Detention of Immigrant Children

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Drs Linton, Griffin, and Shapiro collectively drafted, critically revised, and reviewed this policy.

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abstract

Immigrant children seeking safe haven in the United States, whether arriving unaccompanied or in family units, face a complicated evaluation and legal process from the point of arrival through permanent resettlement in communities. The conditions in which children are detained and the support services that are available to them are of great concern to pediatricians and other advocates for children. In accordance with internationally accepted rights of the child, immigrant and refugee children should be treated with dignity and respect and should not be exposed to conditions that may harm or traumatize them. The Department of Homeland Security facilities do not meet the basic standards for the care of children in residential settings. The recommendations in this statement call for limited exposure of any child to current Department of Homeland Security facilities (ie, Customs and Border Protection and Immigration and Customs Enforcement facilities) and for longitudinal evaluation of the health consequences of detention of immigrant children in the United States. From the moment children are in the custody of the United States, they deserve health care that meets guideline-based standards, treatment that mitigates harm or traumatization, and services that support their health and well-being. This policy statement also provides specific recommendations regarding postrelease services once a child is released into communities across the country, including a coordinated system that facilitates access to a medical home and consistent access to education, child care, interpretation services, and legal services.

INTRODUCTION

Communities nationwide have become homes to immigrant and refugee children who have fled countries across the globe.1 However, in the dramatic increase in arrivals that began in 2014 and continues at the time of writing this policy statement, more than 95% of undocumented children have emigrated from Guatemala, Honduras, and El Salvador (the Northern Triangle countries of Central America), with much smaller numbers from Mexico and other countries. Most of these undocumented children cross into the United States through the southern border.2 Unprecedented violence, abject poverty, and lack of state protection...
of children and families in Central America are driving an escalation of migration to the United States from Guatemala, Honduras, and El Salvador. Children, unaccompanied and in family units, seeking safe haven* in the United States often experience traumatic events in their countries of origin, during the journeys to the United States, and throughout the difficult process of resettlement. In fiscal year (FY) 2014, Customs and Border Protection (CBP) detained 68,631 unaccompanied children and another 68,684 children in family units (a child with parent[s] or legal guardian[s]). In response to these numbers, the US government implemented a media campaign in Central America and increased immigration enforcement at the southern border of Mexico in an effort to deter immigration. Yet despite decreasing numbers of unaccompanied children and children in family units attempting to emigrate to the United States in FY 2015, another significant increase of both groups began in FY 2016, with 59,692 unaccompanied children and 77,674 family units detained in FY 2016. Interviews with children in detention from Mexico and the Northern Triangle Countries revealed that 58% had fear sufficient to merit protection under international law, and in another survey, 77% reported violence as the main reason for fleeing their country.

Children first detained at the time of entry to the United States, whether they are unaccompanied or in family units, are held by the Department of Homeland Security (DHS) in CBP processing centers. If an accompanying adult cannot verify that he or she is the biological parent or legal guardian, this adult is separated from the child, and the child is considered unaccompanied. After processing, unaccompanied immigrant children are placed in shelters or other facilities operated by the US Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR), and the majority are subsequently released to the care of community sponsors (parents, other adult family members, or nonfamily individuals) throughout the country for the duration of their immigration cases. Children detained with a parent or legal guardian are either repatriated back to their home countries under expedited removal procedures, placed in Immigration and Customs Enforcement (ICE) family residential centers, or released into the community to await their immigration hearings.

Pediatricians who care for previously detained immigrant children in communities throughout the United States should be aware of the traumatic events these children have invariably experienced to better understand and address their complex medical, mental health, and legal needs. Pediatricians also have an opportunity to advocate for the health and well-being of vulnerable immigrant children. This policy statement applies principles established by numerous previous statements, including care of immigrant children, toxic stress, and social determinants of health, to the specific topic of detention of immigrant children.

**HISTORY**

In the 1980s, the United States experienced a dramatic increase in numbers of migrant children fleeing Central America as a result of civil wars in those countries. At that time, the Immigration and Naturalization Service (INS), under the Department of Justice, was responsible for enforcing the immigration law and seeking the deportation of unaccompanied children and for their care and custody while they were in the United States. In 1997, after more than a decade of litigation responding to unjust treatment of unaccompanied children in the care of the INS, the government entered into a settlement agreement, still in force today, for the care of children. The Flores Settlement Agreement set strict national standards for the detention, treatment, and release of all minors detained in the legal custody of the INS. It requires that children be held in the least restrictive setting appropriate for a child's needs and that they be released without unnecessary delay to a parent, designate of the parent, or responsible adult as deemed appropriate.

After September 11, 2001, the Homeland Security Act of 2002 attempted to resolve the conflict of interest between the dual role of the INS as both a prosecutor and caretaker of unaccompanied children. That law divided the functions of the former INS between the DHS and HHS (Fig 1). Under the DHS, CBP and ICE are charged with border control and homeland security. The care and custody of unaccompanied immigrant children were transferred to the HHS Administration for Children and Families, specifically the ORR. The responsibility of the ORR is to promote the well-being of children and families, including refugees and migrants.

**CURRENT PRACTICE AND TERMINOLOGY**

Noncitizen children younger than 18 years are processed through the immigration system in several ways depending on where they are first detained, whether they are accompanied or unaccompanied by a parent, and whether they come from a contiguous or noncontiguous

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*The term safe haven encompasses the diverse immigration statuses that may be pursued and acknowledges the humanitarian needs of those seeking relief.
An unaccompanied alien child, referred to as an unaccompanied immigrant child in this policy statement, is defined by the Homeland Security Act as a child who “has no lawful immigration status in the United States; has not attained 18 years of age; and with respect to whom—(i) there is no parent or legal guardian in the United States; or (ii) no parent or legal guardian in the United States is available to provide care and physical custody.”\textsuperscript{11, 23, 24}

A parent or legal guardian is considered “not available” if not present at the time of the child’s apprehension.

Accompanied children are those who are detained with their parent or legal guardian, most often the mother. DHS refers to accompanied children as part of a family unit.\textsuperscript{11} Most children who come into immigration custody are first detained at the border; a smaller number are apprehended within the country (ie, more than 100 miles away from a border), known as internal apprehensions.\textsuperscript{11}

Lastly, the immigration process is different for children who come from contiguous countries (most from Mexico and smaller numbers from Canada). When the Trafficking Victims Protection Reauthorization Act (TVPRA) was passed in 2008, Congress mandated that CBP screen children from Mexico and Canada for trafficking (child labor or sex) and other harms before allowing them to return to their countries and before they are placed in US immigration proceedings. Specifically, CBP must screen a child from Mexico or Canada to ensure that the child is not a potential victim of trafficking, has no possible claim to asylum, and can and does voluntarily accept return. If a child from Canada or Mexico does not have authorization to enter the United States and can be returned safely, the child can be repatriated without ever being placed in immigration proceedings. If any of the answers to the aforementioned inquiries into protection concerns are positive, or if no determination of all 3 criteria can be made within 48 hours, the TVPRA mandates that the child shall “immediately” be transferred to custody of ORR. Once transferred to ORR, Mexican and Canadian children are treated like all other unaccompanied children in detention.\textsuperscript{11, 19}

\textbf{FIGURE 1}
Restructuring of INS after September 11, 2001.\textsuperscript{19} (The Anti-Trafficking in Persons Organization is now called the Office on Trafficking in Persons, and the Division of Unaccompanied Children’s Services is now called the Division of Children’s Services.) Reproduced with permission: Byrne O, Miller E. The Flow of Unaccompanied Children Through the Immigration System. New York, NY: Vera Institute of Justice; 2012:7
Immigration Pathway

**CBP Processing Centers**

When first detained at or near the border, both unaccompanied children and those in family units are sent to CBP processing centers. Each year, hundreds of thousands of detained people are held in these processing centers along the US southern border. By law, under the Homeland Security Act of 2002 and TVPRA of 2008, unaccompanied immigrant children must be moved to ORR custody within 72 hours. Processing centers are secure facilities of various sizes with locked enclosures to detain children and families; the largest, in McAllen, Texas, currently has a capacity of 1000. Reports by advocacy organizations, including interviews with detainees and the DHS Office of Inspector General, have cataloged egregious conditions in many of the centers, including lack of bedding (eg, sleeping on cement floors), open toilets, no bathing facilities, constant light exposure, confiscation of belongings, insufficient food and water, and lack of access to legal counsel, and a history of extremely cold temperatures. At times children and families are kept longer than 72 hours, denied access to medical care and medications, separated from one another, or physically and emotionally maltreated. In processing centers, children and families lack a comprehensive orientation process that outlines procedures and possible time of detainment in each facility. To respond to increasing numbers of children and families who are first detained in the Rio Grande Valley, a central processing center in McAllen, Texas has made changes to increase capacity, expedite processing, and address some of these concerns.

At the time of apprehension by CBP, children pass through 1 or more CBP processing facilities, some of which provide limited medical screening (eg, scabies, lice, varicella); complete medical histories and physical examinations (including vital signs) are not conducted. Screening is performed by a variety of nonmedical and medical personnel, such as border patrol officers, emergency medical technicians, nurse practitioners, or physician assistants. Children with medical problems beyond the scope of aforementioned personnel are taken to a local hospital emergency department.

At the time of release from CBP processing centers, the immigration pathway diverges for unaccompanied immigrant children and children accompanied by a parent or legal guardian.

**ORR Children Shelters: Unaccompanied Immigrant Children**

ORR contracts with a network of child welfare agencies, both nonprofit and government organizations, to care for unaccompanied immigrant children in a variety of facility types that range in size and level of security. A small number of these contracts are with local foster care agencies. With more than 9200 beds located across the country, these shelters have procedures ensuring compliance with federal law regarding the care and custody of immigrant children. Children are provided with dormitory-style rooms, shared bathrooms, showers, clothes, hot meals, year-round educational services, recreational activities, and limited legal services. In FY 2015, the average length of stay in the program was 34 days, although some children remain in ORR custody for significantly longer periods of time, for a number of different reasons.

At the time of entry into an ORR facility, children receive an initial medical and mental health evaluation. The ORR is responsible for providing the children with ongoing medical and mental health care, which may be provided on or off site, while in custody. Pediatricians caring for previously detained children released into communities can access the American Academy of Pediatrics (AAP) Immigrant Health Toolkit (https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Community-Pediatrics/Pages/Immigrant-Child-Health-Toolkit.aspx) for more comprehensive guidelines (eg, universal hearing and sexual health screenings) and can ask the child or sponsor for the medical records, provided to each child at the time of release from the shelter, or request records (including vaccinations and tuberculosis testing) from the ORR Web site (https://www.acf.hhs.gov/orr/resource/unaccompanied-childrens-services).

**Family Residential Centers: Accompanied Children**

Some family units are released from CBP processing centers directly into the community to await immigration proceedings, some undergo expedited return to their country of origin, and others are sent to ICE-contracted family residential centers. Three family detention centers exist nationally, including 2 in Texas, operated by for-profit prison corporations (ie, GEO Group and CCA) and 1 in Pennsylvania operated by local government (ie, Berks County); 2 other centers were closed because of “dangerously inadequate” conditions. The present total operating capacity of the detention facilities is 3326 beds. Each residential center has staff comprising representatives from their contracting organizations and...
ICE employees. In general, multiple families stay in dormitory-style rooms. Nearly all the family detention beds are for mothers with children younger than 18 years, and 1 facility (Berks County) accepts fathers. An August 2015 ruling by a California US District Court in a case brought against DHS, Flore s v Johnson, found that family detention centers are in violation of the Flores Settlement Agreement. The court did not exclude children in family units from the requirement that children be held in the least restrictive environments. Despite this order, children continue to be detained, and even with shorter lengths of stay, some were still found to suffer traumatic effects.

Care of children held in detention centers is subject to the standards outlined on the ICE Web site. Limited medical, dental, and mental health services are provided by the prison corporations in the Texas facilities and through public health services in Pennsylvania. Detention centers also rely on nearby emergency departments and tertiary care centers for the treatment of medical and mental health conditions beyond their scope. Visits to family detention centers in 2015 and 2016 by pediatric and mental health advocates revealed discrepancies between the standards outlined by ICE and the actual services provided, including inadequate or inappropriate immunizations, delayed medical care, inadequate education services, and limited mental health services.

Alternatives to detention offer opportunities to respond to families’ needs in the community as their immigration cases proceed. For most families, release into the community allows families to live their lives as normally as possible. In the setting of community-based alternatives to detention, many families are able to comply with immigration proceedings when they are provided information about rights and responsibilities, referrals to legal services, and psychosocial supports. Some families may benefit from case management, which is cost-effective and can increase the likelihood of compliance with government requirements.

Release of Children Into the Community: Unaccompanied Immigrant Children

Before release, the ORR seeks to reunite an unaccompanied immigrant child with a sponsor, preferably a parent or other family member. Sponsors must be considered suitable for caring for a child and go through background checks, occasionally including home visits. Most children are released to parents or other family members; in some cases, the sponsor may be someone the child does not know well or at all. The ORR must approve the child’s release, but in almost all cases, the sponsor is financially responsible for transportation and other expenses incurred.

Some children receive limited postrelease services from nongovernment organizations funded by ORR. These services are typically provided only to children whose release followed a home study, required for certain children under TVPRA, including those who have histories of abuse or trafficking or those with disabilities. Most children released from the ORR do not qualify for Medicaid, the Children’s Health Insurance Program, or other state and federal public benefit programs. Other important stressors may also arise once the child has been placed with a sponsor, including relationship conflicts between child and sponsor or other household members, school enrollment and other educational challenges, food insecurity, housing insecurity, other financial strain (eg, clothes, school supplies), and acculturation difficulties.

Release of Children Into the Community: Family Units

Family units arriving together at the US border are currently placed into “expedited removal proceedings,” which means that the adult must pass a “credible fear interview” or, in some cases, a “reasonable fear interview” (for families with previous orders of removal from the United States) before a US Customs and Immigration Service officer to establish a basis for the presence of persecution or torture. If the interview is passed, families may be released from the detention center on bond or released under other conditions, such as being required to wear an electronic monitor, but only for the duration of their immigration case. If they do not pass the credible fear or reasonable fear interview or a judge concurs with a negative “fear” decision, they will be removed from the United States. Currently, more than 75% of families held in family residential centers pass their “credible fear” or “reasonable fear” interviews or are successful in appealing adverse decisions after retaining an attorney, meaning that most have a right to seek protection in the United States. Families who are granted release into communities pending immigration proceedings may be taken to nearby bus terminals or local churches but must independently navigate reunification with family members across the country. Families must also find attorneys to represent them in their immigration cases, which will continue until they appear for an asylum hearing before an immigration judge or pursue some other immigration benefit (such as a visa for trafficking victims). These families must rely on family members living in the United States for assistance or incur their own travel and legal expenses. Many adult members of family units have been...
detained and released into the community with electronic monitors to ensure that their whereabouts can be tracked.\textsuperscript{33}

Impact of Detention on Child and Family Health

Detention of children is a global issue condemned by respected human rights and professional organizations both within and beyond US borders.\textsuperscript{11,32,33,51} Moreover, the United Nations Convention on the Rights of the Child, an internationally recognized legal framework for the protection of children’s basic rights (ratified by every country in the world except for the United States), emphasizes freedom from arbitrary arrest and detention (Article 37), the provision of special protection to children seeking asylum (Article 22), humane and appropriate treatment of children in detention (Article 37), and guidelines regarding maintaining family unity (Article 9).\textsuperscript{52} The AAP has endorsed this human rights treaty as an important legal instrument.\textsuperscript{53} US state court proceedings and the United Nations Convention on the Rights of the Child underscore the “best interests of the child,” including safety and well-being, the child’s expressed interests, health, family integrity, liberty, development (including education), and identity.\textsuperscript{54}

Studies of detained immigrants, primarily from abroad, have found negative physical and emotional symptoms among detained children,\textsuperscript{55–57} and posttraumatic symptoms do not always disappear at the time of release.\textsuperscript{56} Young detainees may experience developmental delay\textsuperscript{58} and poor psychological adjustment, potentially affecting functioning in school.\textsuperscript{59} Qualitative reports about detained unaccompanied immigrant children in the United States found high rates of posttraumatic stress disorder, anxiety, depression, suicidal ideation, and other behavioral problems.\textsuperscript{60} Additionally, expert consensus has concluded that even brief detention can cause psychological trauma and induce long-term mental health risks for children.\textsuperscript{51}

Studies of adults in detention have demonstrated negative physical and mental health effects that can reasonably be applied to adult members of detained family units. For instance, detained adult asylum seekers suffered from musculoskeletal, gastrointestinal, respiratory, and neurologic symptoms.\textsuperscript{61} They also commonly experienced anxiety, depression, posttraumatic stress disorder, difficulty with relationships, and self-harming behavior.\textsuperscript{52–66} Detention itself undermines parental authority and capacity to respond to their children’s needs; this difficulty is complicated by parental mental health problems.\textsuperscript{56,67} Although data are limited regarding the effects of a short detention time on the health of children, there is no evidence indicating that any time in detention is safe for children.

In the United States, reports from human rights groups and other child advocates, including pediatricians, corroborate the deleterious effects of detention found in the aforementioned studies.\textsuperscript{33,35,41–44} These reports describe prisonlike conditions; inconsistent access to quality medical, dental, or mental health care; and lack of appropriate developmental or educational opportunities.\textsuperscript{11,33,35,62} Parents interviewed for these reports described regressive behavioral changes in their children, including decreased eating, sleep disturbances, clinginess, withdrawal, self-injurious behavior, and aggression.\textsuperscript{33,44} Parents exhibited depression, anxiety, loss of locus of control, and a sense of powerlessness and hopelessness.\textsuperscript{44,68} Parents often faced difficulty parenting their children and subsequently experienced strained parent–child relationships.\textsuperscript{44} Detained families’ sense of isolation and desperation were intensified by detention center practices that created communication barriers with the outside world (eg, expensive telephone service and lack of Internet services). Additionally, detainees reported being anxious about the lack of access to legal advocates.\textsuperscript{33,68}

After almost a year of investigation, the DHS Advisory Committee on Family Residential Centers ultimately made this recommendation\textsuperscript{34}:

DHS’s immigration enforcement practices should operationalize the presumption that detention is generally neither appropriate nor necessary for families—and that detention or the separation of families for purposes of immigration enforcement or management are never in the best interest of children.

THE ROLE OF PEDIATRICIANS IN THE COMMUNITY

Awareness of the immigration pathway, conditions in detention facilities, and medical care during detention can help community pediatricians provide sensitive and targeted care based on AAP recommendations (https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Community-Pediatrics/Pages/Immigrant-Child-Health-Toolkit.aspx) for newly arrived immigrant children\textsuperscript{30} and Centers for Disease Control and Prevention refugee health guidelines.\textsuperscript{69} Many of these children have never had access to a medical home or regular primary care surveillance. A trauma-informed approach acknowledges the impact of trauma and potential paths for recovery, recognizes signs and symptoms of trauma, responds by integrating knowledge into the system of care, and resists retraumatization.\textsuperscript{70–72} Trauma-informed care is essential for medical, mental health, and community-based services. Unfortunately, access to postrelease services is limited, because lack of legal status leaves immigrant children ineligible for
most public benefits. Most states do not provide health care benefits to children of undocumented immigration status.\textsuperscript{73+1} However, by law children have the right to a free, public education without regard to immigration status.\textsuperscript{74} Pediatricians can make families aware that newly arrived children are entitled to a free education and direct them to local public school districts for enrollment.

By facilitating access to legal representation through screening and referral, pediatricians may ultimately increase access to health care once the immigrant child has lawful status. Furthermore, pediatricians may provide key evidence used by attorneys to assist in children’s immigration cases. By some estimates, nearly 45% of unaccompanied children in deportation proceedings do not have attorneys in immigration court.\textsuperscript{75} Not surprisingly, children without counsel are far more likely to be deported, regardless of the merits of their case or the dangers to which they would return.\textsuperscript{76} The complexity of immigration law makes it all the more imperative for practitioners who care for immigrant children and youth to have a referral network of legal experts (preferably nonprofit or pro bono) with whom they work closely.

A basic understanding of the different forms of legal relief can help pediatricians collect key medical and psychosocial histories and clinical evidence that may be used to support legal claims by children seeking safe haven. The most common legal statuses pursued by previously detained children include special immigrant juvenile status, asylum, and what are often referred to as visas for victims of trafficking (T visa) or serious crimes (U visa).\textsuperscript{11} Histories of abuse, neglect, abandonment, persecution, trafficking, or violence may be disclosed to clinicians but not lawyers because of fear or shame. Furthermore, victims of labor or child sex trafficking and commercial sexual exploitation of children rarely self-identify. When assessing the trauma history of previously detained children, pediatricians may identify concerns for trafficking\textsuperscript{77} and subsequently facilitate needed medical and mental health care and initiate referrals to law enforcement, child protective services, and legal services.\textsuperscript{78} Children who are identified as victims of trafficking may be eligible for a T visa, and children who are victims of crimes in this country, including exposure to domestic violence, may be eligible for a U visa if they are willing to cooperate with law enforcement. Trauma-focused treatment can facilitate disclosure of painful histories to children’s lawyers and judges, thereby improving chances for winning legal relief. By referring children for legal services and providing affidavits or court testimonies, pediatricians can directly advocate on behalf of children facing immigration proceedings.

### Recommendations

Pediatricians have the opportunity to advocate for systems that mitigate trauma and protect the health and well-being of vulnerable immigrant children. Children, especially those who have been exposed to trauma and violence, should not be placed in settings that do not meet basic standards for children’s physical and mental health and that expose children to additional risk, fear, and trauma. Until the unprecedented 2014 increase in Central American migration, children detained with a parent or legal guardian were released into the community. The government’s decision in 2014 to place them in family detention was intended, in part, to send a message of deterrence abroad.\textsuperscript{8} It is the position of the AAP that children in the custody of their parents should never be detained, nor should they be separated from a parent, unless a competent family court makes that determination. In every decision about children, government decision-makers should prioritize the best interests of the child.\textsuperscript{54}

The following recommendations pertain to handling of immigrant children, including their health care, while they are in custody:

- Treat all immigrant children and families seeking safe haven who are taken into US immigration custody with dignity and respect to protect their health and well-being.
- Eliminate exposure to conditions or settings that may retraumatize children, such as those that currently exist in detention, or detention itself.
- Separation of a parent or primary caregiver from his or her children should never occur, unless there are concerns for safety of the child at the hand of parent. Efforts should always be made to ensure that children separated from other relatives are able to maintain contact with them during detention.
- While in custody, unaccompanied children and family units should be provided with child-friendly orientation and regular updates regarding their current status, expectations, and rights.
- Because conditions at CBP processing centers are inconsistent with AAP recommendations for appropriate care and treatment of children, children should not be subjected to these facilities.
- Processing of children and family units should occur in a child-friendly manner, taking place outside current CBP processing.
centers or conducted by child welfare professionals, to provide conditions that emphasize the health and well-being of children and families at this critical stage of immigration proceedings.

- DHS should discontinue the general use of family detention and instead use community-based alternatives to detention for children held in family units.

- Community-based case management should be implemented for children and families, thus ending both detention and the placement of electronic tracking devices on parents. Government funding should be provided to support case management programs.

- Children, whether unaccompanied or accompanied, should receive timely, comprehensive medical care that is culturally and linguistically sensitive by medical providers trained to care for children. This care should be consistent throughout all stages of the immigration processing pathway.

- Trauma-informed mental health screening and care are critical for immigrant children seeking safe haven. Screening should be conducted once a child is in the custody of US officials via a validated mental health screening tool, with periodic rescreening, additional evaluation, and trauma-informed care available for children and their parents.

- When children are in the custody of the federal government, extra precautions must be in place to identify and protect children who have been victims of trafficking and to prevent recruitment of new children into the trafficking trade.

- Children should be provided with language-appropriate, year-round educational services, including special education if needed, throughout the immigration pathway.

- Recreational and social enrichment activities, such as opportunities for physical activity and creative expression, may alleviate stress and foster resiliency and should be part of any program for detained children. At a minimum, outdoor and major muscle activity should meet the minimum standards set by the Flores Settlement Agreement.

- Children and families should have access to legal counsel throughout the immigration pathway. Unaccompanied minors should have free or pro bono legal counsel with them for all appearances before an immigration judge.

- The AAP encourages longitudinal evaluation of the health consequences of detention of immigrant children in the United States.

Given the complex medical, mental health, and legal needs of these children, the following recommendations pertain to postrelease care of previously detained immigrant children in the community. Children and families need a coordinated system that facilitates access to a medical home that can address the children’s physical and mental health needs and facilitates access to education, child care, and legal and interpretation services.

- The AAP advocates for expanded funding for postrelease services to promote the safety and well-being of all previously detained immigrant children and to facilitate connection and access to comprehensive services, including medical homes, in the community. Community-based case management should be implemented for children and families.

- All immigrant children seeking safe haven should have comprehensive health care and insurance coverage, which includes the right to access qualified medical interpretation covered by medical benefits, pending immigration proceedings.

- Children not connected to medical homes may first present to nonprimary care settings. Pediatric providers and staff in these facilities, particularly urgent care and emergency departments, can support referral to the medical home and access to comprehensive services.


- Pediatric providers should familiarize themselves with trauma-informed care and promote access to comprehensive mental health evaluation in the community. The AAP Trauma Toolbox for Primary Care (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Trauma-Guide.aspx) offers an accessible resource for pediatricians to build these skills. Integrated behavioral health in the primary care setting is an optimal model for care of immigrant and other vulnerable children, minimizing the difficulty in navigating the health care system.

- Pediatric providers serving previously detained immigrant children should elicit specific history of abuse, neglect, abandonment, persecution, trafficking, or violence to screen children for legal needs and subsequently refer these children for legal services. Integrated care strategies, such as
medical–legal partnerships, may increase connectivity. Likewise, immigration lawyers should have opportunities to refer children to medical homes if children reach the legal system before seeking medical care.

- Pediatric practices should facilitate children’s enrollment in public educational services, essential to children’s development and future well-being.
- School facilities should be safe settings for immigrant children to access education. School records and facilities should not be used in any immigration enforcement action.
- No child, whether accompanied or unaccompanied, should ever represent himself or herself in court. After release into the community, all previously detained immigrant children should have access to legal services at no cost to the child or his or her sponsor.
- Child trafficking victims and other unaccompanied children should be appointed independent child advocates, pursuant to TVPRA, to advocate for their best interests on all issues, including conditions of custody, release to family or sponsors, and relief from removal.
- Pediatricians everywhere should advocate for comprehensive, high-quality health care in a medical home for all children in the United States, including all immigrant children and those detained or otherwise in the care of the state.

**CONCLUSIONS**

The AAP supports comprehensive health care in a medical home for all children in the United States, including all immigrant children and those detained or otherwise in the care of the state. Children deserve protection from additional traumatization in the United States and the identification and treatment of trauma that may have occurred in children’s country of origin, during migration, or during immigration processing or detention in the United States. The AAP endorses the humane treatment of all immigrant children seeking safe haven in the United States, whether unaccompanied or in family units, throughout the immigration pathway.

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**ABBREVIATIONS**

AAP: American Academy of Pediatrics
CBP: Customs and Border Protection
DHS: Department of Homeland Security
FY: fiscal year
HHS: US Department of Health and Human Services
ICE: Immigration and Customs Enforcement
INS: US Immigration and Naturalization Service
ORR: Office of Refugee Resettlement
TVPRA: Trafficking Victims Protection Reauthorization Act

**POTENTIAL CONFLICT OF INTEREST:** The authors have indicated they have no potential conflicts of interest to disclose.

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Detention of Immigrant Children
Julie M. Linton, Marsha Griffin, Alan J. Shapiro and COUNCIL ON COMMUNITY PEDIATRICS
Pediatrics 2017;139;
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Unaccompanied Migrant Children

Unaccompanied Migrant Children¹ (UMC) are children or adolescents who travel across country borders without a legal guardian and without legal immigration documents. As of 2014, there has been a recent increase in the number of UMC crossing the southern border of the US from Mexico, Guatemala, Honduras, and El Salvador. UMC often embark on their journeys to improve their desperate life circumstances; despite the severe adversities encountered, many cope with these experiences in very resilient, healthy, and productive ways. However, they often present with challenges, such as a lack of trust in authority, fears about service systems, and adjustment issues. Once in the US, their disposition is partially determined by their country of origin. If apprehended by immigration authorities at the border, UMC from Mexico are deported within 24 hours. UMC from non-contiguous countries, e.g., from Central American countries, are held in holding facilities to determine their identity, receive basic medical and social care, and for placement with a sponsor in the US, foster care, or group homes, depending on their particular circumstances and needs.

What have Unaccompanied Migrant Children experienced?

Many UMC have been separated from their parents or caregivers for many years. Many report hardships related to neglect, abuse, community, and gang violence. While in their country of origin, UMC may have experienced traumatic events including the following:

- Lack of consistent caregivers
- Homelessness and lack of other basic needs, e.g., education and food
- Violence (as witnesses, victims, and/or perpetrators)
- Gang and drug-related violence or threats
- Physical injuries, infections, and diseases
- Forced labor
- Sexual assault
- Lack of medical care
- Loss of loved ones
- War
- Torture

¹Unaccompanied Migrant Children are officially referred to as “Unaccompanied Alien Children (UAC)” by the Office of Refugee Resettlement
During migration, UMC often face the same types of traumatic events or hardships that they faced in their country of origin, as well as new experiences such as the following:

- Hazardous train rides
- Robbery, assaults, and intimidation by gangs and thieves
- Coercion or abuse by adults referred to as “coyotes”
- Kidnapping
- Sexual violence
- Exposure to the elements without proper supplies and gear
- Harassment and bribery by local authorities
- Hunger, thirst, and exhaustion
- Separation from family
- Loss of community
- Uncertainty about the future
- Detention

Upon entering the US, UMC may still experience trauma such as community violence, abuse or neglect, and/or lack of basic resources. In addition, they may face stress associated with reunification, foster placement, or entering the US school system.

During reunification with a sponsor, such as a parent or family member, UMC may face the following:

- Disruptions in attachment
- Lack of familiarity and connection with caregivers
- Caregivers with limited parenting experience or knowledge of child development
- Difficulty trusting caregivers
- Stress in caregiver-child relationship
- Limited resources
- Fear of deportation or legal involvement
- Discovery that parents may have a new family
- Caregivers unable to understand or relate to the UMC experience
- Expectations of the US and an idealistic image of a family that does not match their reality
During foster placement, UMC and their foster families may face the following:

- Cultural differences
- Challenges in understanding UMC experiences, including their trauma history
- Differences in cultural and family expectations
- Language and communication challenges
- Possible ongoing legal concerns and stress
- New expectations, such as daily school attendance

UMC may have experienced limited or no previous schooling, significant disruptions in schooling due to poverty, community violence or displacement, and/or limited access to school supplies. Therefore, UMC may face the following challenges when entering the US school system:

- Being unfamiliar with school routines and expectations
- Being placed in a classroom based on age that does not correspond to their skill or experience level
- “First” experiences, such as eating new foods at lunch and taking a school bus
- Discrimination, teasing, or bullying by other children at school due to their appearance, culture, religion, beliefs, or language
- Trauma-related mental health symptoms, which may be exacerbated in a setting with authority figures

For more information on UMC and schools please see Supporting Unaccompanied Children in U.S. Schools [http://brycs.org/webinars.cfm](http://brycs.org/webinars.cfm)
How does trauma impact children, including Unaccompanied Migrant Children?

While exposure to traumatic events can have a profound and lasting effect on the daily functioning of UMC, such exposure can cause the following general symptoms in youth of all ages:

- Hypervigilance and suspiciousness
- Difficulty engaging with caregivers due to emotional detachment and cynicism
- Disruption of attachment
- Stomachaches, headaches
- Pains in the body that don’t appear to have a physical cause
- Crying a lot
- Hopelessness
- Fear or anxiety
- Nightmares
- Sadness or grumpiness
- Trouble paying attention
- Jumpiness
- Trouble falling asleep or sleeping too much
- Recurring and unwanted thoughts about the traumatic event(s)
- Getting upset when things happen that remind him/her of the traumatic event(s)
- Avoiding thinking or talking about anything that reminds him/her of the traumatic event(s)
- Lacking desire to play with others or take part in activities that he/she used to enjoy
- Acting as if the traumatic event(s) is happening right now (when it is something that occurred in the past)
- Trouble managing behavior or emotions

What are some of the complexities of providing treatment to Unaccompanied Migrant Children?

- UMC have traveled a long way and worked very hard to meet their goal. Despite difficulties and hardship, they often demonstrate resilience and resourcefulness that can be leveraged as strengths in the healing process.
- There is a lot at stake for these youth. Some know the dangers and uncertainty before they leave and choose to leave anyway; some make the journey multiple times despite having been deported previously.
- UMC are often in debt because they borrowed money to pay coyotes to help them travel to the US.
- UMC live every day with the possibility of deportation.
- UMC may lack resources including health insurance, transportation, education, and vocational training.
- Complex trauma may be present. UMC may have faced abandonment and neglect in addition to repeated exposure to and experience of traumatic events.
What are the cultural considerations when working with Unaccompanied Migrant Children?

Providing care for UMC is both challenging and rewarding. UMC may come from cultures that differ in fundamental ways from the US. Differences in cultural subgroups—related to gender, socioeconomic status, language/dialect, and ethnicity—may affect the following:

- Understanding of health, mental health, and healing
- Stigma of consulting with a mental health professional
- Beliefs about the best course of treatment
- Expectations of outcomes of treatment
- Trust of providers or service systems

How can providers enhance their cultural and clinical competence?

- Read basic information about the UMC’s country and culture of origin.
- Acknowledge the difficulties that UMC and their families have experienced.
- Learn about the community where UMC live and develop relationships with community providers so you can provide a coordinated response.
- Understand their basic needs and help leverage resources in order to meet these needs.
- Provide culturally and linguistically sensitive services by using cultural brokers or interpreters when possible (for more on using interpreters and cultural brokers link)
- Make efforts to learn and respect UMC understandings of symptoms and healing.
- Remember that UMC’s situations are often tenuous due to their legal circumstances; be aware of how this might affect treatment goals and interventions.

Other resources

- [The Office of Refugee Resettlement (ORR)](http://www.orr.gov) operates a [Parent Hotline](http://www.orr.gov) 7 days a week (800-203-7001) from 9am-9pm ET for parents seeking to locate their children in ORR care.
- [Lutheran Immigration and Refugee Services (LIRS)]
- [Catholic Charities](http://www.catholiccharitiesusa.org) and [Conference of Catholic Bishops](http://www.usccb.org)
- [Bridging Refugee Youth and Children’s Services (BRYCS)]
- [KIND Kids in Need of Defense](http://www.kinderight.org) is a national organization that provides legal counsel for unaccompanied refugee and immigrant children in the US
- [Life is Good Kids Foundation](http://www.lifeisgoodkids.org) trains child care professionals to use the power of play to build life-changing relationships with children in their care.
TECHNICAL REPORT

The Lifelong Effects of Early Childhood Adversity and Toxic Stress

abstract

Advances in fields of inquiry as diverse as neuroscience, molecular biology, genomics, developmental psychology, epidemiology, sociology, and economics are catalyzing an important paradigm shift in our understanding of health and disease across the lifespan. This converging, multidisciplinary science of human development has profound implications for our ability to enhance the life prospects of children and to strengthen the social and economic fabric of society. Drawing on these multiple streams of investigation, this report presents an ecobiodevelopmental framework that illustrates how early experiences and environmental influences can leave a lasting signature on the genetic predispositions that affect emerging brain architecture and long-term health. The report also examines extensive evidence of the disruptive impacts of toxic stress, offering intriguing insights into causal mechanisms that link early adversity to later impairments in learning, behavior, and both physical and mental well-being. The implications of this framework for the practice of medicine, in general, and pediatrics, specifically, are potentially transformational. They suggest that many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities associated with poverty, discrimination, or maltreatment could be reduced by the alleviation of toxic stress in childhood. An ecobiodevelopmental framework also underscores the need for new thinking about the focus and boundaries of pediatric practice. It calls for pediatricians to serve as both front-line guardians of healthy child development and strategically positioned, community leaders to inform new science-based strategies that build strong foundations for educational achievement, economic productivity, responsible citizenship, and lifelong health. Pediatrics 2012;129:e232–e246

INTRODUCTION

Of a good beginning cometh a good end.
John Heywood, Proverbs (1546)

The United States, like all nations of the world, is facing a number of social and economic challenges that must be met to secure a promising future. Central to this task is the need to produce a well-educated and healthy adult population that is sufficiently skilled to participate effectively in a global economy and to become responsible stakeholders in a productive society. As concerns continue to grow about the quality of public education and its capacity to prepare the nation’s future workforce, increasing investments are being made in...
the preschool years to promote the foundations of learning. Although debates about early childhood policy focus almost entirely on educational objectives, science indicates that sound investments in interventions that reduce adversity are also likely to strengthen the foundations of physical and mental health, which would generate even larger returns to all of society.1,2 This growing scientific understanding about the common roots of health, learning, and behavior in the early years of life presents a potentially transformational opportunity for the future of pediatrics.

Identifying the origins of adult disease and addressing them early in life are critical steps toward changing the current health care system from a “sick-care” to a “well-care” model.3-5 Although new discoveries in basic science, clinical subspecialties, and high-technology medical interventions continue to advance our capacity to treat patients who are ill, there is growing appreciation that a successful well-care system must expand its scope beyond the traditional realm of individualized, clinical practice to address the complex social, economic, cultural, environmental, and developmental influences that lead to population-based health disparities and unsustainable medical care expenditures.6,7 The science of early childhood development has much to offer in the realization of this vision, and the well-being of young children and their families is emerging as a promising focus for creative investment.

The history of pediatrics conveys a rich narrative of empirical investigation and pragmatic problem solving. Its emergence as a specialized domain of clinical medicine in the late 19th century was dominated by concerns about nutrition, infectious disease, and premature death. In the middle of the 20th century, as effective vaccines, antibiotics, hygiene, and other public health measures confronted the infectious etiologies of childhood illness, a variety of developmental, behavioral, and family difficulties became known as the “new morbidities.”6 By the end of the century, mood disorders, parental substance abuse, and exposure to violence, among other conditions, began to receive increasing attention in the pediatric clinical setting and became known as the “newer morbidities.”7 Most recently, increasingly complex mental health concerns; the adverse effects of television viewing; the influence of new technologies; epidemic increases in obesity; and persistent economic, racial, and ethnic disparities in health status have been called the “millennial morbidities.”8

Advances in the biological, developmental, and social sciences now offer tools to write the next important chapter. The overlapping and synergistic characteristics of the most prevalent conditions and threats to child well-being—combined with the remarkable pace of new discoveries in developmental neuroscience, genomics, and the behavioral and social sciences—present an opportunity to confront a number of important questions with fresh information and a new perspective. What are the biological mechanisms that explain the well-documented association between childhood adversity and adult health impairment? As these causal mechanisms are better elucidated, what can the medical field, specifically, and society, more generally, do to reduce or mitigate the effects of disruptive early-life influences on the origins of lifelong disease? When is the optimal time for those interventions to be implemented?

This technical report addresses these important questions in 3 ways. First, it presents a scientifically grounded, ecobio developmental (EBD) framework to stimulate fresh thinking about the promotion of health and prevention of disease across the lifespan. Second, it applies this EBD framework to better understand the complex relationships among adverse childhood circumstances, toxic stress, brain architecture, and poor physical and mental health well into adulthood. Third, it proposes a new role for pediatricians to promote the development and implementation of science-based strategies to reduce toxic stress in early childhood as a means of preventing or reducing many of society’s most complex and enduring problems, which are frequently associated with disparities in learning, behavior, and health. The magnitude of this latter challenge cannot be overstated. A recent technical report from the American Academy of Pediatrics reviewed 58 years of published studies and characterized racial and ethnic disparities in children’s health to be extensive, pervasive, persistent, and, in some cases, worsening.9 Moreover, the report found only 2 studies that evaluated interventions designed to reduce disparities in children’s health status and health care that also compared the minority group to a white group, and none used a randomized controlled trial design.

The causal sequences of risk that contribute to demographic differences in educational achievement and physical well-being threaten our country’s democratic ideals by undermining the national credo of equal opportunity. Unhealthy communities with too many fast food franchises and liquor stores, yet far too few fresh food outlets and opportunities for physical activity, contribute to an unhealthy population. Unemployment and forced mobility disrupt the social networks that stabilize communities and families and, thereby, lead to higher rates of violence.
and school dropout. The purpose of this technical report is to leverage new knowledge from the biological and social sciences to help achieve the positive life outcomes that could be accrued to all of society if more effective strategies were developed to reduce the exposure of young children to significant adversity.

A NEW FRAMEWORK FOR PROMOTING HEALTHY DEVELOPMENT

Advances in our understanding of the factors that either promote or undermine early human development have set the stage for a significant paradigm shift. In simple terms, the process of development is now understood as a function of “nature dancing with nurture over time,” in contrast to the longstanding but now outdated debate about the influence of “nature versus nurture.” That is to say, beginning prenatally, continuing through infancy, and extending into childhood and beyond, development is driven by an ongoing, inextricable interaction between biology (as defined by genetic predispositions) and ecology (as defined by the social and physical environment) (see Fig 1).

Building on an ecological model that explains multiple levels of influence on psychological development, and a recently proposed biodevelopmental framework that offers an integrated, functioning network with billions of neurons and trillions of connections is assembled. Because this network serves as the biological platform for a child’s emerging social-emotional, linguistic, and cognitive skills, developmental neuroscience is also beginning to clarify the underlying causal mechanisms that explain the normative process of child development. In a parallel fashion, longitudinal studies that document the long-term consequences of childhood adversity indicate that alterations in a child’s ecology can have measurable effects on his or her developmental trajectory, with lifelong consequences for educational achievement, economic productivity, health status, and longevity.

Additional evidence for the proposed framework comes from insights accrued during the “Decade of the Brain” in the 1990s, when the National Institutes of Health invested significant resources into understanding both normal and pathologic neuronal development and function. Subsequent advances in developmental neuroscience have begun to describe further, in some cases at the molecular and cellular levels, how an integrated, functioning network with billions of neurons and trillions of connections is assembled. Because this network serves as the biological platform for a child’s emerging social-emotional, linguistic, and cognitive skills, developmental neuroscience is also beginning to clarify the underlying causal mechanisms that explain the normative process of child development. In a parallel fashion, longitudinal studies that document the long-term consequences of childhood adversity indicate that alterations in a child’s ecology can have measurable effects on his or her developmental trajectory, with lifelong consequences for educational achievement, economic productivity, health status, and longevity.

The EBD framework described in this article presents a new way to think about the underlying biological mechanisms that explain this robust link between early life adversities (ie, the
Understanding the Biology of Stress

Although genetic variability clearly plays a role in stress reactivity, early experiences and environmental influences can have considerable impact. Beginning as early as the prenatal period, both animal and human studies suggest that fetal exposure to maternal stress can influence later stress responsiveness. In animals, this effect has been demonstrated not only in the offspring of the studied pregnancy but also in subsequent generations. The precise biological mechanisms that explain these findings remain to be elucidated, but epigenetic modifications of DNA appear likely to play a role. Early postnatal experiences with adversity are also thought to affect future reactivity to stress, perhaps by altering the developing neural circuits controlling these neuroendocrine responses. Although much research remains to be performed in this area, there is a strong scientific consensus that the ecological context modulates the expression of one’s genotype. It is as if experiences confer a “signature” on the genome to authorize certain characteristics and behaviors and to prohibit others. This concept underscores the need for greater understanding of how stress “gets under the skin,” as well as the importance of determining what external and internal factors can be mobilized to prevent that embedding process or protect against the consequences of its activation.

Physiologic responses to stress are well defined. The most extensively studied involve activation of the hypothalamic-pituitary-adrenocortical axis and the sympathetic-adrenomedullary system, which results in increased levels of stress hormones, such as corticotropin-releasing hormone (CRH), cortisol, norepinephrine, and adrenaline. These changes co-occur with a network of other mediators that include elevated inflammatory cytokines and the response of the parasympathetic nervous system, which counterbalances both sympathetic activation and inflammatory responses. Whereas transient increases in these stress hormones are protective and even essential for survival, excessively high levels or prolonged exposures can be quite harmful or frankly toxic, and the dysregulation of this network of physiologic mediators (eg, too much or too little cortisol; too much or too little inflammatory response) can lead to a chronic “wear and tear” effect on multiple organ systems, including the brain. This cumulative, stress-induced burden on overall body functioning and the aggregated costs, both physiologic and psychological, required for coping and returning to homeostatic balance, have been referred to as “allostatic load.”

The dynamics of these stress-mediating systems are such that their over-activation in the context of repeated or chronic adversity leads to alterations in their regulation. The National Scientific Council on the Developing Child has proposed a conceptual taxonomy comprising 3 distinct types of stress responses (in contrast to the actual stressors themselves) in young children—positive, tolerable, and toxic—on the basis of postulated differences in their potential to cause enduring physiologic disruptions as a result of the intensity and duration of the response. A positive stress response refers to a physiologic state that is brief and mild to moderate in magnitude. Central to the notion of positive stress is the availability of a caring and responsive adult who helps the child cope with the stressor, thereby providing a protective effect that facilitates the return of the stress response systems back to baseline status. Examples of precipitants of a positive stress response in young children include dealing with frustration, getting an immunization, and the anxiety associated with the first day at a child care center. When buffered by an environment of stable and supportive relationships, positive stress responses are a growth-promoting element of normal development. As such, they provide important opportunities to observe, learn, and practice healthy, adaptive responses to adverse experiences.

A tolerable stress response, in contrast to positive stress, is associated with exposure to nonnormative experiences that present a greater magnitude of adversity or threat. Precipitants may include the death of a family member; a serious illness or injury, a contentious divorce, a natural disaster, or an act of terrorism. When experienced in the context of buffering protection provided by supportive adults, the risk that such circumstances will produce excessive activation of the stress response systems that leads to physiologic harm and long-term consequences for health and learning is greatly
reduced. Thus, the essential characteristic that makes this form of stress response tolerable is the extent to which protective adult relationships facilitate the child’s adaptive coping and a sense of control, thereby reducing the physiologic stress response and promoting a return to baseline status.

The third and most dangerous form of stress response, toxic stress, can result from strong, frequent, or prolonged activation of the body’s stress response systems in the absence of the buffering protection of a supportive, adult relationship. The risk factors studied in the Adverse Childhood Experiences Study include examples of multiple stressors (eg, child abuse or neglect, parental substance abuse, and maternal depression) that are capable of inducing a toxic stress response. The essential characteristic of this phenomenon is the postulated disruption of brain circuitry and other organ and metabolic systems during sensitive developmental periods. Such disruption may result in anatomic changes and/or physiologic dysregulations that are the precursors of later impairments in learning and behavior as well as the roots of chronic, stress-related physical and mental illness. The potential role of toxic stress and early life adversity in the pathogenesis of health disparities underscores the importance of effective surveillance for significant risk factors in the primary health care setting. More important, however, is the need for clinical pediatrics to move beyond the level of risk factor identification and to leverage advances in the biology of adversity to contribute to the critical task of developing, testing, and refining new and more effective strategies for reducing toxic stress and mitigating its effects as early as possible, before irrevocable damage is done. Stated simply, the next chapter of innovation in pediatrics remains to be written, but the outline and plot are clear.

**Toxic Stress and the Developing Brain**

In addition to short-term changes in observable behavior, toxic stress in young children can lead to less outwardly visible yet permanent changes in brain structure and function. The plasticity of the fetal, infant, and early childhood brain makes it particularly sensitive to chemical influences, and there is growing evidence from both animal and human studies that persistently elevated levels of stress hormones can disrupt its developing architecture. For example, abundant glucocorticoid receptors are found in the amygdala, hippocampus, and prefrontal cortex (PFC), and exposure to stressful experiences has been shown to alter the size and neuronal architecture of these areas as well as lead to functional differences in learning, memory, and aspects of executive functioning. More specifically, chronic stress is associated with hypertrophy and overactivity in the amygdala and orbitofrontal cortex, whereas comparable levels of adversity can lead to loss of neurons and neural connections in the hippocampus and medial PFC. The functional consequences of these structural changes include more anxiety related to both hyperactivation of the amygdala and less top-down control as a result of PFC atrophy as well as impaired memory and mood control as a consequence of hippocampal reduction. Thus, the developing architecture of the brain can be impaired in numerous ways that create a weak foundation for later learning, behavior, and health.

Along with its role in mediating fear and anxiety, the amygdala is also an activator of the physiologic stress response. Its stimulation activates sympathetic activity and causes neurons in the hypothalamus to release CRH. CRH, in turn, signals the pituitary to release adrenocorticotropic hormone, which then stimulates the adrenal glands to increase serum cortisol concentrations. The amygdala contains large numbers of both CRH and glucocorticoid receptors, beginning early in life, which facilitate the establishment of a positive feedback loop. Significant stress in early childhood can trigger amygdala hypertrophy and result in a hyperresponsive or chronically activated physiologic stress response, along with increased potential for fear and anxiety. It is in this way that a child’s environment and early experiences get under the skin.

Although the hippocampus can turn off elevated cortisol, chronic stress diminishes its capacity to do so and can lead to impairments in memory and mood-related functions that are located in this brain region. Exposure to chronic stress and high levels of cortisol also inhibit neurogenesis in the hippocampus, which is believed to play an important role in the encoding of memory and other functions. Furthermore, toxic stress limits the ability of the hippocampus to promote contextual learning, making it more difficult to discriminate conditions for which there may be danger versus safety, as is common in posttraumatic stress disorder. Hence, altered brain architecture in response to toxic stress in early childhood could explain, at least in part, the strong association between early adverse experiences and subsequent problems in the development of linguistic, cognitive, and social-emotional skills, all of which are inextricably intertwined in the wiring of the developing brain.

The PFC also participates in turning off the cortisol response and has an important role in the top-down
regulation of autonomic balance (ie, sympathetic versus parasympathetic effects), as well as in the development of executive functions, such as decision-making, working memory, behavioral self-regulation, and mood and impulse control. The PFC is also known to suppress amygdala activity, allowing for more adaptive responses to potentially threatening or stressful experiences; however, exposure to stress and elevated cortisol results in dramatic changes in the connectivity within the PFC, which may limit its ability to inhibit amygdala activity and, thereby, impair adaptive responses to stress. Because the hippocampus and PFC both play a significant role in modulating the amygdala's initiation of the stress response, toxic stress-induced changes in architecture and connectivity within and between these important areas might account for the variability seen in stress-responsiveness.50 This can then result in some children appearing to be both more reactive to even mildly adverse experiences and less capable of effectively coping with future stress.36,45,51

**Toxic Stress and the Early Childhood Roots of Lifelong Impairments in Physical and Mental Health**

As described in the previous section, stress-induced changes in the architecture of different regions of the developing brain (eg, amygdala, hippocampus, and PFC) can have potentially permanent effects on a range of important functions, such as regulating stress physiology, learning new skills, and developing the capacity to make healthy adaptations to future adversity.7,58,59 As the scientific evidence for these associations has become better known and has been disseminated more widely, its implications for early childhood policy and programs have become increasingly appreciated by decision makers across the political spectrum. Notwithstanding this growing awareness, however, discussions about early brain development in policy-making circles have focused almost entirely on issues concerned with school readiness as a prerequisite for later academic achievement and the development of a skilled adult workforce. Within this same context, the health dimension of early childhood policy has focused largely on the traditional components of primary pediatric care, such as immunizations, early identification of sensory impairments and developmental delays, and the prompt diagnosis and treatment of medical problems. That said, as advances in the biomedical sciences have generated growing evidence linking biological disruptions associated with adverse childhood experiences (ACE) to greater risk for a variety of chronic diseases well into the adult years, the need to reconceptualize the health dimension of early childhood policy has become increasingly clear.1,6 Stated simply, the time has come to expand the public's understanding of brain development and shine a bright light on its relation to the early childhood roots of adult disease and to examine the compelling implications of this growing knowledge base for the future of pediatric practice.

The potential consequences of toxic stress in early childhood for the pathogenesis of adult disease are considerable. At the behavioral level, there is extensive evidence of a strong link between early adversity and a wide range of health-threatening behaviors. At the biological level, there is growing documentation of the extent to which both the cumulative burden of stress over time (eg, from chronic maltreatment) and the timing of specific environmental insults during sensitive developmental periods (eg, from first trimester rubella or prenatal alcohol exposure) can create structural and functional disruptions that lead to a wide range of physical and mental illnesses later in adult life.1,6 A selective overview of this extensive scientific literature is provided below.

The association between ACE and unhealthy adult lifestyles has been well documented. Adolescents with a history of multiple risk factors are more likely to initiate drinking alcohol at a younger age and are more likely to use alcohol as a means of coping with stress than for social reasons.54 The adoption of unhealthy lifestyles as a coping mechanism might also explain why higher ACE exposures are associated with tobacco use, illicit drug abuse, obesity, and promiscuity.55,56 as well as why the risk of pathologic gambling is increased in adults who were maltreated as children.37 Adolescents and adults who manifest higher rates of risk-taking behaviors are also more likely to have trouble maintaining supportive social networks and are at higher risk of school failure, gang membership, unemployment, poverty, homelessness, violent crime, incarceration, and becoming single parents. Furthermore, adults in this high-risk group who become parents themselves are less likely to be able to provide the kind of stable and supportive relationships that are needed to protect their children from the damages of toxic stress. This intergenerational cycle of significant adversity, with its predictable repetition of limited educational achievement and poor health, is mediated, at least in part, by the social inequalities and disrupted social networks that contribute to fragile families and parenting difficulties.7,58,59

The adoption of unhealthy lifestyles and associated exacerbation of socioeconomic inequalities are potent
risk factors for poor health. Up to 40% of early deaths have been estimated to be the result of behavioral or lifestyle patterns, and 1 interpretation of the ACE study data is that toxic stress in childhood is associated with the adoption of unhealthy lifestyles as a coping mechanism. An additional 25% to 30% of early deaths are thought to be attributable to either inadequacies in medical care or socioeconomic circumstances, many of which are known to contribute to health care–related disparities.

Beyond its strong association with later risk-taking and generally unhealthy lifestyles, it is critically important to underscore the extent to which toxic stress in early childhood has also been shown to cause physiological disruptions that persist into adulthood and lead to frank disease, even in the absence of later health-threatening behaviors. For example, the biological manifestations of toxic stress can include alterations in immune function and measurable increases in inflammatory markers, which are known to be associated with poor health outcomes as diverse as cardiovascular disease, viral hepatitis, liver cancer, asthma, chronic obstructive pulmonary disease, autoimmune diseases, poor dental health, and depression.

Thus, toxic stress in early childhood not only is a risk factor for later risky behavior but also can be a direct source of biological injury or disruption that may have lifelong consequences independent of whatever circumstances might follow later in life. In such cases, toxic stress can be viewed as the precipitant of a physiologic memory or biological signature that confers lifelong risk well beyond its time of origin.

Over and above its toll on individuals, it is also important to address the enormous social and economic costs of toxic stress and its consequences for all of society. The multiple dimensions of these costs extend from differential levels of civic participation and their impacts on the quality of community life to the health and skills of the nation’s workforce and its ability to participate successfully in a global economy. In the realm of learning and behavior, economists argue for early and sustained investments in early care and education programs, particularly for children whose parents have limited education and low income, on the basis of persuasive evidence from cost-benefit analyses that reveal the costs of incarceration and diminished economic productivity associated with educational failure. In view of the relatively scarce attention to health outcomes in these long-term follow-up studies, the full return on investments that reduce toxic stress in early childhood is likely to be much higher.

Health care expenditures that are paying for the consequences of unhealthy lifestyles (eg, obesity, tobacco, alcohol, and substance abuse) are enormous, and the costs of chronic diseases that may have their origins early in life include many conditions that consume a substantial percentage of current state and federal budgets. The potential savings in health care costs from even small, marginal reductions in the prevalence of cardiovascular disease, hypertension, diabetes, and depression are, therefore, likely to dwarf the considerable economic productivity and criminal justice benefits that have been well documented for effective early childhood interventions.

In summary, the EBD approach to childhood adversity discussed in this report has 2 compelling implications for a full, life span perspective on health promotion and disease prevention. First, it postulates that toxic stress in early childhood plays an important causal role in the intergenerational transmission of disparities in educational achievement and health outcomes. Second, it underscores the need for the entire medical community to focus more attention on the roots of adult diseases that originate during the prenatal and early childhood periods and to rethink the concept of preventive health care within a system that currently perpetuates a scientifically untenable wall between pediatrics and internal medicine.

THE NEED FOR A NEW PEDIATRIC PARADIGM TO PROMOTE HEALTH AND PREVENT DISEASE

In his 1966 Aldrich Award address, Dr Julius Richmond identified child development as the basic science of pediatrics. It is now time to expand the boundaries of that science by incorporating more than 4 decades of transformational research in neuroscience, molecular biology, and genomics, along with parallel advances in the behavioral and social sciences (see Fig 1). This newly augmented, interdisciplinary, basic science of pediatrics offers a promising framework for a deeper understanding of the biology and ecology of the developmental process. More importantly, it presents a compelling opportunity to leverage these rapidly advancing frontiers of knowledge to formulate more effective strategies to enhance lifelong outcomes in learning, behavior, and health.

The time has come for a coordinated effort among basic scientists, pediatric subspecialists, and primary care clinicians to develop more effective strategies for addressing the origins of social class, racial, and ethnic disparities in health and development. To this end, a unified, science-based approach to early childhood policy and practice across multiple sectors (including primary health care, early...
care and education, and child welfare, among many others) could provide a compelling framework for a new era in community-based investment in which coordinated efforts are driven by a shared knowledge base rather than distracted by a diversity of traditions, approaches, and funding streams. Recognizing both the critical value and clear limitations of what can be accomplished within the constraints of an office visit, 21st century pediatrics is well positioned to serve as the primary engine for a broader approach to health promotion and disease prevention that is guided by cutting-edge science and expanded in scope beyond individualized health care. The pediatric medical home of the future could offer more than the early identification of concerns and timely referral to available programs, as enhanced collaboration between pediatricians and community-based agencies could be viewed as a vehicle for testing promising new intervention strategies rather than simply improving coordination among existing services. With this goal in mind, science tells us that interventions that strengthen the capacities of families and communities to protect young children from the disruptive effects of toxic stress are likely to promote healthier brain development and enhanced physical and mental well-being. The EBD approach proposed in this article is adapted from a science-based framework created by the Center on the Developing Child at Harvard University to advance early childhood policies and programs that support this vision (see Fig 2). Its rationale, essential elements, and implications for pediatric practice are summarized below.

**Broadening the Framework for Early Childhood Policy and Practice**

Advances across the biological, behavioral, and social sciences support 2 clear and powerful messages for leaders who are searching for more effective ways to improve the health of the nation. First, current health promotion and disease prevention policies focused largely on adults would be more effective if evidence-based investments were also made to strengthen the foundations of health in the prenatal and early childhood periods. Second, significant reductions in chronic disease could be achieved across the life course by decreasing the number and severity of adverse experiences that threaten the well-being of young children and by strengthening the protective relationships that help mitigate the harmful effects of toxic stress. The multiple domains that affect the biology of health and development—including the foundations of healthy development, caregiver and community capacities, and public and private sector policies and programs—provide a rich array of targeted opportunities for the introduction of innovative interventions, beginning in the earliest years of life.1

![An ecobiodevelopmental framework for early childhood policies and programs. This was adapted from ref 1. See text for details.](image-url)
The biology of health and development explains how experiences and environmental influences get under the skin and interact with genetic predispositions, which then result in various combinations of physiologic adaptation and disruption that affect lifelong outcomes in learning, behavior, and both physical and mental well-being. These findings call for us to augment adult-focused approaches to health promotion and disease prevention by addressing the early childhood origins of lifelong illness and disability.

The foundations of healthy development refers to 3 domains that establish a context within which the early roots of physical and mental well-being are nourished. These include (1) a stable and responsive environment of relationships, which provides young children with consistent, nurturing, and protective interactions with adults to enhance their learning and help them develop adaptive capacities that promote well-regulated stress-response systems; (2) safe and supportive physical, chemical, and built environments, which provide physical and emotional spaces that are free from toxins and fear, allow active exploration without significant risk of harm, and offer support for families raising young children; and (3) sound and appropriate nutrition, which includes health-promoting food intake and eating habits, beginning with the future mother’s preconception nutritional status.

Caregiver and community capacities to promote health and prevent disease and disability refers to the ability of family members, early childhood program staff, and the social capital provided through neighborhoods, voluntary associations, and the parents’ workplaces to play a major supportive role in strengthening the foundations of child health. These capacities can be grouped into 3 categories: (1) time and commitment; (2) financial, psychological, social, and institutional resources; and (3) skills and knowledge.

Public and private sector policies and programs can strengthen the foundations of health through their ability to enhance the capacities of caregivers and communities in the multiple settings in which children grow up. Relevant policies include both legislative and administrative actions that affect systems responsible for primary health care, public health, child care and early education, child welfare, early intervention, family economic stability (including employment support for parents and cash assistance), community development (including zoning regulations that influence the availability of open spaces and sources of nutritious food), housing, and environmental protection, among others. It is also important to underscore the role that the private sector, particularly through supportive workplace policies (such as paid parental leave, support for breastfeeding, and flexible work hours to attend school activities and medical visits).

Defining a Distinctive Niche for Pediatrics Among Multiple Early Childhood Disciplines and Services

Notwithstanding the important goal of ensuring a medical home for all children, extensive evidence on the social determinants of health indicates that the reduction of disparities in physical and mental well-being will depend on more than access to high-quality medical care alone. Moreover, as noted previously, experience tells us that continuing calls for enhanced coordination of effort across service systems are unlikely to be sufficient if the systems are guided by different values and bodies of knowledge and the effects of their services are modest. With these caveats in mind, pediatricians are strategically situated to mobilize the science of early childhood development and its underlying neurobiology to stimulate fresh thinking about both the scope of primary health care and its relation to other programs serving young children and their families. Indeed, every system that touches the lives of children—as well as mothers before and during pregnancy—offers an opportunity to leverage this rapidly growing knowledge base to strengthen the foundations and capacities that make lifelong healthy development possible. Toward this end, explicit investments in the early reduction of significant adversity are particularly likely to generate positive returns.

The possibilities and limitations of well-child care within a multidimensional health system have been the focus of a spirited and enduring discussion within the pediatric community. Over more than half a century, this dialogue has focused on the need for family-centered, community-based, culturally competent care for children with developmental disabilities, behavior problems, and chronic health impairments, as well as the need for a broader contextual approach to the challenges of providing more effective interventions for children living under conditions of poverty, with or without the additional complications of parental mental illness, substance abuse, and exposure to violence. As the debate has continued, the gap between the call for comprehensive services and the realities of day-to-day practice has remained exceedingly difficult to reduce. Basic recommendations for routine developmental screening and referrals to appropriate community-based services have been particularly difficult
to implement. The obstacles to progress in this area have been formidable at both ends of the process—beginning with the logistical and financial challenges of conducting routine developmental screening in a busy office setting and extending to significant limitations in access to evidence-based services for children and families who are identified as having problems that require intervention.

Despite long-standing calls for an explicit, community-focused approach to primary care, a recent national study of pediatric practices identified persistent difficulties in achieving effective linkages with community-based resources as a major challenge. A parallel survey of parents also noted the limited communication that exists between pediatric practices and community-based services, such as Supplemental Nutrition Program for Women, Infants, and Children; child care providers; and schools. Perhaps most important, both groups agreed that pediatricians cannot be expected to meet all of a child's needs. This challenge is further complicated by the marked variability in quality among community-based services that are available—ranging from evidence-based interventions that clearly improve child outcomes to programs that appear to have only marginal effects or no measurable impacts. Thus, although chronic difficulty in securing access to indicated services is an important problem facing most practicing pediatricians, the limited evidence of effectiveness for many of the options that are available (particularly in rural areas and many states in which public investment in such services is more limited) presents a serious problem that must be acknowledged and afforded greater attention.

At this point in time, the design and successful implementation of more effective models of health promotion and disease prevention for children experiencing significant adversity will require more than advocacy for increased funding. It will require a deep investment in the development, testing, continuous improvement, and broad replication of innovative models of cross-disciplinary policy and programmatic interventions that are guided by scientific knowledge and led by practitioners in the medical, educational, and social services worlds who are truly ready to work together (and to train the next generation of practitioners) in new ways. The sheer number and complexity of under-addressed threats to child health that are associated with toxic stress demands bold, creative leadership and the selection of strategic priorities for focused attention. To this end, science suggests that 2 areas are particularly ripe for fresh thinking: the child welfare system and the treatment of maternal depression. For more than a century, child welfare services have focused on physical safety, reduction of repeated injury, and child custody. Within this context, the role of the pediatrician is focused largely on the identification of suspected maltreatment and the documentation and treatment of physical injuries. Advances in our understanding of the impact of toxic stress on lifelong health now underscore the need for a broader pediatric approach to meet the needs of children who have been abused or neglected. In some cases, this could be provided within a medical home by skilled clinicians with expertise in early childhood mental health. In reality, however, the magnitude of needs in this area generally exceeds the capacity of most primary care practice settings. A report from the Institute of Medicine and National Research Council stated that these needs could be addressed through regularized referrals from the child welfare system to the early intervention system for children with developmental delays or disabilities; subsequent federal reauthorizations of the Keeping Children and Families Safe Act and the Individuals with Disabilities Education Act (Part C) both included requirements for establishing such linkages. The implementation of these federal requirements, however, has moved slowly.

The growing availability of evidence-based interventions that have been shown to improve outcomes for children in the child welfare system underscores the compelling need to transform “child protection” from its traditional concern with physical safety and custody to a broader focus on the emotional, social, and cognitive costs of maltreatment. The Centers for Disease Control and Prevention has taken an important step forward by promoting the prevention of child maltreatment as a public health concern. The pediatric community could play a powerful role in leading the call for implementation of the new requirement for linking child welfare to early intervention programs, as well as bringing a strong, science-based perspective to the collaborative development and implementation of more effective intervention models. The widespread absence of attention to the mother-child relationship in the treatment of depression in women with young children is another striking example of the gap between science and practice that could be reduced by targeted pediatric advocacy.

Extensive research has demonstrated the extent to which maternal depression compromises the contingent reciprocity between a mother and her young child that is essential for healthy cognitive, linguistic, social, and emotional development. Despite that well-documented observation, the treatment of depression in women with
young children is typically viewed as an adult mental health service and rarely includes an explicit focus on the mother-child relationship. This serious omission illustrates a lack of understanding of the consequences for the developing brain of a young child when the required “serve and return” reciprocity of the mother-child relationship is disrupted or inconsistent. Consequently, and not surprisingly, abundant clinical research indicates that the successful treatment of a mother’s depression does not generally translate into comparable recovery in her young child unless there is an explicit therapeutic focus on their dyadic relationship. Pediatricians are the natural authorities to shed light on this current deficiency in mental health service delivery. Advocating for payment mechanisms that require (or provide incentives for) the coordination of child and parent medical services (eg, through automatic coverage for the parent-child dyad linked to reimbursement for the treatment of maternal depression) offers a promising strategy that American Academy of Pediatrics state chapters could pursue. As noted previously, although some medical homes may have the expertise to provide this kind of integrative treatment, most pediatricians rely on the availability of other professionals with specialized skills who are often difficult to find. Whether such services are provided within or connected to the medical home, it is clear that standard pediatric practice must move beyond screening for maternal depression and invest greater energy in securing the provision of appropriate and effective treatment that meets the needs of both mothers and their young children.

The targeted messages conveyed in these 2 examples are illustrative of the kinds of specific actions that offer promising new directions for the pediatric community beyond general calls for comprehensive, family-centered, community-based services. Although the practical constraints of office-based practice make it unlikely that many primary care clinicians will ever play a lead role in the treatment of children affected by maltreatment or maternal depression, pediatricians are still the best positioned among all the professionals who care for young children to provide the public voice and scientific leadership needed to catalyze the development and implementation of more effective strategies to reduce adversities that can lead to lifelong disparities in learning, behavior, and health.

A great deal has been said about how the universality of pediatric primary care makes it an ideal platform for coordinating the services needed by vulnerable, young children and their families. In this respect, the medical home is strategically positioned to play 2 important roles. The first is to ensure that needs are identified, state-of-the-art management is provided as indicated, and credible evaluation is conducted to assess the effects of the services that are being delivered. The second and, ultimately, more transformational role is to mobilize the entire pediatric community (including both clinical specialists and basic scientists) to drive the design and testing of much-needed, new, science-based interventions to reduce the sources and consequences of significant adversity in the lives of young children. To this end, a powerful new role awaits a new breed of pediatricians who are prepared to build on the best of existing community-based services and to work closely with creative leaders from a range of disciplines and sectors to inform innovative approaches to health promotion and disease prevention that generate greater effects than existing efforts.

No other profession brings a comparable level of scientific expertise, professional stature, and public trust—and nothing short of transformational thinking beyond the hospital and office settings is likely to create the magnitude of breakthroughs in health promotion that are needed to match the dramatic advances that are currently emerging in the treatment of childhood disease. This new direction must be part of the new frontier in pediatrics—a frontier that brings cutting-edge scientific thinking to the multidimensional world of early childhood policy and practice for children who face significant adversity. Moving that frontier forward will benefit considerably from pediatric leadership that provides an intellectual and operational bridge connecting the basic sciences of neurobiology, molecular genetics, and developmental psychology to the broad and diverse landscape of health, education, and human services.

SUMMARY

A vital and productive society with a prosperous and sustainable future is built on a foundation of healthy child development. Health in the earliest years—beginning with the future mother’s well-being before she becomes pregnant—lays the groundwork for a lifetime of the physical and mental vitality that is necessary for a strong workforce and responsible participation in community life. When developing biological systems are strengthened by positive early experiences, children are more likely to thrive and grow up to be healthy, contributing adults. Sound health in early childhood provides a foundation for the construction of sturdy brain architecture and the achievement of a broad range of skills and learning capacities. Together these constitute the building blocks for a vital and sustainable society that invests in its
human capital and values the lives of its children.

Advances in neuroscience, molecular biology, and genomics have converged on 3 compelling conclusions: (1) early experiences are built into our bodies; (2) significant adversity can produce physiologic disruptions or biological memories that undermine the development of the body’s stress response systems and affect the developing brain, cardiovascular system, immune system, and metabolic regulatory controls; and (3) these physiologic disruptions can persist far into adulthood and lead to lifelong impairments in both physical and mental health. This technical report presents a framework for integrating recent advances in our understanding of human development with a rich and growing body of evidence regarding the disruptive effects of childhood adversity and toxic stress. The EBD framework that guides this report suggests that many adult diseases are, in fact, developmental disorders that begin early in life. This framework indicates that the future of pediatrics lies in its unique leadership position as a credible and respected voice on behalf of children, which provides a powerful platform for translating scientific advances into more effective strategies and creative interventions to reduce the early childhood adversities that lead to lifelong impairments in learning, behavior, and health.

CONCLUSIONS

1. Advances in a broad range of interdisciplinary fields, including developmental neuroscience, molecular biology, genomics, epigenetics, developmental psychology, epidemiology, and economics, are converging on an integrated, basic science of pediatrics (see Fig 1).

2. Rooted in a deepening understanding of how brain architecture is shaped by the interactive effects of both genetic predisposition and environmental influence, and how its developing circuitry affects a lifetime of learning, behavior, and health, advances in the biological sciences underscore the foundational importance of the early years and support an EBD framework for understanding the evolution of human health and disease across the life span.

3. The biology of early childhood adversity reveals the important role of toxic stress in disrupting developing brain architecture and adversely affecting the concurrent development of other organ systems and regulatory functions.

4. Toxic stress can lead to potentially permanent changes in learning (linguistic, cognitive, and social-emotional skills), behavior (adaptive versus maladaptive responses to future adversity), and physiology (a hyperresponsive or chronically activated stress response) and can cause physiologic disruptions that result in higher levels of stress-related chronic diseases and increase the prevalence of unhealthy lifestyles that lead to widening health disparities.

5. The lifelong costs of childhood toxic stress are enormous, as manifested in adverse impacts on learning, behavior, and health, and effective early childhood interventions provide critical opportunities to prevent these undesirable outcomes and generate large economic returns for all of society.

6. The consequences of significant adversity early in life prompt an urgent call for innovative strategies to reduce toxic stress within the context of a coordinated system of policies and services guided by an integrated science of early childhood and early brain development.

7. An EBD framework, grounded in an integrated basic science, provides a clear theory of change to help leaders in policy and practice craft new solutions to the challenges of societal disparities in health, learning, and behavior (see Fig 2).

8. Pediatrics provides a powerful yet underused platform for translating scientific advances into innovative early childhood policies, and practicing pediatricians are ideally positioned to participate “on the ground” in the design, testing, and refinement of new models of disease prevention, health promotion, and developmental enhancement beginning in the earliest years of life.

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The Lifelong Effects of Early Childhood Adversity and Toxic Stress
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Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children

Laura C N Wood

ABSTRACT
In April 2018, the US government introduced a ‘zero tolerance’ illegal immigration control strategy at the US-Mexico border resulting in the detention of all adults awaiting federal prosecution for illegal entry and the subsequent removal of their children to separate child shelters across the USA. By June 2018, over 2300 immigrant children, including infants, had been separated from their parents for immigration purposes. Media reports and scenes of distraught families ignited global condemnation of US immigration policy and fresh criticism of immigration detention practices. Detention of children for immigration purposes is known to be practised in over 100 countries worldwide, despite a significant body of research demonstrating the extensive harm of such policies. This review explores and contextualises the key potential impacts of family separation and detention of children for immigration purposes including damaged attachment relationships, traumatisation, toxic stress and wider detrimental impacts on immigrant communities. As such, it is critical for host nation governments to cease the practice of family separation and child detention for immigration control and promote postmigration policies that protect children from further harm, promote resilience and enable recovery.

INTRODUCTION
In recent months, the Trump administration has been subject to damning condemnation from child health and human rights experts for their pursuit of a ‘zero tolerance’ immigration strategy requiring the detention and federal prosecution of all adults apprehended for illegal entry at the US-Mexico border, including those seeking asylum. As US law does not permit child detention in federal jail, the consequences of such parental arrests included the enforced removal of accompanying children to separate detention facilities. Between April and June 2018, over 2500 immigrant children, reportedly including preverbal, breastfed infants were relocated to separate child detention shelters across the USA to await resolution of their parent’s case and hopeful, but not guaranteed, reunion.

In late June 2018, after extensive public and political outrage President Trump signed an executive order ending the policy of separating children from their parents at the US-Mexico border. Promises of ongoing ‘zero-tolerance’, prosecution of adults and family detention remained. Subsequent reunification of separated families has been hampered by a grievous lack of foreplanning and complex interactions with parents regarding child return and repatriation. By August 2018, reports estimated that 700 children, including 40 children under the age of 4 years remained separated from their parents.

The USA is not alone in the punitive management of immigrant children. Over 100 countries are known to detain children for migration-related reasons including the UK, Australia and Canada despite emphatic criticism of the practice as a child rights violation, in contravention of the principle of the best interests of the child and significantly detrimental to child well-being. The Royal College of Paediatrics and Child Health, the American Academy of Pediatrics, the Canadian Paediatric Society, the American Medical Association, the Canadian Medical Association and the International Society for Social Pediatrics & Child Health all recently produced strong statements condemning the systematic splitting of immigrant families, bringing concerns over immigrant child detention and welfare in the USA and their own nations to the fore.

This article considers the recent US immigration practice as a case example and context to explore the key potential impacts of punitive immigration policies on the well-being of affected children, the wider sequelae of hostility towards immigrant families and a call to advocate for children subject to detention and detrimental immigration policy.
Global child migration and detention

In 2016, the United Nations High Commission for Refugees estimated that 50 million children had migrated across country borders or were forcibly displaced. Twenty-eight million (1 in every 80) children fled violence and insecurity, a figure that has more than doubled between 2005 and 2015. Twelve million of these children were recorded as refugees or asylum-seekers. Sixteen million children were internally displaced within their home countries. A further 7 million children had been displaced due to natural disasters. In 2015 and 2016, at least 300,000 children were registered unaccompanied or separated as they crossed borders in over 80 countries.

No validated data are available regarding the number of children in immigration detention worldwide at any given time. The number of children impacted per day through personal or parental detention is estimated in millions. In many countries, immigration detention remains synonymous with widespread human rights violations, lamentable conditions, child maltreatment, abuse and torture. Lack of transparency regarding immigration detention is widespread, severely hampering monitoring of practice and informed public and policy debate.

There is no research available evidencing child detention as beneficial to children or functioning as a successful immigration control strategy.

At the end of May 2018, the US Department of Health and Human Services reported 10,773 unaccompanied immigrant children in its custody, including the 20% swell in numbers since April 2018 due to enforced separation of children from parents at the US-Mexico border. In 2013, Australia experienced a large surge of illegal maritime arrivals leading to the detention of 2,000 children. As of April 2018, 7 children under the age of 18 years were in immigration detention in Australia with 22 children in the highly controversial offshore Nauru Regional Processing Centre. In Canada, 155 minors have been kept in detention facilities in the past year. While Canada separates children from parents only as a last resort, by keeping immigrant children in adult detention facilities with their mother (fathers are detained separately) as ‘housed minors’ rather than detainees, child rights remain violated. In the UK, 42 immigrant children were detained in 2017. Data on child immigration detention across Europe are poorly aggregated leaving the situation unclear. Concern continues to mount regarding the number and condition of child detainees in Greece, with Save the Children reporting ‘appalling conditions’ driving a mental health crisis.

While few countries can take the moral high ground regarding the detention of children for immigration purposes, the systematic separation and detention of immigrant families en masse, without warning or opportunity to challenge, is a phenomenon specific to recent US Trump administration policy.

Illegal immigration at the US-Mexico border

Immigrants detained at the US-Mexico border are primarily asylum-seekers from Guatemala, Honduras and El Salvador; chronically destabilised regions plagued by grave levels of human rights violations, insecurity, poverty, drug cartel infiltration, violence and corrupt justice systems. Criminal gangs target children and mechanisms of exploitation and control are notoriously brutal. Migration through Mexico to the USA is equally gruelling and perilous with immigrants reporting violence, kidnapping, sexual and physical abuse, human trafficking, extortion and ill treatment by officials. Access to adequate shelter, nourishment and medical care is precarious. As immigrant children reach the US-Mexico border, their compounding exposures to detrimental social determinants of health and cumulative adverse experience places them at eminent risk of developmental, mental and physical harm.

Child immigration detention in the USA

Concerns regarding child detention in the USA are not new. In 2017, the American Academy of Pediatrics reported that the basic standards of care for immigrant children in detention were not met. Egregious conditions in processing centres included inadequate bathing and toilet facilities, constant light exposure, children sleeping on concrete floors, confiscation of belongings, insufficient food, denial of access to thorough medical care, lack of mental health support plus physical and emotional maltreatment. Health assessments are performed without parental presence and medical history.

Recent reports of conditions for detained children also include indiscriminate use of the ‘no touch’ rules designed to prevent inappropriate physical contact. While such rules may have their place in safeguarding unaccompanied adolescents, depriving very young children of physical comfort serves to significantly heighten distress. Such circumstances clearly increase the risk of undetected, undertreated, exacerbated and new-onset health conditions. Research is clear however, that even with the provision of safe and sanitary environments the separation of a vulnerable child from their parents may carry severe consequences.

The trauma continuum

Childhood trauma occurs when a child is in a situation that induces a sense of intense fear and helplessness. Traumatic stress responses are best viewed as a continuum (table 1)—nuanced and dependent on a range of features of the traumatic event(s), internal child resilience and the post-trauma environment of the child. Type I trauma occurs primarily after time-limited exposure to an extreme event such as a road traffic accident, recovering without significant injury in an environment of supportive adult relationships. Type II trauma is characterised by repeated, prolonged trauma exposure such as sexual abuse in the home. Type III trauma occurs when a child experiences multiple, pervasive, prolonged,
violent actions initiating at an early age (even in utero—such as domestic violence during pregnancy), creating an extremely hostile environment for development. It is vitally important to recognise different forms and severity of childhood adverse experience as a guide to the extent of traumatic stress and damage to the developing child’s brain.

It is the combination of conscious and deep, subconscious experiences of threat that drives the subsequent neurological and physical damage caused by childhood adversity and trauma. When a lack of safety or threat is perceived, primary neural activity in the brainstem initiates the ‘fight, flight or freeze’ response, promoting the outpouring of stress hormones epinephrine and cortisol that prepare the physical body to respond in a protective manner. During intense fear, the rational considerations of the prefrontal cortex are bypassed leading to behaviour profoundly driven by the subconscious. Children’s brains have a remarkable level of neuroplasticity, and in situations of multiple, prolonged, pervasive adversity their brain will chronically adapt to a level of functioning that seeks to preserve and protect life at the expense of all peripheral learning and relationships.

Such children may develop complex patterns of protective responses that can include hyperarousal—hyper-vigilance, agitation, flashbacks and emotional reactivity, or hypoarousal—dissociative responses, emotional numbing (self-harm may be used as a tool to ‘feel alive’), passive compliance and poor access to cognitive functioning. The well-known diagnosis of post-traumatic stress disorder fails to capture the wider developmental out-workings of complex trauma, including the impact on preverbal children and it should not be considered the only marker of trauma response.

Threatened attachment
The separation of children from their parents threatens the attachment bond, forming an additional root of fear and lack of safety. This deep, enduring affectional bond between a child and caregiver begins in infancy and is critical to the child’s inherent sense of safety and protection. Neurologically, attachment relationships drive the brain development foundational for subsequent physical, emotional, social and cognitive maturation. When parents are removed from a child’s life suddenly and without adequate support, the attachment relationship is threatened.

Children tend to respond to separation from their caregiver in three fluid phases. First, children enter an acute phase of protest characterised by fear, distress, crying and urgent seeking of their caregiver that may last from a few hours to days. As the length of separation continues, children enter a phase of despair during which crying weakens, movement lessens and children reject the approach of alternative adults. With prolonged parental absence, children may become passively compliant with care staff, giving the appearance of having ‘settled in’ to their new environment. Disturbingly, this can signify that the child has detached from the parents and is now living in a perceived state of ‘fear without resolution’. Children reunited while they are in the early separation protest phase usually fare well. Children in despair may respond to the reappearance of their parent with hostility or ambivalence, taking many weeks to rebuild their bond. Children who have detached from their parents may reject their approaches or treat them as strangers. Additionally, when children interpret themselves as ‘abandoned’ by parents, they may develop a profound sense that they have done something wrong to cause their caregiver to leave, igniting shame and complex emotions that can damage the lifelong relationships with themselves and others.

Immigration detention also grossly undermines parenting capacity and parental mental health, whether separated or in family detention settings. This can further damage the attachment relationship, adding to the precarious conditions for children in need of a stable, caring adult relationship to support them in trauma processing.

Through the lens of attachment, it has been concerning to observe the recorded reunions of parents and children following immigration release in the USA. While some reunions have been joyful, others evidence warning flags of significant attachment damage.

Toxic stress
The chronic pounding of stress hormones through the physical bodies of children risks becoming toxic, driving architectural organ damage with lifelong developmental and health sequalae. Stress hormone cascades activate inflammatory and immune changes, considered to be a response to the increased risk of physical injury and healing required in situations of danger. Such processes drive the development of disease and disorder. A child with high adversity exposure has triple the lifetime relative risk of lung cancer, 3.5 times the relative risk of ischaemic heart disease and up to a 20-year reduction in life expectancy. Cancers, diabetes, autoimmune disease...
and numerous other health problems (table 2) are associated directly with toxic stress (not only secondary to unhealthy coping habits, ie, smoking). Worryingly, the outcomes most strongly linked with childhood adversity impact the next generation; notably, substance use, violence and mental illness.41

Given our understanding of the background levels of complex, intergenerational adverse circumstances faced by Central American families seeking asylum in the USA, there is considerable concern about the levels of child traumatisation and mental health needs prior to US entry.42 For such children to then be separated from their primary caregivers and resilience relationships, detained for unknown duration in unsuitable child detention facilities and deprived of relational environments to support resilience and stress response stabilisation, we are witnessing a perfect storm for the development of toxic stress and severe, complex, type III trauma.

**Wider impacts on immigrant health**

Hostile policy and rhetoric regarding immigrant families can create a form of structural racism rendering immigrants (particularly those entering illegally) racialised, devalued, dehumanised ‘others’,13 with wider society increasingly normalised to the stereotyping and suffering of this group. This in turn impacts the social determinants of health for immigrants via multiple pathways that increase and drive cyclical inequalities in health and well-being.44 Hostile policies impact those directly affected and extend influence over wider immigrant communities, of whom children are some of the most vulnerable.45 Patterns of ‘othering’ of societal groups have fed many of the most aggressive acts in human history.46

In the USA, Hispanics (including Central Americans) are the largest minority ethnic group, projected to represent 29% of the US population by 2060. They are also the youngest ethnic group with 32% of Hispanics under the age of 18 years and 26% between the ages of 18 and 33 years. Hispanics remain disproportionately affected by poor conditions of daily life, the social determinants of health (SDH) shaped by complex structural and social factors including immigration status, income and health policy. SDH also exert health effects on individuals via chronically activated stress pathways, eliciting biological processes aligned with toxic stress. Significant physical and mental health disparities have been detected compared with white peers yet rates of health insurance and utilisation of health services remain disproportionately low. While the causes are complex and the group heterogeneous, fear of stigmatisation and deportation are cited as key reasons why Hispanic immigrant children have unmet health needs.47

Recent US policy decisions risk further Hispanic isolation, stress and disengagement with health services creating substantial health inequalities for immigrant children.

**Resilience, recovery and prevention of further harm**

While it is recognised that childhood trauma, abuse and adversity can have profoundly damaging effects on children’s health and development, decades of research regarding the resilience of children has evidenced that many children are indeed, given time, able to overcome serious threat and adversity, particularly when protective relationships and safety are restored.48 49 Resilience has been poetically described as an ‘ordinary magic’—a normal, dynamic, positive process of adjustment and development in spite of severe stressors and adverse experiences.48 49 Refugees, as individuals who have experienced profound, complex, multilayered threats and hardships are frequently described as ‘remarkably resilient’—holding the ability and determination to overcome and lead productive, healthy lives that contribute significantly to their local communities and host nations.50

The ability of a child to outwork their inherent capacity for resilience can be impacted by many factors including key social and environmental influences that compromise or enhance the protective systems around them. Host countries have significant opportunities to mitigate

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**Table 2** Disease and disorder outcomes associated with multiple adverse childhood experiences and toxic stress (not exhaustive)

<table>
<thead>
<tr>
<th>Behaviour with significant health consequences</th>
<th>Mental health</th>
<th>Social inclusion difficulties</th>
<th>Chronic disease and organ damage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive food consumption leading to high body mass index and obesity</td>
<td>Mental ill health and psychiatric diagnoses Anxiety</td>
<td>Harms to life prospects including: education, employment, poverty and healthy relationships</td>
<td>Cancer Heart disease</td>
</tr>
<tr>
<td>Smoking</td>
<td>Depression</td>
<td></td>
<td>Respiratory disease</td>
</tr>
<tr>
<td>Heavy or problematic alcohol use</td>
<td>Suicidality</td>
<td></td>
<td>Liver or digestive disease</td>
</tr>
<tr>
<td>Problematic drug use</td>
<td>Self-directed and interpersonal violence</td>
<td></td>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Sexual risk taking and teenage pregnancy</td>
<td>Poor life satisfaction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Hughes et al.41
Further harm to asylum-seeking and refugee children by developing postmigration policies, processes and environments at individual, family and community levels that are trauma-informed and protective. Key considerations include the critical need for each child to have access to safety, protection and health services. This includes access to culturally competent psychological and psychiatric support where necessary for children deeply wounded and developmentally disrupted by trauma. At family level, the reunification of parents and children must be prioritised and expedited with ongoing support for families to remain intact. At community level, asylum claims must be resolved as quickly as possible to enable stable settlement and integration. Protracted bureaucratic processes, instability, delays and frequent relocations negatively impact parent and child mental health. Concerted efforts need to be made to reduce inequalities and inequities of access to education, health, social, economic and political resources.  

Conclusion: a call for the end of family separation and child detention

Separation of vulnerable immigrant children from their parents on the background of chronic and acute adversity creates a perfect storm for attachment damage, toxic stress and trauma. Children in immigration detention remain at significantly increased risk of physical, mental, emotional and relational disorders in the short and long term. Hostility towards immigrants raises further barriers to health service engagement and risks increasing the health disparities and number of children living with unmet health needs.  

Host countries have a decisive opportunity to reduce harm and promote the resilience and recovery of traumatised children by developing protective postmigration policies and processes. It is crucial that the USA and other countries practising child immigration detention expedite the reunion of immigrant families and end child detention. It is also critical for policy leaders to recognise that family detention is not a ‘kinder’ alternative and the ‘othering’ of immigrants and normalisation of suffering should never be tolerated. All forms of immigration detention are highly detrimental to children and adults and the many effective alternatives must be considered. Paediatricians, healthcare professionals and researchers must continue to advocate for children and families exposed needlessly to immigration detention by bringing robust evidence of harms to the policy debate. We must also engage with policy makers regarding health-promoting practices, enabling all children to thrive and contribute positively to society.  

We must urge our leaders to end detention in our homelands, promote justice and enjoyment of child rights for all children and call on the USA to end its punitive practice of child and family detention.

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Mental Health and Wellness of Children Detained by United States Immigration and Customs Enforcement and Kept Separated from their Families

July 2019
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I. The Nexus Between Traumatic Stress, Separation, and Incarceration and Negative Health and Mental Health Outcomes in Children

A. The Profound and Long-lasting Impact of Trauma on Children Generally

Experiencing adverse or traumatic events during childhood can have lasting effects on children’s psychological and neurological outcomes. Children who have experienced trauma are at a significantly elevated risk for developing lasting mental health problems, including emotional and behavioral problems as well as posttraumatic stress disorder (PTSD), mood disorders, anxiety disorders, learning disorders, and personality disorders (American Psychiatric Association, 2013; American Psychological Association, 2008; Darnell, Flaster, Hendricks, Kerbrat, & Comtoi, 2018; Heim & Nemeroff, 2001; Hovens et al., 2010; Lubit, Rovine, Defrancisci, & Eth, 2003). Emotional and behavioral problems include fearfulness, nervousness, restlessness, impulsivity and disobedience (Darnell et al., 2018; Lorek et al., 2009). Symptoms of trauma-related disorders, anxiety disorders, and mood disorders include depressed mood, anhedonia, changes in appetite/weight, panic symptoms, excessive worry, difficulty concentrating, insomnia, fatigue, emotional numbing, negative changes in cognitions, intrusive thoughts, nightmares, muscle tension, feelings of guilt or worthlessness, psychomotor agitation or retardation, experiential avoidance, and suicidal thoughts (American Psychiatric Association, 2013; American Psychological Association, 2008). Exposure to childhood trauma may also contribute to the development of personality disorders that incorporate additional enduring and pervasive disturbances to an individual’s sense of self, as well as his/her ability to regulate emotions and form positive interpersonal relationships (American Psychiatric Association, 2013).

In addition to these psychological forms of harm, trauma experienced during childhood is also related to deleterious community and individual psychosocial outcomes, including increased risk of self-harm, substance use, domestic violence, and suicide (Van Der Kolk, 2015). These injurious effects can cause significant impairments in a child’s ability to function in a variety of settings, including in school, with peers, and with family members (American Psychiatric Association, 2013; American Psychological Association; Darnell et al., 2018; Lorek et al., 2009). Additionally, children who have experienced trauma have an increased risk of subsequent physical health problems (Pepys & Hirschfield, 2003; Danesh et al., 2004; Lacey, Kumari, & McMunn, 2013).
B. The Multidimensional Effects of Childhood Separation from Parents

Early separation from parents is associated with a range of psychiatric symptoms that can persist even into older adulthood (Pesonen et al., 2007; Pesonen et al., 2009). The Helsinki Birth Cohort (HBSC) study provides some of the most widely-used epidemiological data on temporary childhood separations from parents. Individuals included in the data set were born in Finland during World War II, some of whom were voluntarily evacuated to foster care in other countries for periods ranging from <1 year to > 3 years (Raikkonen et al., 2011). The HBSC has served as an invaluable longitudinal natural experiment on the psychiatric outcomes of brief childhood separations from parents.

The results of the HBSC study find parallels in other research on childhood separation. This research shows that the loss of a parent, and especially a same-sex parent, during early childhood can impact the severity and course of depressive symptoms throughout the lifespan (Tukeuchi et al., 2002). Depressed individuals who experienced parental loss exhibit poorer coping skills and functional outcomes compared to age-matched controls (Tukeuchi et al., 2002). These individuals endorse greater difficulties overcoming symptoms of sedation and depressed mood and experience everyday tasks as requiring significantly more effort.

Even temporary separation from parents in childhood is associated with an increased risk of mental illnesses severe enough to warrant hospitalization or directly contribute to an individual’s cause of death. This applies to any psychiatric diagnosis but is particularly relevant to personality and substance use disorders. Serious and dramatic personality disorders are significantly more common in adults with histories of separation from parents (Lahti et al., 2012). Furthermore, the prevalence of serious personality disorders is highest among those with co-occurring serious mental illness (Lahti et al., 2012). Temporary separation is associated with an increased risk of death as a result of acute intoxication due to increased rates of substance abuse (Raikkonen et al., 2011). This compounded risk of psychiatric problems caused by childhood separation from parents provides a salient example of how pervasively disruptive this type of early life trauma is to healthy development.

The long-term impact of early childhood separation is attributable to physiological changes that occur in children. Such separations often lead to a significant impairment in the central nervous system’s ability to respond to and recover from stress. Individuals who were separated from both parents during early childhood (average age = 3-years-old) exhibit higher levels of reactivity to stress measured by HPA-axis activation compared to those separated from fathers only (Lahti et al., 2012). The psychiatric and neurological effects of separation from parents appear to be the most pronounced in children who are separated after infancy and before the age of five (Lahti et al., 2012; Pesonen, 2009). These children demonstrate the highest risk of developing serious and dramatic personality disorders; they also exhibit greater susceptibility to HPA-axis dysregulation (Lahti et al., 2012; Pesonen, 2009). This harm is not easily remedied.
Indeed, increases in depressive symptoms related to childhood parental separation have been demonstrated nearly sixty years post-separation (Pesonen et al., 2007).

C. Deleterious Effects of Detention on Children

The environment of immigration detention has a substantially detrimental effect on the psychological wellbeing of children. The detention of children prevents their basic needs from being adequately met (Calvert, 2004; Mares, 2016; Zwi & Mares, 2015). They are denied appropriate stability, education, and recreation during a period of their development when these experiences are critical to healthy psychical and psychological development (Mares, 2016; Zwi & Mares, 2015; Zwi, Mares, Nathanson, Tay, & Silove, 2018). Additionally, the substandard conditions of detention present an additional source of trauma. Unsurprisingly, research has consistently found that children in immigration detention experience negative mental health outcomes similar to those that result from other forms of severe trauma. Specifically, they have significantly elevated rates of emotional problems and behavioral problems as well as symptoms of anxiety, depression, and PTSD (Lorek et al., 2009; Newman & Steele, 2008; Mares, 2016; Zwi & Mares, 2015; Zwi et al., 2018). Additionally, suicidal ideation (recurring thoughts of suicide) is not uncommon among detained children (Zwi & Mares, 2015; Zwi et al., 2018). Children in immigration detention are aware of the risks to their mental health and have reported trying to stop themselves from becoming suicidal (Zwi & Mares, 2015).

Among children in immigration detention, prolonged detention and family separation compound the mental health damage imposed by being confined in detention (Zwi et al., 2018). Research has found that the duration of detention is positively correlated with deterioration of mental health and overall functioning (Calvert, 2004; Mares, 2016; Zwi & Mares, 2015; Zwi et al., 2018). This is attributed, in part, to the ongoing uncertainty and associated distress of immigration detention (Zwi & Mares, 2015; Zwi et al., 2018). Further, the separation from family compounds the uncertainty and distress, leading to further psychological harm (Mares, 2016; Zwi & Mares, 2015; Zwi et al., 2018). It is important to note that any form and duration of immigration detention will lead to lasting negative mental health outcomes for children including, but not limited to emotional problems, behavioral problems, developmental delays, and mental illness (Lorek et al., 2009; Mares, 2016). Still, these effects are exacerbated by prolonged detention and separation from family (Calvert, 2004; Mares, 2016; Zwi & Mares, 2015; Zwi et al., 2018). Additionally, prompt access to appropriate physical and psychological health services is critical to mitigating the harmful effects of immigration detention (Newman & Steele, 2008; Zwi et al., 2018).

All told, the research is clear that immigration detention puts children—even when they are accompanied by their parents—at significant risk for negative mental health outcomes and overall poorer socioemotional functioning (Zwi & Mares, 2015; Zwi et al., 2018). These impacts become more acute when accompanied by indefinite family separation.
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Attorneys For Children Guide to Interviewing Clients:

*Integrating Trauma Informed Care and Solution Focused Strategies*

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Introduction:

This guide focuses on the importance of taking trauma into account when interviewing children who have been traumatized. Representing and advocating for a child who has been abused or neglected involves communicating with someone already distrustful due to significant trauma. In order to work for child-clients it is critically important that the attorney for the child considers the impact of trauma on the child’s mentality and how the resultant shift in functioning affects the child’s ability to communicate. In 2001, Harris and Fallot published an innovative guide that examined the necessary elements of integrating trauma informed work into service systems to increase efficacy of the support being provided to persons who are survivors of trauma.\(^1\) Since its publication, the support by systems for integrating trauma informed care has spread widely, including the penetration of its concepts into child welfare cases. The integration of trauma informed care into mental health and service systems sparked a creative design for communicating with clients. Applying the strategies used in Brief Solution-Focused Therapy can provide a language for practitioners to use in partnership with their client to create solutions to a problem and honor the client as being expert to their own story and situation.\(^2\)

Family court attorneys who represent parties engaged in litigated civil disputes often find themselves at an impasse where the parties (particularly the children) have experienced high rates of exposure to traumatic events ranging from witnessing domestic disputes to being the victim of direct physical harm. The attorneys who represent children, despite their highest level of professionalism and expertise are often challenged with limitations for time and access to develop a working relationship with their client. Further, the ability to effectively engage with their client and wholly interview and counsel their client can be hindered by the impacts that traumatic exposure has had on the child’s developmental and emotional communication and thought processes. Integrating the theories of trauma informed care and solution focused strategies into the family court process can provide an opportunity for dialogue and connection within the attorney-client relationship.\(^3\) This guide defines a framework from which an attorney for the child can utilize the theories of trauma informed care and solution focused strategies to develop a meaningful and trusting relationship their client. Further, this guide provides a means for attorneys to formulate a comfortable, successful approach to interviewing children. Section I describes the Solution Focused model and its applicability to interviewing child clients. Section II provides the background information and research on the concepts advocated as best practices for interviewing children both independent of and within the context of abuse and/or neglect. Section III includes tools for courts/attorneys and describes their uses. These tools were developed using the research detailed in Section II: concepts from the Solution Focused Thinking methods created by Insoo Kim and Steve de Shazer.

Section I:

The concepts and language put forth by this guide are based on the Solution Focused Thinking model of communication. Brief Solution-Focused Therapy was developed by Insoo Kim as a way to shift the system of therapy from problem-solving to the creation of solutions.\(^4\) This model can be applied in cases of children affected by trauma. The goal is to transfer the
Integrating Trauma Informed Care and Solution Focused Strategies

Integrating information on child development and the thinking patterns of children affected by trauma will make the interview process less anxiety producing for the child and more effective for the attorney. Introducing techniques for interacting with children in a manner that allows them the most expression despite their underlying trauma will enable more successful legal advocacy for the child.

Section II:

In addition to using the basic skills of interviewing the child while applying the most successful methods, the child’s history of abuse and/or neglect must be considered as well. The concepts on interviewing children who have not been abused apply; they are simply tempered with consideration of the impact that trauma has on the child’s mindset and functioning. The core concepts of interviewing children – creating a comfortable environment, taking language development into account, and maintaining cultural awareness – remain important when speaking with a child in the family court system. Recognizing a child affected by trauma’s vulnerability, increased susceptibility to shame, and specific language needs augment the skills already used when interviewing children. These added concepts facilitate an easier interview process for both the child and the attorney.

The child’s comfort is paramount in an interview setting. Not only does the attorney want to avoid creating anxiety in the child, a comfortable environment will help facilitate dialogue between the child and the attorney. Children do not respond well to direct questioning. Sitting face to face with an adult (inherently an authority in the child’s mind) creates unease and will dissuade the child from divulging information. Using other activities (driving, eating, playing) to soften the import of the conversation will put less pressure on the child and encourage honesty. The use of an activity to access a child’s thoughts is less intrusive and allows for more freedom of expression on the part of the child. Making a child comfortable and building a relationship between the interviewer and the child facilitates a productive interview that supports
the child. Nonverbal cues from the attorney will, likewise, make the child more comfortable. Sitting next to the child as opposed to across from them, appearing engaged and interested, and matching the child’s body language give the message that the attorney is a safe, non-threatening figure.\textsuperscript{10}

When interviewing children, a basic consideration is their developmental linguistic ability to communicate.\textsuperscript{11} The child’s ability to communicate verbally may not align with the standard for their chronological age, so developmental patterns are especially important. The language uses of different aged children require specific communication methods on the part of the interviewer. The young child’s tendency towards concrete thinking juxtaposed with the adolescent’s hypersensitivity to perceived condescension illustrates the extent to which communication between an attorney and his child-client must be personalized by linguistic developmental age.\textsuperscript{12} Techniques that are ubiquitous for all age groups – using open ended questions, avoiding verbosity, and active listening - are the basis to approach interviewing any child.\textsuperscript{13} Open ended questions provide a platform from which a child can give his thoughts on a subject without being limited by the scope of the question.\textsuperscript{14} Children are trained into believing that agreeing with an adult pleases the adult and that disagreeing may have negative consequences.\textsuperscript{15} A child will often say “yes” simply to garner approval. Thus, open ended questions prevent the child from agreeing out of habit or fear. For instance, asking “Where did you go?” instead of “Were you at the park?” allows the child to tell his version of events. This method also reduces the possibility of the child agreeing with the interviewer’s supposition because he believes it is what the attorney wants to hear. By eliminating the use of direct questions, the interviewer opens the lines of communication. Asking wordy, drawn out questions obstructs the child’s ability to respond. Especially with developmentally younger children, the full meaning of a long question is lost as the ability to process the information peters out.\textsuperscript{16} By keeping questions simple and concise, the interviewer increases likelihood that the child will be able to understand the question and respond truthfully. Children also often fear being ignored or declared untruthful.\textsuperscript{17} Actively listening will increase the attorney’s understanding of the child, it will also encourage the child to engage in the conversation. By validating what the child says, confirming that the interviewer understands correctly, and asking for the child to elaborate, the interviewer indicates that he is interested in what the child has to say.

Guarding against unintentional introduction of judgment into an interview requires cultural awareness of both ethnicity and social stigmata. The need to avoid assumptions is especially important in regard to different cultures, as recognized actions and belief sets of one culture may not be the accepted mode of conduct or perception in another culture.\textsuperscript{18} Minorities’ communities are built around a sense of kinship, so the bonds between children and their family/community is a major deterrent from speaking out about their issues.\textsuperscript{19} Emotionally, children are less able to go against social norms in order to advocate for themselves.\textsuperscript{20} Children who are concerned about being judged will not voice an issue as a method of escaping possible censure. In issues such as sexuality, interpersonal relationships, and wrongdoing children will only offer information if they trust that they will not be criticized for it. The introduction of judgment on cultural or social differences is often unintentional. If the interviewer is working from a societal premise that is different from the child’s, the judgment can be inherent in the form of the questions. It is therefore important that the interviewer recognize and remove his own bias from questions in order to prevent seeming culturally inappropriate or critical.

When interviewing a child who has experienced trauma, there are some additional concerns. As previously mentioned, children who have been traumatized think in a different way
from other children. These children experience an increase in emotion, agitation, and have difficulty trusting others. Children who have been the subject of abuse or neglect carry a feeling of hopelessness, have low confidence, and have difficulty imagining a future for themselves. The feelings of helplessness, powerlessness, anxiety, and distress lead to social isolation and difficulty communicating. Specific language and techniques can be used to improve the interview process for a child affected by trauma. Focusing on empowering the child, avoiding judgment, and using language adapted for distressed children is fundamental. Additionally, it is vital that the interviewer address any personal traumas or emotional concerns surrounding the child’s circumstances so as to be able to provide a healthy interview setting for himself and for the child.

A child who is involved with the Family Court system is incredibly vulnerable. In a position of powerlessness in almost every aspect of their lives, such children do not get the opportunity to impact their life in a meaningful way. When interviewing a child who has been traumatized, it is therefore important to recognize and build upon the child’s strengths. When trying to ascertain what the child’s position is on issues, it is important to allow the child to choose the solution he prefers. Furthermore, allowing the child to formulate positive next steps, and work with the attorney to create the child’s preferred outcome engages the child in the process.

Avoiding judgment is a way to make the child feel more comfortable disclosing information. For children who have been traumatized, the feeling of embarrassment often immediately translates into a feeling of shame. This shame is almost paralyzing for children, preventing them from communicating with the interviewer in any positive manner. In order to avoid passing judgment unwittingly, the interviewer’s own biases (outlined above) must be addressed. The attorney should enter the interview situation understanding his own biases and regulating his questions in order to minimize his biases’ impact on the child. Negatively posed questions about the child or the child’s family will often be interpreted as judgment by the child. Another method of avoiding the placement of unnecessary judgment upon a child is through focusing on the positive aspects of the child’s circumstances.

The language used in an interview with a child who has not experienced trauma must be modified to consider an abused/neglected child’s mental state. Clarity, fact-based questioning, and deference to the child’s knowledge of his situation are vital to open communication with a child impacted by trauma. Given the differing thought processing of an abused or neglected child and that of his non-abused counterpart, an abused child needs especially clear, concise questions in order to be able to comprehend what the interviewer is asking. A baseline of easily answered, factual questions allows the child to gain confidence in his answers and willingness to answer future questions. Allowing the child’s answers to stand as fact is also important when conducting an interview of a child who has experienced trauma. When answers given by a child are conflicting, it is important to ask for clarification not in terms of the child’s previous answers being incorrect, but as a wish for a clearer understanding on the part of the interviewer. Confronting a child about conflicting answers creates a feeling of embarrassment and/or shame in the child which both deters the child from answering any further questions and increases the likelihood that the child will respond with what he thinks the attorney wishes to hear.

Section III:

Three practical materials are included in order to help attorneys conduct a more successful interview with a child-client who has experienced trauma. The attached “Concepts on
Interviewing Child Clients”, “Question Reference Guide”, and “Attorney Guide” address practical ways for attorneys to integrate best practices into their interviews.

The “Concepts on Interviewing Child Clients” document (included on pages 6-10) provides an outline of different phases of an interview and concepts that are important in each. It delineates the concerns present in the rapport building and information gathering phases of an interview, including considerations that can help the attorney avoid common pitfalls. These concepts are a synthesis of the information on interviewing children and abused/neglected children previously discussed. As part of this document there are also age-specific recommendations based on developmental, not chronological age. Some concepts and suggestions are duplicated where they pertain to multiple categories. Attorneys can use this document as an aid in formulating questions or planning an interview.

Additionally, the “Question Reference Guide” (included on page 11-14) gives attorneys suggested phrasing and lines of questioning. This list can serve as a question resource for attorneys to use if the attorney is not comfortable creating questions based on the concepts in the “Concepts on Interviewing Child Clients” document. This guide provides many ways of asking the same questions, allowing the attorney to utilize whichever questions make the client and/or the attorney most comfortable. This guide goes through both the rapport building and information gathering portion of an interview.

The “Attorney Guide” (included on page 15-16) is a short synthesis of the previous two documents intended to be used as a guide during the conduct of an interview. The most vital concepts and sample questions are included. This document includes suggestions for five phases of an interview: introduction, engagement, questioning, response, and closing of an interview.
Concepts on Interviewing Child-Clients

I. Child’s Comfort
   a. Create a child-friendly environment (provide snacks, toys, other inviting items)
      i. Giving the child something to hold onto (a spinning top, squeeze toy, Rubik’s cube) while talking will help them decrease their anxiety
      ii. Talking to a child while driving them somewhere or while eating will often make them much more receptive to a conversation
   b. Use techniques that will make the child feel more powerful and make the attorney more approachable to the child
      i. Sit on the same level as the child
      ii. Limit the number of words in your sentence
      iii. Try to replace “why” with “what”, “feel” with “think”, and “but” with “and”
      iv. Use names instead of pronouns (e.g. “Amelia” instead of “she”)
      v. If concerned about the child’s understanding, ask further questions to make sure the child is not confused
         1. For example, ask “Can you tell me what you just heard me say?” or “Tell me what that means to you.”
   c. Consider that the child is likely nervous about this meeting
      i. Consider allowing the child to bring their caretaker or other adult into the meeting with them until the child becomes more comfortable
      ii. Ask the child fact-based questions to which he readily knows the answer
   d. Give the child a way to communicate without speaking
      i. Use a Time Out or Take a Break Tool – keep a ball or other small object that the child can pick up when they feel overwhelmed
      ii. Set up a signal with an object so that a child can ask to stop talking about a subject by picking up or holding up the object without having to verbally communicate their discomfort.
      iii. Children often struggle with disobeying authority. Using this tool gives the child a means of telling the interviewer that they are uncomfortable, scared or overwhelmed without having to actually say it.
         1. E.g. “Bounce the ball to say ‘I don’t want to talk about it.’”
      iv. Using methods of non-verbal, non-confrontational communication will assist in preventing meltdowns, silence, or acting out.
   e. Avoid subjecting the child to a barrage of questions.
      i. A child will be more receptive to answering questions and more open with their answers if the questioning is done through an activity or with frequent breaks for a low-pressure activity/subject matter.
   f. Focus on Listening
      i. Children can sense whether the person they are speaking with is engaged or not.
      ii. Nonverbal cues can provide insight into what the child is thinking/feeling.
         1. Reflect to the child what emotion they seem to be exhibiting. “You seem [excited, frustrated, concerned, etc.] about that.”
iii. Validating what the child says by being attentive and/or repeating back what he says to ensure that the attorney fully understands what the child means helps encourage the child to share

g. Establish what the child already knows/ is misinformed about
   i. Consider asking the child why they think they are here/ why they think they are talking with an attorney

h. Explain role of attorney for the child
   i. Inform the child of the power they have through their attorney
   ii. Explain the concept of attorney-client privilege and confidentiality
   iii. Ask the child what he hopes to gain from the interview
   iv. Tell the child what the attorney hopes the child will gain from the interview

II. Child’s Involvement in the Court Process
   a. Inform the child of what will happen
   b. Inform the child of their rights and responsibilities
   c. Consider that most children think attorneys’ role is to get people “out of trouble” and will therefore assume that talking with an attorney means they are in trouble
   d. Define the roles of all involved persons (judge, attorneys, DSS caseworker, CASA, foster parent/caregiver, therapist, etc.)
   e. Give older children a written list of legal terms that they are likely to come across.
      i. This list should include the term, a simple definition, and room for the youth to take notes
   f. Explain the purpose of the proceedings
   g. Review the concepts of truth and falsity
      i. Explain to the child the importance of being truthful in this circumstance
   h. Ask if the child would like the attorney to say anything to the judge or if the child themselves would like to say something to the judge (as appropriate)
      i. For older children: offer the child the opportunity to write down anything they would like mentioned to the judge
      ii. Invite younger children to draw a picture of what they would like the Judge to know. Then ask the child “Tell me about your drawing” to gain insight into the child’s wishes to be represented.

III. Addressing Past Events
   a. Explain to the child what has already happened
   b. Ensure that the child understands that he/she is not to blame
   c. If the child has been separated from their parent(s) make sure the child knows where their parent is and what is happening to them

IV. Discussing Abuse/Neglect
   a. Avoid direct questions unless absolutely necessary
   b. Encourage the child to give descriptions of both neutral and relevant subjects
   c. Use neutral subjects (child’s favorite hobbies, friends, school, etc.) to provide a basis from which to move towards more relevant subjects
   d. Ensure that the child understands that what they say will not be discussed with anyone (including parents, caseworkers, etc.) without their consent
   e. Avoid leading questions – allow the child to furnish details through broad spectrum questioning
i. Do not discuss details of alleged abuse/neglect established by a third party until the child has already disclosed such details themselves
f. Avoid yes/no questions
g. Help the child find small steps that can be taken to improve their situation
   i. Children will rarely believe an adult who offers a “solution”, it builds more trust to consistently follow through on small steps that slowly move towards a better circumstance
h. Frame things in terms of what works well and what can be improved

V. For Foster Children
   a. Discuss what the situation at the foster home is like
   b. Address changes to school, doctor, child’s support system (grandparents, past teachers, family friends)
   c. Ascertain what aspects of the transition are still problematic (important belongings left behind, issues with new foster siblings, inadequate transfer of services)
   d. Children need to maintain connections to friends, siblings, family activities, former neighborhoods, and former foster parents. Be sure to specifically explore each of these necessary connections.
   e. Ensure that the child is getting the desired visitation with his parent(s)

VI. For Developmentally Disabled Children
   a. Meet multiple times to gauge their understanding of your conversations
   b. Gain as much knowledge from the child himself as possible
   c. Treat any assistive device as part of the personal space of the child
   d. Speak with parents, foster parents, teachers, etc. to increase understanding of child

VII. Cultural Awareness and Social Norms
   a. Avoid assumptions
      i. Children may have issues that have not yet been identified because the child is embarrassed. If the child believes the attorney will judge them for an aspect of their life/personality, he will be reluctant to share information.
      ii. Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) youth are especially sensitive to being judged. Commonplace terminology (boyfriend/girlfriend vs. partner, asking gender-specific questions) can deter them from disclosing information for fear of being “outed”.
   b. Consider the child’s ethnic background
      i. In many cultures, child-rearing is a communal responsibility so extend the scope of inquiries to contemplate more than the nuclear family
      ii. Kinship bonds in immigrant families are especially strong, making it more difficult for a child to speak against a member of his family or community
      iii. Historic oppression and lack of economic opportunity often fosters resentment towards the government and people of different races or socio-economic backgrounds

VIII. Addressing Comprehension and Effectiveness Based on Age/Development
   a. Consider the modality of the child’s thinking
      i. Until late adolescence, children are often limited to dichotomies (good/bad, wrong/right) and cannot understand middle ground
b. Meet multiple times with children to gauge how much they comprehend

c. Explain concepts to an age appropriate level, keeping in consideration that older children have a much greater understanding of their situation

d. Consider and address accordingly which portion of communication (input, processing, or output) is hindered for the child

IX. For Children Who Are Experiencing Challenges

a. For these children, embarrassment often transfers immediately into shame

i. An adult expressing disappointment or frustration will tend to make the child feel shameful and the child will often become less able to meet the expectations

b. Frame any present challenges in terms of what was positive in the past

i. Try to elicit what helped the child succeed in the past rather than what is contributing to his struggle in the present

c. Avoid telling the child what he needs to do

i. Giving the child options and letting him choose will increase his engagement

ii. Telling the child what jobs need to be done for the court to move forward is less confrontational

1. Consider the phrasing: “We all have jobs. The court’s job is to…, Mom/Dad’s job is to…, your job is to…” outlining necessary tasks.

X. For Babies (0-3yrs)/Non-verbal Children

a. Look for signs of wellness through observation

b. Unusual fussiness; a lack of receptiveness to being held; avoidance of eye contact; excessive sleeping; holding his own hands together and focusing on them; other signs of discontentment.

c. Ensure, through speaking with parents/foster parents/CASA/etc., that the child has all important belongings (security blanket/toy; medications)

d. Check medical records for any currently untreated conditions

e. Interview should provide a sense of how secure the child feels

XI. For Toddlers (3-6yrs)

a. Keep in consideration toddlers’ tendency towards concrete thinking

b. Toddlers assert their will power to try and be autonomous, so it is difficult to have structured conversations/activities

c. Gain as much knowledge from the child as his ability to communicate allows

d. These children are likely to give inaccurate information when they do not know what they are being asked, feel confused, or want to avoid telling what they know

e. Consider that these children often have no concept of what has happened to their parents or where their parents are

i. These children have little concept of time, so understanding when they will be reunited with their parents may take additional explanation

ii. These children are often worried that their parent is sick, hurt, or has died/disappeared

iii. Telling a child that you do not know something is alright. Tell them what is known. Consider focusing on small time frames (no more than a month in advance).
XII. For Young Children (6-9yrs)
   a. Children of these ages are especially likely to take blame upon themselves
   b. These children are more comfortable with people of the same gender
   c. These children need to feel a sense of control over what they will be doing in the interview
   d. These children have some concept of what has happened to their parents, but they are still scared that their parent is sick, hurt, or has died/disappeared

XIII. For Prepubescent Children (9-12yrs)
   a. These children enjoy being challenged through more complex activities
   b. These children are especially likely to take blame upon themselves
   c. Consider that these children are able to understand more of their situation and therefore can benefit from a more thorough explanation of the court process
   d. These children are more comfortable with people of the same gender
   e. Offer these children the opportunity of going to court hearings and being part of the process (as appropriate) as a way to engage them in their case

XIV. For Adolescents (12-17 yrs)
   a. Consider that these children are very resentful of condescension
   b. These children have the cognitive abilities to understand the realities of their life situation
      i. However, these children are often very reluctant to ask for clarification or acknowledge that they don’t understand
   c. Offer these children the opportunity of going to court hearings and being part of the process (as appropriate) as a way to engage them in their case

XV. Finishing the Interview
   a. Thank the child for his/her cooperation
   b. Reserve time for the child to return to a state of equilibrium if the child has been stressed by the interview
      i. Allow for a few minutes of silence, shift to neutral topics or end with a game.
   c. Make sure the child does not leave the meeting confused
   d. Make sure the child (and their caretaker) know how to contact the attorney
Question Reference Guide

Breaking the Ice:
- Possible games/activities:
  - Providing juice, a small piece of candy, or a snack will often make a child feel more comfortable and start a conversation.
  - Squiggle Game/Doodle: the child and the interviewer each take a turn making a “squiggle” on a blank sheet of paper. The child creates a drawing from the squiggle and describes what they’ve drawn.
  - Draw Yourself: Ask the child to draw a picture of himself. After the child creates this drawing, ask the child to tell you some words that describe what this child is like, thinking, or feeling.
  - Build a Man (approx. 8yrs+): As the child to draw a platform and pick a word for you to guess. Consider asking the child to pick a word that will tell you how the child feels about being in this interview. The child then draws blank lines to represent each letter of the word below the platform. Begin guessing letters; if they are not part of the word, the child writes the letter on the paper and begins to “build you” by putting a part of the body on the platform for each letter guessed incorrectly. Establish in advance which body parts will be drawn. If you guess the correct letter, it is written on the appropriate blank line.
  - Having toys available such as bubbles, blocks, Legos, or dolls/action figures gives children a way to participate in activities that are normal for them, decreasing their anxiety.

Introduction:
- What do you know about coming to meet with me?
- What do you know about me?
- What do you think I’m here to do for you?
- Is there anything that would make you more comfortable having this meeting?
- Is there anyone (CASA volunteer, caseworker, caregiver etc.) who you would like here for support?
- Do you understand what has happened so far?
- What do you think about it?
- What are you wondering about?
- What are your biggest concerns about the case?
- Do you have any questions about the case/court process?
- What do you hope to have happen?
- Don’t tell me what you think I want to hear - this is your chance to let the court know what you want.
- For older children:
  - What do you want to come out of this meeting?
  - What can I do that would be helpful to you?

Court Proceedings:
- Can you tell me what you know about what is happening in court?
- How did you know?
- Is there anything you want the judge to know?
- Do you understand what your mom/dad’s job is?
- Explain what the parent is doing.
- Explain what the child’s “job” is.
  - Explain that the parent is trying to be reunited with the child.
- What questions do you have about what your mom/dad is doing? About what you are doing?
Child:
- Tell me about yourself.
- How old are you?
- Where do you live?
- Who lives with you?
- Who is important to you?
- Tell me about them.

Fun Activities:
- What is your favorite color?
- What are your favorite hobbies?
- Do you have pets? Describe.
- What is your favorite game/toy? Tell me what you like.
- What is your favorite food/drink?
- What are your favorite things to do?
- When you go out, where do you like to go best? Tell me about it.
- Tell me about your friends.
- What do you like to do with your friends?

School/Schoolwork:
- On a scale of 1-10, 1 being that you never want to go to school and 10 being that you would go to school all the time if you could, where would you rate going to school?
  - What makes it a [\#]?
  - What could make it a [+1]?
- On a scale of 1-10, 1 being that you never go to school and 10 being that you have never missed a day of school, where would you rate yourself?
  - What makes it a [\#]?
  - What could make it a [+1]?
- On a scale of 1-10, 1 being that you never go to school and 10 being that you have never missed a day of school, where would you rate yourself?
  - What makes it a [\#]?
  - What could make it a [+1]?
  - What would your mom/dad rate you?
  - What makes them say it is a [\#]?
- On a scale of 1-10, 1 being that you never can even try your homework because it’s too hard and you don’t want to do it and 10 being that homework is no problem at all, where would you rate your homework?
  - What makes it a [\#]?
  - What could make it a [+1]?
- How do you manage to go on the days you are at school?
- How do you manage to get your homework done on the days you complete it?

Brothers/Sisters:
- Do you have any brothers/sisters?
  - What are their names? Ages?
  - Tell me about them.
- What do you do with your brother(s) and/or sister(s)?
- On a scale of 1-10, 1 being that you don’t ever want to play with your siblings and 10 being that you always want to play with them, where are you?
  - What makes it a [\#]?
  - What could make it a [+1]?
Health:
- Tell me about how you think your body is doing.
- On a scale of 1-10, 1 being that every part of your body doesn’t work/hurts and 10 being that everything is working perfectly, how would you rate yourself?
  - What makes it a [#]?
  - What would make it a [+1]?
- Follow up questions:
  - How often does that happen?
  - Can you tell me about a time when everything in your body worked?
- If you went to the doctor, what would he say?

Home Life:
- If your life were a movie that I was watching, what would I see when:
  - You wake up?
  - You go to school?
  - You are at school?
  - You are at home?
  - You are happy?
  - It is the weekend?
  - You are with mom/dad?
  - You have dinner?
  - You go to bed?
- Do you ever babysit yourself?
- For how long?
- On a scale of 1-10, how safe do you think you are at home?
  - What makes it a [#]?
  - How could it become a [+1]?
  - If your friends came over, where would they rate how safe your house is?
  - How do you rate how safe your friend’s house is?
  - Tell me about your mom/dad.
- Compared to your friends’ houses, how safe do you think your house is?
- On a scale of 1-10, how would you say things are at home? What makes it a [#]?
  - When you are a [+1], what will be different at home?
  - What are the rules at mom/dad’s house?
  - What do you think about them?
  - What does mom/dad do if you do something wrong?
- If you woke up without [problem], how would you know? What would be different?
- Tell me about the times when everyone is getting along? What is different about those times?
- How do you let mom/dad know when you are:
  - happy?
  - scared?
  - hungry?
  - not feeling well?
- Do you ever get scared? When?
- What do you do when you get scared?
- What does mom/dad do when you get scared?
- When everything is better, what will be different?
- What do you hope for the future?
- If you had a magic wand and could change anything you want, what would you change?
- Are there any issues that you think are especially important?

For Children in Foster / a Relative’s Care:
- How did you end up living where you live now?
  - How did you get there?
  - When did you get there?
- On a scale of 1-10, where 1 is completely different in every way and 10 is entirely the same, how would you rate the difference between your old house and your new house?
  - What makes it a [#]?
  - What would make it a [+1]?
- Do you feel settled where you live now?
- Do you feel safe where you live now?
- Are you going to a different school?
  - If yes:
    - On a scale of 1-10, where 1 is completely different in every way and 10 is entirely the same, how would you rate the difference between your old house and your new house?
      - What makes it a [#]?
      - What would make it a [+1]?
      - Tell me about your friends.
      - If you have a problem at school, what do you do?
- If you made a movie about your new home, what would I see when:
  - you are with your foster parents?
  - you are in your room?
  - you are playing?
  - you are happy?
  - You eat dinner?
  - You are with your foster siblings?

**Visitation:**
- Your caseworker tells me you get [X] visitation with your mom/dad? Is that what is happening?
- Are you seeing your parent(s) enough?
- On a scale of 1-10, 1 being it’s the worst and 10 being it’s the best, how would you rate the visitation?
  - What makes it a [#]?
  - What would make it a [+1]?
  - What would your mom/dad rate the visitation as?
  - How do you know?
- If I was watching the visitation with your mom/dad, what would I see?
- Is there anyone who you want to be seeing (grandparents, siblings, etc.) who you are not seeing? Who?

**Questions for Toddlers (3-6 yrs):**
- What did you do today?
- What did you have for breakfast?
- Are you going to do anything after you leave?
- What is the silliest thing you’ve ever done?
- What is your favorite color? What makes it your favorite?

**Questions for Adolescents (12-17yrs):**
- What would you want to say if you were in court?
- What do you think I can do for you?
- Explain that this is the teenager’s opportunity to address his concerns or questions and share his views.
- Explain that the attorney is the teenager’s voice in the courtroom.

**Conclusion:**
- What questions do you have? (give examples of possible questions)
# Attorney Guide

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<th>Action</th>
<th>Description</th>
<th>Suggested Phrasing</th>
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| **Introduce** | - Explain your role and the role of others the child will meet with (judge, DSS, CASA)  
- Make the child comfortable with a child-friendly environment  
- Invite the child to have a caregiver or other adult present until the child feels more comfortable | - What do you know about coming to meet with me?  
- What do you think I'm here to do for you?  
- Is there anyone (CASA volunteer, caseworker, etc.) who you would like here for support?  
- Do you understand what has happened so far?  
- What do you think about it?  
- What are you wondering about it?  
- What are your biggest concerns about the case?  
- Do you have any questions about the case/court process?  
- What do you hope to have happen?  
- Don't tell me what you think I want to hear - this is your chance to let the court know what you want.  
- What do you know about what is happening in court?  
- How did you know?  
- Is there anything you want the judge to know? |
| **Engage** | - Make general conversation to ascertain the developmental age of the child and build rapport.  
- Avoid jargon or acronyms  
- Engage the child in a discussion of their care  
- Actively listen to the child | - Tell me about yourself.  
- How old are you?  
- Where do you live?  
- Who lives with you?  
- Are you close to any family members who are not your parent(s)?  
- Tell me about them.  
- Are there other adults in your life (other than your family) that you are close to?  
- Tell me about them.  
- What is your favorite:  
- Do you have pets? Describe.  
- When you go out, where do you like to go best?  
- Tell me about your friends.  
- What do you like to do with your friends? |
| **Ask** | - Question the child with the goal being to get a narrative, not specific answers  
- Ask non-judgmental, solution focused questions  
- Try to get a holistic view of the child’s life | - On a scale of 1-10, 1 being that [X] and 10 being that [Y], where would you rate [issue]?  
  - Going to school; health; safety of the home;  
    how things are at home; differences between home and foster home; difference between schools; visitation; et cetera  
- What makes it a [?]?  
- What could make it a [+1]?  
- When you are at a [+1] what will be different?  
- What would your mom/dad/doctor/friend rate you?  
- What makes them say it is a [?]?  
- If your life were a movie, and I were watching it, what would I see when X  
  - [you wake up? you go to school? you are at home? you are happy? you are with mom/dad?] |
### Integrating Trauma Informed Care and Solution Focused Strategies

**Respond**
- Validate the child’s input
- Recite back your understanding of the child’s words
- Encourage the child to elaborate

**Closing**
- Allow a few minutes of silence to let the child think and to give control back to the child
- Move to a neutral topic
- Discuss something good that has happened or play a game
- Give the child contact information
- Make sure the child does not leave the meeting confused
- Answer the child’s questions
- Thank the child for his cooperation

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<thead>
<tr>
<th>Respond</th>
<th>Closing</th>
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<tbody>
<tr>
<td>- If you woke up without [problem], how would you know? What would be different? - Tell me about the times when everyone is getting along? What is different about those times? - How do you let mom/dad know when you are [happy? scared? hungry? not feeling well? et cetera] - If you had a magic wand and could change anything you want, what would you change? - Tell me about your mom/dad. - How did you end up living where you live now? - How did you get there? - When did you get there? - Your caseworker tell me you get [X] visitation with your mom/dad? Is that what is happening?</td>
<td>- So, you are saying that X? Is that right? - Tell me about it. - Tell me more. - Then what happens? - What do you think about that? - The next time we see each other will be when… - This is what is going to happen next… - What questions do you have? - Thank you for meeting with me today.</td>
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Works Cited


Supporting the Mental Health of Migrant Children: Consulting Lawyers in Interviewing Children for the *Flores* Settlement
Ryan Matlow, Ewen Wang and Paul Wise

**Background**

The current document is intended as a reference and resource guide for attorneys working with the Center for Human Rights and Constitutional Law (CHRCL) conducting site inspections and class member interviews under the settlement agreement of *Flores vs. Sessions*. As class counsel, CHRCL “can appoint volunteer lawyers and paralegals to inspect detention facilities and to interview detained minors” (CHRCL email communication, 7/25/18). The volunteer lawyers and paralegals that commit to this important effort come with a wide range of previous experience in working with youth, with minors held in detention, and/or with immigrant families and communities. In their efforts, volunteer lawyers work directly with children who are inherently in the midst of an ongoing traumatic experience (i.e., forced detainment and separation from primary caregivers) and are also likely to have been previously exposed to traumatic life events and adverse experiences. Therefore, lawyers are interacting with children experiencing intense psychological distress that is likely to manifest during interviews that inquire about their immigration, separation, and detention experiences. It is important that lawyers are prepared and equipped to conduct interviews and to engage with children in a supportive fashion that minimizes risk for unintended negative consequences of the interview (both for the child and for the lawyer). There is a need to provide resources and training on best practices for interviewing trauma-exposed children being held in detention. The current guide seeks to address this need.

Of note, our recommendations in this report aim to provide a resource to improve current practices related to volunteer lawyer involvement in site inspections and class member interviews, but this report does not necessarily endorse the current standard of practice. First, the report authors are not fully familiar with the system of practice across settings and site inspections. Second, the report authors recommend that volunteer lawyers be knowledgeable and experienced in interviewing trauma-exposed children from Latin America. Third, this document does not examine the procedures and resources provided to families throughout the process of separation, assessment, and follow up, in its entirety. While we recognize that the amount of resources and number of qualified lawyers is limited given the massive undertaking of interviewing all class members within the *Flores* settlement, we also recommend that *every possible effort* be taken to identify and select the most qualified lawyers, and to provide adequate training and preparation, for the sake of both the children and the lawyers.

Finally, the current guide is expressly focused on the consideration and evaluation of the mental health functioning of children under the *Flores* settlement. A comprehensive health assessment is needed. This guide should therefore be thought of as a resource that fulfills one component of a more holistic comprehensive health assessment.
Recommendations and Resources on Interviewing Children Under the *Flores* Settlement

The following recommendations and resources on interviewing class members are provided not only because they will help children feel better during the interview process, but also because they are instrumental for conducting effective interviews and for gathering accurate information while avoiding negative unintended consequences for the child (and their interviewer). While the information below is meant to provide recommendations, resources, and information to assist with the child interview process, reading and review of these recommendations in itself does not necessarily prepare professionals to conduct interviews with trauma-exposed youth; we recommend that interviewers obtain training from a mental health professional with experience in trauma and development. A sample interview script with prompts and questions that take the following recommendations into account is included in Appendix 1.

*Provide a warm and careful introduction to the interview process.* Greet children by their first name and introduce yourself and any other people in the room. Provide a clear explanation and rationale for the purpose of the interview. Set clear expectations and parameters for the interview (United States Department of Justice, 2015). For example, explain that you will be asking questions, and that the child may or may not know all of the answers; let children know that it is OK to say, “I don’t know.” Help them anticipate and prepare for potential distress (given the nature of interview content), and help them to identify things they can do if they begin to feel upset (for example, take a break, stretch, draw, practice deep breathing). Build rapport and comfort with children by getting to know them, their interests, and their experiences (US DOJ, 2015). For example, take time to ask about their day and how they are doing. Adapt your style of speech, tone, and body language to mirror the child’s.

*Maximize children’s sense of control during the interview process.* Remind children that the interviews are voluntary, and that they don’t have to talk about anything they don’t want to talk about. Give them advanced permission to request breaks or pauses. Allow children to guide the flow and timing of the conversation; be patient with children’s pacing.

*Use a simple and straightforward interview and conversational style.* Use short sentence and phrases that contain only one thought or question. Provide questions and statements one-at-a-time, allowing time for children to reflect on questions/statements and respond in a way that is comfortable for him/her.

*Use open-ended questions and sensitive delivery.* Open-ended questions can yield more detailed and spontaneous responses. Verbally reinforce the child’s detailed responses in the early phase of the interview by providing encouragement (taking care to praise effort as opposed to content). This can increase the level of detail in
their responses throughout the interview (US DOJ, 2015). Begin with more general questions and progress to more specific. When seeking more information, say, “tell me more,” or ask, “what happened next?” After posing questions, allow time for silence, hesitation, and reflection. Avoid suggestive questioning that sets expectations for how the child should be feeling. For example, rather than asking “are you sad?” ask “how are you feeling?” (perhaps offering a variety of examples of different types of feelings, if children need some prompting; visual cues such as feelings faces can be helpful tools in this effort).

**Build a positive relationship and interactional style by identifying, acknowledging, and reflecting children’s experiences and affect.** Express empathy and understanding for children’s experiences and affect. Normalize any potential distress that children may be feeling (e.g., “it is okay to be nervous”, “it is okay to cry”). Remember that the experience of feeling seen, heard, and understood by others increases regulation (through biologically-engrained processes of co-regulation) and reduces distress, facilitating a more effective interview process. This experience can be accomplished by using summary statements and reflective statements that show you have understood both the content and affect being communicated by the child. Demonstrating your understanding and attention to children’s experiences and affect will increase their comfort, willingness, and ability to share further information.

**During the interview process, check in regularly with children about their experience and stress level.** This maximizes both (1) the child’s sense of control and (2) her/his experience of been understood and supported. Use tools and scaffolding as needed (for example, emotions thermometers, feelings faces, rating scales). Again, normalize any distress the children endorse or exhibit: help them to know that they are not “crazy” for feeling sad, angry, scared, and that the feelings they experience are expected in the situation they are in. Utilize in-the-moment coping and relaxation skills as needed (e.g., movement/stretching, art, deep breathing, muscle tension and relaxation, etc.).

**Understand and attend to the various modes of children’s expression and communication.** Remember that children are in the process of developing their verbal and linguistic skills, and they do not always express themselves through explicit language. Children often rely heavily on body language, play, art, and expressed affect to communicate their experiences and needs. Use of tools such as figures, drawings, puppets, and/or dolls can be effective for eliciting child narratives, particularly for younger children (i.e., under 12 years old; American Academy of Child and Adolescent Psychiatry, 1995). Stay attuned to children’s alternative modes of expression and try not to rely solely on language for gathering information.

**Understand the importance of child development.** Children at different developmental stages will express themselves differently and also demonstrate different manifestations of distress. Interviewers need to have familiarity with
stages of development and related capacities in order to effectively adapt their interview approach based on children’s developmental stage.


**Understand the impact of trauma on development.** Trauma exposure and traumatic stress is associated with developmental regression. Therefore, given children’s exposure to current and past traumas, interviewers should anticipate that some children in the *Flores* class might possess developmental capacities that are behind their stated or apparent age. In addition, the elicitation of trauma-related content (inherent in *Flores* inspection interviews) may also cause in-the-moment developmental regression (sometimes related to posttraumatic stress symptoms, such as flashbacks or dissociation). Interviewers will need to adapt their approach accordingly.

**Understand the role of cultural differences in interpersonal interactions, forms of psychiatric expression, and idioms of distress.** Be aware that individuals (and children) from Latino cultures are more likely to endorse somatic symptoms of psychological distress, such as headaches or stomach pain. Children may not have had prior experiences that emphasize verbal expression of affect or distress. Make note of culture-specific manifestations and descriptions of distress (e.g., *ataques de nervios*, *susto*). There are also cultural variations in expectations for interacting with adults, which may influence children’s tendencies for eye contact, communication, and/or self-expression.

**Be on the lookout for warning signs (“red flags”) or cues for intense psychological distress that may be associated with risk.** For example, persistent thoughts about death (suicidal ideation), expressed desire to harm oneself, and/or reported or observed previous attempts at self-harm or suicide (e.g., scars, cuts) are indicators of risk. Be prepared to notify the appropriate authorities (i.e., those liable for custody or care of the child) of any potential risks in order to ensure the child’s safety both during and after the interview process.

**Anticipate and prepare for secondary stress reactions and vicarious traumatization experienced by the interviewer.** Challenging emotional, psychological, and physical reactions are common and expected following provider/advocate interactions with children experiencing traumatic stress; these
reactions can look like symptoms of posttraumatic stress disorder and/or other forms of anxiety, depression, and burnout. Hearing children’s stories and bearing witness to their distress affects us as human beings, resulting in secondary stress and vicarious trauma. These reactions may be present immediately after interviews, or may emerge with some delay (often after return to the home or workplace). In general, coping with secondary trauma (or vicarious trauma) involves:

- **Awareness** of our reactions. Recognize that we may feel sad, irritable, or exhausted; we may have intrusive thoughts of trauma; or we may avoid trauma content; etc., because of the work we are doing and the stress we are carrying; these are *not* signs of weakness.
- **Getting support** and consultation from others and having a space to process our reactions. In some cases, seeking counseling, therapy, or clinical support to address secondary trauma, and/or related triggers from our individual trauma histories.
- Staying true to our **self-care practices and routines** and maintaining balance as best we can. This involves making a conscious effort to honor our experiences, while also finding ways to “step away from them” through fun and relaxing activities (which is different than spending our time trying to push away our feelings and reactions).
- **Accepting** our reactions: knowing we experience secondary trauma reactions because we are caring and attuned individuals. In supporting and advocating for children by hearing and acknowledging their experiences, we will also carry some of their distress.

Additional resources and information on secondary traumatic stress and vicarious traumatization are listed below:

- National Child Traumatic Stress Network resources:
- Vicarious Trauma Toolkit: [https://vtt.ovc.ojp.gov](https://vtt.ovc.ojp.gov)
- Professional Quality of Life (ProQoL) resources on compassion fatigue and vicarious trauma
  - Includes ProQoL Helper Pocket Card (see Appendix 2 or [http://proqol.org/Helper_Pocket_Card.html](http://proqol.org/Helper_Pocket_Card.html))

**A Case for the Immediate and Follow-Up Care of Detained and Separated Families**
Trauma exposure is associated with significant mental health consequences and related detrimental impact on individual and family functioning. Given the nature of the trauma of separation and detention (in conjunction with prior histories of exposure to trauma and adversity), we can expect many of the children and families involved in the *Flores* settlement to demonstrate clinically significant mental health symptoms and diagnoses including, but not limited to, depression, anxiety, posttraumatic stress disorder, substance abuse disorders, and other mood disorders. These symptoms and disorders may surface while in detention, and/or may emerge or continue well after release from detention, and even following family reunification (when this is achieved). Therefore, it is imperative that children and families receive adequate clinical and forensic services to address mental health concerns both *during* and *after* detention.

In the current report, we focus specifically on recommendations and resources for lawyers to prepare for interviews with children. However, addressing the immense need for clinical services and infrastructure may involve advocacy from lawyers and legal groups, to include appeals to local, state, and federal systems. Please see our accompanying report on “Mental Health and Wellness of Children Detained by United States Immigration and Customs Enforcement and Kept Separated from their Families” for specific recommendations regarding the appropriate provision of service access and related reparations to address the psychological and psychiatric harms incurred by family separation and detention.

**A Case for the Immediate and Follow-Up Care of Lawyers and Legal Advocates**

We recommend that volunteer lawyers and paralegals working with CHRCL to conduct Flores site inspections receive adequate training and clinical care (when needed) to support their efforts. This training and care will not only help with the continued engagement and retention of lawyers in the current effort, but will promote more sensitive and more effective interactions with children. Therefore, we suggest that volunteer lawyers participate in a 1-day training, at a minimum, to cover and practice the child interview recommendations and techniques described above. This training should include information and resources about secondary stress reactions and vicarious traumatization. Furthermore, volunteer lawyers should be directed towards mental health resources and networks of care within their home communities, in the event that they should warrant and/or desire ongoing psychological support. Training materials related to working with children exposed to trauma can be accessed through the National Child Traumatic Stress Network (https://www.nctsn.org/resources/training).

**Reference and Additional Resources**

Appendix 1: Sample Script and Interview Guide

The following introductory prompts and questions provide examples of an approach for inquiring about mental health related information for adolescents held in detention and potentially separated from families. These prompts and questions are for purposes of demonstration and example, but are not prescribed scripts and may not be appropriate for younger children.

Hello, my name is {name} and I will be meeting with you for about an hour to ask you some questions about how you are doing. There are 3 different topics that you will be asked about today. We will ask you about your experience of being here and when you arrived. We will be asking about your feelings and what it has been like to be here. We may also focus on what happened when you were separated from your family. And we may ask you information to help locate everyone’s families and find out where they might be.

It is important you understand what we are doing with this information so you don’t worry about talking with us. All of this information is to help make things better for you and others in your situation. What you tell us is confidential and private, and there are only a few people who are allowed to see it.

Do you have any questions for me?
Do you feel safe talking with me/us?
What can I do to help you feel better about talking with us?
Do you feel it is OK to be honest/truthful with the answers you share? What can we do to help you feel better about telling us the truth?

Once I start asking my questions, you can stop me at any time to ask questions and if you decide it is too hard to answer these questions, we will stop the interview. You don’t have to answer any questions you don’t want to, and you can let me know if you want to take a break.

How do you spend your time here? What do you do on most days?

How do you get along with the other kids/teens in the facility?
  - Do you have friends here?
  - Are there any kids here you are afraid of or you feel scared of? Any kids that: yell at you, threaten you, hurt you, take things from you, touch you, tease you, or bully you?
  - What do you do if you have trouble with other kids? Who do you go to for help?

What do you think about the adults who work here?
  - How do the adults here make you feel?
  - Is there an adult here who worries you or makes you feel unsafe?
  - Is there an adult here who helps you? Makes you feel safe?

Do you feel you are in danger? What makes this place dangerous?
  - Are you worried someone here might hurt you?

Who, in here, do you go to if you feel upset or worried or sad?
Have any adults helped you with the feelings or stress you have experienced?

Have you seen a Doctor since you were placed here? What happens if you get sick here?
  - Do you take any medications in here?
  - Did you take any medications before you came here? Are there medications you need to be taking now?

When did you leave your home country? Who came with you? When was the last time you saw them?
  - Do you have any siblings, cousins, relatives or family friends in here with you?

What do you understand about your situation? Do you understand why you are here, and what is happening in your/your family’s situation?

How do you feel (generally) about what is happening for you and your family?

Have there been any times since you’ve been here when you have felt good or had positive feelings?
For example: feeling happy? having fun? feeling relieved? feeling hopeful?

You’re doing great! Why don’t we stand up and take a stretch and some deep breaths?

You are in a difficult and stressful situation. When we are under stress, or in difficult situations, it is normal have strong feelings (like feeling scared, sad, or angry) and strong reactions in our body, which can sometimes affect how we act or behave. I’m going to read some statements that describe how kids in your situation might feel or experience. I would like to know how often you have felt this way in the past 2 weeks. This will help us think about what might be helpful for you and other kids in similar situations. There are no right or wrong answers to these questions.

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>0=never/not true</td>
</tr>
<tr>
<td>1</td>
<td>I feel scared or worried</td>
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<tr>
<td>2</td>
<td>I feel unhappy, sad, or depressed.</td>
</tr>
<tr>
<td>3</td>
<td>I have a hard time managing or controlling my feelings.</td>
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<tr>
<td>4</td>
<td>I have scary thoughts or pictures in my head over and over again.</td>
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<tr>
<td>5</td>
<td>I am having nightmares.</td>
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<tr>
<td>6</td>
<td>I feel scared and I don’t know why.</td>
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<tr>
<td>7</td>
<td>I have a hard time controlling my body and actions.</td>
</tr>
<tr>
<td>8</td>
<td>I feel fearful or afraid.</td>
</tr>
<tr>
<td>9</td>
<td>I feel very upset.</td>
</tr>
<tr>
<td>10</td>
<td>I am having a hard time sleeping/I can’t sleep.</td>
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<tr>
<td>11</td>
<td>I am sleeping all of the time.</td>
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<tr>
<td>12</td>
<td>I am constantly looking out for danger.</td>
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<tr>
<td>13</td>
<td>I feel jumpy or I startle easily.</td>
</tr>
<tr>
<td>14</td>
<td>I try to stop my feelings.</td>
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<tr>
<td>15</td>
<td>I try not to think about my situation or family.</td>
</tr>
<tr>
<td>16</td>
<td>I feel like there is nobody that I can trust.</td>
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<tr>
<td>17</td>
<td>I have a hard time concentrating or paying attention.</td>
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<tr>
<td>18</td>
<td>I am afraid that bad things will keep happening.</td>
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<tr>
<td>19</td>
<td>I argue a lot.</td>
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<tr>
<td>20</td>
<td>I feel sick (I have stomachaches or headaches).</td>
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<tr>
<td>21</td>
<td>I feel like I can’t breathe.</td>
</tr>
<tr>
<td>22</td>
<td>I have experienced changes in my appetite (I am not hungry/don’t want to eat OR I am very hungry/want to eat more than usual)</td>
</tr>
<tr>
<td>23</td>
<td>I feel like what happened is my fault.</td>
</tr>
</tbody>
</table>
I feel like things are not real (like I am in a dream, or I am not in my body)

I have trouble remembering things that happened recently.

I hear voices or see people and things that are not there.

Thank you. We are almost finished. Now I want to know:
- Is there anything else you would like to talk about?
- Did any of my questions make you think of something else you want to tell me?
- Is there anything else important about you or your family you want me to know?
- Do you have any questions for me?

Many kids tell me that after answering all those questions they might not feel so good. Let’s take a few minutes to relax our minds and bodies by focusing on something else.

(While doing the activities continue to look for dysregulation, avoidance/withdrawal, disorganization of content, re-enactment of trauma.)

What are some things that you do that help you feel relaxed?
- Deep breathing
- Counting
- Progressive muscle relaxation
- Stretching, movement, yoga
- (Guided) Visual imagery
- Art, drawing

How are you feeling right now? Before we stop, pick one of these things to choose from to do:
- Think of a memory, an image, or word (related to your family) that helps you feel calm, happy or safe
- Tell me about a time when you felt loved, cared for, or safe. (Where do you feel that in your body?)
- Where would you like to be five years from now? What will you be doing?

Thank you for talking with me today. I wish you all the best in the future and we will do our best to try and the situation for you, your family, and other families like yours. I notice you are [Make positive statements that feel true i.e./ smart, thoughtful, kind, brave, courageous, etc. What you have told me today will be very valuable to other kids like you.

If you have other thoughts or ideas about our conversation, or if you want to talk to someone, you can...
INTRODUCTION

Each year more than 10 million children in the United States endure the trauma of abuse, violence, natural disasters, and other adverse events. These experiences can give rise to significant emotional and behavioral problems that can profoundly disrupt the children’s lives and bring them in contact with child-serving systems. For therapists, child welfare workers, case managers, and other helping professionals involved in the care of traumatized children and their families, the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Individual and supervisory awareness of the impact of this indirect trauma exposure—referred to as secondary traumatic stress—is a basic part of protecting the health of the worker and ensuring that children consistently receive the best possible care from those who are committed to helping them.

Our main goal in preparing this fact sheet is to provide a concise overview of secondary traumatic stress and its potential impact on child-serving professionals. We also outline options for assessment, prevention, and interventions relevant to secondary stress, and describe the elements necessary for transforming child-serving organizations and agencies into systems that also support worker resiliency.
How Individuals Experience Secondary Traumatic Stress

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoidance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal resources; and disruption in their perceptions of safety, trust, and independence. A partial list of symptoms and conditions associated with secondary traumatic stress includes:

- Hypervigilance
- Hopelessness
- Inability to embrace complexity
- Inability to listen, avoidance of clients
- Anger and cynicism
- Sleeplessness
- Fear
- Chronic exhaustion
- Physical ailments
- Minimizing
- Guilt

Clearly, client care can be compromised if the therapist is emotionally depleted or cognitively affected by secondary trauma. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies have shown that the development of secondary traumatic stress often predicts that the helping professional will eventually leave the field for another type of work.

Understanding Who is at Risk

The development of secondary traumatic stress is recognized as a common occupational hazard for professionals working with traumatized children. Studies show that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.

Any professional who works directly with traumatized children, and is in a position to hear the recounting of traumatic experiences, is at risk of secondary traumatic stress. That being said, risk appears to be greater among women and among individuals who are highly empathetic by nature or have unresolved personal trauma. Risk is also higher for professionals who carry a heavy caseload of traumatized children; are socially or organizationally isolated; or feel professionally compromised due to inadequate training. Protecting against the development of secondary traumatic stress are factors such as longer duration of professional experience, and the use of evidence-based practices in the course of providing care.

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary traumatic stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

Compassion fatigue, a label proposed by Figley as a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with that term.

Vicarious trauma refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client. It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material. The primary symptoms of vicarious trauma are disturbances in the professional's cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy.

Burnout is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

Compassion satisfaction refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.
Identifying Secondary Traumatic Stress

Supervisors and organizational leaders in child-serving systems may utilize a variety of assessment strategies to help them identify and address secondary traumatic stress affecting staff members.

The most widely used approaches are informal self-assessment strategies, usually employed in conjunction with formal or informal education for the worker on the impact of secondary traumatic stress. These self-assessment tools, administered in the form of questionnaires, checklists, or scales, help characterize the individual’s trauma history, emotional relationship with work and the work environment, and symptoms or experiences that may be associated with traumatic stress.4,9

Supervisors might also assess secondary stress as part of a reflective supervision model. This type of supervision fosters professional and personal development within the context of a supervisory relationship. It is attentive to the emotional content of the work at hand and to the professional’s responses as they affect interactions with clients. The reflective model promotes greater awareness of the impact of indirect trauma exposure, and it can provide a structure for screening for emerging signs of secondary traumatic stress. Moreover, because the model supports consistent attention to secondary stress, it gives supervisors and managers an ongoing opportunity to develop policy and procedures for stress-related issues as they arise.

Formal assessment of secondary traumatic stress and the related conditions of burnout, compassion fatigue, and compassion satisfaction is often conducted through use of the Professional Quality of Life Measure (ProQOL)7,8,10,11 This questionnaire has been adapted to measure symptoms and behaviors reflective of secondary stress. The ProQOL can be used at regular intervals to track changes over time, especially when strategies for prevention or intervention are being tried.

Strategies for Prevention

A multidimensional approach to prevention and intervention—involving the individual, supervisors, and organizational policy—will yield the most positive outcomes for those affected by secondary traumatic stress. The most important strategy for preventing the development of secondary traumatic stress is the triad of psychoeducation, skills training, and supervision. As workers gain knowledge and awareness of the hazards of indirect trauma exposure, they become empowered to explore and utilize prevention strategies to both reduce their risk and increase their resiliency to secondary stress. Preventive strategies may include self-report assessments, participation in self-care groups in the workplace, caseload balancing, use of flextime scheduling, and use of the self-care accountability buddy system. Proper rest, nutrition, exercise, and stress reduction activities are also important in preventing secondary traumatic stress.

PREVENTION

| Psychoeducation |
| Clinical supervision |
| Ongoing skills training |
| Informal/formal self-report screening |
| Workplace self-care groups |
| (for example, yoga or meditation) |
| Creation of a balanced caseload |
| Flextime scheduling |
| Self-care accountability buddy system |
| Use of evidence-based practices |
| Exercise and good nutrition |
Strategies for Intervention

Although evidence regarding the effectiveness of interventions in secondary traumatic stress is limited, cognitive-behavioral strategies and mindfulness-based methods are emerging as best practices. In addition, caseload management, training, reflective supervision, and peer supervision or external group processing have been shown to reduce the impact of secondary traumatic stress. Many organizations make referrals for formal intervention from outside providers such as individual therapists or Employee Assistance Programs. External group supervision services may be especially important in cases of disasters or community violence where a large number of staff have been affected.

The following books, workbooks, articles, and self-assessment tests are valuable resources for further information on self-care and the management of secondary traumatic stress:

- Self-Care Assessment Worksheet [http://www.ecu.edu/cs-dhs/rehb/uploa Wellness_Assessment.pdf](http://www.ecu.edu/cs-dhs/rehb/uploa Wellness_Assessment.pdf)
- Compassion Fatigue Self Test [http://www.ptsdsupport.net/compassion_fatigue-selftest.html](http://www.ptsdsupport.net/compassion_fatigue-selftest.html)
- *ProQOL 5* [http://proqol.org/ProQol_Test.html](http://proqol.org/ProQol_Test.html)
Worker Resiliency in Trauma-informed Systems: Essential Elements

Both preventive and interventional strategies for secondary traumatic stress should be implemented as part of an organizational risk-management policy or task force that recognizes the scope and consequences of the condition. The Secondary Traumatic Stress Committee of the National Child Traumatic Stress Network has identified the following concepts as essential for creating a trauma-informed system that will adequately address secondary traumatic stress. Specifically, the trauma-informed system must

- Recognize the impact of secondary trauma on the workforce.
- Recognize that exposure to trauma is a risk of the job of serving traumatized children and families.
- Understand that trauma can shape the culture of organizations in the same way that trauma shapes the world view of individuals.
- Understand that a traumatized organization is less likely to effectively identify its clients’ past trauma or mitigate or prevent future trauma.
- Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices.

These elements should be integrated into direct services, programs, policies, and procedures, staff development and training, and other activities directed at secondary traumatic stress.

“We have an obligation to our clients, as well as to ourselves, our colleagues and our loved ones, not to be damaged by the work we do.”

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About the National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.
Taking Care of Yourself

During this time, you and your colleagues may be experiencing different reactions. There are several ways you can find balance, be aware of your needs, and make connections. Use this list to help you decide which self-care strategies will work for you.

- Practice brief relaxation techniques during the workday
- Check in with other colleagues
- Prepare for worldview changes that may not be mirrored by others in your life
- Increase leisure activities, stress management, and exercise
- Pay extra attention to health and nutrition
- Self-monitor and pace your efforts
- Maintain boundaries: delegate, say no, and avoid getting overloaded with work
- Pay extra attention to rekindling close interpersonal relationships
- Practice good sleep routines
- Make time for self-reflection
- Find things that you enjoy or make you laugh
- Participate in formal help if extreme stress persists for greater than two to three weeks
- Increase experiences that have spiritual or philosophical meaning to you
- Keep a journal to get worries off your mind
- Access support from colleagues routinely by sharing concerns, identifying difficult experiences and strategizing to solve problems
- Stay aware of limitations and needs
- Recognize when one is Hungry, Angry, Lonely or Tired (HALT), and taking the appropriate self-care measures
- Increase activities that are positive
- Practice religious faith, philosophy, spirituality
- Spend time with family and friends
- Learn how to “put stress away”
- Write, draw, paint
- Limit caffeine and substance use

Think of self-care as having three basic aspects:

<table>
<thead>
<tr>
<th>Awareness</th>
<th>The first step is to seek awareness. This requires you to slow down and focus inwardly to determine how you are feeling, what your stress level is, what types of thoughts are going through your head, and whether your behaviors and actions are consistent with the who you want to be.</th>
</tr>
</thead>
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<tr>
<td>Balance</td>
<td>The second step is to seek balance in all areas of your life including work, personal and family life, rest, and leisure. You will be more productive when you’ve had opportunities to rest and relax. Becoming aware of when you are losing balance in your life gives you an opportunity to change.</td>
</tr>
<tr>
<td>Connection</td>
<td>The final step is connection. It involves building connections and supportive relationships with your co-workers, students, friends, family, and community. One of the most powerful stress reducers is social connection.</td>
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</table>

*Adapted from Psychological First Aid for Schools*
Resource Description

Offers providers a list of ideas for self-care strategies to use after a difficult event. This checklist outlines the three basics aspects of self-care including awareness, balance, and connection.

Resource Type:
Type: Fact Sheet

Trauma Type:
Sexual Abuse

Language:
English

Published in 2018

Source URL: https://www.nctsn.org/resources/taking-care-of-yourself

Links