Clinical Considerations for Immigrant, Refugee, and Asylee Youth Populations

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KEYWORDS

• Immigrant • Refugee • Asylum • Child • Adolescent • Youth

KEY POINTS

- Immigration policies that have positive effects on child mental health and promote healthy child development prioritize family preservation and child development, improve care and appropriate custody of children and ensure access to social safety nets for immigrant children and families.
- The COVID-19 pandemic had disproportionately greater effects on immigrant, refugee, and asylee populations.
- Overall, youth of immigrant backgrounds are better adjusted in countries with better immigrant integration and multicultural policies.

INTRODUCTION

Throughout global history, migration has persisted. According to the United Nations, youth ages 19 or under comprise 14% of the world's migrant population and half of the world's refugees (. In the first half of 2021, there were *26.6 million* refugees in the world—the highest ever seen; 50.9 million internally displaced people; and. 4.4 million asylum-seekers.[1] Over the years, there have been increasing numbers of refugees and asylum seekers trying to escape unfavorable conditions in their homelands. In response, many countries—including the US—developed extreme policies to deter mass numbers of refugees seeking entry into the country.

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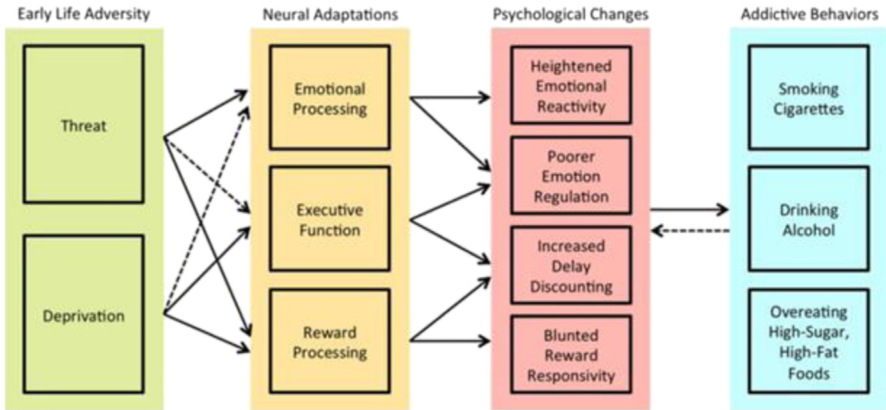

Fig. 1. The effect of 2 dimensions of early life adversity (ELA)–threat and deprivation–on brain development. Neural adaptions to ELA affect emotion, reward, and cognitive networks. These neural adaptions affect 4 psychological processes that have downstream consequences for health-risk behaviors. Smoking cigarettes, drinking alcohol, and overeating highly palatable foods further heighten emotional regulation, increase delay discounting, and blunt reward responsivity, leading to a positive feedback loop for addictive behaviors. Duffy, K.A., McLaughlin, K.A. and Green, P.A. (2018), Early life adversity and health-risk behaviors: proposed psychological and neural mechanisms. Ann. N.Y. Acad. Sci., 1428: 151–169. https://doi.org/10.1111/nyas.13928.

UNACCOMPANIED MINORS AND FAMILY SEPARATION

One such strategy of deterring immigration in the United States was “forced separation” of children and adolescents from their parents, despite the credible warning of the inevitable “traumatic psychological injury.”[2,3] This was conducted without a systematic plan for reunification in place.[2] Quite often “reunification has failed for migrant children in custody as relatives or kinship members may be undocumented or parents may be deported.”[4] Many if not most arrivals to the border already experienced significant trauma only for the children and adolescents to be met with the trauma of being separated from their parents. Such an experience would be considered an Adverse Childhood Event (**Fig. 1**).[5,6] “ACEs are linked with the disruption of neurodevelopment and with negative effects on social, emotional, and cognitive functioning.[7,8] ACEs have also been associated with negative intergenerational effects.[9]” Repeated adverse events put them at risk for developing toxic stress as well as overtime developing poor coping strategies and resorting to substance use, violence and likely developing mental illness[10,75]

Children can navigate “great hardship in the presence of parents with whom they feel protected and cared for.” The act of separating the 2 compromises the child’s ability to self-regulate and develop resilience.[6,11] It was theorized that the separation “exacerbated pre-existing trauma from events and incidents in their home country.” Hampton and colleagues demonstrated that even after reunification, “most met diagnostic criteria for post-traumatic stress disorder (PTSD), major depressive disorder (MDD), or generalized anxiety disorder (GAD).”[2]

For both parents and children, psychiatric symptoms were present at the time of the family separation as well as the time of the examination postreunification. Chief concerns included feelings of confusion, general upset to severely depressed mood, constant worry/preoccupations, frequent crying, difficulty sleeping, difficulty eating (loss of appetite), recurring nightmares, and overwhelming anxiety. The asylum-seekers

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also reported physiologic manifestations of anxiety and panic (racing heart, shortness of breath, and headaches) as well as experiencing "pure agony," emotional and mental despair, hopelessness, and being "incredibly despondent.[2]"

"The children exhibited reactions that included regression in age-appropriate behaviors, such as crying, not eating, having nightmares and other sleeping difficulties, excessive parental attachment, clinging to caregivers, urinary incontinence, and recurring feelings of fear following reunification with their parents."[2]

Though less common, some asylum-seeking children have also been known to develop pervasive refusal syndrome (PRS). PRS is a "severe life-threatening condition that affects young asylum seekers" typically with comorbid depression, anxiety, or PTSD. Depressive Devitalization (DD) forms within the spectrum of this condition but is a more passive form of refusal. PRS typically requires hospitalization and even nasogastric feedings as part of management. "A premorbid high-achieving, perfectionist, conscientious personality seems to play an important role in the etiology of PRS generally, as can a psychiatric history of parents or child."[12]

Family is the cornerstone "for emotional and social support for resettled refugee youth." The structure allows them to develop resilience and adapt in the face of the adversity associated with "war and displacement." In the absence of the "secure attachments" formed with parents, these minors can find it difficult to develop a sense of identity. For refugee minors who remained unaccompanied, it makes sense that they would make efforts to develop a sense of a support system or simulated family dynamics, with "employees, foster parents, significant others" social workers and so forth as they moved toward integration.[13]

PSYCHIATRIC SEQUALAE OF FAMILY SEPARATION AND THERAPEUTIC OPTIONS

Asylum-seeking youth typically experience numerous external, internal, and community-based losses starting from the premigration period.[14,15] Even after reunification, they might experience "the psychological absence of parents who are very overwhelmed themselves by the magnitude of their losses." Additionally, the stresses that a parent may have due to resettling, such as concern about finances, can impact the mental health of the minor.[14]

There is an "increasing interest in systemic approaches to refugee care, moving beyond the individual level and emphasizing dynamics within family and community contexts." This is largely based on the understanding that "cultural idioms of distress" common to a culture or family can be an important manifestation of mental health symptoms[14] and might even inform management strategies.

"Migrant adolescents are at a higher risk than their native-born counterparts of psychiatric disorders, and their care is a public health issue." Not only do they often require treatment of longer periods of time, but their condition is often resistant to the "First Line Therapists (FLT)." As a result, alternative therapeutic techniques must be considered. One such alternative is "transcultural psychotherapy" (developed in France). "The clinical approach relies on elements from systemic and psychoanalytic family therapy, narrative therapy, and cultural mediation. The patient, accompanied by his or her family, is received by a group of therapists (psychiatrists, psychologists, and nurses) of diverse cultural origins, trained in transcultural psychotherapy; the group also includes trainees." This technique provides a better foundation for a therapeutic alliance to develop. Other countries such as the US are encouraging strategies such as teaching providers' cultural competency, "ethnic matching" of therapist and patient as well as supervision and developed models relying on interpreters and cultural mediators.[16]

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EFFECTS OF THE COVID-19 PANDEMIC

Coronavirus disease 2019 (COVID-19) has profoundly affected life all over the world. Factors such as isolation, contact restrictions, and economic shutdown imposed a “complete change in the psychosocial environment of affected countries.” The situation has affected children, adolescents, and their families in distinct ways.[2,76]The life course of children and adolescents who are refugees, asylum, and unaccompanied minors were fraught with adverse childhood experiences (ACEs) prepandemic, ultimately making them more susceptible to the effects of the pandemic than children without said experiences. Most significantly, ACEs are associated with a higher risk for developing mental health problems.[13] Maltreatment has been associated with consequent heightened neural response to signals of threat[17] which leads to an increase in emotional reactivity and a decrease in emotional regulation.[18] This suggests that children and adolescents who experienced adversity before the pandemic are at higher risk to develop anxiety and adopt dysfunctional strategies to cope with the COVID-19-associated challenges such as developing addictive behaviors.[13,18]

“Pandemics such as COVID-19 have population-level mental health effects, with vulnerable groups such as migrants” (Qiu and colleagues, 2020)[19] “having a greater mental health risk” (Morganstein, Fullerton, Ursano, Donato, & Holloway, 2017).[20] “Social distancing measures and the closing of schools and places of work also meant increased boredom and isolation as well as reduced daily structure, negatively affecting overall functioning of children and youth.”[21] At the same time, some clinicians noted that “having experienced violence and war before migration, families showed resilience while adapting to the current crisis.”[21] Reasons for this could be varied. Further insight into the level of trauma-informed work and coping tools already provided to these specific children and families would be useful in understanding the contributing factors to their ability to cope with the stress induced by the pandemic.

Encounters at the border, including those with unaccompanied minors, plummeted in early 2020 amid the beginnings of the COVID-19 pandemic but have since risen steadily, reaching an all-time high—with nearly 150,000 unaccompanied minors at or near the US–Mexico border in 2021. About 76% of unaccompanied children in federal care are 15 years of age or older, though authorities have detained infants and toddlers.[22] Immigration detention facilities are congregate settings whereby the infection rate and death toll from COVID-19 are disproportionately high.[23] The number of people per month who tested positive for SARS-CoV-2 in ICE detention between April and August 2020 was between 5.7 to 21.8 times higher than the case rate of the US general population during that same time.[24] Eighty percent of refugees in ICE detention centers reported never being able to maintain a six-foot distance from others in their eating area. 96% reported that they were less than six feet from their neighbor while sleeping. Eighty-two percent of people reported not having access to hand sanitizer anywhere in the detention facility. Interviewees reported long wait times to see a medical professional, with an average wait time of 100 hours.[25] Further, studies have shown that “airway infections are a leading cause for acute morbidity in underage refugees.” They are often subjected to refugee camps and communal living spaces before arriving in their destination country which makes them more susceptible to communicable diseases such as COVID-19.[26]

Exacerbating this, refugees often come across language barriers in the country of destination and because of this they often do not get the latest information regarding COVID-19-preventive measures and guidelines.[27,28] This, as well as administrative, financial, and legal barriers, cumulatively prevent refugees from accessing health care services and thus, they remain excluded from COVID-19 testing and

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treatment.[29–31] This may be more exaggerated for unaccompanied refugees who have limited adult guidance and supervision with regards to hand hygiene, social distancing and mask wearing. This population has always struggled with access to care due to barriers such as lack of transportation, “navigating complex medical and insurance systems, overcoming language and cultural barriers, institutional mistrust, and the residual impacts of trauma.”[32] However, the disruptions and duration of the pandemic presented new barriers and enhanced some that already existed. These barriers are primarily rooted in a lack of resources available to marginalized and underserved populations. While the use of technology such as computers and access to the internet became the norm for many, access to these “could not be presumed when working with this population.”[33] Even when technology and internet were present to facilitate tele-medicine, these children and adolescents still faced these barriers as a result of their family and home structures such as lack of privacy, sharing rooms with other members of the household, inadequate or insufficient interpretation services and “reduced proficiency in technology.”[33,34] Many parents were laid off which led to food and housing insecurity, and increased difficulty in accessing health insurance. Because of undocumented status, many families were unable to receive government relief packages.[21,35] Schools implemented remote education which simply was not feasible for many who had technological barriers.[21]

COVID-19 also created barriers to access to legal support for refugees. Widespread border closures prevented refugees from their right to seek asylum. Movement restrictions coupled with legal status concerns can limit access to health care services and hamper the delivery of medical supplies and doctors.[36] The closure of courts and the reduced activities of authorities caused even slower asylum processes and the postponement of legal decisions concerning refugee status associated with a general reduction of administrative services.[28] Also, some search and rescue operations were put on hold due to logistical difficulties in the context of lockdowns and travel bans.[31]

In addition to restrictions on daily activities requiring families to stay at home together, many refugee parents have also suddenly been required to fulfill the full-time role of childcare and educator for children as school and day-care were no longer open.[37] Alternatively, many refugee parents work in jobs that are deemed to be “essential service” jobs in the context of COVID-19, which often leaves children unsupervised. Consistent with family stress models of children’s mental health difficulties, this stress increases susceptibility to relational conflict and in extreme cases, family violence.[38,39] Compounding this is the reality that many refugees (parents and children) have limited access to the police, legal and social services and safe shelters owing to the lack of registration and a prevalent fear of authorities.[31]

In 1959, the UN declared that all children have a right to protection, education, health care, shelter, and good nutrition.[40] While we know the refugees, asylum, and unaccompanied minors are often not protected in these regards, the pandemic has further challenged these basic rights. The “pandemic highlights entrenched inequalities in health, education, and economic opportunity and the effects of racism and xenophobia through COVID-19’s disproportionate harm to minorities and vulnerable populations.”[21]

IDENTITY FORMATION AND YOUTH IMMIGRANT POPULATIONS

The development of one’s personal identity is a complex process. Education and interpersonal relationships are important pillars and have implications for adolescent adjustment and psychological well-being.[41] There are 2 processes involved in

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establishing personal identity: exploration, which refers to the active questioning and weighing of alternative roles, beliefs, values, and life plans, before deciding which to adopt and pursue; and commitment making, which involves personal investment in particular alternatives, and the adoption of a course of action that will lead to the implementation of these choices.[42] For refugees and immigrants, their development of identity is further complicated by their immigrant status. Ethnic Identity refers to the sense of membership one has with regard to his/her cultural background, ethnic heritage, or racial phenotype while national identity refers to the sense of belonging to the nation.[43] In a longitudinal study in Greece, which investigated immigrant adolescents in middle school, it was found that exploration and commitment to ethnic, national and personal identities all occurred simultaneously. Ethnic and national identities were linked negatively over time and were disconnected from the youths' formation of personal identity which authors attributed to the assimilatory society which discouraged the achieving of dual identities.

Four acculturation strategies are defined: assimilation, separation, integration, and marginalization. Assimilation is the adopting the receiving culture and discarding the heritage culture; separation, the rejecting of the receiving culture and retaining the heritage culture; integration, the adopting the receiving culture and retaining the heritage culture; and marginalization, rejecting both the heritage and receiving cultures.[44] The "need" for ethnic identity within a given immigrant group may be directly related to that group's extent of perceived cultural difference from the dominant host-national group.[45] Perceived rejection from the host-national group may cause immigrants to detach from the national identity and from the labels that the ethnic group imposes on them. Some ethnic groups may even make their own labels to distinguish themselves from other members of the nation and to express pride in that distinction. Examples include Chicano (Mexican Americans) and Boricua (Puerto Ricans residing on the United States mainland).[46]

Native residents, as well as second-generation immigrants with only one foreign-born parent, are more likely to be in favor of assimilation compared with first-generation immigrants and second-generation immigrants with 2 foreign-born parents. First- and second-generation immigrants (with both parents born abroad) are more supportive of multiculturalism than natives are. The preference for multiculturalism among residents with an immigration background is in keeping with the theoretic argument that this model creates less acculturation stress. In one longitudinal study in Luxembourg, support for assimilation among the native population increased significantly within a 10-year period. As realistic group conflict theory implies, this increase in preference for assimilation can be attributed to the increased diversity of the society during this period. Interestingly, nonnatives also displayed a very similar growth in support of assimilation. Authors proposed that these results might be explained by the fact that the heterogeneity of these multilingual and multinational societies forces all residents to find common ground on which they can live together, resulting in increased support for assimilation and decreased support for multiculturalism, even among residents with a migratory background.[47]

School and home are very important aspects of adolescents' lives and the shaping of their identities through interactions. Adolescents' acculturation orientations are influenced by the perceived acculturation orientations endorsed by their migrant parents and the perceived acculturation preferences of their nonmigrant classmates. Parents' influences are significantly stronger than classmates' influences with regard to adolescents' adoption of the destination culture. This suggests that parents are perceived as the primary socialization context, particularly as it pertains to the adaptation of destination culture.[48] This does not minimize the role school plays in acculturation and identity

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formation. In fact, positive teacher–student relationships are linked to higher self-esteem[49] as well as a more positive attitude toward the majority group.[43] Ethnic identity may also be a protective factor by buffering the negative effect of perceived teacher discrimination on children's academic attitudes and school belonging.[50] Higher mainstream language fluency indirectly encourages adopting parts of the destination culture as it has been linked to better grades, lower school absenteeism, and less disruptive behavior in class[51] as well as to greater support from classmates. Cross-ethnic friendships are also linked to positive outcomes such as greater well-being, greater conflict-solving ability, higher self-esteem, and better social adjustment.[52]

The general society can also shape immigrant adolescents' ethnic and national identities as well. Assimilationist societies force immigrants to choose between their ethnic and cultural identities thus generating conflict between both while multicultural societies which are more receptive give immigrant youth the space and option to nurture, explore and keep both which leads to less conflict between the 2.[53] Large, united immigrant groups may be viewed as most threatening to host nationals and natives' views are most negative during times of mass immigration.[54] When the majority group believes that the minority group is threatening their economic, cultural, and future societal position, they become less open to diversity and prefer assimilative strategies. Even in a country with objectively low levels of realistic and symbolic threat and a generally positive attitude toward the foreign community, threat perceptions seem to be closely linked to native residents' acculturation preferences. Stronger perceptions of threat are related to more support for assimilation among all residents and to less support for multiculturalism among native residents and culturally close immigrants. More contact with natives is associated with more support for assimilation among culturally close immigrants and with more threat perceptions among culturally distant immigrants, which is indirectly associated with more support for assimilation.[55] A higher level of education was associated with more positive attitudes toward unaccompanied refugee minors (URM).[56]

Politics also influence identity of the URM population. Defensive measures such as travel bans and deportation of illegal immigrants may be the result of increased perceived threat and this in turn also stifle the immigrants' identity. As ethnic and national identity influence personal identity, hostility toward these groups may also impact personal identity. Some states have banned ethnic-centered classes as a way to prevent the ethnic community from developing. Defensive policies hinder immigrant bicultural development.[57] Right-wing political attitudes led to a lower acceptance of URM, showing that a more conservative political attitude led to lower levels of acceptance regarding the intake of more refugees than a more liberal attitude.[58]

The different types of acculturation have also been connected with mental illness. Stronger ethnic identity is linked to fewer depressive symptoms and internalizing and externalizing behaviors, greater self-esteem, well-being, life satisfaction, school engagement, academic achievement, and better physical health.[59] Those who endorsed a marginalized acculturation style showed the strongest association between severity of acculturative hassles and PTSD. Older age was found to attenuate the relationship between trauma and symptoms of depression. The marginalized and separated groups reported higher depression symptom levels than the assimilated and integrated groups, suggesting that having an acculturative style that excludes participation in the host culture or both the host culture and ethnic culture has a potential negative effect of not feeling a sense of identification, and it may create additional challenges.[60] Studies have highlighted that first-generation immigrants show poorer psychological adaptation (lower life satisfaction, self-esteem, and greater psychological problems) compared with the second generation.[61]

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Overall, youth of immigrant backgrounds are better adjusted in countries with better immigrant integration and multicultural policies.[62] Initial high levels of ethnic identity may help the refugee youth to establish supportive relationships with other members of their ethnic group, which in turn may provide more psychological safety. The maintenance and further development of one's ethnic identity provide a certain amount of continuity in their self-perception and identity.[63] Studies suggest that 4 or 5 years after arrival, refugees "return to normal life" wherein they adapt to aspects of majority culture while their attachment to the country and culture of origin are less complicated.[63]

POLITICS AND EFFECTS ON YOUTH MENTAL HEALTH

As policies relating to asylum and immigration differ across the world, several key concerns have been raised about the management of unaccompanied children or the effects of family separation on child development and well-being.[64] Whereas immigration policies affect the mental health of children fleeing persecution, many policies are not developed with the consideration of a child's mental health or well-being.[64]

Asylum procedures are often guided by concerns about enforcement instead of protection. Tasked with a law-enforcement mandate, US Customs and Border Patrol (CBP) facilities have been described as "inhumane" with references to lack of bedding and bathing facilities, inadequate access to food and water, open toilets, confiscation of belongings, and lack of access to essential medical care, sexual violence by staff against children custody, inappropriate use of solitary confinement, and lack of timely medical treatment contributing to the death of at least 9 children under immigration custody since 2018.[65]

Political, ethical, and logistical challenges are created because of this debate between enforcement versus protection.[66] Deterring migrants from crossing borders were implicit in US immigration policy from 2016 to 2020.[66] The increased focus on enforcement had social, emotional, and developmental repercussions for the children involved in migration to the US–Mexico border.

In the US when children come to the border, they are placed in CBP. Under the trafficking victims protection reauthorization act, unaccompanied children must be transferred within 72 hours from CBP custody to the Office of Refugee Resettlement which manages 170 shelters, group homes, foster care and therapeutic facilities across the country. The increase of children and families in immigration detention was amplified by the "zero tolerance" policy in April 2018, which criminalized crossing the border to seek asylum.[67]

In contrast, Canada's immigration policies embrace different priorities. Immigration is a part of the economic growth strategy of Canada.[68] Therefore, immigration policies allow for a temporary pathway to permanent residency.[68] Immigration is easier for applicants seeking Canadian residence status who work in "essential" jobs. These jobs include cashiers, janitors, and butchers. In addition, graduate students and health care workers can seek a temporary pathway to permanent Canadian residency.[68] Before the COVID-19 pandemic, Canadian immigration previously prioritized English-speaking skilled workers.[68] Since the 2019 COVID-19 pandemic, the criteria for pathways to Canadian residency have broadened.[68]

Steele and colleagues (2002) looked at health and social policy changes in Ontario, Canada, and the effect on recent immigrants and refugees in inner-city Toronto. They postulated that socio-economic factors are likely more important as determinants of health for immigrants versus nonimmigrants and that, therefore, during times of policy change affecting the socio-economic environment, immigrants are more vulnerable.

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Women seemed to bear disproportionately higher burden as primary caregivers whose financial independence is affected by cuts to welfare, home care support, and community services.[69]

When thinking about immigrant children today, we are likely to picture clusters of youth crowded into unsanitary detention centers, scared and crying behind wired fences[70] The zero-tolerance policy enacted in April 2018 in the United States put a spotlight on the more than 5400 children separated from their parents at the US–Mexico border, along with thousands more kept in detention with their families.[70] But, the category of immigrant children is significantly larger than those caught in the turbulence at the US southern border. Immigrant children, defined comprehensively as all children of all immigrants living anywhere within the United States, represent 19.6 million children, nearly 1/4 of all children in the United States.[71,72] This is a heterogeneous group that includes refugees, asylum-seekers, recipients of the deferred action for childhood arrival policy or of special temporary status, and unaccompanied minors.[70] The group also includes first-generation Americans- US citizens by birth, any children born to immigrant parents or those living in households in which at least one parent is an immigrant.[70]

The topic of immigration and child mental health shines a light on what some call "political determinants of health."[70] This is the idea that nearly all of the social determinants of health are affected by political decisions.[70] Policy making can also positively impact children. For example, social safety net programs such as the Children's Health Insurance Program (US), the Canada Child Benefit are products of political wrangling that led to policies of value for children's health.[70]

Policies such as child and family separation, however, have been associated with negative mental health effects such as trauma exacerbation, fear, anxiety, and depression. If conditions in detention facilities for youth in detention are substandard, the consequence can even be death.[70]

Immigration policies that have positive effects on child mental health and promote healthy child development have 4 characteristics.[73,74] Bassett and Yoshikawa, 2020 recommend[73]:

1. Prioritize Family Preservation
2. The policies prioritize child development by enlisting trained and licensed child welfare professionals with expertise in children's psychological, emotional and physical needs and ensuring hygienic, child-friendly spaces for screening and processing children's cases.
3. Improve care and appropriate custody of children.
4. Ensure access to social safety nets for immigrant children and families.

Children are innocent bystanders in the varying political conflicts and tensions in the global immigration debate. In the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance. As clinicians and child advocates, we are uniquely positioned to offer scientific and clinical input into policy for the ultimate benefit of immigrant, refugee children, children of recent immigrants, and children seeking asylum.

CLINICS CARE POINTS

- It is important to evaluate ACE risk factors in migrant youth.
- Consider alternative therapeutic techniques in migrant youth demonstrating resistance to psychotherapy.

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- Assessing the stressors parents or caregivers of migrant youth are encountering can contribute to more effective treatment of the child.
- If working in an immigration assessment setting, advocate for hygienic and child-friendly spaces during screening and processing.

DISCLOSURE

Authors have nothing to disclose.

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