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Issue Brief

Mitigating the Effects of Trauma among Young Children of Immigrants and Refugees

The Role of Early Childhood Programs

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Executive Summary

As awareness of the impacts of trauma on young children increases, policymakers and early childhood education and care (ECEC) program administrators are becoming more cognizant of the need for early childhood programs and professionals to take a trauma-informed approach to service provision. ECEC programs have the potential to play a critical role in identifying and addressing mental health challenges faced by young children and their families. To fully realize this potential, however, their capacity to serve the children of refugees and other immigrants must be strengthened.

As of 2013–17, children of immigrants comprised more than one in four of all U.S. children under the age of 5. These young children of immigrants—and especially those in refugee families—are more likely than their peers to be affected by trauma due to experiences before, during, or after migration, such as witnessing violence and losing family members. While some children experience this trauma directly, others may be affected secondhand through their parents or other family members. However, information on their specific needs is scarce, as are resources to support them. Moreover, young children in immigrant families are enrolled in preschool at lower rates than their peers. And despite the considerable potential for ECEC programs to identify and respond to the early signs of trauma in children, there is a general lack of capacity and training on how to do so effectively among young children of immigrants. Trauma-informed policies and programs designed to support this young child population are similarly limited across other key fields, including mental health care and organizations that support the refugee resettlement process.

A number of opportunities exist for states and programs to better support the healthy socio-emotional development of young children of immigrants, including:

- integrating trauma-informed strategies into ECEC programs to address infant and early childhood mental health (IECMH) concerns by, for example, providing access to infant and early childhood mental health consultations (IECMHC);
- ensuring that home-visiting programs—an increasingly popular two-generation service model and one of the few services to reach children in their first years—are equipped to serve diverse populations and to identify and address the impacts of trauma;
- encouraging collaboration and referrals between physical and mental health systems, ECEC providers, and organizations that serve immigrants and refugees as a

way to ensure that young children and their families are connected with services that can mitigate the effects of trauma; and

- promoting the systematic use of standardized mental health screening instruments that are appropriate for use across cultures and with young children.

Because trauma can have significant negative consequences across generations, addressing gaps in the services available to young children of immigrants and refugees and their families promises to have long-standing, society-wide effects.

I. Introduction

The first five years of a child's life are a time of exceptional growth and development, and one that can be profoundly influenced by traumatic experiences. A well-established body of research now firmly refutes the commonly held belief that infants and toddlers are "too young" to be affected by traumatic events, calling for interventions and support to mitigate their documented negative impacts. However, while awareness of childhood trauma has increased among policymakers and service providers, discussions of how the early childhood education and care (ECEC) field should adapt often overlook the unique experiences of children in immigrant and refugee families.

Box 1. Key Terms

Trauma can result from exposure to one or more events that are threatening to one's physical or emotional wellbeing.

Complex trauma entails multiple traumatic incidents that are often intrusive and involve other people.

Secondary trauma can occur through exposure to people who have been traumatized; for example, children of traumatized parents and service providers working with traumatized populations may suffer secondary trauma.

Toxic stress describes the sustained activation of stress response systems due to severe, extended, and/or recurrent adverse events.

Adverse childhood experiences (ACEs) are defined as a set of ten threats organized into three categories: abuse, household challenges, and neglect. The term comes from a 1995–97 study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente.

Sources: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Center for Integrated Health Solutions, "Trauma," accessed December 21, 2018, www.integration.samhsa.gov/clinical-practice/trauma; National Child Traumatic Stress Network, "Complex Trauma," accessed December 21, 2018, www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma; Harvard University, Center on the Developing Child, "Toxic Stress," accessed December 21, 2018, https://developingchild.harvard.edu/science/key-concepts/toxic-stress/; Centers for Disease Control and Prevention, "About the CDC-Kaiser ACE Study," updated June 14, 2016, www.cdc.gov/violenceprevention/acestudy/about.html.

Young children in immigrant and refugee families are particularly likely to be exposed to trauma and other severe stressors in their early years, with possible implications for their healthy socioemotional and cognitive development. Yet research and resources that highlight effective strategies for addressing trauma in such children are scarce, and few services—whether in ECEC, mental health, or refugee resettlement systems—focus on supporting them. Moreover, immigrant parents, who play a critical and primary role in laying the foundation for their children's future health and success, may be isolated and face barriers to accessing mental health and other services that could promote their own and their children's wellbeing.

This issue brief seeks to raise awareness of the need for trauma-informed services for young children of immigrants and refugees as well as for their families. In addition to providing a profile of this population and an overview of the effects that trauma, if unaddressed, can have on child development, the brief suggests potential strategies to improve and expand supports for these children.

II. Young Children of Immigrants and Refugees in the United States

Children with one or more immigrant parents comprised 25 percent of all young children (ages 0 to 5) in the United States as of 2013–17.[1] The vast majority—94 percent—of these 6 million children are U.S. citizens.[2] This large and diverse group includes subpopulations with widely varying characteristics, including young children of refugees and those who live in mixed-status families (where family members do not all share the same legal status). As a whole, young children of immigrants are more likely to live in poverty than peers with only U.S.-born parents (27 percent versus 22 percent, respectively), and they are more likely to lack health insurance.[3] They are also less likely to be enrolled in preschool,[4] in spite of the many proven benefits of high-quality early childhood education and its potential to prevent or reduce later gaps in achievement for at-risk populations.[5]

Research demonstrates that a large proportion of young children in the United States experience trauma in their early years, with 48 percent of all children having experienced at least one traumatic event.[6] The prevalence of adverse childhood experiences (ACEs) is uneven across racial lines. For example, 51 percent of Hispanic children have experienced at least one ACE, compared with 40 percent of White non-Hispanic children.[7] However, commonly used definitions that studies rely on to measure the prevalence of ACEs may not effectively capture the specific adverse experiences of immigrant and other minority populations, potentially obscuring higher rates of exposure within these groups.[8] In general, ACE surveys focus on conditions in the home environment rather than the surrounding community or outside actors. As a result, they may be less effective in revealing the types of trauma that children in immigrant and refugee families may experience, such as past or ongoing violence in their home countries, tumultuous migration journeys, discrimination or difficulty adjusting to a new society upon arrival, or, among unauthorized immigrants, risk of deportation.

While the effects of trauma are evident across all socioeconomic levels, young children in low-income households are at significantly higher risk of exposure.[9] Furthermore, in addition to experiencing higher poverty rates, children of immigrants are disproportionately likely to encounter traumatic events and other challenges to their healthy socioemotional development due to factors related to their own or their parents' migration and integration experiences, as well as the sociopolitical environment surrounding them.

Refugee families, for example, flee violence or persecution in their home country and may experience separation from or loss of family members. After fleeing, many spend considerable time in precarious situations while in refugee camps or displaced in urban areas prior to being selected for resettlement. Children in

refugee families may directly experience flight and resettlement, or they may suffer secondary trauma as a result of the hardships that their parents or other caretakers have endured. Some refugee parents, for example, may have been victims of torture, which can have particularly powerful, long-term effects on survivors and their families.[10] In a 2013 study involving 251 refugees from three countries who had recently arrived in the United States and were screened for mental health issues during public health visits, 30 percent exhibited high levels of depression and anxiety.[11] Refugee women, many of whom are the survivors of rape and other forms of abuse, are particularly likely to be stigmatized or victimized, and one study found them ten times more likely than women in the general population to develop symptoms of posttraumatic stress disorder (PTSD).[12] Furthermore, refugees are at higher risk of experiencing the severely negative effects of "complex trauma," which involves repeated and/or prolonged trauma of an extreme nature.[13]

In addition to refugees arriving through the resettlement program, some immigrants seek asylum from within the United States or at U.S. borders, including an increasing number of families from Central America who have applied for asylum after arriving at the Southwest border in recent years.[14] Many have undergone fraught and perilous journeys to reach the border, with reports of extortion, kidnapping, and gender-based violence common along the route to the U.S.-Mexico border, for instance.[15] Because it can take months or even years for asylum claims to be resolved, these families may also experience stress related to their uncertain legal status once in the United States. And shifting federal immigration policies, including those intended to deter illegal border crossings and narrow the grounds for asylum, may create additional uncertainty and fear of possible family separation and/or deportation.[16]

Mixed-status families that include at least one unauthorized immigrant family member contend with many challenges that can affect their emotional wellbeing and mental health.[17] As of 2009–13, 5.1 million children under age 18 were estimated to live in mixed-status households nationally.[18] Although the vast majority of children in such families are U.S. citizens, those with unauthorized parents are more likely than peers with parents who are native born or legal immigrants to experience psychological distress and economic instability, factors that have been shown to negatively affect child development.[19] The lack of legal status also affects parents' eligibility for and likelihood of accessing many public benefits, which in turn affects their children's access to critical supports.

The expansion of immigration enforcement under the Trump administration has increased anxieties around detention, deportation, and family separation among immigrant families with unauthorized members, with damaging consequences for young children.[20] Other immigration policy changes also have the potential to affect family wellbeing. For example, proposed changes to the federal "public-charge" rule could prevent some noncitizens from obtaining lawful permanent residence (i.e., a green card) or renewing a temporary visa if they are using, have used, or are deemed likely to use an expanded list of public benefit programs.[21] Though not yet implemented, the proposed rule has reportedly already made some immigrants reluctant to access programs such as Medicaid due to anxieties about the immigration consequences.[22] The administration has also moved to end temporary relief from deportation for unauthorized immigrants who are beneficiaries of the Deferred Action for Childhood Arrivals (DACA) program as well as for Temporary Protected Status (TPS) holders from six countries.[23] Though both actions are facing legal challenges, they have increased the fear of losing legal protections or facing deportation among affected immigrant families.[24]

Meanwhile, the challenges posed by chronic exposure to discrimination and racism, language barriers, the process of adjusting to a new culture, and the need to negotiate the divide between home and school life affect a wide range of children of immigrants, including those in families where all members have secure legal status. Indeed, postmigration and acculturative

stressors encountered within the United States have the potential to considerably affect the mental health and wellbeing of immigrant and refugee families.[25] It is important that these be recognized and addressed, alongside stressors related to migration experiences.[26]

III. The Impacts of Trauma on Child Development

While trauma experienced before, during, or after migration can negatively affect immigrants of any age, the consequences for children are particularly noteworthy, and often under-recognized. A robust body of research demonstrates that young children are highly vulnerable to both the short- and long-term effects of trauma, due in part to the rapid brain growth occurring during these formative years.[27] However, symptoms of trauma among infants, toddlers, and preschoolers manifest in ways that the untrained observer may not easily recognize.[28] Children may act in ways that are interpreted as being "difficult" or "disruptive." Alternatively, some children may be quietly or passively coping with the effects of trauma without drawing attention to their needs. [29] Misunderstandings may be exacerbated by racial bias, and may be amplified for young children of immigrants and refugees who speak a language other than English at home and who are rooted in a culture that is foreign to ECEC staff.

Symptoms associated with traumatic stress among young children can include cognitive indicators such as poor early verbal skills, problems with memory, and the development of learning disabilities. Behavioral symptoms might include an excessive temper, aggressive behavior, imitation of the traumatic event, difficulty forming friendships, or fear of being separated from a parent or caregiver. Physiological symptoms, such as poor sleep habits, nightmares, stomachaches and headaches, or digestive problems may also be present. As a result, young children who experience mental health problems are at heightened risk of being expelled or chronically absent from preschool (if they are enrolled in one), with implications for their school readiness.[30] In the long term, trauma experienced during these early years can lead to an array of negative physical, mental, and emotional health outcomes, and can in some cases result in serious medical conditions, alcoholism, drug abuse, depression, or suicide, in addition to a higher likelihood of unemployment and poverty.[31]

The detrimental effects of trauma, moreover, can be transmitted across generations through intergenerational trauma.[32] This means that in addition to being affected by their direct experiences of trauma, children can be affected by the trauma that their parents and other family members have experienced.[33] Untreated trauma can affect parenting practices; parents may neglect their children or be unable to form healthy bonds and attachments. Maternal depression, which is widespread among low-income mothers, has been shown to negatively impact young children's cognitive, socioemotional, and behavioral development.[34] Research also reveals physical evidence of this transmission through, for instance, links between maternal stress and undesirable birth outcomes such as preterm births and low birth weight.[35] The chain of transmission can even extend beyond the home: children can be affected by the trauma experienced by members of their surrounding community, even when their own family was not directly affected, through a phenomenon known as historical trauma.[36]

However, not all young children who are exposed to trauma will experience negative effects, and several mitigating and protective factors can greatly influence the long-term impacts of ACEs and other stressors. Many factors, including genetics, cognitive ability, and self-esteem, can all influence children's resiliency in the face of trauma.[37] Most importantly, the relationship young children have with their caregivers is the primary factor that can protect them from negative outcomes. Beyond their parents and guardians, social support from a loving and stable adult can have a powerful effect in mitigating the potentially negative consequences of personal or intergenerational trauma.[38] Thus, high-quality

ECEC services that take a relationship-based approach to care and learning are well placed to help young children and families deal with the impacts of trauma.[39]

IV. Gaps in Services to Address Trauma

Although ECEC and other services have the potential to promote the resiliency of young children of immigrants and refugees and their families, capacity to effectively respond to traumatic stress in this population is critically lacking at both the program and system levels.

High-quality ECEC programs that provide supportive and stable relationships with caring adults can significantly buffer the negative impacts of trauma and stress for young children.[40] Importantly, such programs also reach a larger segment of the young child population than specialized mental health and counseling services. Research has shown that nonclinical approaches to addressing trauma can be highly beneficial, and may even be a necessary precursor to formal therapy for a traumatized child.[41] Yet children of immigrants and refugees are less likely to access high-quality ECEC programs than their peers due to a range of structural barriers, including cost, transportation, service hours that are incompatible with parents' work schedules, a lack of support to help newcomer families navigate unfamiliar systems, and a dearth of culturally and linguistically responsive programming.[42] Immigrant families are also frequently underserved by home-visiting programs that, by providing in-home support for new and expectant parents, would otherwise be well positioned to address intergenerational mental and socioemotional health concerns through an intensive, relational, and two-generation approach.[43] Moreover, Migration Policy Institute research has found that many ECEC programs serving refugee families have identified a need to incorporate a trauma-informed approach but lack the training, resources, and capacity to do so.[44]

For refugee families, other forms of support are available through the U.S. refugee resettlement program, though these too are limited when it comes to identifying and mitigating childhood trauma. The resettlement program is focused primarily on the goals of employment and economic self-sufficiency and provides little direct support for refugee children's healthy socioemotional development. Although refugees are initially provided a comprehensive health assessment and referrals to health services, there are no specific, standardized guidelines for mental health assessments across states. A 2012 survey found that only half of states offered some type of mental health screening for refugee adults, with even fewer screening children.[45] Furthermore, while the Refugee Health Screener-15 (RHS-15)—the instrument used for initial screening in many (though not all) states—was developed to be a culturally sensitive tool capable of identifying emotional distress in newly arrived refugees of different backgrounds,[46] there is no equivalent instrument for refugee children under the age of 14. Indeed, the few mental health services that are tailored to refugees focus on adults and older children; no specific consideration is given in most cases to issues such as maternal health, despite the well-documented effects of, for example, maternal depression on the development of young children.

It is critical to address this lack of resources and capacity to respond to trauma among young children of immigrants and refugees across both the ECEC and refugee resettlement fields, particularly given the well-documented racial and ethnic disparities in access to mental health care. Asian Americans, for example, are three times less likely to seek mental health services than are Whites.[47] A 2008 study also found that among a sample of people with a diagnosed need for mental health care, 22 percent of Latinos and 25 percent of African Americans received care as compared with 38 percent of Whites.[48] These racial disparities in treatment appear to be widening over time.[49]

Immigrant and refugee parents of young children may have difficulty accessing needed mental health supports due to factors including their cost, a lack of insurance, concerns related to eligibility and immigration status, cultural beliefs or stigmas regarding mental health, and a lack of culturally competent services. In addition, 50 percent of immigrant parents of young children had limited English proficiency as of 2013–17,[50] indicating that they are likely to encounter language barriers when seeking to obtain quality mental health care. The pending change to the public-charge rule, described in Section II, may further exacerbate inequities since immigrant families—including some unaffected by the rule's provisions—may become more wary of participating in needs-based services.[51]

ECEC programs and other services that act as a touchpoint for immigrant families with young children therefore represent a critical opportunity to reach those affected by trauma who may not otherwise be able to identify and access needed supports. For older children of school age, delivery of mental health services through school systems has been identified as an ideal entry point to improve access for immigrant and refugee children who face financial and structural barriers.[52] But even at this level, very few initiatives are designed specifically with the needs of children of immigrants in mind.

V. Opportunities to Expand Access to Trauma-Informed Services and Mental Health Supports

Expanding immigrant families' access to trauma-informed services has the potential to tap into young children's resilience and protect them against a host of negative outcomes. States and localities can build capacity across multiple systems, including ECEC, health care, and refugee resettlement, to integrate trauma-informed principles and improve access to intergenerational mental health supports for immigrant, refugee, and all young children who have been exposed to trauma. Key opportunities include the following:

- **States can support ECEC programs in building their capacity to address mental health concerns and adopting a trauma-informed approach in their services.**

Trauma-informed strategies can be integrated into ECEC programs to mitigate the effects of trauma in a nonclinical setting with a wide reach. State policies might, for example, encourage the provision of professional development opportunities that expose ECEC professionals to evidence-based trauma-informed care practices. States can also invest in initiatives that encourage ECEC programs to connect the families they serve with other community resources that address socioemotional and mental health needs.[53] Early Head Start, home-visiting, and child-care programs can institute formal partnerships, for example, with health and mental health services.

Infant and early childhood mental health consultation (IECMHC) conducted in ECEC or other nonclinical settings has been identified as a particularly effective strategy to provide critical socioemotional supports and identify and address mental health concerns among young children.[54] As they conduct IECMHC, mental health professionals work collaboratively with ECEC professionals, pediatricians, and other service providers through techniques such as skilled observations, the strengthening of teacher-family relationships, identification of at-risk children, and the provision of referrals to additional supports.[55] States could expand IECMHC efforts using resources available through a number of federal and state funding streams, including the Child Care and Development Block Grant (CCDBG), Temporary Assistance for Needy Families (TANF), and Medicaid.[56]

Some states have already made significant strides toward integrating mental health supports into their ECEC systems. In Maryland, for example, early childhood mental health consultations are being integrated into all existing

early childhood programs including Head Start as well as family child-care providers, where many immigrant and refugee families are likely to seek and find care.[57] The Center for Infant Studies at the University of Maryland School of Medicine also provides services specifically for refugee and asylee families, such as Parenting Young Children workshops run in collaboration with a local organization serving asylum seekers to provide tailored, culturally competent support—a promising partnership that could serve as a model for similar initiatives.[58]

At the federal level, Head Start and Early Head Start Program Performance Standards require that a licensed mental health professional provide regular consultations in these programs.[59] And in 2017, the U.S. Department of Health and Human Services' Administration for Children and Families released a Resource Guide to Trauma-Informed Services that includes resources specific to early childhood and immigrants and refugees. This is intended to guide programs (including direct service programs such as Head Start, but also administrative staff in programs such as the Supplemental Nutrition Assistance Program, or SNAP) in expanding their capacity to respond sensitively to trauma and ACEs.[60]

- **States and localities can explicitly target vulnerable immigrant and refugee families in home-visiting programs and utilize models designed to address trauma and intergenerational mental health needs.**

Many states and communities are increasingly utilizing home-visiting programs as a way to effectively boost outcomes for both vulnerable young children and their families. Because parent-child relationships and interactions are central to addressing the effects of trauma among infants and toddlers,[61] home visiting represents an ideal vehicle for intervention. Research has shown dyadic interventions (those involving parents alongside their children) to be particularly effective in improving mental health outcomes, especially in families that have experienced serious trauma.[62]

However, Limited English Proficient and immigrant families are often underserved by home-visiting efforts, despite being a key target population for services.[63] Some program models, such as Baby TALK and the Parent Child Home Program (PCHP), have been shown to work successfully with immigrant, refugee, and other families who speak languages other than English at home. In particular, the Baby TALK model seeks to directly address the impacts of trauma, and has been shown in a 2018 randomized controlled trial to improve young children's socioemotional outcomes as well as to reduce maternal stress and trauma symptoms, specifically among refugee families.[64]

As many states and localities continue to invest in home-visiting initiatives, they can explore programs and models that take a culturally competent and trauma-informed approach to ensure that immigrant and refugee families are both equitably and effectively served. Incorporating such models into the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program would also leverage an important opportunity to address infant and early childhood mental health (IECMH) issues for this population.

- **States can improve guidelines for preventive screenings and diagnoses of young children's mental health. Importantly, primary care providers should be trained to recognize and address signs and symptoms of trauma in young children, and to be familiar with immigrant- and refugee-specific considerations.**

Because most young children regularly interact with the pediatric health-care system, medical professionals such as pediatricians, family doctors, and nurses are well placed to identify, treat, and prevent early childhood trauma, particularly for populations that may otherwise have difficulty accessing mental health services.[65] Given appropriate training and resources, primary care providers can offer critical connections and referrals to immigrant and refugee families to

ensure that needed interventions are identified and obtained in a timely manner. The Medical Home[66] model offers an example of team-based and coordinated primary care. This approach co-locates providers in one place, reducing the stigma related to going somewhere specifically for mental health care and reinforcing the reality that mental health is indeed a part of overall health. This model is being implemented in Maryland's Center for Global Migration and Immigrant Health, which collaborates with state and local health departments as well as refugee resettlement agencies, and conducts mental health screenings for all newly arrived refugees and asylees ages 14 and older.

Another option could be to expand HealthySteps,[67] an integrated care model supported by a strong evidence base, including a 15-site national evaluation.[68] HealthySteps specialists connect with families during well-child visits as part of primary care teams, offering screening and support for common and complex concerns that physicians often do not have the capacity to address, including feeding, behavior, sleep, attachment, trauma, depression, social determinants of health, and helping parents adapt to life with a baby or young child.

More generally, states could expand preventive screening for IECMH concerns through their Medicaid policies by requiring developmental, social-emotional, and maternal depression screenings for young children who are beneficiaries—though several states fail to do so.[69] States can also require providers to adopt diagnosis guidelines that are specifically designed for use in infancy and early childhood, such as the DC:0–5, as has been done in Minnesota, for example.[70] Such efforts are important since commonly used diagnosis tools are designed for adults and older children and may be inappropriate for use with young children.

- **The mental health field overall should seek to increase the diversity of its practitioners and bolster linguistic and cultural competency. In the meantime, immigrant- and refugee-serving agencies can act as bridges and navigators to connect families with relevant services.**

A lack of cultural competence among mental health providers can both discourage families from accessing critical services and contribute to misdiagnoses. Additionally, because interpretation services are critical to facilitating access for many immigrants and refugees, interpreters trained specifically to work in the mental health field are needed. Efforts to change the status quo can be seen at both the state and program level. The Office of Refugee and Immigrant Assistance in Washington State, for example, is training mental health providers in issues relevant to refugee families.[71] And some refugee-serving organizations, such as Catholic Charities in San Diego, CA, employ licensed therapists to offer direct counseling services and reduce cultural stigma around mental health issues.[72]

- **Refugee resettlement agencies can improve and standardize mental health screening processes and collaborate with ECEC providers to holistically address the needs of young children in refugee families.**

According to a 2012 survey, only 25 state refugee health coordinators regularly provide mental health screenings to newly arrived refugees, and 17 of these do so through informal conversations rather than standardized measures.[73] Expanding the use of culturally validated instruments such as the RHS-15 across states would increase the likelihood of refugee families receiving needed mental health supports in a timely manner. However, an appropriate tool to effectively screen children under the age of 14 is also needed in order to directly identify refugee children's mental health needs at a critical and sensitive time in their socioemotional and cognitive development.

State refugee resettlement services can also work with ECEC partners, including early learning policy and program leads and home-visiting administrators, to connect families to needed

services and address disparities in access to high-quality programs that offer socioemotional support. A Head Start pilot project established in 2011 in Arizona, for example, brings the state refugee resettlement program and local Head Start sites together in a partnership that facilitates the identification of key barriers to refugee families' access and that has improved outreach and services to increase enrollment and participation.[74]

Opportunities such as these, which would expand the quality and accessibility of infant and early childhood mental health services, can be leveraged to realize the potential of ECEC and other systems to mitigate the effects of trauma among young children in immigrant and refugee families and to disrupt trauma's intergenerational cycle.

Endnotes

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