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Case 20-2020: A 7-Year-Old Girl with Severe Psychological Distress after Family Separation

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and Fiona S. Danaher, M.D., M.P.H.

PRESENTATION OF CASE

Dr. Rachel M. Erdil (Medicine and Pediatrics): A 7-year-old girl who had immigrated to the United States from Central America was evaluated in the asylum clinic of this hospital — where forensic medical evaluations of asylum seekers are performed to document evidence of persecution — because of psychological distress after family separation while in U.S. immigration detention.

Seven months before this evaluation, the patient and her mother fled their village in Central America because of physical and emotional abuse. They traveled by foot, motorcycle, bus, and truck for thousands of kilometers, with limited access to food, water, and other basic resources during their journey. They traveled without legal authorization; on one occasion, they hid in a farmhouse for several days to evade local authorities.

Six months before this evaluation, the patient and her mother crossed the United States–Mexico border. The mother reported that they had been surrounded by border patrol officers and instructed to relinquish personal belongings and remove pieces of clothing; these items were not returned. The patient and her mother were driven to a border detention facility in the Southwest region of the United States and were placed with approximately 40 other women and children in a room that was locked and guarded by male guards. The room had cement floors, a toilet shielded by a partial wall, and a mattress for every four people.

After 2 days of detainment, the patient's mother was instructed to bathe the child, dress her in an oversized, unmarked uniform, and place her in a line of children approximately 5 to 12 years old. The children were led out of the room without their mothers and transported to a facility in another state. The patient and her mother were not informed of the destination or told when they would be able to communicate. The mother was told that she would be deported and would not see her child again.

Five days later, the patient's mother was transported to a facility more than 1000 km away from the patient's new facility. After 15 days of separation, the

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patient and her mother communicated by telephone for the first time. During the next month, they talked approximately once per week.

The patient described that, while she was in the facility, she was bullied by other children. They called her names, insulted her, and stole a hat that she had made for her mother. A boy hit the patient in the face and loosened a tooth; another child kicked a ball toward her mouth and caused a nosebleed. The patient befriended a girl and cried for days when that girl was transported to another location without notice. When the patient had a fever, cough, and conjunctivitis, she was held in isolation for an unknown amount of time; the symptoms resolved spontaneously. The patient felt uncomfortable with male staff members and requested that female staff members be assigned to care for her; she reported that this request had not been granted.

Four months before this evaluation and approximately 5 weeks after crossing the border, the patient's mother filed for asylum in the United States. She was released and traveled to New England, at which point she petitioned for the release of the patient. After 2 months of separation, the patient was released and transported to New England to join her mother.

During the evaluation in the asylum clinic, the patient's mother reported that the girl no longer had interest in activities that she had previously enjoyed. She had performed well in school but now had trouble focusing during class and had become afraid of other children, especially boys. She had begun to have aggressive behavior — such as throwing rocks at people, cursing, and frequently getting into fights with other children — along with food aversions; the patient now ate only soup from a cup and had no interest in foods she had previously enjoyed.

The patient's mother also reported that the girl had anxiety, which was worse when she was separated from her mother. During these times, the patient had catastrophic thoughts, such as thoughts of her mother dying or being run over by a vehicle. She insisted that her mother walk her to the door of her school every day. At night, she could not fall asleep unless she was holding her mother's hand, and she had frequent nightmares. The patient scratched and kicked during sleep and would awake suddenly, screaming and crying.

The patient had no history of illness and had met normal developmental milestones. She took no medications and had no known drug allergies. She lived with her mother in a suburban area of New England. In Central America, the patient had lived with her parents and grandparents. Her father drank alcohol and used illicit drugs.

The patient reported that, in Central America, "bad people wanted to kill my mother." She was aware that her mother had been abducted at gunpoint and held against her will for an extended period. She recalled a burglary of the family's home. The patient had also witnessed her father hitting her mother. She reported that she had heard her father tell her mother that he wished the mother would die. On multiple occasions, he had locked the patient and her mother inside their home for several days while he drank alcohol or used drugs. The father had used a belt to strike the patient.

The patient was well developed and appropriately dressed. She was alert and cooperative but detached. Speech was spontaneous and fluent in Spanish. Mood and affect were normal initially but became more negative during the interview. She became visibly anxious when discussing her childhood in Central America and her detention in the Southwest.

A diagnosis and management decisions were made.

DISCUSSION OF EVALUATION

Dr. Matthew G. Gartland: This 7-year-old girl, who had been exposed to multiple traumatic events, presented with severe psychological distress after prolonged separation from her mother while in U.S. immigration detention. She had been referred by a lawyer to an asylum clinic for a forensic medical evaluation (sometimes called an "FME") to document the psychological consequences of past trauma. The challenge of this evaluation is balancing the importance of gathering clinical information to inform the forensic assessment with the risk of retraumatization.

FORENSIC MEDICAL EVALUATION OF ASYLUM APPLICANTS

In this case, the purpose of the forensic medical evaluation was to document signs and symptoms of psychological distress resulting from traumatic events, including family separation in immigration detention, to provide important context for the mother's asylum case. Asylum may be granted

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to a person who is unwilling to return to their country because of a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a social group. Medical providers can be a resource for asylum applicants by conducting a forensic medical evaluation to assess the consistency of medical and psychological findings with the reported abuse (Fig. 1).[1,2] Asylum is granted to 89% of applicants who undergo a forensic medical evaluation by a trained evaluator, as compared with 37.5% of applicants who do not undergo the evaluation.[3]

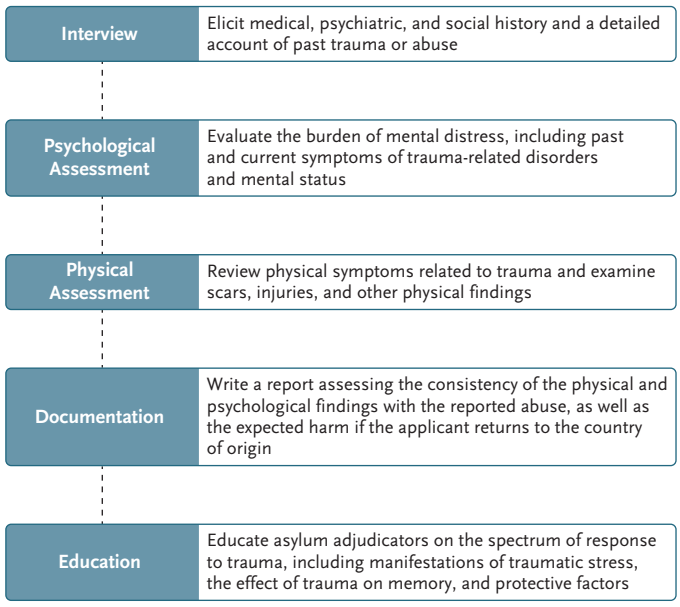

Figure 1. Forensic Medical Evaluation of an Asylum Applicant.

TRAUMA-INFORMED APPROACH TO DIAGNOSIS IN AN ASYLUM EVALUATION

When the evaluators first met this patient, they used a trauma-informed approach to diagnosis, based on the principles of trauma-informed care (Table 1), to protect the well-being of the child during the evaluation while gathering the information necessary for a rigorous clinical assessment. Obtaining a history of trauma from a child can be difficult because the child may have feelings of guilt, shame, and avoidance.[7] Developmental stage and limitations in memory and language may also hinder a child's ability to communicate details of past trauma and related symptoms.[8] In addition, distressing memories and emotions are likely to resurface when the child describes the traumatic events.[9] The evaluation of this patient highlights the tension between the importance of obtaining a comprehensive history to support a thorough assessment and the risk of triggering distress. In this case, the patient became anxious when speaking about past traumatic experiences. The role of the evaluator included monitoring the child's distress and providing a safe environment to mitigate the risk of harm.

Table 1. Principles of Trauma-Informed Care.

Source	Principles
Substance Abuse and Mental Health Services Administration[4]	According to the "Four Rs," a program, organization, or system that is trauma-informed acts as follows: Seeks to actively *resist* retraumatization *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices *Realizes* the widespread effect of trauma *Recognizes* the signs and symptoms of trauma Key principles include safety, trustworthiness and transparency, collaboration, and awareness of cultural, historical, and gender issues
National Child Traumatic Stress Network[5]	Realize the high prevalence of trauma in children Use evidence-based, culturally responsive assessment tools Engage in efforts to strengthen resilience and protective factors Address trauma in the parent or caregiver Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress
Miller et al.[6]	Create an immigrant-friendly health care environment Ask for permission to discuss potentially difficult subjects Use a two-generational approach Recognize that trauma may not end after immigration

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INTEGRATING KNOWLEDGE OF TRAUMA INTO PRACTICE

In an asylum evaluation, the evaluator's approach to the interview is just as important as the conclusions of the assessment. The evaluator creates a child-friendly and collaborative environment. The use of open-ended questions may be more effective than closed or focused questions in eliciting an accurate history from children.[10] Evidence-based forensic interview guides, trauma screening tools, and structured play may be helpful in obtaining a comprehensive history.[11,12] During this evaluation, the patient's mother provided support and served as an additional source for history and observations of the child's behavior.[13]

This patient had a history of multiple traumatic events that had put her at risk for trauma-related distress. While she was in her country of origin, she experienced and witnessed multiple episodes of domestic violence and was aware of threats to her mother outside the home. Repeated violence and threat of harm forced the mother and child to flee.

During their migration, the patient and her mother were faced with a scarcity of food and with other insecurity. In immigration detention, they were initially held together in crowded conditions and then separated for almost 2 months with minimal contact. Neither the mother nor the child knew whether they would be reunited. The patient lacked stable relationships and was bullied by other children and staff.

Unfortunately, this patient's experiences are representative of the harmful conditions children have experienced in immigration detention around the country. Reports from several government agencies have documented poor access to medical care, sleep deprivation due to constant exposure to light, a lack of adequate bedding, and numerous examples of inappropriate or punitive use of medical isolation.[14-16] Even without an analysis of specific conditions, detention and family separation are known to be fundamentally injurious to a child's well-being and development, putting the patient at lifelong risk for physical and mental health consequences.[17-20]

RECOGNIZING SIGNS AND SYMPTOMS OF DISTRESS

The presentation of trauma-related psychiatric disorders differs across developmental stages. Classification systems such as the *Diagnostic and Statistical Manual of Mental Disorders* have started to incorporate aspects of symptom expression across specific developmental stages; however, it remains difficult to recognize signs and symptoms of traumatic stress in young children.[21,22]

This patient had signs and symptoms of multiple overlapping mental disorders. Her symptoms of anxiety included apprehension during the interview, catastrophic thoughts, separation anxiety, and irritability. Her symptoms of depression included detachment and isolation at school, negative affect and mood during the evaluation, and loss of interest in activities. Difficulty concentrating and sleep disturbances are common features of both anxiety and depression.

Although a diagnosis of coexisting anxiety and depressive disorders is common in children who have experienced trauma, the diagnosis of post-traumatic stress disorder (PTSD) best fits this patient's symptoms. She has unique features of a trauma-related disorder that help to guide our clinical assessment.[12]

The features seen in this patient fulfill formal diagnostic criteria for PTSD (Table 2), including exposure to harm and threat of serious injury, intrusive memories, avoidance, negative alterations in cognition and mood, and hyperarousal.[21] Still, this diagnosis does not convey the intensity of her symptoms or the degree of her functional impairment, and it does not capture trauma-related developmental regression and somatic symptoms. The child has shown changes in her ability to communicate and form social relationships, and she is no longer able to sleep independently. Her food aversions may be a somatic gastrointestinal manifestation of traumatic stress.[23] Finally, it is important to note that the child's resilience has been bolstered by protective factors including a loving relationship with her mother and previous success in school.

DR. MATTHEW G. GARTLAND'S DIAGNOSIS

Post-traumatic stress disorder.

DISCUSSION OF MANAGEMENT

Dr. Jose A. Hidalgo: Delivery of care in a "medical silo" is not likely to be effective in the treatment of this patient. The child and her mother have basic safety, survival, medical, and psychiatric needs that have not been met, along with socio-

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economic challenges. Given that the patient has multiple problems and few resources, her needs must be triaged, with assessment of her social environment and access to care simultaneous with her trauma symptoms and capacity for emotional regulation. Treatment is directed at stabilizing the child's social environment and improving her emotional regulation.[24]

PHASE-ORIENTED APPROACH TO THE MANAGEMENT OF TRAUMA

Evidence-based treatment for trauma consists of a phase-oriented approach (Table 3). Before attempting a detailed inquiry into traumatic experiences, the physician must prepare the patient in order to avoid retraumatization. Trauma treatment typically begins with safety and skill development. The patient would be offered psychoeducation, training in emotional regulation skills, social support, and advocacy. Close attention is paid to issues related to resettlement and acculturation.[26]

Different layers of the social environment interact and influence outcomes, for better or for worse. First, it is important to target the outer layers of this patient's social environment (e.g., school and housing) to decrease symptoms and promote successful adaptation, according to the principles described previously.

Pediatricians and community providers sometimes lack knowledge about traumatic stress or the home culture of migrant families. Pediatricians often feel alone in wanting to intervene in the child's new social environment. Caregivers can access a wealth of information through the National Child Traumatic Stress Network.[27] Teamwork and inclusion of the local community are essential in advocating for and organizing a multidisciplinary team to address the child's and family's needs. In cases like this one, it is typically up to the physician to organize a team using any available resources. In this case, a team could be formed with the child's lawyer and community advocate.

This patient is struggling in school. She is afraid of other children, especially boys, and is showing aggressive behavior toward them. School is probably a reminder of her past trauma and a trigger for exaggerated fear and aggressive behavior. The team would contact school officials, listen to any concerns, offer background information about the source of the child's behaviors in order to promote empathy, and offer suggestions of how to mitigate these behaviors. I would recommend identifying a person in school with whom the child feels safe and scheduling regular check-ins between that person and the patient to help her feel safer. When school officials are approached in a collaborative spirit, they are often both relieved and grateful to collaborate with a team to address the child's sometimes-bewildering behaviors.

Healing from traumatic experiences can hap-

Table 2. Summary of Diagnostic Criteria for Post-Traumatic Stress Disorder.*

Exposure (directly or through a close family member) to actual or threatened death, serious injury, or sexual violence
Intrusion symptoms (≥1 of the following): recurrent distressing memories, frightening dreams, dissociative reactions, or intense psychological distress
Persistent avoidance of stimuli (≥1 of the following): avoidance of distressing memories, thoughts, or feelings or avoidance of external reminders that arouse distressing memories
Negative alterations in cognition and mood (≥2 of the following): inability to remember an important aspect of the trauma, persistent negative beliefs, self-blame, negative emotional state, diminished interest, detachment or estrangement, or inability to have positive emotions
Marked alterations in arousal and reactivity (≥2 of the following): irritable behavior and angry outbursts (verbal or physical aggression), reckless or self-destructive behavior, hypervigilance, exaggerated startle, problems with concentration, or sleep disturbance
Duration of disturbance of more than 1 month
Disturbance causing clinically significant distress or impairment in social, occupational, or other important areas of functioning
Disturbance not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition

* Data are from the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition.[21] The symptoms listed must be associated with a traumatic event.

Table 3. Four Phases of Treatment for Children and Adolescents with Trauma.*

Ensure safety in the patient's environment, including the home, school, and community
Develop skills for emotional regulation and interpersonal functioning; may include use of medication
Make meaning of past traumatic events so the patient may have more positive, adaptive views about himself or herself in the present and have hope about the future
Enhance resiliency and integration into a social network

* Data are from the National Child Trauma Stress Network.[25] In general, it is important to approach the treatment sequentially to ensure that the child has sufficient emotional regulation and safety to face traumatic memories with a sense of mastery. In practice, clinicians routinely return to earlier phases of treatment when new challenges arise.

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pen only in the context of safe and loving relationships. Thus, it is important to pay attention to the mother's well-being and to help repair any attachment problems between mother and child. The mother has her own history of profound trauma. Ideally, she would be screened for anxiety, depression, and PTSD, as well as assessed for resilience factors. If indicated, emotional support, treatment, and appropriate referrals would be offered to the mother. In the aftermath of trauma in a child, the parents often express excessive guilt and shame. After validating the parents' experience, the pediatrician can provide helpful reframing of cognitive distortions, for example, by saying, "Under the circumstances, you did the best you could." In this case, it is important to take advantage of resilience factors by encouraging the mother to remember how she managed her extreme hardship and to draw on those skills to manage her current adversities. Relating to patients and families according to their needs and strengths provides a good foundation for forming a solid therapeutic alliance.

This child has acute PTSD symptoms. I would coach the mother to reestablish familiar rituals and routines, since this strategy promotes a sense of safety and stability. Also, I would teach the mother emotional regulation skills that she can practice with her daughter at home. For example, during office visits, the pediatrician could model breathing exercises (Fig. 2). The child's acute hyperarousal symptoms, nightmares, and insomnia could be treated with alpha-adrenergic agents and melatonin. At the same time, referrals to expert mental health services would be made.

MEDICAL–LEGAL FRAMEWORK

Dr. Fiona S. Danaher: The circumstances surrounding the development of PTSD in this patient are unfortunately far from unique. In recent years, record numbers of Central American children and families fleeing extreme violence and poverty have immigrated to the United States. To deter unauthorized immigration, in July 2017, the U.S. government quietly began piloting a "zero tolerance" policy of criminalizing and detaining asylum seekers, and that policy was expanded across the entire southern border in April 2018. Legal constraints that were designed to protect immigrant children prevented them from being detained for prolonged periods, so rather than releasing families, the government separated them and sent the children to shelters across the country while their parents remained incarcerated. The federal government had anticipated that the risk of family separation would serve as a further deterrent to immigrants seeking asylum.

Internal memos indicate that the federal government had expected to separate as many as 26,000 immigrant children from their parents, but the policy was met with swift public backlash as photographs and audio recordings of traumatized children permeated the news media.[28] The policy formally ended in June 2018, by which time approximately 4370 children had been separated from their families. However, the practice has continued to a lesser extent, with at least another 1090 families separated in the ensuing 1.5 years.[29] The true number affected remains unclear, as the government acknowledges that it lacks adequate technological infrastructure to track the families it separates.[28]

Although family separations at the border garner much public attention, similar separations occur insidiously within the United States every day as a result of Immigration and Customs Enforcement (ICE) actions. There are more than 5 million U.S.-citizen children of unauthorized immigrants, accounting for approximately 1 in every 15 children in the United States; another half million U.S. citizens are children of Temporary Protected Status (TPS) or Deferred Action for Childhood Arrivals (DACA) recipients, whose legal immigration status is also under threat.[30] From 2011 to 2017, ICE deported more than 340,658 immigrant parents of U.S.-citizen children.[31] Such deportations alone are estimated to have increased foster care placements among Hispanic children by 15 to 21% from 2001 to 2015.[32]

The detention or deportation of a parent triggers abrupt, severe stress in a child while simultaneously disrupting the child's most crucial social–emotional buffer, the family unit. Aggressive and indiscriminate immigration enforcement thereby inflicts emotional stress during a sensitive period of development, placing children at risk for detrimental health effects across the entire life span.[17]

The Department of Health and Human Services, which oversees placements of immigrant children who have been separated from their families, maintains a list of commonly cited

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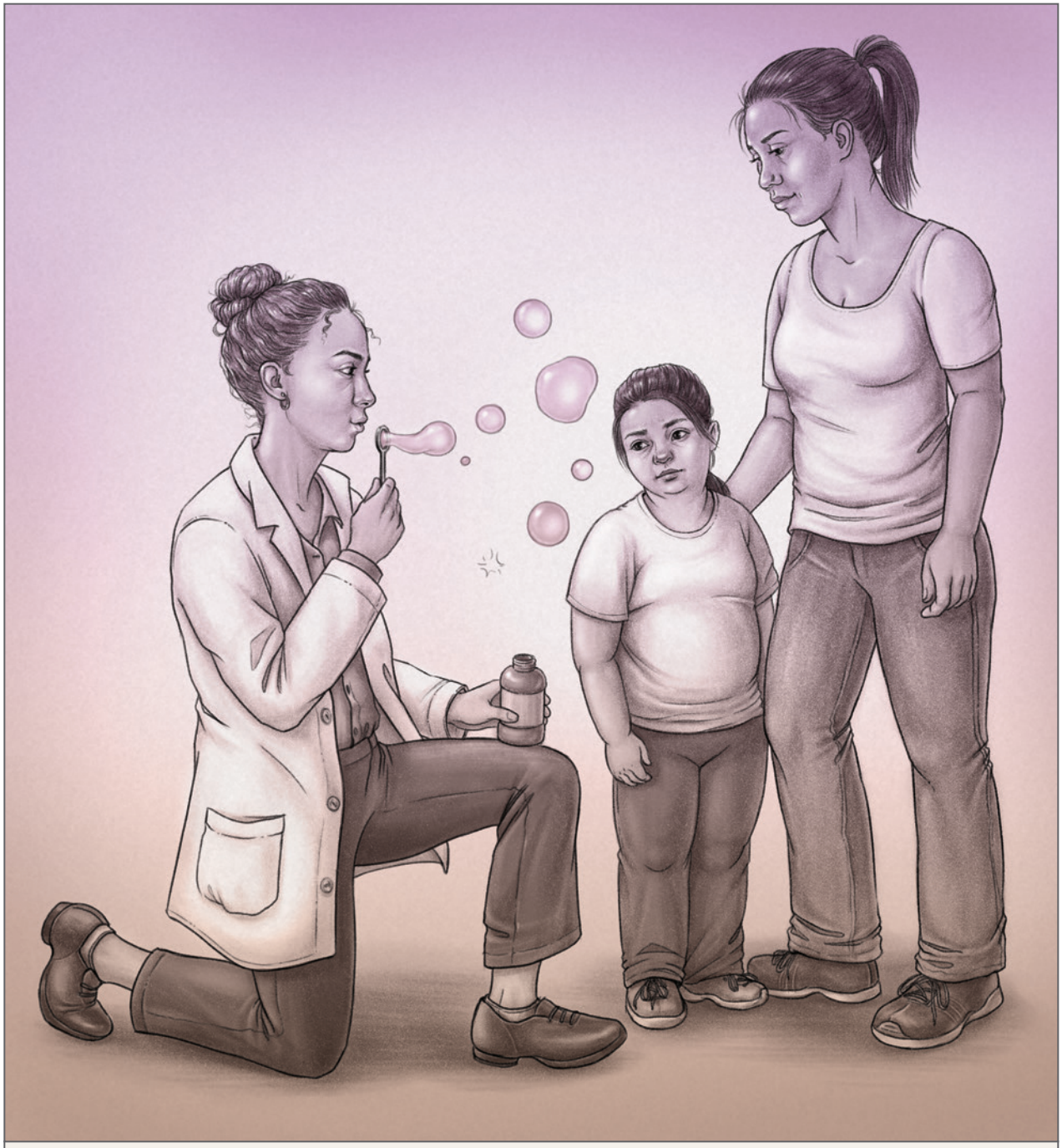

Figure 2. Modeling of Emotional Regulation Skills during an Office Visit.

The illustration shows a pediatrician blowing bubbles with the patient and her mother. This simple activity can create a sense of fun, ease, and connection and can be used to teach a relaxation skill. First, the pediatrician, mother, and patient each take a turn blowing bubbles. Then, the pediatrician demonstrates how to take a special breath: breathe in, count to three, and hold for a few seconds; breathe out, count to three, and hold for a few seconds. The breathing should be relaxed and not forced. During the out breath, the child is encouraged to think of something that is fun, safe, and relatively neutral (e.g., the bubbles). Everyone takes a turn. Next, the pediatrician puts away the bubbles and demonstrates the special breathing without the bubbles. Everyone takes a turn. Finally, the pediatrician encourages the child to do special breathing, or to "blow bubbles," when she is nervous or scared and encourages the mother and child to include this practice in their routines. The child gets to take the bubbles home.

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guiding principles for promoting the "best interests of the child" that are standard in child welfare law. These principles include recognizing the "importance of family integrity and preference for avoiding removal of the child from his or her home"; emphasizing the "health, safety, or protection of the child"; promoting the "importance of timely permanency decisions"; and providing "assurance that a child removed from home will be given care, treatment, and guidance that will assist the child in developing into a self-sufficient adult."[33] The adverse conditions encountered by this patient and thousands of other separated children in immigration detention fail to meet such standards, as is amply documented in whistleblower accounts, medical–legal literature, and the government's own reports.[16,20,34-37]

Mitigating the profound trauma inflicted by family separation requires clinicians to envision advocacy as part of treatment. Immigrant families navigate stigma in addition to cultural, linguistic, and legal barriers to access the often-limited resources available to their children. Providing effective care thus entails building medical homes with inclusive and welcoming environments, adequate language capabilities, knowledgeable care teams, institutional policies reflective of immigrant patients' concerns, and commitment to ongoing quality improvement. It also necessitates facilitating individual patients' connections to community-based mental health, education, nutrition, housing, and legal resources, while identifying resource gaps and advocating at a systems level for programs to remedy them.

Clinicians bear witness to their patients' stories and thus play a crucial role in educating the public and legislators to propel policy change. A broad coalition of professional medical organizations spoke out in opposition to family separation.[38] Physicians for Human Rights conducted an analysis of families affected by the zero tolerance policy and documented that the psychological effects meet the international definition of torture.[39] By combining firsthand knowledge of individual patients' experiences with an understanding of public health implications, physicians are integral in promoting policies that protect the health and rights of immigrant children and their families.

Dr. Erdil: This patient has continued to have mental distress and instability at school. After arriving in New England, she and her mother were supported by a community organization. The patient was enrolled in limited Medicaid, and pediatric care was established. She received a diagnosis of latent tuberculosis infection after routine screening and has completed treatment to prevent illness.

The patient's mother reports that the child continues to have anxiety, emotional lability, and social isolation. Her weight has gone from being in the 45th percentile for age on arrival to being in the 90th percentile for age at a recent well-child visit. Her mother suggests that this weight gain is related to overeating as a coping mechanism. The patient has been bullied at school. A classmate has teased her by saying that she and her mother would be deported.

The patient's pediatrician has attempted to arrange counseling through the patient's school, but the school does not have the capacity to meet this need. The pediatrician describes barriers to mental health services, including inadequate insurance, long wait times, and a lack of Spanish-speaking providers in the region. One year after the patient's evaluation in the asylum clinic, physician advocacy resulted in referral to a Spanish-speaking therapist in the patient's community.

The patient and her mother have legal representation. The mother's asylum case has been postponed on several occasions, with her next hearing scheduled in 2022.

FINAL DIAGNOSIS

Post-traumatic stress disorder.

This case was presented at combined Pediatrics and Global Health Grand Rounds.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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