk of suicidal behaviour is greater if several signals occur simultaneously and over a longer period. Sudden behavioural changes – especially with a background of risk factors, gloominess, hopelessness and depression – may be an important sign. For instance, a young person who is usually very sociable suddenly becomes very quiet and withdrawn. Young people express their emotions more easily through their behaviour than with words; so they are more likely to give non-verbal than verbal signals. Lack of sleep as a consequence of brooding reinforces the risk of suicidal behaviour. That's why it is important to pay sufficient attention to these signals [6].

Being alert to signals does not always imply that suicidal behaviour can be predicted. The signs may not be clear and are often only recognised as such afterwards. It is, however, possible to calculate the risks and to activate protective factors.

Assessing the risk of suicide
When several signals occur simultaneously, it is important to discuss this with the young person. Talking about it is the only way to break the negative spiral in which suicidal children and young people may find themselves. Moreover, in order to assess the risk of suicide adequately it is important to clarify how acute the threat is; in other words, we must find out where to situate the young person in the suicidal process. Is it just some vague thoughts

[6] Retrieved from a training of Dienst Suïcidepreventie CGGZ, Brussels, 2013.

occasionally, or do they have concrete plans? The only way to find this out is by asking directly and explicitly. The more concrete the plans, the deeper the young person finds themselves in the narrowing tunnel, the higher the risk of suicide.
Some people avoid the subject of suicide for fear that it may put ideas into the person's mind. This assumption is incorrect. Most of the time young people are relieved if you ask them questions on the subject. This is because they don't dare to bring it up themselves. Talking openly about suicide may help a young person to feel understood and to break out of their isolation. By simply asking them if they have suicidal thoughts, you show that suicide is not a taboo for you.

Consider all the factors and assess how serious they are:

Slight:

The young person has occasional, fleeting thoughts about suicide, hasn't worked out a plan, doesn't think they will commit suicide, can also think about other things, realises what the consequences might be for their family and friends, … but toys with the idea as a possibility. The young person would rather live than die.

Ambivalence*:*

The young person wants both to commit suicide and to go on living. Suicide implies breaking with others, it is related to disappointments in relationships and sometimes there are thoughts about revenge. Suicide is quite an impulsive idea, detailed plans or preparations have not yet been made. The young person alternately wants to die and to live.

Serious:

Thoughts and images of suicide continuously go through the young person's mind; they feel desperate, can't think of anything else, find the idea of suicide very appealing, have considered different methods, have made a detailed plan with various preparations, think it is better for others that he/she no longer exists but can still postpone the suicide for some time. Goodbye letters have sometimes been written. The young person would rather die than go on living and their own impulsiveness scares them.

Very serious:

The young person is desperate, keeps thinking about suicide and doesn't see any of the consequences for the people they leave behind; they have made a detailed plan and may even have practised it. The young person suffers from insomnia and is in a state of emotional collapse. He or she has lost self-control. Vision has narrowed (tunnel vision is the clearest pre-suicidal symptom), is not approachable, sometimes doesn't want to communicate, is restless and desperate, has no energy left to go on living, absolutely does not want to go on living, can't wait much longer to commit suicide. At any moment there could be an impulsive breakthrough leading to suicide.

There are no clear boundaries between these levels. They overlap, but the seriousness of the risk of suicide may differ greatly. A young person can change from slight risk to serious risk and vice versa. Not all of them will fit into the descriptions of the different levels.

Suicide prevention

When giving guidance and support to an unaccompanied child who has suicidal thoughts, it is important to discuss them. What are the thoughts, how concrete are the thoughts, what is it that the child wants to get rid of or wants to stop? The answers to these questions can help assess the seriousness of the threat and what kind of professional help is needed. Concrete thoughts on how to commit suicide are very alarming, whereas not actually having concrete thoughts about the suicide itself but still cutting themselves off from stress reduction and anything else that may help is a far less alarming situation. If the situation is alarming, a safety plan for day and night should be made with support from the child's network.

Non-suicidal self-harm

Self-harm is intentional, direct self-injury to body tissue, mostly done without suicidal intent. Examples of this include cutting, scraping, burning, eating glass, etc. This is seen as a non-verbal way of expressing 'I'm not OK', and that the child does not have any other means of dealing with stress. The reasons why someone self-harms (the function of the behaviour) are manifold. Most often reported are 'regulating emotions (relaxing, stimulating)' and 'punishing yourself' (Klonsky, 2007, 2009). It is very important to find out which function self-harm has for the child and to look for another, less harmful way of dealing with these issues (but with the same function). This way they can distract themselves by focusing on something or someone else (e.g. playing a computer game, chatting to friends) or caring for themselves in a non-harmful way (doing sports, meeting others, etc.) (Claes, 2012).
Non-suicidal self-harm often occurs amongst refugees as a way to decrease stress. Unaccompanied children explain that it distracts them from all their pain, that they don't feel the pain for a moment. It is important not to confuse this behaviour with suicidal behaviour. Suicide and self-harm are linked in different ways. Self-harm can help someone deal with tensions or difficult situations by inflicting pain on themselves, and this can help prevent that person committing suicide. However, it can make a child more vulnerable to suicide because they have already learned to tolerate and be less afraid of pain. Furthermore self-harm can lead to unintentional death.[7]

1.3.5 Destructive or inappropriate behaviour

In reception facilities for unaccompanied children in the Netherlands there is, especially during the first phase of reception, a lot of destructive and otherwise inappropriate and rebellious behaviour such as aggression, vandalism, threats and conflicts.

It is helpful to be able to recognise the cause of this inappropriate behaviour. Does it originate from trauma triggers and a high level of stress – hyperarousal – or is it acquired

[7] Retrieved from a training of Dienst Suïcidepreventie CGGZ, Brussels 2013.

survival behaviour to get something done, or behaviour seen as positive in the home country (like being a good fighter) that was part of the child's education and upbringing?

When destructive behaviour is caused by hyperarousal or trauma triggers, punishment is not effective. The behaviour will not stop, because it is the result of a reflex (classic conditioning). It is important to increase the "window of tolerance" by creating a feeling of safety. Methods to achieve this are: human contact, predictability, structure and reliability. Offering understanding and recognition of the intensity of their emotions gives a good opportunity to connect with the child and search for ways to enable them to foresee this kind of situation by recognising the tension and triggers that can result in an intense outburst. The child can be taught in a cognitive way to prevent escalation by withdrawing from the situation at the right time.

When destructive behaviour is caused by acquired behaviour (operant conditioning), good results can be reached with a behavioural approach in which the child agrees to a reward programme if they succeed in showing new behaviour. This behaviour can be conditioned in a later stage.

Tips: preventing escalation
Working with a 'thoughts report' such as an ABC chart or an Emotional Barometer can help the child learn to recognise situations and their own reactions.

ABC model
To be able to change behaviour, it first has to be understood. Why does a child behave in a certain way? The ABC model shows the connection between factors that precede the behaviour (Antecedents), the behaviour itself (Behaviour) and factors that follow the behaviour (Consequences). An antecedent provokes certain behaviour, it is the reason for this behaviour. The consequence that follows the behaviour reinforces and maintains the behaviour (positive consequences) or reduces the behaviour (negative consequences).

The non-violent resistance or new authority approach described in 3.2.3 can also have good results with children who show destructive of self-destructive behaviour.

1.3.6 Psychological guidance and treatment of unaccompanied children

As mentioned earlier, unaccompanied children often have difficulty with the Western approach to psychological issues. They are generally not used to discussing everything in their lives and often do not know how to describe psychological issues. Nor do they think that talking about their problems will solve anything, as they often experience their symptoms as physical. Specialised transcultural services are therefore more likely to be able to make a real connection with these children.

In this section, several tools are described which can also be used to support and treat unaccompanied children.

Strengths and Difficulties Questionnaire (SDQ)
The SDQ is a screening tool that screens problems and skills in children aged 2-17. There is a short list of questions for children aged 2-4, a separate list for children aged 4-17 (both to be used by parents or teachers) and a self-report for children aged 11-17) . The problems screened are: emotional, behavioural, hyperactivity/inattention and peer relationships. The tool can be used to support the assessment of a child. There may be several reasons for outcomes not matching that assessment. The list is not defining but additional. By working with the SDQ, the psychological functioning of a child can be made visible. Although the list has not been validated for unaccompanied children, the outcomes can be used, for example, as an indication for reception: to determine extra vulnerability and the need for care, and as points of particular interest for a transfer or an action plan. The questionnaires are available in 80 languages as free downloads and can be scored on the site www.sdqinfo.org.

Psycho-education
Psycho-education is always important, as it provides children and their environment (teachers, friends) with insight into the child's functioning. It helps them all to understand the difficulties, which can manifest themselves as worrying, depressed feelings or angry outbursts.

Psycho-education is a method that aims to enable people to acquire competences that contribute to their mental health (Van Daele, Hermans, Vansteenwegen, van Audenhove & van den Bergh, 2010; Buwalda, 2008) and should be effective in mental healthcare for depression (Van Rooijen & Ince, 2013). Psycho-education can be done individually or within a group as part of a treatment or a stand-alone intervention. It can be restricted to information transfer, in which the clinical psychological picture is explained: how it can manifest itself during different phases of life, what causes it may have, how you can cope with the symptoms, and the possibilities for treatment. Information can also be given about acquiring self control, problem solving and cognitive skills. The person will then practise these skills in daily life, sometimes as homework assignments. This promotes their independence and a feeling of being in control of the symptoms and problems and being able to solve them. (Van Daele et al., 2010; Buwalda, 2008).

A sense of control will also be strengthened if the chosen treatment matches religious customs and the views of family and traditional healers. It is also important to take into account the need for secrecy, the hesitation to talk about negative experiences, and gender-specific aspects.

Good practice: using a 'trauma processing line'

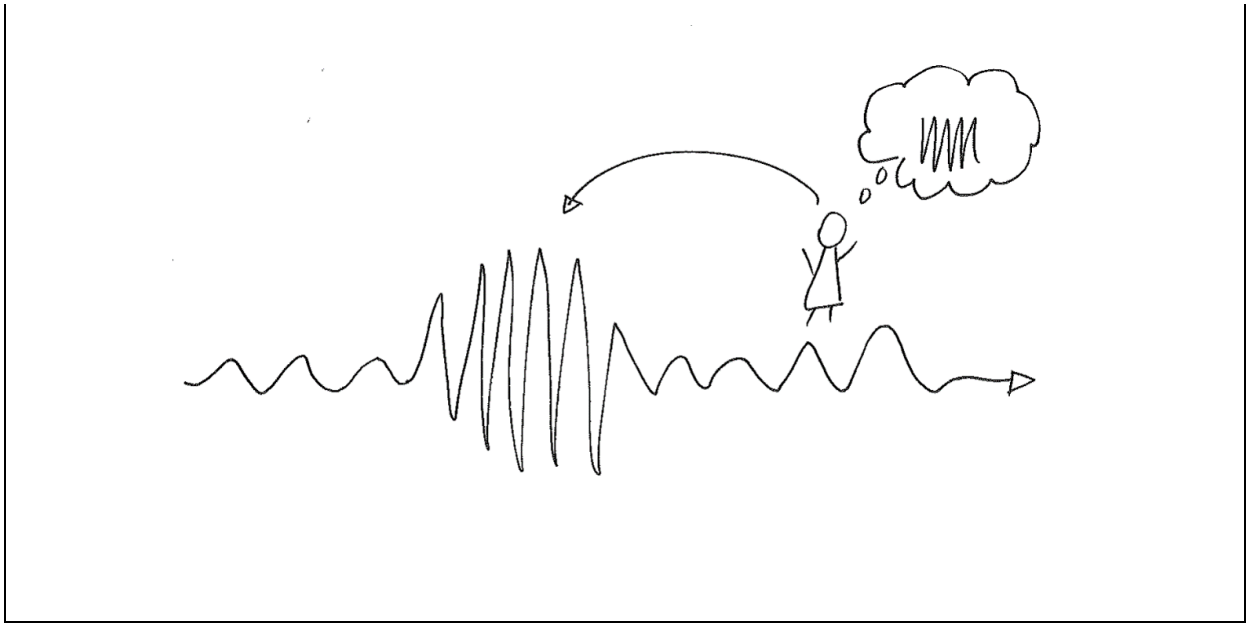
Minor-Ndako uses a 'trauma processing line' for giving psycho-education. A timeline is drawn with the explanation that high waves are the difficult things that you experience, whereas small waves picture normal life with its good and bad moments. If the child wants to do so, they can draw their own timeline and indicate the difficult moments in their life. If the child seems to just want to listen, the therapist can draw an example themselves while explaining it.

A person can be drawn on the timeline whilst referring to difficult things that have happened. The therapist may say the following to the child: 'if someone has had to experience very difficult things, they can have problems much later because of that. When these difficult things happened, you may have been very frightened and tense. You might have reacted in different ways. Some people want to flee, others want to fight, but some people just freeze, not knowing what to do. These are all normal reactions of people in despair who have to very quickly decide what to do.

Most children do not want to relive all those difficult experiences, they want to look to the future. But those feelings may suddenly return, for example when you see something that reminds you of the experience or when you dream of it. These feelings can be very disturbing. The memory can also suddenly pop into your mind. This could make you feel restless, you might find it hard to concentrate or sleep, or notice that you are more alert or get easily irritated.

Some children might keep thinking back to how they reacted to the experience. They can feel guilty because they did something that they would rather not have done. Or because they did not do anything (for example, protect someone).

These are all very normal feelings and reactions to extraordinary situations. Most of the time, the feelings gradually go away after a while. Like a wound that heals: you have a scar but it doesn't hurt anymore. A mental wound doesn't always heal easily. So it is important for people to look at the wound and treat it.'



Cognitive behavioural therapeutic approach

According to Van Rooijen and Ince (2013) most psychological/psychotherapeutic interventions aim at the reduction of fear and mood problems based on the principles of cognitive behavioural therapy. The cognitive behavioural therapeutic approach is based on the assumption that what individuals feel and how they behave is determined by what they think. The effects measured in different studies are not clear-cut, but the author concludes that there is a decrease of symptoms and thus positive effects for both fear and mood problems (Van Rooijen & Ince, 2013). Treatment of depression, also in children, identifies and changes the negative or self-destructive thoughts that evoke depressed feelings by means of 'cognitive restructuring'. This technique is meant to turn the negative meaning that causes depressive feelings into 'better' or 'helping' thoughts (Van Rooijen & Ince, 2013). As soon as self-destructive thoughts are recognised by the social worker, intervention is needed to prevent a negative spiral that evokes more stress and fear (Van Lieshout, 2009).

Mindfulness

An easy accessible intervention that works for both post-traumatic stress and depression in young people is mindfulness (Tan & Martin, 2012). Mindfulness can be given as training for emotion regulation to try to improve the reaction system. It is effective in increasing the awareness and attention given to experiences, thoughts and feelings. This is done by observing and thinking about the many physical sensations of a particular moment while also being aware of emotions, meanings and their understanding of that moment. The values and standards the client has with regard to themselves and others is also part of the mindfulness training. The aim is to accept the sensations without judgement or acting, and to be 'in the remembering' instead of doing all kinds of things to avoid the painful memory (van Deursen, 2006).

Good practice: mindfulness
At Minor-Ndako, a number of children followed an eight-week mindfulness training called Boost Your Mind-Refugees (BYM-V). The programme was adjusted for the target group of young refugees aged around 14 years old. The effect of this programme is currently being researched by professor Peter Kuppens and doctor Katleen Van der Gucht of Leuven University. There is cautious evidence that the programme can be supportive to at least some children for regulating stress and general well-being. The small group of participants and difficulties with measurement tools mean that scientifically underpinned conclusions cannot yet be given.

Good practice: cultural mediator
Minor-Ndako has had positive experiences with group discussions led by a psychologist working together with a cultural mediator. A cultural mediator interprets both language and culture for understanding on both sides.

System approach
System therapy approaches clients' problems in connection with their family and context. Rhmaty, a transcultural system therapist, considers it important that, in dealing with migrants from we-orientated cultures, attention is paid to the larger cultural system rather than, as is the practice, to the nuclear family only. With her clients, Rhmaty examines the family system to identify sources of strength, support figures and solution strategies. Highlighting an important difference between education in Iran and the Netherlands, Rhmaty describes how it is customary in the Iranian culture for parents to make all the important decisions and arrange everything.

Strengths and solutions for clients of we-orientated systems can often be found in the family system, in Fariby Rhmaty's experience. Families form a protective system and have the wisdom required to solve problems. Families can guide you towards sources of power, support figures, advice and solutions that may help a client. If a family is not present physically, they can still be given a place in the support structure.

Rhmaty always looks for weaknesses in the workings of the family system using a genogram and uses the extended family to guide her in ways to heal her client. One of the things she does is to hang the genogram in the treatment room, placing photographs and objects, and ask the client to express the voices of important support figures and people of authority. She asks her client who would be a support figure and what advice the grandmother, uncle or cousin would give, or she may ask them who makes the decisions in the family and what decision this person of authority would take in this case. In that way she embeds the solutions for her client in the original support structure. She asks circular questions such as:

"If grandma was an important support figure in Iran, what would your grandma have advised in this situation?" Rhmaty's experience is that the answer almost always helps to guide her client in their current situation (Rhmaty, 2011).

Support with identity development

As described in module 1 of the Alternative Family Care manual, developing an identity that is suitable to the new environment is an extra developmental task for unaccompanied children.

Good practice: "life story of the cosmopolitan" method

Minor-Ndako has found that the "life story of the cosmopolitan" method can help unaccompanied children to develop an identity that is suitable to their new environment. This specific way of discussing migration and its effects on the identity concept, with attention given to feelings of alienation. was developed by Annelies Huybrechts. It can be used with unaccompanied children who are going to live in a reception family. The method creates a safe way to discuss important topics relating to the past, the present and the future.

A long split arrow is drawn, so that there are in total three arrows with enough space to draw and write in them.

In one of the arrows, a list of countries can be written. Most children like to participate and are happy to share the list of countries they have crossed. Children can also add flags or names of the cities or villages where they have lived and where they are living now.

In another arrow, the houses or places where they have lived can be drawn, together with people who were important to them. Many children also add boats, prisons, mountains, tents, parks or trucks to this part. If the child draws family members, it often shows that they were used to being surrounded by a lot of family and feel isolated here.

In the third arrow, the children can indicate their quality of life in the different periods in their life. They find it easy to follow the instructions that a soft and flowing line means a normal life with its ups and downs, and a strong sharp-edged line means a difficult or very difficult moment or period in their life.

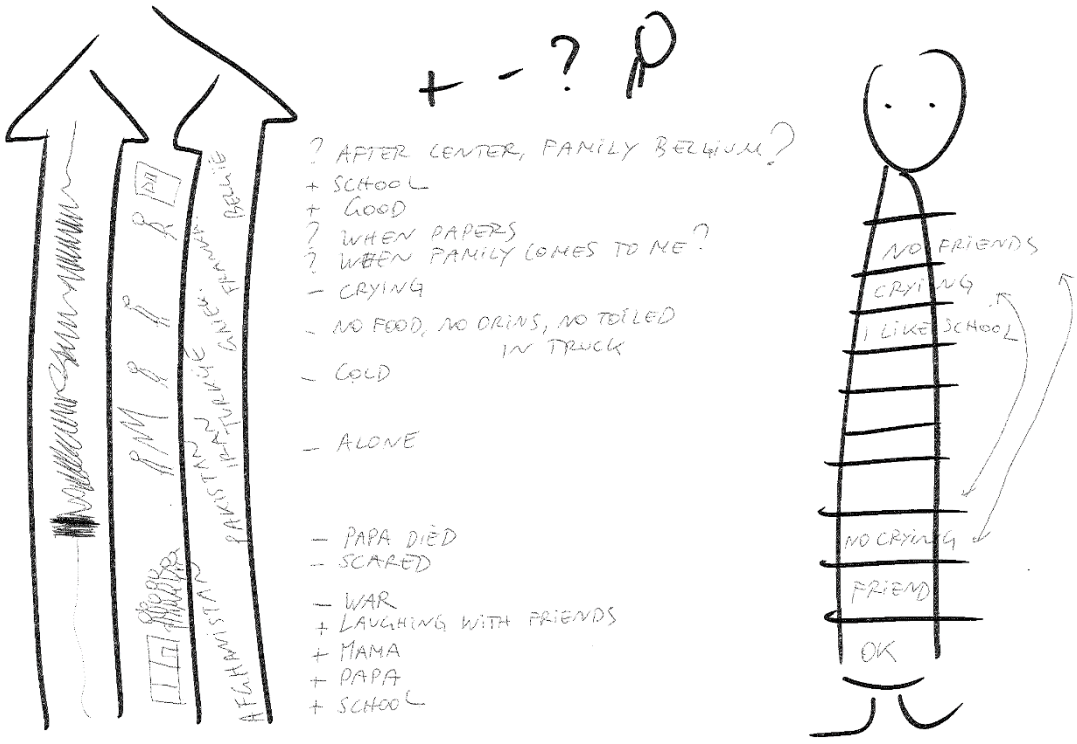
If children want to share more, they may start to talk about something. Their story can be summarised in a few key words next to the arrow. Old memories are put at the bottom of the list, while new life experiences are positioned at the top. A negative or positive symbol is added to indicate a positive memory or a negative one.

The child is also asked if there are things that are or were unclear and still need to be answered. These questions are written with a question mark. Some of the questions that have been asked by children include: "What would my father tell me if he was still alive?" – "What would my mother tell me if I could ask her if it is OK to live in a foster family?"– "Why did they kill my brother?" – "When will there be peace in Afghanistan?"- "Am I a good

child?"

Mirrors are used as symbols for the question: "How did/do people describe you?". This social feedback is important in relation to the identity concept. Examples are "A good child." – "A child with many friends." – "A child that helps their mother." – "A child that is stubborn." – "A child that can study well...".
This collection of life experiences enables the therapist to see what is most important in the child's life.

Finally, how does the child see themselves? Which terms fit with their self-concept and where do those words go in the drawing. Old self-concepts are put at the bottom and new ones higher up. This exercise shows, for example, where there are conflicts: "normal and not normal" – "intelligent and not intelligent enough" – "happy and not happy" – "together and alone"... Many conflicting terms may be the result of the migration process and the changing context. This method can be used again in follow-up sessions.



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