

Immigration Toolkit:

Displacement, Trauma and Mental Health Among Migrant Youth and Their Families

By the APA Council on Children, Adolescents, and Their Families

Background

Recent surges of migrants at the U.S.-Mexico border highlights the extent of the global displacement crisis. According to the UNHCR, there are currently 80 million individuals worldwide who are displaced from their homes, and many of these individuals experienced trauma due to armed conflict, torture, persecution, and natural disasters. As migrants present at the U.S. border in increasing numbers, psychiatrists are likely to encounter migrant children and their families in the community-based systems of care in which they practice.

Human Rights

Human rights are standards that recognize and protect the dignity of all human beings. The Convention on the Rights of the Child (CRC) aims to protect children's civil, political, social, health, economic and cultural human rights, and well-being (Convention, 1990). It is built on the principle of upholding children's best interests and welfare globally and of protecting children against discrimination and exploitation.

The CRC declares that all children are citizens of society just as adults are, and they have special interests and needs associated with their age and development. Therefore, they should have a separate human rights document protecting their rights. The principles of the CRC frame immigration policy as an issue of child and family safety, well-being, and human rights. Some principles important to immigration policy for children, adolescents and their families included in the CRC are:



- Childhood is a specific period of life, and adversity during this period affects a person's future identity formation, i.e., if the child is raised in a violent environment, they are at risk of internalizing that violence and trauma.
- Children should be protected against discrimination and oppression.
- Whenever possible, children should remain in their parents' care.
- Governments should make sure children are protected and looked after by their caregivers.
- Governments should ensure that people responsible for looking after children are sufficiently trained and doing a good job.
- Governments should help families and communities teach their children about their rights and best ways to use them.

- Every child has the right to life. Governments must make sure that children survive and develop in the best possible way.
- Children have the right to their own identity – an official record of who they are which includes their name, nationality, and family relations. No one should take this away from them, but if this happens, governments must help children quickly recover their identity.
- Children should not be separated from their parents unless they are not being properly looked after – for example, if a parent hurts or does not take care of a child. Children whose parents don't live together should stay in contact with both parents unless this might harm the child.
- If a child lives in a different country than their parents, governments must let the child and parents travel so that they can stay in contact and be together.
- Children with disabilities deserve the opportunity to thrive. Governments should help children with disabilities become independent and participate in the community.
- Children have the right to high quality health care, clean water to drink, healthy food and a clean and safe environment to live in. All adults and children should have information about how to stay safe and healthy.
- Children placed away from home - whether for their care, protection, or health – should have their situation continually reassessed for progress and the possibility of better alternatives.
- Children have the right to education.

The United States has not ratified the CRC and remains silent on international child protection issues. Despite widespread ratification of the CRC, violations are common. By virtue of its influence over other countries, the United States' ratification of the CRC would help promote the protection of children's rights globally.

The use of children in military or child labor and under conditions of slavery, leads to displacement, migration and asylum seeking and poorer health

outcomes. The CRC equips NGOs to carry out their advocacy work successfully while protecting children's rights.

The Flores Settlement

The Flores Settlement regulates the detention, release, and treatment of children in the custody of federal immigration authorities (Flores, 1996). It is an agreement approved by the District Court for the Central District of California in 1997, in settlement of a class action lawsuit filed in 1985 against the federal government on behalf of unaccompanied minors held in custody by the Immigration and Naturalization Service (INS). In resolution of that lawsuit, the federal government agreed to be bound by certain minimum standards designed to ensure that all children in the custody of federal immigration authorities would be treated “with dignity, respect and special concern for their particular vulnerability as minors.” Flores is aligned with the CRC because it focuses on the well-being of children and ensures that the federal government adheres to basic standards of care for and release of accompanied and unaccompanied immigrant children in federal custody. The agreement requires that:

- Facilities provide children in their custody access to sanitary and temperature-controlled conditions, water, food, medical assistance, ventilation, adequate supervision, and contact with family members;



- Facilities ensure that children are not held with unrelated adults;
- The government releases children from detention without unnecessary delay to parents or other approved sponsors; and
- If a child cannot be released from care, the child be placed in the “least restrictive” setting appropriate, based on his or her age and needs.

Definitions

- 1. Migrant:** Person who moves from one place to another, especially to find better living conditions, safety, and security.
- 2. Displacement:** The enforced departure of people from their homes, typically because of war, persecution, or natural disaster.
- 3. Humanitarian Relief:** Policies and procedures which allow migrants to safely and securely relocate in another country while providing assistance in resettlement (for example, asylum).
- 4. Refugee:** Person who has been forced to flee their home country due to persecution because of their race, religion, nationality, political opinion, or membership in a particular social group (e.g., members of the LGBT community).
- 5. Asylum-seeker:** A person who has fled persecution in their home country, seeking safe haven in a different country, but has not yet received legal recognition or status.
- 6. Internally displaced persons:** Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, as a result of or in order to avoid the effects of conflict, violations of human rights or disasters, and who have not crossed an internationally recognized State border.
- 7. Unaccompanied Child Seeking Asylum:** A person who is under the age of eighteen, unless, under the law applicable to the child, majority is, attained earlier and who is “separated from both parents and is not being cared for by an adult who by law or custom has responsibility to do so (UNHCR, 1997).
- 8. Pre-Migration Trauma:** Trauma endured by displaced migrants prior to leaving their country of origin (for example, armed conflict).
- 9. Migration Trauma:** Trauma endured by displaced migrants en route to their destination (for example, assault by gangs en route).
- 10. Post-Migration Trauma:** Trauma endured by displaced migrants following arrival at their destination (for example, detention).
- 11. Trauma-Informed Care:** Developing healthcare systems which presume the presence of trauma in patients and also potentially staff and avoids re-traumatization of patients through warm and empathic clinical interactions and calming and soothing treating environments.
- 12. Culturally Sensitive Care:** The provision of healthcare that respectfully acknowledges the importance of the patient’s self-identified culture by supporting and aligning with cultural values, normalizing experiences, and empathizing with hardships without making assumptions or using stereotypes.
- 13. Intergenerational Care:** Clinical care which conceptualizes the patient as a part of a larger family unit and takes into account shared experiences within the family unit while then assisting the family members to support one another in their healing.



Clinical Implications

Psychiatrists may treat migrants who have endured substantial pre-migration, migration, or post-migration trauma. Pre-migration trauma may be in the form of physical or sexual assault, domestic violence, forced recruitment into gangs or forced militarization of child soldiers, governmental persecution, famine, or natural disasters. Migration trauma may involve physical or sexual assault, domestic violence, kidnapping, trafficking, and treacherous crossing conditions with a high likelihood of morbidity and mortality. Post-migration trauma may include family separation, detention, deportation, exploitation, trafficking, discrimination, or bullying.

Clinical care with migrants must be culturally sensitive, trauma-informed, and intergenerational as they may have experienced discrimination and trauma, have language-barriers and experienced adverse circumstances as a family. Such an approach calls on the family to support one another and heal as a unit.

Clinicians can support their migrant patients by writing letters to patients' attorneys documenting the mental health impact of patients' trauma and attesting to qualities of citizenship in the patient and their family. Clinicians can also link migrants

to needed services, such as psychoeducation, case management, job skills training, school-based services, legal services at immigrant law centers, non-profit and grassroots community organizations that link the patient to their own local cultural community for additional support, language learning support, and advocacy groups.

Access to Care Challenges

Immigrant and displaced youth may face several barriers keeping them from understanding the need for mental health services. Some of the barriers include cultural beliefs and stigma and language, emphasizing the need for qualified translators and interpreters familiar with mental health issues.

Migrants may experience bias and discrimination, making it important that clinicians continually evaluate their own conscious and unconscious biases and tendencies to stereotype. A thorough assessment examining levels of acculturation, presence of intergenerational conflict and the presence (or absence) of resilience and support from one's cultural background can identify future challenges and strengths.

Incorporating positive cultural values and beliefs, assuring mutual respect, and striving for



collaboration in the treatment of these young people may help support their mental health needs. Involving the family or community when appropriate and without sacrificing confidentiality, may be important for the advancement of treatment. Because of stigma, some youth and families may prefer the involvement of a spiritual or traditional healer in their care in lieu of or in addition to relatives.

Tools and Clinical Considerations

Tools to help in evaluation and treatment include DSM-5 Cultural Formulation Interview (CFI), the revised Outline for Cultural Formulation, and the accompanying CFI Immigrant & Refugee Module as well as the American Academy of Child and Adolescent Psychiatry Practice Parameters for Cultural Competence in Child and Adolescent Psychiatry Practice. (Practice Parameters 2013)



- It is recommended that clinicians learn about their patient's culture, values, and beliefs to understand their illness narrative, and familiarize themselves with the cultural formulation interview and the accompanying online module addressing immigrants and refugees.
- Engage the clinical team in identifying cultural factors that may impact assessment and treatment.
- Find local mental health resources to further support the care of displaced and traumatized migrant young people and their families.

Policy Implications

The CRC aims to protect children's civil, political, social, health, economic and cultural rights, and well-being. APA has responded with policies highlighting the mental health needs of this vulnerable

population. Following the unprecedented level of migration as a result of several socio-political and economic factors of the 21st century, APA published a [Position Statement on the Mental Health Needs of Immigrants and People Affected by Forced Displacement](#) and a [Position Statement on Immigration, Children, Adolescents, and Their Families](#):

Immigrants, asylum seekers, refugees, persons in the temporary protected status program, and persons in immigration custody should be treated with dignity and respect during all phases of migration, including access to timely, affordable, trauma-informed, culturally accessible quality health care, encompassing mental health care and substance use treatment. To this end, the APA supports:

- Partnerships with government agencies, healthcare agencies, and other community groups to identify and address gaps in care of immigrants;
- Research on the mental health conditions, treatments, and health outcomes of members of all immigrant groups; and
- Clinical education and training to enhance the quality of care for immigrants.



The APA opposes laws, policies, and practices that erode the dignity of and respect for these members of immigrant groups, including:

- Prolonged detention, inhumane detention conditions, or separation of families;
- Obstruction of access to legal services or needed healthcare;
- The for-profit detention of migrants, which creates a financial incentive for centers to maximize occupancy and minimize costs, quality, safety, and resources;
- The use of medical records or clinical notes against an individual's interest during any phase of migration.

The APA supports immigration policies and practices that protect immigrant children's and adolescents' mental health and development, including:

- Expeditious reunification of children with community caregivers following forcible separation to avoid further trauma;
- Timely access to healthcare and legal services;
- Pathways to seek asylum and safety;
- Measures to ensure the physical and mental safety and dignity of families fleeing danger;
- Living in a violence-free environment;
- Access to evidence-based, trauma-informed, and culturally, linguistically, structurally and developmentally appropriate physical and mental health care services;
- Best practices in screening, prevention, and early intervention in medical health, mental health and education; and,
- Measures to help slow the spread of COVID-19 and other communicable illnesses.

The APA opposes immigration policies and practices that negatively impact children's and adolescents' mental health and development, including:

- Forcible separation of children from their parents;

- Displacement, return, or retention in a third country without adult protection, access to health care, and/ or a defined pathway to asylum and safety;
- Prolonged detention and other forms of inhumane treatment; and
- Limited or no access to timely, quality healthcare.

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Legal Implications

The treatment and care of displaced/migrant minors should strive to match the treatment and care provided to non-displaced/non-migrant minors in the community at large. Due to the sensitivity of their circumstances, certain precautions necessary to consider are outlined below.

Child Abuse

All children and adolescents should be screened for signs of child abuse and allegations reported to the appropriate state or federal authorities. Allegations may be complicated by the presence of severe psychiatric symptoms, such as paranoia, reactive attachment, hypervigilance, and histories of psychological trauma at any point during the migration process. While reporting allegations of abuse to the receiving agency, it may be necessary to discuss the presence of psychopathology and its impact on the minor, especially if an abuse allegation may adversely affect a families' application for asylum, whether founded or unfounded.

Parental Identification

Especially young children separated from their parents during their migration to the United States or while in detention awaiting a court hearing, may not remember or be able to identify their parents.

While immigration and customs agents may have established protocols for the identification and reunification of children with their parents, such as birth certificates or governmental identification documents and the use of biological tests to establish parentage, parents (or other guardians) may be reluctant to communicate with such agents if their own legal status is uncertain and they fear



future misuses of their biological and personal information. Further, it may be difficult to locate parents if they have already been removed from the country or if their whereabouts are unknown. Human trafficking can also be a concern if there are no reliable ways to identify parents or legal guardians. Even when parentage can be reliably established, the age of the child and the length of time spent away from their parents (and in some cases, unfamiliarity with the presenting parent), may pose an emotionally difficult reunification.

Liability

Psychiatrists working with detained young people and their families should first identify their role, that is, whether they are providing clinical treatment as part of an overseeing agency, are acting as experts conducting asylum evaluations on behalf of the evaluatee, the Court or some other agency, or simply acting as a community volunteer. They may consult with their professional risk management agencies to determine whether their malpractice insurance coverage extends to work in these settings and under what specific conditions.

Informed Consent

Involuntary detention settings can inherently be coercive and warrant special attention when obtaining assent from the young person and consent from the available legal guardian. All efforts should be made to discuss any treatment recommendations with a parent in their preferred

language, prior to the initiation of treatment. When parents or an appropriate legal guardian are not available to provide consent for a recommended treatment, the psychiatrist should discuss their treatment recommendations with the assigned social worker or presiding judge (as called for in their jurisdiction when recommending treatment to minor dependents of the Court). Pharmacological interventions may be indicated in the treatment of psychiatric symptoms but should be administered with the assent of the minor, if possible, and should never be used for the purposes of behavioral control or as a form of punishment.

Confidentiality

When providing direct clinical care, every effort should be made to maintain the patient's right to confidentiality. Barring any applicable mandated reporting duties, young people in detention retain the right to privacy and the expectation that what they share in confidence with any member of their healthcare team will not then be disclosed or used in court proceedings against them. Invoking therapeutic privilege may be both appropriate and necessary if asked to disclose treatment records without sufficient legal justification and in the absence of consent to do so.

Case Vignettes

1. A 17-year-old male Iraqi refugee, Hani, was admitted to the inpatient unit after getting in a fight with a peer on the school grounds. Because of his extreme rage and aggression, the police were called. He felt threatened, attacked the police officer when the officer was in his face. He remembered the daily attacks by older boys while living at the Zaatari refugee camp for over 5 years.
2. Celia is a 12 y/o girl from Mexico who was gang raped by drug cartel members in her village when her brother refused to 'join up'. She was also sexually assaulted by a 'coyote' on her way to the US. She presents with her aunt who she is living with in California, due to nightmares, flashbacks, panic attacks and anxiety. She recently was seen by a pediatrician, who referred her after seeing the carved gang logo tattooed crudely on her back. Celia recently has lost weight, telling her aunt that she wants 'a new body' like she had 'before'.15-year-old.
3. Hind and her friend were kidnapped by ISIS fighters on their way home from school. They were beaten, threatened and told their parents were killed. They were offered to two ISIS fighters as their brides. Hind jumped off a moving truck in the middle of the night while the fighters were changing location. She found herself in the Syrian Desert and was discovered a day later by locals who were able to return her to her family. Hind and her family arrived in the U.S. three years later as refugees. She struggled with frequent nightmares, always closing the door and the blinds, asking if the U.S. has ISIS fighters, and she refused to go to school.
4. A 5-year-old boy from the Central American Northern Triangle presents with his mother who is concerned about developmental regression, including language regression, a return to enuresis and encopresis after having been potty-trained, and both attachment and separation difficulties impacting both school and home life. The family spent time in detention and separated at shelters prior to being reunited in the community.
5. Tomas is a 13-year-old boy from El Salvador who is brought to the clinic by his mother whom he recently reunited with after five years of separation. Mom brings him in due to his wanting to dress in women's clothes, be called Tonya, and refuses to use the men's toilet. Mom is frightened and overwhelmed and afraid of what people might say if she allows him to dress this way in public. She feels he may be possessed and had been contemplating taking him to the 'Mesa' to see the 'Padre' for an exorcism. Tomas is tearful and frightened and states, 'they will never accept or understand me.'

Provider Self-Care and Wellness

Psychiatrists working with forcibly displaced children can be exposed to intense emotional experiences ranging from extremely meaningful to highly stressful. Working with communities who have experienced polyvictimization and multiple traumatic events can place clinicians at risk of compassion fatigue and vicarious trauma (Nimmo & Haggard 2013). Listening empathically and bearing witness to stories of human suffering can challenge deeply held beliefs, assumptions, and expectations with attendant emotional and behavioral consequences (Evces, 2015). Various related but distinct conceptualizations describe these emotional and behavioral sequelae. Burnout refers to a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations. Symptoms may include depression, cynicism, boredom, loss of compassion, and discouragement. These symptoms are typically constrained to work environments. On the other hand, vicarious trauma and secondary traumatic stress refer to negative changes in the clinician's view of self, others, and the world resulting from repeated empathic engagement with patients' trauma-related thoughts, memories, and emotions (McCann & Pearlman, 1990). In the case of secondary traumatic stress, symptoms can mimic those of PTSD. Vicarious trauma and secondary traumatic stress both describe altered cognitions and relational patterns that are not confined to the workplace and can affect the entirety of our personal and professional lives. There are multiple personal and professional risk and protective factors that play a role in the development of vicarious trauma (NCTSN 2011).

Personal risk and protective factors for experiencing vicarious trauma include:

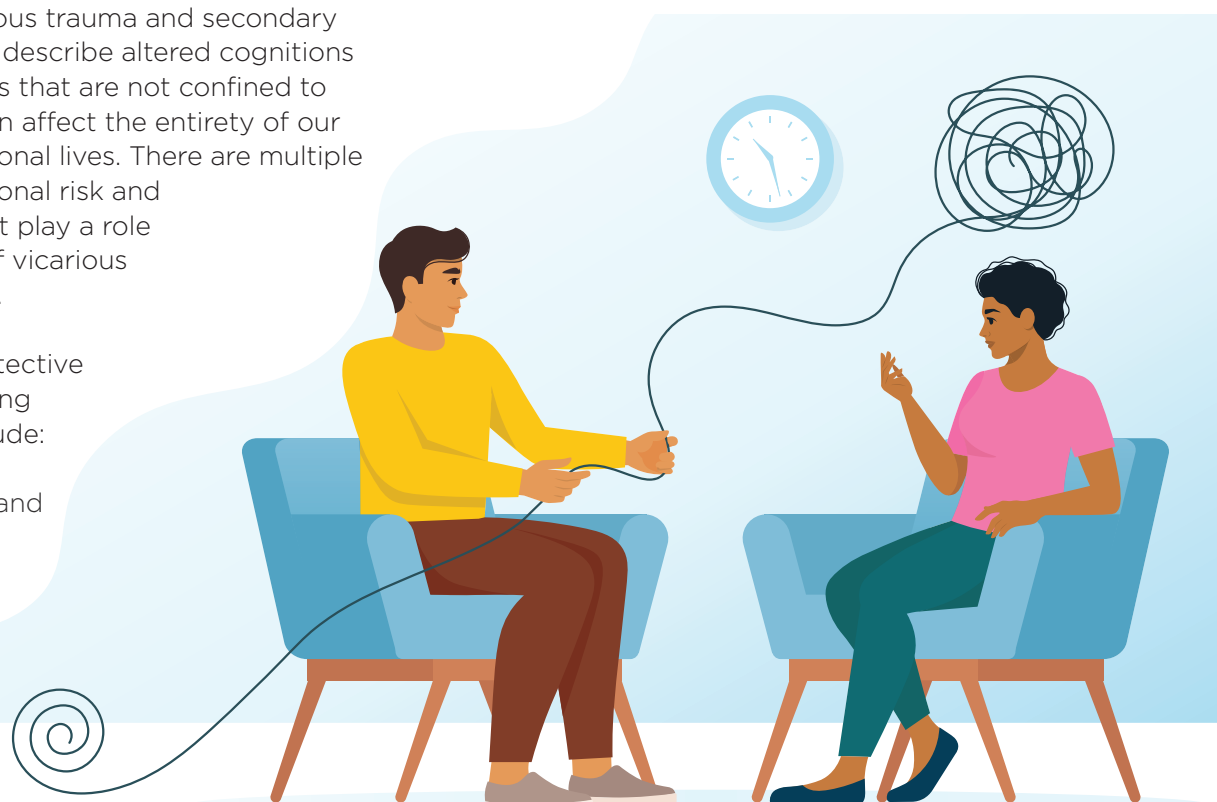
- Past mental health and trauma history
- Personality

- Current life circumstances
- Capacity to set personal boundaries
- Social supports

Professional risk and protective factors for experiencing vicarious trauma include:

- Role and responsibility at work
- Work culture of the organization
- Support by colleagues, leadership, staff
- Affected population in which one is working with

Although the risk of experiencing vicarious trauma may be higher when working with forcibly displaced migrant youth and their families, clinicians can take steps to prevent or mitigate the negative impacts of the work on their personal and professional lives. Mitigating the effects of trauma work can occur at both systemic and individual levels. Systemic interventions can occur at the level of organizations doing work with migrant youth and their families. This could include advocacy work, which can provide an outlet for feelings of helplessness that may arise with exposure to trauma narratives, as well as integrating trauma informed principles into



the functioning of service organizations (e.g recognition of the effects of secondary trauma and how it affects organizational decisions, integrating peer supervision and process groups into the mechanics of clinical workflow, patient management to limit/spread exposure to trauma) (NCTSN 2011).

Vicarious trauma and burnout can also be addressed on the individual level. Self-care practices can be integrated into daily practice. Clinicians can build self-awareness to be attentive to the signs of stress and vicarious trauma, then engage in self-soothing, relaxing activities to look after one's own physical and mental wellbeing. While difficult, maintaining a healthy balance between work and life can be supported by engaging in outside interests and activities that bring the clinician joy and a sense of mastery. Clinicians can also be realistic about goals-- being mindful of what can or cannot be accomplished and what clinicians should take responsibility for. The mental health needs of displaced youth and families are complex, and it is not expected that clinicians can "solve" or "fix" problems alone.

Clinicians can be mindful of their caseload by building a mix of patients across the severity of distress, take regular breaks and vacations as able, and rely on peer support if available.

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Further Reading

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