Trauma Informed Best Practices and Resiliency

Jeanette M. Scheid, MD, PhD

KEYWORDS

• Immigration • Asylum • Children • Development • Trauma-informed

KEY POINTS

- Children and youth experiencing the immigrant/asylum process will have experienced trauma that will impact their emotions and behavior.
- Children's developmental stages will affect their responses to the immigrant/asylum experiences and associated traumatic exposures.
- Child and adolescent psychiatrists can use both their knowledge of child development and trauma-informed care principles when working with children, youth, and families.
- Child and adolescent psychiatrists should use their knowledge and expertise to advocate for environments that support health, safety, and resiliency.

INTRODUCTION

Children who experience fleeing from their home countries, whether with family members or unaccompanied, will likely have experienced trauma in their home country[1] and possibly in government custody.[2] The specific circumstances will be different for each child, as well as its impact on their sense of safety and wellbeing. The response of caring systems should remain grounded in the known principles of trauma-informed care, an understanding of best practices based on evidence-based and informed principles, culturally responsive interventions, and the developmental process. In addition, care providers should be working to maximize the safety of the environment in which they are interacting with children and youth and considering the style, approach and content of each interaction to balance the purpose of the interaction with the safety and security needs of each child or youth. In doing so, it will be possible to address multiple needs ranging from basic care and support to diagnosis and treatment to determining eligibility for asylum.

PRINCIPLES OF TRAUMA-INFORMED CARE

The Substance Abuse and Mental Health Services Administration's Trauma and Justice Strategic Initiative (2014)[3] defined the concept of trauma as resulting from event(s)

Michigan State University, 909 Wilson Road B119, East Lansing, MI 48824, USA
E-mail address: scheid@msu.edu

Child Adolesc Psychiatric Clin N Am 33 (2024) 181–191
https://doi.org/10.1016/j.chc.2023.09.005
childpsych.theclinics.com

or circumstances experienced by the individual as physically or emotionally harmful or life threatening and having lasting adverse effects on functioning and well-being. The initiative identified 4 key assumptions to drive trauma informed care systems (**Fig. 1**) and defined 6 key principles defining a trauma-informed approach to care (**Fig. 2**). These principles will be reflected throughout the suggestions for approaching children and families in this article.

The National Child Traumatic Stress Network (NCTSN) has developed and collected an array of materials that health care practitioners, including child and adolescent psychiatrists, can use as they prepare to work with children and youth affected by immigrant and refugee-related trauma (see Refugee Trauma Section in references).[4] These range from a formal report of the American Psychological Association Presidential Task Force on Immigration to a story of the impact of traumatic stressors on a Guatemalan immigrant family to an exploration of mandated reporting in the context of immigration to a resource focusing on bridging and collaboration among refugee-serving and children's services providers.

The definitions, assumptions, and principles summarized earlier should be integrated not only into individual clinical contacts between children/youth and child and adolescent psychiatrists but also as child and adolescent psychiatrists consult with agencies in developing programs intended to support children and youth who are immigrants seeking asylum and safety. Subsequent sections of this article outline practical approaches for this integration across a range of clinical and consultative encounters.

DEVELOPMENTAL TASKS AND IMPACT OF IMMIGRANT/REFUGEE TRAUMA

Infants

Infants require nearly constant attention from a limited number of dedicated caregivers who provide adequate responses to the limited variety of basic needs, that is, feeding, changing, and soothing. This attention promotes the achievement of the primary developmental tasks of building attachments and acquiring the capacity for basic regulation of daily routine that form the building blocks of learning trust and cause and effect and developing emotional awareness and regulation.

We know from developmental neuroscience as reviewed by Van den Bergh and colleagues (2020)[5] that even prior to delivery, maternal stress can make children more vulnerable to gaps in developing self-regulation and challenge their capacity to respond as expected to usual caregiving. Children involved in refugee/asylum settings may also experience developmental challenges.[6] When working with parent-infant

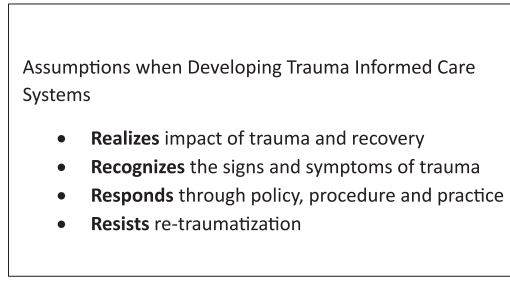

Fig. 1. Assumptions when developing trauma informed care systems.[3]. (Reference 3: Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014)

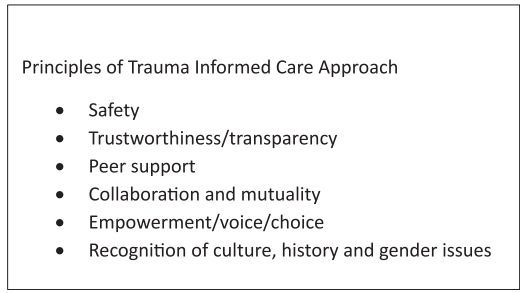

Fig. 2. Principles of trauma informed care approach.[3]. (Reference 3: Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014)

dyads in the setting of immigration, refugee, and asylum services, it is important to ask about the prenatal period, screen for developmental and intellectual disorders, refer for formal assessment as needed, and provide education to parents about the possibility that the infant may be more reactive and irritable than expected even though their caregiving is appropriate.

Because infants may also be impacted by other risks, including family members with developmental disorders, or other prenatal exposures including parental substance use, it will be important to inquire about these exposures, recognizing the importance of doing so in a manner that is both generally culturally sensitive and also aware of how the information gathered may impact the immigration or asylum process at the family level and child protection law in the local jurisdiction.

Teams working in settings where parents who are caring for infants in short term refugee/asylum settings need to advocate for an environment that provides the capacity to regulate lighting, to limit noise, and to maximize privacy. Child and adolescent psychiatrists working in these settings should engage parents in discussions about family history and prenatal circumstances, perinatal events, and parents' observations of their infant. If the child and adolescent psychiatrist is less comfortable providing general psychiatric services, it may be necessary to advocate for access to a broader team including general psychiatry and/or substance use services providers who can support parents. Finally, teams providing ongoing care regardless of setting should have information about the child's history as gathered by previous healthcare providers and should be alert to indications of delays in achieving developmental milestones.

If infants have been separated from their parents they must have access to a small number of attentive caregivers. Under these circumstances the infants are likely to be especially stressed, so a quiet, calm environment will be particularly important to fostering safety. Early in separation if infants have been breast fed, it will be important to be attentive to any impact from change to formula feeding.

Toddlers

The chief tasks for toddler age children are to use the secure attachment platform and basic self-regulation achieved in infancy to engage in a broader exploration of their environment and work toward additional self-control including toilet training and responding to appropriate correction or direction. They will still need frequent opportunities to return to their trusted caregivers during their explorations.

Toddlers experiencing the disruption of immigration and asylum are likely to lose some of the developmental milestones they may have achieved at least for a time. Children who have been toilet trained may have bowel and bladder incontinence, and those who have generally been sleeping well may have difficulty falling asleep or sustaining sleep and may experience nightmares or night terrors even if they haven't had these before. Children perceived to be clingy and anxious or more irritable may actually be seeking safety and connection.

Understanding the child's developmental course to date, the family environment/stressors prior to the immigration/refugee process, and the time frames of the family's immigration and asylum journey are critical to understanding the context of any current difficulties. It will be important to provide education to parents/caregivers that when children are stressed it is normal for them to lose capacities for some period and typical for them to regain these capacities with time, care, and support.

When possible, advocating for an organizational structure that recognizes parents' primary role as their child's safe haven and providing them the support to engage effectively based on their culture and experience should limit the impact of the traumatic events to the extent possible. This support, including access to formal early childhood mental health resources, should be maintained throughout the process of immigration and when settling into a new home and community.

When children are separated from parents, they are more likely than children who remain with parents to experience sleep, emotional, and behavioral disturbances more intensely and for a longer period of time. Other explanations for sleep disturbances should also be assessed as soon as possible during the immigration process because healthy sleep is important to development and wellbeing.[7] Alternative caregivers should be made aware of the child's history, should be provided the resources they need to provide attentive caregiving, and should be part of a team engaged in ongoing assessment and treatment to ensure that the child regains age-appropriate functioning.

Young Children

Preschool-age children are focused on navigating the rules of engagement with parents and reinforcing their sense of family roles and relationships. This is the work necessary to move into the broader world of school and peer relationships comfortably. Children who are experiencing immigration/seeking asylum with their families are attempting to accomplish these developmental tasks in a setting where the broader family system is stressed and may not be able to reflect usual family roles. Even when children's experiences up to this point have not been traumatic, the stresses related to immigration will likely result in some regression that may include irritability and limit testing as well as anxiety-driven challenges to restful sleep. If children are separated from their parent(s) at this stage, the loss of security arising from familiar parental relationships will increase their distress.

In this age group, children may be able to describe their experiences and emotions more clearly than possible for younger children. Treating teams should afford the space for this exploration first and provide age-appropriate reflection and support based on the child's report. This may include formal treatment of trauma-related symptoms and other sources of distress.

As is true of younger children, the family unit should be maintained if possible. Teams should work with organizations to provide family space together. Parents should be supported in maintaining their parenting style and family routines like eating and sleeping. When children are separated from their parents, new caregivers need as much information as possible about the child. Any known issues that could affect

health, emotions, and behavior should be provided and caregivers provided the support to address these.

School-Age Children

In the best of circumstances children in this group would be positioned through successful completion of earlier developmental stages to be comfortable spending a large part of every day with peers and teachers and having a solid home base they can return to at the end of the day. It is also in the school setting that even children without exposure to significant trauma may demonstrate emotional, behavioral, and/or learning issues. The circumstances related to immigration, refugee, and asylum-seeking[2] may increase this risk. It is unlikely that parents will have records of their children's academic progress from their country of origin. Language may provide an additional barrier to communication about this history. Finally, children who have attended school and engaged in peer relationships in their home country communities are likely to experience a sense of loss and disconnection from their home culture.

When children are with their parents, the family unit should remain the home base and source of support and cultural grounding. Parents are also the best source of information about their child's prior health and mental health history, their schooling, and their past social environment. Children who have been separated from parents may be able to provide some of this information, though their ability to do so will depend on their level of distress. Caregivers in any environment should focus first on creating an environment with as much safety and comfort as possible while caregivers and other team members attempt to obtain information from the child and other sources. Services and supports, including those related to school access, should be established as efficiently as possible early on and maintained throughout the asylum process. School systems can provide a valuable source of supports and routines to children throughout their immigration journey.

Adolescents and Young Adults

Youth in this age group are more likely to be unaccompanied and will have had variable experiences related to their history of family relationships. If they did experience nurturing family relationships, then they may have an age-appropriate sense of self that can provide a reserve under the circumstances of their immigration/refugee journey. If they also have some means of regular contact with family members, they can use this as an additional source of support. When youth and their families were under sustained stress in their home country prior to attempting immigration/asylum, these stressors, perhaps going back to early childhood, will be a burden the youth carries,. It is also possible that the youth will have experienced family/relational trauma aside from those related to the immigration process and may or may not have had any opportunity to obtain support or treatment. As it is normative for adolescents to exercise more independence, youth may not appear interested in family support. If they have been used to fending for themselves, they may brush off attempts to engage supportive adults including family. Youth in these circumstances will also be working through cultural identity issues that may affect their functioning.[8,9] As it will likely be true that unaccompanied youth will be in temporary housing with other youth, teams working with adolescents should advocate both for age-appropriate privacy consistent with the youth's cultural experience and for age-appropriate peer-to-peer interaction time.

Teams working with unaccompanied youth should determine their sources of support, whether family and friends in their origin country or family/relatives/new communities of support in the United States, and arrange for contact as frequently as

possible. Consider inviting supports to appointments, following the Trauma Informed Care principle of peer support. These same supports may prove to be a source of historical information about the youth that will help with developing a plan of care over the intermediate and long term. Second, it will be important to identify factors outside of language barriers that impact the youth's capacity to engage in the assessments that are needed, whether clinical assessment for the purpose of diagnosis and treatment, or an assessment to determine eligibility under asylum rules. Third, those working with children and families need to be aware that children's stress may be affected by their parents' legal status in a similar fashion to those who have grown up with an undocumented parent.[10,11] This could include a stated or perceived responsibility for finding employment to contribute to the family's financial needs. Addressing these barriers early will enhance the ability of helping teams to meet the youth's needs.

In summary, child and adolescent psychiatrists have the training and experience in child and adolescent development, the impact of family relationships, and the impact of exposure to trauma that provides a firm platform from which to draw as they approach trauma-informed care with immigrant and refugee children, youth, and families. This knowledge and skill can and should be brought to bear both as clinicians and as advocates. In approaching this work, child and adolescent psychiatrists should refresh their understanding of trauma-informed principles and practices generally and the specific circumstances characterizing the immigrant and refugee experience. Resources to do so are listed at the end of this article.

ENVIRONMENT: HOW TO SET UP FOR CONNECTIONS AND CONVERSATIONS

Setting

The physical settings in which most children adolescents and families are waiting for immediate decisions about their next steps are far from ideal for any kind of encounter intended to learn more about the issues facing a child or adolescent. Conditions may be crowded, and there may be limited privacy. There may be little in the way of age-appropriate toys or other activities to engage the child when the focus is on parents or to use to engage the child when they are the focus of an interview.

Individuals working in these settings should advocate for devoting some space and basic materials to support assessments, including comfortable chairs for adults, child sized tables and chairs, and some way to shield the space both from outside noise and from those outside the space hearing the assessment conversations. Chairs should also be moveable to allow for children and family members to arrange seating that will maximize their comfort, addressing both safety and empowerment/voice/choice.

Plain paper along with coloring books or sheets reflecting a range of age needs along with crayons, markers, and pencils should be provided. If possible, a white board with markers should be available either for children to write/draw or to support dialog between the clinician and the child/family, increasing transparency. Clinicians should have access to any commonly used screening or assessment questionnaires written in the languages likely to be used by the people in these settings. Finally, because children and youth may need breaks during an assessment, there should be a room close by that can be supervised appropriately but is also comfortable and where calming items can be made available.

Interviewer Body Language

Interviewers need to be aware of their body language. Being able to sit comfortably in an open posture, but also to shift to more alertness and focus is important. It is

also important to be aware of body language in the context of history, culture, and gender. Children may benefit from the opportunity to engage in playful interactions, and if the assessment is being done in a setting where more than one child is present, being aware of and responding appropriately to other children may increase parent and child engagement. Prior to engaging in an interview, it will be important to inquire about and prepare for specific cultural norms for interaction, including whether to engage in frequent direct eye contact, who should be approached first when multiple family members are in the room, and whether and/or how to engage individual children or adolescents separately from their families. The NCTSN resources may be useful here, as would peer support. Interviewers can also ask children and families directly about their cultural norms and responding to this information addresses transparency and empowerment. In the heightened stress of immigration/refugee/asylum settings the clinician will need an additional level of awareness of these issues and be able to flexibly adjust their posture and approach when children and/or families show escalated distress. For example, attempts to engage in playful interactions with children that may be typical in most settings may not be perceived as safe under these circumstances, so acute awareness of responses to such overtures are necessary. Asking about children's usual interactions with peers and adults and in different settings can improve the clinician's capacity to be respectful during interactions.

Interviewer Spoken Language

Another barrier to communication in immigration/refugee settings will likely be related to language. Any clinician engaging in assessments of any kind who is not fluent in the primary language used by the child and family should have an interpreter present who is fluent in that language. An interpreter should have some training in the assessment process and in the boundaries of their role. Clinicians unfamiliar with using interpreter services may need to do some background preparation as well so that they are equipped to set up the interview space correctly and engage the child and family members directly through body language and eye contact. Although family members or other informal contacts sometimes offer to serve as interpreters, and may be the only option for focused assessments in emergency circumstances if unable to access professional interpreters, they should not provide interpretation for full psychiatric assessments, especially when the primary goal or some aspect of the assessment relates to asylum status eligibility.[11]

Once primary language barriers are addressed, clinicians engaging children, youth, and families in addressing any health, behavioral health or legal status issues should screen for developmental barriers to communication including expressive/receptive language disorders, reading difficulties that may impact the capacity to complete any requested rating scales, or any challenges to non-verbal communication that may impact interview findings.

Along with identifying and addressing developmental barriers to communication, the interviewer must consider the impact of the individual's emotional state on information gathering throughout any interview process. The issues that need to be explored will vary depending on the purpose of the interaction, as will be discussed later, but as suggested by O'Brien (2016) beginning the interview with more neutral topics and building some degree of rapport before exploring more substantive issues may allow the child and their parents to reduce initial anxiety and engage more successfully.[12] During the early parts of an interview, the clinician can also introduce the possibility that difficult topics may be discussed, normalize shifts in emotional state, and provide concrete information about the steps that the child and/or family

can take to address discomfort during the interview, including taking a break or using resources like a calming space and then returning to the interview process.

UNDERSTANDING AND NAVIGATING THE SHIFTING GOALS OF INTERACTION

Clinicians working with children and families involved with immigration, asylum, or refugee related services may be called upon to engage in various interactions. Some of these, for example, determining eligibility for asylum, have very specific requirements and need specific training/expertise. Others, including providing general emotional support in detention settings, conducting a clinical assessment, or guiding level of care recommendations, are more driven by individual goals. If a child and family are involved in assessments for different purposes over time, the goals and processes of different assessments may overlap, and information obtained from one interaction may inform others. Understanding factors that affect disclosure of life stories, for example, those documented by van Os and colleagues,[13] including children's mistrust as a barrier to disclosure and the interviewer's respectfulness and patience as a facilitator to disclosure, is important. From the standpoint of trauma-informed principles, specifically those *promoting safety, empowerment, and transparency*, being clear about how all information is used and stating that teams may use information obtained in some settings to inform other assessments may reduce the times that a child or family needs to provide the same information, especially information that is difficult to share.

Collaboratively determining the goal or extent of the assessment aligns with the principle of mutuality, empowerment/choice/voice. Assessments may need to be completed over multiple sessions.

Supporting Comfort

Supporting comfort may be the most common element all the interactions teams will have with children and families. At its most basic this involves ensuring that basic needs for food and shelter are met and supporting family time. Although these basic needs are often outside the direct control of a clinician, gaps in basic needs can be an area for consultation and advocacy with supporting systems.

During any interaction children and families may talk about life experiences, both good and bad. These disclosures are an opportunity to build an understanding of the child and the impact of all experiences on their emotions and well-being. It may also provide insight into the child's strengths including interests and strategies they use to calm distress. With the child's or parents' permission, these could be incorporated into other assessments including those to determine asylum eligibility to reduce the likelihood of retraumatization.

Supporting Asylum Evaluation

The process of assessing a youth for the purposes of asylum are well-defined and discussed in the literature. Asylum examinations should only be conducted by someone with appropriate training and experience. Engaging in the process of asylum determination is nearly certain to range from emotionally uncomfortable to significantly painful. Using some of the setting (privacy, place to take a break, and calm) and interaction (starting with less loaded topics and attentiveness to emotional reactions to content in discussion) strategies may make these difficult conversations more comfortable for the asylum seeker and more productive.

In addition to managing the interview process itself, it will be important to educate the child and family about possible distress and include time and space for the child

and family to decompress after an asylum interview. This may include additional time in a quiet, calming space, returning to family if they are present, or engaging in any activity that they identify as enjoyable. It will also be important to alert anyone working with the child/adolescent to be made aware that they have engaged in an asylum interview so that the staff can be aware of any discomfort the child or adolescent may display in the days following the interview. If the youth is prone to anger outbursts or destructive behavior both the youth and the staff will need supports to reduce safety risks. Taking all these steps promotes safety and empowerment.

Supporting Diagnostic and Treatment Evaluation

As is true of asylum determination, there are guidelines and best practices for comprehensive diagnostic interviews and subsequent treatment planning. Clinicians working in this sphere should follow guidelines such as those provided by the American Academy of Child and Adolescent Psychiatry, including the historic Practice Parameters for the Psychiatric Assessment of Children and Adolescents (1997)[14] and other practice guidelines for assessment and treatment. In fact, one could argue that under these circumstances it is particularly important to think comprehensively about a child's strengths, needs, symptoms, and likely diagnoses. Accomplishing what is often a challenging task may be particularly difficult because of the realities of immigrationFor children with their families, parents should be sources of important information. For children not with their immediate families, it may be possible to reach families by phone, or to engage with extended family, especially if the family members are planning to provide ongoing supervision or support.

If a diagnostic interview is occurring in a context where an asylum interview has also occurred, and if it is possible to do so, the information from the asylum interview should be incorporated into the clinical interview and documentation. The interviewer could note the information mentioned in the asylum interview but focus on the thoughts, emotions, and behavior related to the experiences during the clinical interview. The documentation may be important to include in multiple sections of the clinical report including the history of present illness, medical history, social history, mental status examination, case formulation, and recommendations. If a diagnostic interview occurs before a planned asylum interview, the clinician will need to be aware of the limits of confidentiality and provide only the information that is possible under confidentiality rules, or obtain permission from the child and family to disclose information that may reduce the stress associated with the asylum interview.

As is true of an asylum interview, children may be distressed following a clinical interview as well. This potential can be normalized by the clinical provider, support can be offered, and staff working with the child and family can be engaged to provide support as the child settles back to some degree of calm.

Addressing Gaps in Access or Contact with Families

Throughout all the immigration processes for children/youth who are unaccompanied by parent(s) there should be efforts to maintain direct contact and to provide updates to both children and parents about the status of the other. There should be accommodations made to provide direct contact, preferably by video conferencing, although if this is not possible then telephone calls or any other means of connection should be used. Clinicians working with children will need to assess any safety concerns, including assessing for parental maltreatment, as a prerequisite to this planning.

Parents should be engaged in providing historical information for all levels of assessment whether considering how to provide basic needs and comfort, understanding factors that may impact the child's capacity to engage in assessments for

any purpose and for collateral information related to both asylum and clinical assessments. If a clinical assessment results in any recommendations for medication intervention, parents should be engaged to provide this consent, although there may be local and regional law, policies, and rules to allow teams to provide treatment if it is not possible to engage parents. Similar to any of the evaluation processes that occur with children and families, interpreters should be engaged so that treatment recommendations can be explained adequately, and parents can provide informed consent. It is especially important to engage caregivers about their reservations about medication and to try and understand their own ideas about how to support the child.

SUMMARY: PUTTING IT ALL TOGETHER–BUILDING A FULL UNDERSTANDING OF THE CHILD/YOUTH

Throughout a time that children and their families are engaged in detention or other formal "holds", whether families are separated or together, the goals should be to provide immediate support for basic health and well-being needs, to engage in appropriate information gathering for a variety of purposes from asylum requests to diagnostic evaluations, to engage in treatment when needed, and to use all interactions efficiently and transparently to maximize the benefits of the assessment and to minimize and mitigate the distress that such evaluations may cause.

The information obtained during these early parts of the child's and family's immigration journey should also be documented well and forwarded on to subsequent teams in the broader systems of care including caregivers, health providers, mental health providers, schools, and community supports so that the ongoing needs of the child and family can be identified and addressed in the context of their story. Doing so will provide the best likelihood that children and families will be successful in their journey.

CLINICS CARE POINTS

- Using existing knowledge of child development is key to providing and advocating for the optimal environment for migrant children and families.
- Following trauma informed principles: safety, trustworthiness/transparency, peer support, collaboration and mutuality, empowerment/voice/choice, and recognition of cultural historical and gender issues should guide all interactions with migrant children, youth, and families.
- When possible use interactions and information obtained for one purpose for other migrant and asylum needs to minimize traumatic exposures.

DISCLOSURE

No commercial financial disclosures. The author provides non-clinical consulting services under contract between Michigan Department of Health and Human Services and Michigan State University as part of faculty duties.

REFERENCES

1. Thomas S, Thomas S, Nafees B, et al. 'I was running away from death' – the pre-flight experiences of unaccompanied asylum seeking children in the UK. Child Care Health Dev 2004;30(2):113–22.

2. Kronick R, Rousseau C, Cleveland J. Asylum-seeking chilren's experiences of detention in Canada: a qualitative study. Am J Orthopsychiatry 2015;85(3): 287–94.
3. Substance Abuse and Mental Health Services Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014.
4. NCTSN – Refugee Trauma (https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma).
5. Van den Bergh BRH, van den Heuvel MI, Lahti M, et al. Prenatal developmental origins of behavior and mental health: the influence of maternal stress in pregnancy. Neurosci Biobehav Rev 2020;117:26–64.
6. Morinaga M, Rai D, Hollander A-C, et al. Migration or ethnic minority status and risk of autism spectrum disorders and intellectual disabiliity: systematic review. Eur J Publ Health 2020;31(2):304–12.
7. Mindell JA, Williamson AA. Benefits of a bedtime routine in young children: sleep, development, and beyond. Sleep Med Rev 2018;40:93–108.
8. Patel SG, Bouche V, Thomas I, et al. Mental health and adaptation among newcomer immigrant youth in United States educational settings. Current Opinion in Psychology 2023;49:101459.
9. Cowden JD, Kreisler K. Development in children of immigrant families. Pediatr Clin 2016;63:775–93.
10. Sidhu SS, Song SJ. Growing up with an undocumented parent in America: psychosocial adversity in domestically residing children. J Am Acad Child Adolesc Psychiatr 2019;58(10):933–5.
11. Levy J, Using an interpreter in psychiatric practice, *Carlat Child Psychiatry Report*, 11(5&6), 2020, 3-4.
12. O'Brien KH, Schlechter A. Is talking about what's wrong necessarily right: a positive perspective on the diagnostic interview. J Am Acad Child Adolesc Psychiatr 2016;55(4):262–4.
13. van Os ECC, Zijlstra AE, Knorth EJ, et al. Finding keys: a systematic review of barriers and facilitators for refugee children's disclosure of their life stories. Trauma Violence Abuse 2020;21(2):242–60.
14. King RA, Work Group on Quality Issues. Practice Parameters for the psychiatric assessment of children and adolescents. J Am Acad Child Adolesc Psychiatr 1997;36(10 Suppl):4S–20S.