

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**How Should Clinicians Respond to Children in Transgenerationally Traumatized Families?**

Diego Chaves-Gnecco, MD, MPH

**Abstract**

Pediatricians have obligations to respond with care to all children's clinical and social vulnerabilities. Finding and addressing causes of children's stress (ie, family separation, child abuse, and trauma) are also obligations. Preventive and rescue interventions should be implemented to address potential short- and long-term harms of toxic stress and their short- and long-term consequences.

*To claim one AMA PRA Category 1 Credit<sup>™</sup> for the CME activity associated with this article, you must do the following: (1) read this article in its entirety, (2) answer at least 80 percent of the quiz questions correctly, and (3) complete an evaluation. The quiz, evaluation, and form for claiming AMA PRA Category 1 Credit<sup>™</sup> are available through the [AMA Ed Hub<sup>™</sup>](#).*

**Case**

Dr A practices primary care in a US plains state that is home to many recent Honduran refugees. HH is an 11-year-old patient brought to the free clinic by their mother for a routine check-up. Dr A greets HH and HH's mother and interviews HH, who does not make eye contact. Dr A confirms that HH doesn't hurt anywhere, is eating well, and attends school. "Are you sleeping all right?"

HH shrugs. HH's mother states, "It has been hard on my children," and explains why the family recently fled Honduras. HH's ancestors lived on land now known as Honduras for centuries until recent political upheaval made life there intolerable. HH's father was murdered near their home. This necessitated that the remaining family members leave Honduras on foot and seek asylum by crossing through Mexico and entering the United States. At the US border, they were separated and detained for several weeks. HH's family members were each granted asylum and have been staying with cousins.

HH's mother begins to cry after saying, "I don't know what would've happened to us if we didn't have any cousins here."

HH begins to cry, too, but does not want to speak with a counselor. Dr A wonders how to respond.

## Commentary

Pediatricians have obligations to respond with care to all children's clinical and social vulnerabilities. Yet pediatricians might feel unprepared to deal with the complexity of **care for refugees and immigrants**. While providing care to HH, Dr A should address all their immediate medical needs while ensuring that all factors that affect well-being are taken into consideration, including the trauma that HH and their mother have experienced. The National Child Traumatic Stress Network (NCTSN) outlines 7 principles of trauma-informed care: (1) "Routinely screen for trauma exposure and related symptoms," given the high prevalence of trauma in children; (2) use evidence-based, culturally sensitive tools for assessment and treatment of traumatic stress and associated mental health symptoms; (3) "make resources available to children, families, and providers on trauma exposure, its impact, and treatment"; (4) "engage in efforts to strengthen the resilience and protective factors of children and families" that have been affected by trauma; (5) address trauma in both parents and caregivers and address its impact on the family; (6) "emphasize continuity of care and collaboration across child-service systems"; and (7) "maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress."<sup>1</sup> These principles are recommended as practical guidelines to ensure that clinicians recognize and **respond to the impact of trauma**. Discussion of this case considers how clinicians can recognize, assess, and respond to trauma.

## Clinical Assessment

*Trauma.* Dr A is probably aware of the high prevalence of trauma in immigrants, refugees, and children who have experienced separation from their parents.<sup>2</sup> The case relates that HH is not making eye contact. Dr A should consider several reasons for HH's lack of eye contact, including trauma and conditions such as anxiety, depression, and posttraumatic stress disorder (PTSD). Dr A appropriately asks about HH's sleep as part of the routine interview but perhaps also as a way to start assessing for HH's experience of and response to trauma. Children with any of these conditions typically present with various sleep problems: difficulties in falling asleep, middle-of-the night awakenings, difficulty falling back asleep, disruption in sleeping patterns and schedules, or oversleeping.<sup>3</sup> Dr A also assessed the child's appetite and eating patterns, as many children with emotional distress, depression, anxiety, or PTSD will present with appetite changes or disruption in eating patterns.<sup>4</sup> Dr A confirms that HH is eating well. Identifying and addressing the causes of emotional distress is an obligation for any pediatrician. Different causes must be considered, including **family separation**, child abuse, and trauma. Often, the first sign of emotional distress, anxiety, depression, or PTSD is a change in school attendance or school performance. Although in this case vignette HH is attending school, the case does not include complete information pertaining to HH's school attendance and academic performance. Also important are HH's social interactions. Does HH have friends at school? Does HH see their friends outside of school? What do they do together in their free time inside or outside of school?

HH's mother describes several stressful events that the family has endured recently, including the violent loss of HH's father, family members' need to leave their home country and pursue asylum, and the separation and detention that they experienced at the border. HH's mother cries while describing these events. While her emotional reaction is appropriate, Dr A, as a pediatrician, has to wonder whether HH's mother herself is experiencing emotional distress, depression, anxiety, or PTSD. Dr A thus should also address HH's mother's experience of trauma when addressing HH's

problems. If indicated, Dr A should refer HH's mother to a therapist and help her connect with resources that would help both her and HH. Studies have documented how the presence of trauma, emotional distress, anxiety, depression, or PTSD in parents affects the well-being of their children.<sup>5</sup> When left untreated, these conditions can undermine healthy parenting.<sup>5</sup>

*Counseling referral.* Although HH does not want to speak with a counselor, it is extremely important for the care of both HH and their mother to include behavioral support. HH might have feelings of guilt, shame, and avoidance that can make obtaining the history of trauma difficult.<sup>6</sup> HH's developmental stage and limitations in memory and language might also alter HH's capability to share details of past experiences and trauma from the death of their father, leaving their home country, crossing the border, being separated from their mother, and now adapting to a new home and a new country.<sup>7</sup> Dr A should refer HH to a therapist. Although many free clinics might not have therapists who provide counseling on-site, a reasonable recommendation is to have a list of potential local therapists who can offer services pro bono or on a sliding-scale fee. Some of these resources could be obtained through local colleges and universities or through federally qualified health centers. Therapists might employ different techniques to engage and elicit communication from children who have experienced trauma. These techniques might include play therapy, **drawing**, or reenacting. It is important to take into account that HH's distressing memories and emotions are likely to resurface when describing the traumatic events that they have endured.<sup>8</sup> Therapists and other members of the treating team should share the child's primary language or use linguistically appropriate resources (eg, certified interpreters) and developmentally appropriate techniques as well as show cultural awareness.

*Child abuse.* Consideration should always be given to the possibility of child abuse by any caregiver—in this case, by HH's mother or other adults that cared for HH while HH was separated from their mother, such as immigration officers. Red flags include, but are not limited to, lesions discovered upon physical examination, reports of physical or sexual abuse made by HH or their mother, or unexpected or unusual behaviors, such as hypersexual activity. All 50 states have laws requiring reporting of child abuse, and 46 states have criminal penalties for failure to report child abuse.<sup>9</sup>

*Persecution or torture.* Frequently, asylum cases require or include forensic evaluations.<sup>10</sup> A pediatrician can ethically undertake a **forensic evaluation**. Indeed, pediatricians are in a unique position to perform forensic asylum evaluations, as they know all the conditions of their patients and can be the best advocates for the well-being of their patients.

### **Long-Term Effects**

HH's long-term health and cognitive and physical development might be hindered by their experiences following departure from their home country, especially the mutual separation that HH and their mother endured. During the time of their separation, probably neither HH nor their mother knew if or when they would be reunited and both suffered from toxic stress. It is well established that childhood stressors, including detention and family separation, are harmful to a child's well-being and development, putting the child at lifelong risk for negative physical and mental health consequences.<sup>2,11,12,13</sup> While experiencing toxic stress, both HH and their mother were, and might still be, in survival mode. Their brains and bodies are fixated on ensuring immediate survival. HH, as a child, is especially vulnerable to the effects of toxic stress

because he is still undergoing major brain development. As HH experiences toxic stress, survival takes priority over other normal childhood activities, such as cognitive development and physical growth. The trauma that HH experienced while being separated from their mother most likely has neurodevelopmental sequelae. During toxic stress, stress hormones affect the development of critical synapses and neurological connections that are essential to child development, learning, academic performance, and emotional maturation. The neurodevelopmental sequelae of toxic stress have physical and mental health implications that might be lifelong.<sup>11</sup>

### Conclusion

HH and their mother's situation is quite complex. Treating their basic medical and mental health needs requires triaging the appropriate resources. In assessing asylees' social environment, needs, and current support, clinicians must evaluate their trauma symptoms while taking into account their capacity for emotional regulation.<sup>8</sup> Dr A should consider involving an interdisciplinary or a multidisciplinary team to address HH's and HH's mother's needs. While the involvement of such a team is not necessarily an ethical obligation, it certainly helps in fulfilling the ethical obligation to promote the well-being and best possible care of the patient. An ideal team might include behavioral therapists, social workers, other mental health care professionals (eg, developmental behavioral pediatricians, child psychiatrists) as well as schoolteachers and counselors, community advocacy leaders, and immigration lawyers. In the case vignette, Dr A might believe that referral is necessary to address HH's and their mother's needs—in particular, those related to traumatic stress or its exacerbation by [asylum interviews](#).<sup>8</sup> Dr A and all health care professionals, especially pediatricians caring for children and families who have experienced situations similar to those of HH and their mother, can access helpful information through the NCTSN.<sup>14</sup> Although pediatricians and other health care professionals might perceive themselves as ill prepared to address the unmet needs of immigrant families, they have the resources and they have the moral and ethical obligation to identify these needs and refer patients to the proper resources. Pediatricians and all health professionals also have obligations to advocate for their patients and encourage local, state, and federal appropriation of resources to improve conditions in care settings for immigrant and refugee patients.

### References

1. Creating trauma-informed systems. National Child Traumatic Stress Network. Accessed August 3, 2020. <http://www.nctsn.org/resources/topics/creating-trauma-informed-systems>
2. MacLean SA, Agyeman PO, Walther J, Singer EK, Baranowski KA, Katz CL. Mental health of children held at a United States immigration detention center. *Soc Sci Med*. 2019;230:303-308.
3. Keeshin BR, Berkowitz SJ, Pynoos RS. Pediatrician's practical approach to sleep disturbances in children who have experienced trauma. *Pediatr Ann*. 2019;48(7):e280-e285.
4. Runyon MK, Faust J, Orvaschel H. Differential symptom pattern of post-traumatic stress disorder (PTSD) in maltreated children with and without concurrent depression. *Child Abuse Negl*. 2002;26(1):39-53.
5. England MJ, Sim LJ, eds; Committee on Depression, Parenting Practices, and the Healthy Development of Children, National Research Council and Institute of Medicine. Associations between depression in parents and parenting, child health, and child psychological functioning. In: *Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and*

*Prevention*. National Academies Press; 2009:chap 4. Accessed August 3, 2020. <https://www.ncbi.nlm.nih.gov/books/NBK215128/>

6. Cohen JA, Kelleher KJ, Mannarino AP. Identifying, treating, and referring traumatized children: the role of pediatric providers. *Arch Pediatr Adolesc Med*. 2008;162(5):447-452.
7. Tedeschi FK, Billick SB. Pediatric PTSD: clinical, forensic, and diagnostic understanding. *J Am Acad Psychiatry Law*. 2017;45(2):161-169.
8. Schock K, Rosner R, Knaevelsrud C. Impact of asylum interviews on the mental health of traumatized asylum seekers. *Eur J Psychotraumatol*. 2015;6:26286.
9. Geiderman JM, Marco CA. Mandatory and permissive reporting laws: obligations, challenges, moral dilemmas, and opportunities. *JACEP Open*. 2020;1(1):38-45.
10. Gartland MG, Hidalgo JA, Danaher FS. Case 20-2020: a 7-year-old girl with severe psychological distress after family separation. *N Engl J Med*. 2020;382(26):2557-2565.
11. Shonkoff JP, Garner AS, Siegel BS, et al; Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129(1):e232-e246.
12. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(3):174-186.
13. Linton JM, Griffin M, Shapiro AJ; Council on Community Pediatrics. Detention of immigrant children. *Pediatrics*. 2017;139(5):e20170483.
14. National Child Traumatic Stress Network. Traumatic separation and refugee and immigrant children: tips for current caregivers. Accessed October 28, 2020. [https://www.nctsn.org/sites/default/files/resources/tip-sheet/traumatic\\_separation\\_refugee\\_immigrant\\_children\\_tips\\_current\\_caregivers.pdf](https://www.nctsn.org/sites/default/files/resources/tip-sheet/traumatic_separation_refugee_immigrant_children_tips_current_caregivers.pdf)

**Diego Chaves-Gnecco, MD, MPH** is a developmental-behavioral pediatrician and an associate professor in the Department of Pediatrics at the University of Pittsburgh School of Medicine in Pennsylvania. He is also the program director and founder of Salud Para Niños, the first bilingual bicultural clinic in southwestern Pennsylvania. One of his primary interests is providing care for Hispanic/Latino children.

**Editor's Note**

The case to which this commentary is a response was developed by the editorial staff.

**Citation**

*AMA J Ethics.* 2021;23(6):E465-470.

**DOI**

10.1001/amajethics.2021.465.

**Conflict of Interest Disclosure**

The author(s) had no conflicts of interest to disclose.

*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*