Investigating the Mental Health Needs of Unaccompanied Immigrant Children in Removal Proceedings: A Mixed Methods Study

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ABSTRACT

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In recent years there has been a dramatic increase in the number of children migrating to the United States without a parent. In Fiscal Year 2014 alone, U.S. immigration authorities apprehended and detained almost 70,000 unaccompanied children, compared to less than 9,000 in 2010. This rapid rise has been fueled primarily by children arriving from Central America, one of the world’s most violent regions. The available literature on unaccompanied children in the United States suggests that they are a vulnerable and underserved population, who are at risk for repeated exposure to extreme psychosocial adversities at every stage of their migration and frequently face many of these challenges alone. However, to date there has been little formal study of their mental health needs.

The aim of this exploratory study was to obtain initial data regarding the psychosocial context, mental health presentation, and mental health service utilization of unaccompanied children released to guardians in the community pending immigration hearings to determine their eligibility to remain in the United States. The study employed a mixed methodology combining qualitative and quantitative data. The sample comprised 26 unaccompanied children and their guardians residing in the New York City metro area, interviewed between September 2013 and December 2014.
Results showed that children in our sample had complex reasons for migration, frequently combining push factors such as fleeing gang violence and pull factors such as a desire for reunification with parents in the United States after long separations. Most had been exposed repeatedly to extreme psychosocial stressors prior to and during their migration, including almost two-thirds who had witnessed violence, serious injury, or death and over one-third who had witnessed domestic abuse or had been physically abused themselves. However, children also described benefitting from an array of supports that protected against stressors and promoted their wellbeing, and in their narratives they emphasized overcoming adversity rather than victimization.

On a structured mental health diagnostic interview, the majority of children met criteria for one or more past-year anxiety and depressive disorders. Few received diagnoses for behavioral problems. Compared against these data, child-report measures screened more effectively for internalizing disorder diagnoses and guardian-report measures screened more effectively for externalizing disorder diagnoses. Despite the high rates of diagnosable disorders in the sample, most children appeared to be functioning well in family, social, and educational domains. No children were receiving formal mental health services at the time of their study interview, although several were being monitored by school counselors.

Children presenting with mental health concerns were provided with referrals to mental health treatment services and contacted for a brief telephone follow-up interview three months later. At follow-up, a number of children had received counseling. Availability of school counselors and referral to therapists in the community through pediatricians were the primary facilitators of service access. Lack of knowledge of available, Spanish-speaking services and cost of treatment were common obstacles to seeking treatment. Some children and their guardians did
not perceive a need for services, and most of these children appeared to be functioning well at follow-up.

This study was designed to be largely descriptive and to provide data to inform future, theory-driven research. In the discussion section, social ecological models of risk and resilience and Hobfoll’s Conservation of Resources theory are presented as potential paradigms for understanding unaccompanied children’s migration processes, with stressors and supportive factors interacting across systemic levels and over time to determine children’s access to resources and their mental health, functioning, and wellbeing. Finally, the implications of the study’s findings for future research, psychosocial intervention, and rights-based advocacy with unaccompanied children are considered.
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ABBREVIATIONS

A&A: Adaptation and Attitude questionnaire
CBCL: Child Behavior Checklist
CBP: United States Customs and Border Protection
COR: Conservation of Resources theory
DACA: Deferred Action for Childhood Arrivals
DISC-IV: Diagnostic Interview Schedule for Children Version IV
DHS: United States Department of Homeland Security
DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
FY: Fiscal Year
HHS: United States Department of Health and Human Services
HSCL-37A: Hopkins Symptom Checklist for Adolescents
LOPC: Legal Orientation Program for Custodians
NYC: New York City
ORR: United States Office of Refugee Resettlement
PAR: participatory action research
PRS: post-release services
PTSD: posttraumatic stress disorder
RATS: Reactions of Adolescents to Traumatic Stress questionnaire
SAD: separation anxiety disorder
SIJS: Special Immigrant Juvenile Status
SLE: Stressful Life Events questionnaire

TVPRA: William Wilberforce Trafficking Victims Protection Reauthorization Act

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations Children’s Fund
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DEDICATION

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“Well, as they say, when one is an immigrant, one always has a story. Each person has a story to tell of how he or she got here. Each story is very different.”

17-year-old Guatemalan boy and study participant
CHAPTER I:
INTRODUCTION

The overarching aim of this study was to investigate the mental health needs of a sample of unaccompanied immigrant children ages 10 to 18 who were living in the New York City (NYC) metro area. These were children and adolescents who had migrated to the United States without a parent, had been apprehended and detained by U.S. immigration authorities, and then had been temporarily released to guardians in the community while awaiting immigration hearings to determine whether they would be allowed to stay in the United States or deported to their countries of origin.

The number of unaccompanied children migrating to the United States has been increasing slowly for decades. However, in recent years there has been an escalation in the gang violence and insecurity that have long afflicted Central America, and the Northern Triangle region comprising El Salvador, Guatemala, and Honduras has become one of the deadliest areas in the world. This coincided with a more than 400% rise in the number of unaccompanied children apprehended along the U.S.-Mexican border in the three-year period from 2011 to 2014, when almost 70,000 unaccompanied children were detained (CBP, 2016). This crisis, frequently referred to as “the surge,” has brought the plight of unaccompanied children to national attention, and made their situation a matter of urgent legal, political, and public health significance. A 2014 study by the United Nations High Commissioner for Refugees (UNHCR) indicated that the majority of unaccompanied children surveyed were likely eligible for refugee status or other forms of international protection (UNHCR, 2014). Meanwhile, the volume of children arriving has compromised the ability of the government to balance its enforcement and protection roles,
resulting in massive overcrowding and poor conditions in immigration detention facilities, long delays in processing of children’s claims for immigration relief, and challenges to whether overwhelmed courts are providing due process. The child migrant crisis has also contributed to an already divisive popular and political debate about migration in the United States and thus created additional challenges to the integration and acculturation of unaccompanied children into local communities (Rosenblum, 2015).

The vulnerable legal and emotional status of unaccompanied children and their families and their frequent wariness of official institutions make them a challenging group both to help and to study. The available literature has largely focused on children’s reasons for coming to the United States (e.g., Kennedy, 2014; UNHCR, 2014), stressors endured during their migration process (e.g., Bhabha & Schmidt, 2006; Chavez & Menjívar, 2010), the adverse impact of prolonged detention in immigration facilities (e.g., Bhabha & Schmidt, 2006; Women’s Refugee Commission, 2002, 2009), and the legal challenges faced by these youth (e.g., Byrne & Miller, 2012; Nafziger, 2006). Much of this work has taken the form of policy papers (e.g., Rosenblum, 2015) and briefs by legal advocacy groups (e.g., American Immigration Council, 2015). Together, it suggests that unaccompanied children are a unique and vulnerable population of youth. They are vulnerable to severe stressors at every stage of their migration: in their countries of origin, while traveling to the United States, following apprehension by immigration authorities, and during immigration proceedings. They frequently encounter these stressors with limited familial support and without access to the other protective resources (e.g., schooling and health care) that a stable, secure home life brings. Furthermore, their acculturation process in the United States is complicated by the possibility that they may ultimately be deported. However,
there has been little empirical research to date on the mental health needs of unaccompanied children.

This dissertation is the latest project in a research collaboration with Schuyler Henderson, a psychiatrist at Bellevue Hospital, addressing the needs of unaccompanied children in the NYC area. Several years ago, Dr. Henderson and I were contacted by local lawyers who were looking for mental health providers to give expert psychological testimony in support of children’s immigration cases and to provide counseling for children who were struggling to acculturate following difficult pre-migration and migration experiences. These lawyers consistently reported mental health concerns about a high proportion of their unaccompanied child clients and a scarcity of appropriate, accessible psychosocial services. In addition to providing individual referrals, we wanted to understand and address these children’s needs at a broader, systemic level. In 2010, we wrote a literature review mapping out unaccompanied children’s psychosocial context (Baily, Henderson, Ricks, Taub, & Verdeli, 2011). Then, in 2011, we conducted a survey of NYC lawyers inquiring about their perceptions of the mental health needs of their unaccompanied child clients and their referral practices with these children (Baily, Henderson, Taub, O’Shea, Einhorn, & Verdeli, 2014). Given the vulnerability of unaccompanied children, and with the principles of beneficence and nonmaleficence (American Psychological Association [APA], 2010) in mind, this anonymous survey of stakeholders seemed the most ethical starting point for our research.

Lawyers surveyed in our study reported high rates of distress in their unaccompanied child clients following frequently harrowing childhood and migration experiences. They often took on a broad advocacy role to compensate for these clients’ lack of other psychosocial supports. Within this, they frequently sought psychological assistance for the children but in
general they had great difficulty accessing needed services (Baily et al., 2014). We used these findings to provide training to lawyers on identifying distress in migrant youth, interviewing children with trauma histories, and accessing mental health services. Overall, the study confirmed a considerable gap between a high percentage of unaccompanied children in distress and a lack of resources to help them; it also suggested that lawyers’ role in supporting unaccompanied children’s rights and wellbeing would need to be part of a broader, interdisciplinary approach. The high levels of unmet need identified in the study also indicated that more involved research with unaccompanied children and their caregivers was warranted.

New York has one of the highest populations of unaccompanied children in the country, with 5,683 children released in Fiscal Year (FY) 2014 to sponsors in the downstate area alone (Feerick Center & Vera, 2015). Our research on their mental health needs has been one small part of a wider effort by researchers, lawyers, social workers, and other stakeholders involved in their care to better understand, serve, and advocate for local unaccompanied children. In 2014, NYC established an interagency taskforce to coordinate educational, healthcare, legal, and social services for unaccompanied youth in the city (NYC Office of the Mayor, 2014). In 2015, Fordham Law School’s Feerick Center for Social Justice and the Vera Institute of Justice, a research and policy advocacy organization, published a qualitative study investigating the circumstances and ongoing challenges accessing needed resources experienced by unaccompanied youth in the NYC metropolitan area. Although all the youth participants had traveled to the United States before the age of 18, the study recruited a broad range of adolescents and young adults ages 15 to 24, with varying living situations, legal statuses, and number of years in the country. The major challenges identified were isolation, painful separations and lack of familial support, identity issues arising from their unauthorized legal
status, and experiences of discrimination and stereotyping. These youth also often had difficulty enrolling in school, finding housing, acquiring healthcare, and obtaining legal assistance. However, despite vulnerabilities, many exhibited strong coping and resourcefulness and were continuing to move forward in their lives (Feerick Center & Vera, 2015).

The current study aims to contribute to this growing body of research. Unlike prior research, it focused specifically on unaccompanied children released from government detention to sponsors in the NYC area while awaiting adjudication of their immigration cases. In contrast with previous studies, it used a mixed methodology combining quantitative and qualitative data. In this way, we sought to obtain a broad, multifaceted, and integrated view of the psychosocial context, mental health needs, and mental health service utilization of unaccompanied children living in the community in NYC. Between September 2013 and December 2014, a period which saw the height of the Central American child migrant crisis, 26 unaccompanied children and their guardians were interviewed. (Whereas sponsor is the official term used by the government for adults who assume temporary custody of unaccompanied children in the community pending children’s immigration cases, for the purposes of this dissertation it is typically replaced with the less formal guardian). Participants completed child- and caregiver-report mental health screening measures, a semi-structured narrative interview, a structured diagnostic interview, an autoethnographic journal, and (for the subsample referred to mental health services) a telephone follow-up interview. The study findings were intended to be used as pilot data to help: generate future research on risk and resilience processes in unaccompanied children; inform the ongoing development of a feasible, acceptable, and cohesive infrastructure of psychosocial resources for unaccompanied children in NYC; and identify areas for rights-based advocacy.
CHAPTER II:
BACKGROUND AND LITERATURE REVIEW

The Legal Context of Unaccompanied Children in the United States

Section 6 U.S.C. § 279(g)(2) of the Homeland Security Act of 2002 defined an
unaccompanied alien child as any child or adolescent under the age of 18 who is in the United
States without lawful immigration status and who does not have a parent or other legal guardian
present to provide custody (Haddal, 2007). The definition includes children with a range of
immigration situations, to include asylum seekers, recognized refugees, and other externally
displaced people (Shah, 2005). In the academic literature in the United States and abroad,
unaccompanied children have been categorized variously as “unaccompanied refugee minors,”
“juvenile asylum seekers,” “juvenile aliens,” “separated aliens,” “refugee children,”
“unaccompanied minors,” and “unaccompanied youth” (Baily et al., 2011). These variations
underscore the wide array of legal policies, political attitudes, and social contexts
unaccompanied children encounter in different countries and at different stages of their migration
process (Chavez & Menjívar, 2010). Within the U.S. immigration system, the designation
unaccompanied alien child is applied to any child who does not have a parent or legal guardian
with them at the time of their apprehension (Byrne & Miller, 2012).

There is an inherent conflict of interest between the U.S. government’s immigration
enforcement and child protection roles (Baily et al., 2011; Rosenblum, 2015; Women’s Refugee
Commission, 2009). The past 30 years have seen a series of legislative and organizational
changes to address this tension. Starting in the 1980s, a decade of litigation against the
government for detaining unaccompanied children in poor conditions culminated in 1997 in the
Flores Settlement Agreement, which stipulated that unaccompanied children be released “without unnecessary delay” to “the least restrictive setting appropriate” (typically the closest available adult relative in the community) and provided standards for the treatment of unaccompanied children in immigration detention (Byrne & Miller, 2012; U.S. Department of Health and Human Services [HHS]), 2008; Lutheran Immigration and Refugee Service, Women’s Refugee Commission, & Kids in Need of Defense, 2014).

Following the passage of the Homeland Security Act in 2002, responsibility for detained children was transferred away from the government’s immigration enforcement arm (represented by three agencies within the U.S. Department of Homeland Security [DHS]: Customs and Border Protection [CBP], Immigration and Customs Enforcement [ICE], and U.S. Citizenship and Immigration Services [USCIS]) to the Office of Refugee Resettlement (ORR) within the U.S. Department of Health and Human Services (HHS). ORR then created the Division of Unaccompanied Children’s Services (DUCS) to attend specifically to the needs of unaccompanied children within its agency (Byrne & Miller, 2012). The 2008, the William Wilberforce Trafficking Victims Protection Reauthorization Act (TVPRA) strengthened protections available to unaccompanied children including limiting children’s detention in DHS custody to 72 hours, non-adversarial adjudication of many children’s cases, and safe repatriation for children ordered to be deported (Byrne & Miller, 2012). Another important consequence of these expanding provisions and the separation of the government’s prosecutorial and caretaking roles is that children may be released from detention to family members regardless of the relative’s immigration status (Rosenblum, 2015).

One of the repercussions of these legislative and structural changes is that unaccompanied children undergo a complex and frequently disjointed immigration process. Children follow
different pathways through the system based on whether they are accompanied by a legally responsible adult, their country of origin, age, perceived flight risk, and the availability of an appropriate sponsor in the community. Whereas unaccompanied youths from contiguous countries (i.e., Mexico and Canada) or those over the age of 18 are typically deported quickly to their home countries following an interview from a Customs and Border Protection immigration agent to determine rights to protection, for unaccompanied children from further afield the government assumes a duty of care pending more thorough adjudication of their right to immigration relief (Rosenblum, 2015). At this point, children are transferred from the CBP facilities where they are detained immediately after apprehension to ORR-funded facilities with varying levels of security and service provision depending on the child’s history and perceived needs. ORR case workers then initiate the process of finding and releasing children to the least restrictive appropriate setting. Ideally, children are placed in the community with parents, other adult relatives (e.g., brothers, sisters, aunts, uncles, and grandparents), or a non-family-member designated by the child’s parent or legal guardian. In cases where suitable sponsors are not available or release to the community is otherwise deemed inappropriate to the child’s needs, children may remain in ORR custody in long-term foster care, extended-care group homes, or residential or staff-secure treatment programs (Byrne & Miller, 2012). However, between 2008 and 2014, the government increased the proportion of children placed with sponsors in the community from approximately 56 to 85% (Graham, 2014).

The children recruited for this study shared the most common and, generally speaking, preferred set of circumstances for unaccompanied children’s passage through the immigration system: they had been apprehended by CBP, identified as unaccompanied, transferred to ORR custody, and then released to guardians in the community. A simplified version of their
immigration process is presented in Figure 1. (For a more comprehensive diagram of children’s flow through the U.S. immigration system, see the 2012 report by Byrne and Miller.)

**Figure 1.** Typical flow of unaccompanied children through U.S. immigration system (simplified).

In addition to improving the treatment of unaccompanied children as they move through the immigration system, legislation over the last 25 years has expanded the forms of immigration relief available to them. The Immigration Act of 1990 created a new form of immigration petition called Special Immigrant Juvenile Status (SIJS) with broader grounds for relief based on abuse, abandonment, or neglect and consideration of the best interests of the child (Byrne, 2008).
SIJS has become the most common form of immigration petition sought for unaccompanied children, with a high rate of successful claims (Shah, 2005). Some children may also be eligible for Refugee Status, U-visas as victims of crime, or T-visas as victims of trafficking (Byrne & Miller, 2012). Unlike criminal defendants, immigration petitioners do not have a right to appointed counsel under U.S. law, and this can have a significant bearing on cases. While acknowledging that children with more compelling claims for immigration relief may be more likely to seek out and obtain legal representation, it remains striking that between FY 2012 and FY 14, 85% of unaccompanied children without legal representation in their court cases were deported, compared to just 27% of children with lawyers (Transactional Records Access Clearinghouse [TRAC], 2014). Recognizing this gap, the 2008 TVPRA bill mandated that children be provided with pro-bono legal representation whenever possible (Byrne & Miller, 2012). Legal advocacy programs from national nonprofit organizations such as Legal Aid and Catholic Charities and immigration clinics within law schools provide free representation to unaccompanied children and train and supervise other attorneys who offer to take on children’s cases pro bono as part of their practice. Since 2005, ORR has contracted with the Vera Institute of Justice to recruit, train, and mentor pro-bono attorneys and in 2008 Kids in Need of Defense (KIND) was founded to further expand legal advocacy for unaccompanied youth (Baily et al., 2011; Byrne & Miller, 2012). However, despite efforts to improve access to counsel, as of October 2014 less than a third of unaccompanied children presenting in immigration court had access to legal representation (TRAC, 2014). Whereas there are dedicated legal services programs for the minority of unaccompanied children who remain in ORR facilities, those who have been released to the community often particularly struggle to find attorneys (Byrne & Miller, 2012). Some
judges concerned that children may not receive due process without representation delay hearings until a lawyer has been found, but this has created increased backlog and pressure on the judicial system (Rosenblum, 2015).

The Historical Context of Unaccompanied Child Migration from Central America and the Child Migrant Crisis of 2012 to 2014

Before 2010, the great majority of unaccompanied children apprehended by U.S. immigration authorities were Mexican youth. Rather than being detained by ORR pending processing of potential immigration claims, most were placed in expedited removal proceedings and deported without appearing before an immigration judge. For example, although the total numbers of children apprehended by CBP in FY 2004, 2005 and 2006 were 109,494, 114,563, and 101,952, the numbers detained as unaccompanied children and transferred to the care of the Office of Refugee Resettlement were 6,200, 7,787, and 7,746 (Haddal, 2007). Nevertheless, over time there was a gradual rise in the number of unaccompanied children detained, from less than 5,000 in 2003 to over 8,000 in 2010 (Graham, 2014). This was primarily due to the steadily increasing numbers of unaccompanied children from El Salvador, Guatemala, and Honduras (who are not subject to the same expedited removal procedures as Mexican youth) arriving at the border.

Between 2011 and 2014, the number of unaccompanied children apprehended by CBP rose hugely, from 16,056 in FY 2011 (CBP, 2013) to 68,631 in FY 2014 (CBP, 2014). The vast majority of these children were migrating from Latin America, with 68,541 of the apprehensions in FY 2016 occurring along the southwest border (CBP, 2016). This surge was due to a rapid rise in arrivals of unaccompanied children from El Salvador, Guatemala, and Honduras, from 3,933 children apprehended in FY 2011 to 51,705 in FY 2014. By comparison, the number of
unaccompanied children from Mexico fluctuated up and down between approximately 12,000 and 18,000 arrivals annually (CBP, 2016). The increase in the proportion of non-Mexican children apprehended led to a corresponding increase in the number of children transferred to ORR, from 13,625 in FY 2012, to 57,496 in FY 2014 (ORR, 2016d). The surge was also associated with other demographic changes among unaccompanied children: between FY 2009 to 2010 and FY 2014, the proportion of female unaccompanied children in ORR custody rose from 27% to 34% and the proportion under the age of 15 rose from 27% to 37% (ORR, 2016d). The increase in arrivals of unaccompanied children also coincided with a dramatic rise in the number of families apprehended at the Southwest border, from 14,855 family apprehensions in FY 2013 to 68,445 in FY 2014 (CBP, 2016). However, these increases in unaccompanied child and family apprehensions contrast dramatically with a large overall decline in unauthorized migration to the United States: in FY 2000, U.S. immigration authorities apprehended a total of 1,676,438 unauthorized migrants, compared to 486,651 in FY 2014 (CBP, 2013, 2014). An unknown number of unaccompanied children enter the country undetected each year, a population about whom very little is known (Byrne, 2008).

**Historical origins.** The migration of unaccompanied children from Central America to the United States has its origins in the longstanding violence and poverty of the region (Eguizábal, Ingram, Curtis, Korthuis, Olson, & Phillips, 2015; Rosenblum, 2015). The civil wars fought there in the 1970s and 1980s destroyed the region’s economy, weakened civil institutions, left a heavily armed population, and initiated family separations as many adults migrated to the United States to work and send money to support family at home. The region was further weakened by the growth of criminal organizations, such as the notorious Salvadoran gang *Mara Salvatrucha* (also known as *MS-13*), that established themselves after thousands of gang
members were deported from the United States. Frequently they targeted children, capitalizing on the familial and community fragmentation caused by mass migration and on weak and corrupt local governance to terrorize neighborhoods with impunity. This prompted additional emigration, further damaging the economy and social order. Young people, in particular, were left with few educational and employment opportunities. Even among Central Americans who are able to find work, a third earn less than $4 daily (Rosenblum, 2015). By 2012, one in five Salvadorans and one in 15 Guatemalans and Hondurans were living in the United States (Rosenblum, 2015). However, most Central Americans in the United States are undocumented or have a form of time-limited immigration relief known as Temporary Protected Status, and in either case they are not eligible to sponsor family members to come to the United States legally. For unaccompanied children hoping to reunite with parents, unauthorized migration is typically the only option (Rosenblum, 2015).

**Reasons for the recent child migrant crisis.** The surge in unaccompanied child migration over the last few years has corresponded with the violence in Central America reaching new extremes. Transnational drug cartels, such as the Zetas, have taken hold in the Northern Triangle countries as their activities in the United States, Caribbean, and Mexico have been curtailed. The making and breaking of several large-scale gang truces has led to further instability and violence, and the 2009 coup in Honduras severely weakened the country’s ability to prevent and prosecute crime. These factors coincided such that, by 2013, Honduras, El Salvador, and Guatemala had the highest, fourth highest, and fifth highest rates of intentional homicide in the world (United Nations Office on Drugs and Crime, 2013). For some families hoping to reunite in the United State at some point but wary of the dangerous journey north, the risk calculus met a tipping point. Sensing a business opportunity, ever more professional
smugglers started offering services to deliver children from their home communities the whole way to family members in the United States, ensuring safe passage (by paying off Mexican officials or working with gangs) for fees frequently upwards of $5,000 per child (Rosenblum, 2015).

The extent to which U.S. immigration policy with respect to unaccompanied children and their families may have contributed to the child migrant crisis is a matter of some debate. Paradoxically, stricter immigration enforcement measures such as aggressive U.S. deportation practices and increased U.S.-Mexican border security may be one factor, disrupting the pattern of circular migration whereby Mexicans and Central Americans come and go to the United States seasonally for work. This may have caused unanticipated separations, leading parents to send for their children rather than returning home to them (Androff, 2016). In addition, critics of the Obama administration have suggested that the creation of “pro-immigrant” policies such as the Deferred Action for Childhood Arrivals (DACA) program may have encouraged more children to come, although the beginnings of the surge predated DACA and this program does not assist any child arriving in the United States after 2006 (American Immigration Council, 2015).

However, smugglers keen for customers appear to have deliberately spread rumors that the United States was giving _permisos_ (granting amnesty) to children to stay in the United States (Androff, 2016). Unaccompanied children’s release from custody to family members in the United States pending court dates that were often delayed for years may have contributed to the belief in many Central American communities that children were being allowed to stay in the country indefinitely (Rosenblum, 2015). The additional pressure placed on the U.S. immigration system by increased arrivals, leading to ever longer wait times, may have served as a catalyst for still further arrivals.
Two large studies completed during the child migrant crisis (Kennedy, 2014; UNHCR, 2014) asked unaccompanied children themselves their reasons for migrating to the United States. From May to August 2013, UNHCR interviewed 404 unaccompanied children from El Salvador, Guatemala, Honduras, and Mexico detained in ORR custody. Some differences were noted by country, but overall 81.4% reported migrating to reunify with family and have better opportunities, 47.5% due to societal violence, 21.0% because of abuse in the home, and 15.8% as a result of poverty and social exclusion. The study noted only one instance of a child reporting the possibility of benefitting from immigration reform among the reasons for migration (UNHCR, 2014). The authors estimated that 58% of the children had been forcibly displaced for reasons that would likely qualify them for international protection (UNHCR, 2014), building on data from a 2012 government-sponsored project suggesting that 42% of unaccompanied children surveyed in FY 2011 might be eligible for relief (ORR, 2012).

From January to May 2014, Kennedy (2014) interviewed 322 children who had been deported from Mexico back to El Salvador while attempting to migrate to the United States. The most common reason for migration provided was escape from crime, gang threats, and violence, reported by 59.7% of responders. Other, often-overlapping, reasons given (reported in Graham, 2014) included family reunification (35.9%), study (31.7%), work (26.7%), poverty (5.4%), abuse (3.2%), and adventure (3.2%). Noting the low reporting of abuse compared to other recent studies (Kids in Need of Defense [KIND], 2013; UNHCR, 2014), Kennedy hypothesized that presence of a caregiver during interviews may have inhibited some children from citing this as a reason for migration. A common theme of these studies was that most children had multiple reasons for coming to the United States, in many cases blurring the distinction between migration due to protection-related concerns that might qualify children for immigration relief.
(e.g., violence inside or outside the home) and migration for non-protection-eligible reasons (e.g., desire for family reunification, to work, and to study).

The majority of children who participated in our study migrated to the United States at the height of the surge in FY 2014. Of the 68,651 unaccompanied children apprehended at the U.S.-Mexican border that year (CBP, 2016), 57,496 were referred to ORR (HHS, 2016a). After placements in ORR facilities averaging 35 days, 85% were referred to family members, of whom about 75% were parents (Graham, 2014). Nationwide, over 60% of immigration cases initiated at the beginning of FY 2014 had not been resolved almost two years later (Pierce, 2015).

**Psychosocial Stressors Associated with Unaccompanied Child Migration**

Although it is the recent migrant crisis that has brought unaccompanied children into the national spotlight, over the past 20 years a growing body of research has documented their situation. This research has tended to focus on the psychosocial stressors faced by unaccompanied children, highlighting the triple risk faced by unaccompanied children (Baily et al. 2011): they are at elevated risk of exposure to extreme psychosocial adversities at every stage of the migration process, even compared to other immigrants populations (Bean, Derluyn, Eureligns-Bontekoe, Broekaert, & Spinhoven, 2007a; Hodes, Jagdev, Chandra, & Cunniff, 2008); they frequently confront these stressors without the support of parents and other loved ones (Bhabha & Schmidt; 2006); and following arrival in the United States, the uncertainty and instability caused by their unsettled legal status may exacerbate the impact of traumas experienced throughout their migration and impede their acculturation process (Derluyn & Broekaert, 2008). In keeping with the broader literature on psychosocial stressors associated with migration (e.g., Lustig et al., 2004; Pumarienga & Rothe, 2010), the unaccompanied child
literature has supported a phasic model of migration with each stage of the migration process presenting distinct vulnerabilities, challenges, and experiences.

**Pre-migration stressors.** During the long periods of civil war in Central America, children frequently witnessed violence and were separated from family members, forcibly recruited into military or paramilitary organizations, and forced to flee from their homes (Chavez & Menjívar, 2010; Locke, Southwick, McCloskey, & Fernández-Esquer, 1996). Although these wars have now largely come to an end, they have left a legacy of social and political turmoil that disproportionately affects children. Military and paramilitary organizations have been replaced by gangs that terrorize communities throughout the region (Dalrymple, 2006; Hiskey, Malone, & Orcés, 2014). They recruit children starting from early adolescence, frequently exposing new members to violent initiations, including, for females, sexual violence (American Immigration Council, 2015). Children who refuse to join risk continued harassment, robbery, rape, and even their lives (Bhabha & Schmidt, 2006; UNHCR, 2014). Ill-equipped and sometimes corrupt law enforcement agencies offer communities little protection (Hiskey et al., 2014).

The under-resourced communities in which Central America’s gangs flourish present many other stressors for children and families. High levels of poverty lead to high rates of malnutrition and infectious disease, limited access to health services, inadequate schools, and high dropout rates as children are compelled by economic necessity to go out to work (Kennedy, 2014; Stark, Shapiro, Muñiz de la Peña, & Ajl, 2015). Frequently lethal natural disasters displace many families and put a further strain on economic, health, and social resources (Chavez & Menjívar, 2010). The poverty of the region and limited work opportunities have also compelled many parents to separate them from their children and go to the United States to earn money they can send home to support their families (Rosenblum, 2015). These long separations, with no
fixed endpoint, are a stressor in and of themselves. However, they also leave children at increased risk for abuse, neglect, abandonment, exploitation, prostitution, and trafficking as they are passed to different family members or left to fend for themselves (Bhabha & Schmidt, 2006; Chavez & Menjívar, 2010; UNHCR; 2014).

**Journey stressors.** Unaccompanied children traveling from Central America to the United States face a journey fraught with dangers. As immigration controls have tightened, coyotes (people smugglers) are increasingly being hired to bring children to the United States, placing children at risk of abuse and physical and sexual exploitation (Bhabha & Schmidt, 2006; Fazel & Stein, 2002). Girls, in particular, are at heightened risk for rape and sex trafficking (Jones & Podkul, 2012; Stark et al., 2015). In addition, many of the region’s most notorious drug gangs have expanded their operations to people smuggling. They patrol the road and rail routes north threatening children and demanding money, whether they are traveling with coyotes or on their own. Gangs also frequently kidnap and hold children for ransom in “safe houses,” demanding large sums of money from their families for the children’s release (Chavez & Menjívar, 2010; Stark et al., 2015; United Nations Children’s Fund [UNICEF], 2016). Children are also at risk of being seized by Mexican authorities. In some cases, this results in children being deported to their home countries. In other instances, corrupt officials threaten or assault children and demand bribes to let them continue on their journeys (Casillas, 2006; Seugling, 2004).

The journey also poses physical risks. The poorest children (those whose families cannot afford a coyote or who have undertaken the journey unannounced) typically travel north on the freight trains known collectively as *la bestia* (the beast). Holding on to the roof, sides, or undercarriage of trains, they are at danger of following off, and accidents in which people lose
limbs or even die are common (Chavez & Menjívar, 2010). Children who have paid for safe passage may nevertheless be housed in squalid conditions and poorly fed by unscrupulous coyotes, interested only in making as much profit as possible (Hagan, 2008). Depending on the time of year, children may be in danger of drowning while crossing rivers and they are at risk of death through exposure in the hot deserts of Mexico and the southern United States (Eschbach, Hagan, Rodriguez, Hernandez-Leon, & Bailey, 1999).

**Apprehension and detention stressors.** After their long and dangerous journeys, apprehension and detention by U.S. immigration can also be very stressful. While some children give themselves up voluntarily in anticipation of being sent on to their families, many assume that if caught they will be sent back to their home countries. This leads many children to attempt to evade arrest, and can lead to terrifying experiences such as being pursued through the bush by authorities and being physically restrained by officials. Children’s capture is often followed by anxiety and despair about anticipated deportation (Bhabha & Schmidt, 2006).

Following apprehension by Customs and Border Protection officials and identification as being unaccompanied, children are separated from any adult family members or other companions with whom they made the journey and housed in CBP facilities pending transfer to ORR custody. Over the last 15 years efforts have been made to improve the conditions in which unaccompanied children are held by immigration enforcement, in response to reports of inhumane practices such as children being detained among adult or juvenile criminal offenders, denied access to legal counsel, forced to wear prison-like uniforms, hand-cuffed or shackled, and prevented from contacting family members (Chavez & Menjívar, 2010; Women’s Refugee Commission, 2009). Despite some progress (Byrne, 2008; Women’s Refugee Commission, 2009), the surge in arrivals over the last few years has placed tremendous pressures on CBP
facilities and has led to renewed concern about how they are treating unaccompanied children. There are reports both from legal advocacy organizations (e.g., Huebner, Pinheiro, Anderson, Dasse, & Lyall, 2014; Women’s Refugee Commission, 2009) and the popular media (e.g., Redden, 2014) of children being kept for days in overcrowded, cold, dirty cells, without mattresses, and with bright lights that remain on day and night and make it hard to sleep. Children have also reported inadequate provision of food and water, limited communication of information, being denied the opportunity to contact family members or lawyers, and not having access to medical care. In addition, there have been allegations against guards of verbal abuse, physical and sexual assault, use of shackles, and children being placed in stress positions as a form of punishment (Huebner et al., 2014).

Concerns have also been raised about CBP’s processing of children’s cases. For example, legal advocacy organizations have issued complaints that immigration officials are not assessing children sufficiently for rape, abuse, trafficking and other safety concerns, particularly in the case of Mexican children who are not subject to the same legal provisions as other unaccompanied children and may be deported without further assessment of their protection needs (American Immigration Council; 2015; Women’s Refugee Commission, 2009). In addition, some children are being held in CBP facilities for longer than the 72-hour maximum period permitted prior to release to more child-appropriate ORR shelters (Huebner et al., 2014).

Once in shelter facilities, children still face a stressful, uncertain period while social workers identify and assess potential sponsors to whom children can be resettled. Although the proportion of children released to sponsors in the community has increased significantly over the last decade, approximately 15% of children remain in government facilities with varying degrees of restriction for many months while their cases are being processed (Byrne & Miller, 2012;
Graham, 2014), without the support of family or friends or access to many of the community resources essential to healthy child development.

**Post-migration resettlement stressors.** Unaccompanied children released to the community still face a difficult period of adjustment and uncertainty (Derluyn & Broekaert, 2008; Ehntholt & Yule, 2006). Children may be released to family members they have not seen for many years, leading to a host of challenges: reacquainting with loved ones who nevertheless feel like strangers; copings with lingering misunderstanding, hurt and resentment over separations; and adjusting to new family constellations, such as parents who have separated or had more children (Roth & Grace; 2015). Alternatively, children may be released to other relatives or family friends they do not know well, who may not have been anticipating their arrival, or who may not be fully financially or emotionally equipped to accommodate them (Baily et al., 2011). While navigating these relationships, children are also frequently missing loved ones who raised them in their home countries, as well as other family members, friends, and their local communities (Derluyn & Broekaert, 2008; Roth & Grace, 2015). They may also feel guilty for leaving home and concerned for loved ones’ safety (Roth & Grace, 2015).

While adjusting to new home environments, unaccompanied youth face the difficult task of adjusting to new communities, a different language, and a foreign culture (Derluyn & Broekaert, 2008; Roth & Grace, 2015). Like other child migrants, they may struggle in school with the language barrier, a different curriculum, and integrating into existing social groups (Hicks, Lalonde, & Pepler, 1993; Portes, 1999). Beyond school enrollment, some unaccompanied children and their sponsors struggle to obtain other needed resources including healthcare, counseling, housing, and legal representation (Roth & Grace, 2015). Unaccompanied youth who have passed their eighteenth birthday while awaiting adjudication of their cases may
be ineligible for many of these services, are less likely to have family to support them, and in some cases find themselves homeless (Feerick Center & Vera, 2015). Some children burdened with debt from their journeys or anxious to support family at home may feel compelled to seek work despite lack of legal authorization to do so, potentially compromising their immigration cases, leaving them susceptible to exploitation by unscrupulous employers, and placing them at risk for forced prostitution and trafficking (Feerick Center & Vera, 2015; Fong & Berger Cardoso, 2010). Some children report that their tenuous legal situation causes a loss of identity, makes them feel reduced to their unaccompanied alien child legal status, leads to them being stereotyped and discriminated against, and can even provoke self-stigma (Derluyn & Broekaert, 2008; Feerick Center & Vera, 2015; Perez Foster, 2001). While children are attempting to acculturate, develop relationships, and build new opportunities, they face the possibility that their claims for immigration relief will be rejected and they will be deported (Derluyn & Broekaert, 2008; Kohli & Mather, 2003).

To date, much of the data on the psychosocial stressors associated with unaccompanied children’s migration has come from research reports by social and legal advocacy organizations. Embedded within these reports there are often short vignettes detailing aspects of the stories of individual children. Additional research is needed to record and analyze more systematically the migration experiences of unaccompanied children. This will facilitate the investigation of common themes and processes in children’s experiences, such as their attitudes towards being separated from their parents, their coping resources, and their perceptions of the legal process to secure immigration relief. There is also a need for more integrated research examining the relationship between migration stressors, psychopathology, and broader risk and resilience processes in unaccompanied children.
Mental Health Needs and Psychosocial Services for Unaccompanied Children

Recent years have seen an increase in global research on the mental health of unaccompanied and other displaced children (Fazel, Reed, Panter-Brick, & Stein, 2012). This has focused, variously, on the assessment of psychopathology in unaccompanied children, risk and protective factors for mental health diagnoses, resilience, and the development of psychosocial interventions tailored to unaccompanied children’s needs.

Prevalence of psychopathology in unaccompanied children. Documenting psychopathology in unaccompanied children serves several important functions: it highlights the impact of children’s exposure to traumatic stressors and, from a legal perspective, can play a key role in children’s petitions for immigration relief (Baily et al., 2014); it can be used to draw attention to harmful practices such as keeping children in long-term detention (Women’s Refugee Commission, 2009); and it may assist in identifying discrepancies between treatment need and availability of services, and in advocating for more psychosocial services for unaccompanied children (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006).

Most of the empirical studies investigating rates of psychopathology in unaccompanied children have been conducted in Northern Europe using standardized child- and caregiver-report measures (Bean et al., 2007a; Derluyn, Broekaert, & Schuyten, 2008; Hodes et al., 2008; Sourander, 1998; Vervliet, Lammertyn, Broekaert, & Derluyn, 2014). Whereas the great majority of unaccompanied children in the United States are from Central America, most of the youth interviewed in these European studies were from Eastern Europe, the Middle East, and Africa. In most instances, they remained in some form of government-sponsored setting rather than being released to family members in the community. Every study reported elevated rates of psychopathology. In a sample of unaccompanied children in Belgium (N = 166), between a third
and half of children screened positive across measures of depression, anxiety, and posttraumatic stress (Derluyn & Broekaert, 2007). In a study of unaccompanied children in Finland ($N = 46$), approximately half of children had behavioral symptoms in the clinical or borderline range, with somatic complaints and symptoms relating to posttraumatic stress disorder (PTSD), depression, and anxiety being the most common difficulties reported (Sourander, 1998). In a longitudinal investigation with unaccompanied children in the Netherlands ($N = 920$), over 50% of participants continued to report severe psychological distress at one-year follow-up (Bean, Eurelings-Bontekoe, & Spinhoven, 2007). However, the generalizability of findings from these studies to unaccompanied children in the United States is likely limited, given differences in the countries of origin, migration experiences, legal systems, and resettlement conditions of unaccompanied children in European countries compared to the United States.

By contrast, the majority of U.S. research documenting psychopathology in unaccompanied children has been qualitative and has not assessed diagnostic prevalence rates. Several reports by legal advocacy groups assessing the impact of prolonged detention in immigration facilities have described high rates of PTSD, anxiety, depression, aggression, psychosomatic complaints, and suicidal ideation among detained unaccompanied children based on staff reports (e.g. Bhabha & Schmidt, 2006; Women’s Refugee Commission, 2002; Women’s Refugee Commission, 2009). However, detention policies and practices with unaccompanied children have changed in the years since some of these reports were compiled and although some children are still detained long-term it is unclear to what extent their circumstances and mental health presentation might generalize to the majority of unaccompanied children now reunified to family living in the community pending their immigration cases.
Our survey with lawyers (Baily et al., 2014) provided some preliminary data on psychological difficulties in unaccompanied children in immigration proceedings in NYC. Lawyers reported mental health concerns in about half of the unaccompanied children they represented (based on their last three clients). They described a variety of diagnostic impressions, symptoms, and behaviors indicative of internalizing and externalizing difficulties. These included mood difficulties, behavioral problems, anxiety, traumatic stress, self-harm, suicide attempts, substance abuse, academic difficulties, and social difficulties. However, the inferences that can be drawn from these data are necessarily limited by the fact that they were reported by non-mental health professionals and were based on their summary impressions of characteristic signs and symptoms.

Further, structured assessment using standardized measures is required to gain a clearer impression of the types and rates of mental health difficulties experienced by unaccompanied children in the United States. This research should consider cross-cultural and age-dependent variations in the presentation of distress, particularly in response to multiple traumas. Whereas common trauma reactions in young children include separation anxiety, tantrums, and developmental regression, in school-age children generalized anxiety, sleep disturbance, poor attention span, somatic complaints, and externalizing problems such as aggressive behavior are more typical responses. In adolescents, frequent trauma reactions also include guilt, heightened shame, social withdrawal, and self-destructive or reckless behavior (Workgroup on Adapting Latino Services [WALS], 2008). The impact of children’s pre-migration traumas may be compounded by repeated traumatic exposure during the migration process (Robjant, Hassan, & Kasona, 2009), and can lead to complex trauma reactions including attachment problems, physical and cognitive deficits, poor self-image, dissociative episodes, and emotional and
behavioral regulation difficulties (Courtois, 2004; National Child Traumatic Stress Network, 2003). In addition, challenges in the cross-cultural assessment of psychopathology should be considered and the reliability and validity of standardized measures for use with unaccompanied children from Central America assessed.

**Assessment of psychopathology in unaccompanied children.** A number of different parameters need to be considered when assessing psychopathology in immigrant youth: the goal of the assessment (e.g., epidemiological research, treatment evaluation, or ongoing clinical care); the setting (e.g., general medical clinic, mental health center, or school); the type of instrument (e.g., screening measure, structured diagnostic interview, or semi-structured clinical interview); the scope of questioning (i.e., broad, selective, or targeted); the informant (e.g., child-report, parent/caregiver-report, or teacher-report); ease of administration (i.e., instrument length, clarity, and availability in multiple languages); the domains addressed (e.g., strengths, difficulties, behaviors, emotions, symptoms, functioning, and exposure to past stressors); the trade-off between instrument sensitivity and specificity; and, critically, the reliability and validity of the measure for the target population (Birman & Chan, 2008).

Standardized assessment of mental health symptoms in unaccompanied children has mostly employed child- and caregiver-report measures administered on a one-off basis (as opposed to monitoring symptom change as part of a clinical intervention) and has typically been conducted with children in government shelter or school settings. It has placed considerable emphasis on the assessment of PTSD (Huemer, Karnik, & Steiner, 2009) and thus tended to use targeted measures of trauma exposure and PTSD symptomatology (e.g., the Harvard Trauma Questionnaire, the Reactions of Adolescents to Traumatic Stress questionnaire [RATS], and the Stressful Life Events questionnaire [SLE]).
Research on the reliability and validity of standardized assessment measures for unaccompanied children has been largely limited to Northern Europe. Bean and colleagues conducted comprehensive validation studies of multiple language versions of the Hopkins Symptom Checklist for Adolescents (HSCL-37A), a targeted measure of anxiety and depression symptoms (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007b), and the Reaction of Adolescents to Traumatic Stress questionnaire (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2006). These studies showed strong internal consistency and good construct, content, and criterion validity for the measures. In a third study, Bean and colleagues found good internal consistency and moderate to good construct and criterion validity for the caregiver-report Child Behavior Checklist (Bean, Mooijart, Eurelings-Bontekoe, & Spinhoven, 2006). In each of these studies, assessment of criterion validity was based on the relationship between test scores and children’s perceived need for and use of mental health services.

Studies using comprehensive diagnostic interviews as part of their methodology are largely lacking. One exception is a study by Jakobsen and colleagues (2014), in which 160 unaccompanied asylum-seeking male adolescents from Afghanistan, Somalia, and Iran residing in asylum centers in Norway were assessed using the Composite International Diagnostic Instrument five to six months after their arrival in the country. The depression, anxiety, and PTSD modules of the measure were administered, with 41.9% of the sample meeting diagnostic criteria for at least one current diagnosis (Jakobsen, Demott, & Heir, 2014). Further research using structured interviews is needed to provide thorough assessments of unaccompanied children’s diagnostic presentation. Inclusion of such measures could also assist in validation of screening instruments for use with unaccompanied children (Bean, 2006). This would allow
greater confidence in the routine use of standardized screening measures to identify unaccompanied children in need of further support.

In order to provide a comprehensive view of unaccompanied children’s needs, that includes a focus on children’s strengths as well as vulnerabilities, ideally assessment of psychopathology should be one component of a broader research strategy that includes other domains of functioning (e.g., children’s internal coping resources and academic and social competencies) and incorporates other methodologies (e.g., children’s qualitative accounts of their own experiences). These types of mixed methods designs have proliferated in psychological research over the past 15 years, as a means of asking complex questions and conducting comparative research across cultures while safeguarding as far as possible against ignoring contextual factors and imposing Western norms on other populations (Bartholomew & Brown, 2012). Although mixed methods approaches have been used with other immigrant youth (e.g., Montgomery, 2008, Weine et al., 2013), thus far they are lacking in research on unaccompanied children. However, there have been some advances in championing child-centered methodologies with this population. In their study of unaccompanied youth in NYC, researchers from the Feerick Center and Vera (2015) used an innovative, participatory action research (PAR) approach to gather qualitative data drawn from focus groups of unaccompanied children designed and facilitated by unaccompanied youth peer researchers. These data were combined with information from interviews with unaccompanied youth and key informants from the education, housing, employment, welfare, health, and housing sectors. This methodology enabled understanding of little explored aspects of unaccompanied children’s context, such as identity issues and their experience of discrimination. Further studies placing unaccompanied children at the center of the research process are needed.
Risk and protective factors for psychopathology among unaccompanied children.

Although diagnostic research suggests that many unaccompanied children develop mental health difficulties, it also shows that many do not. Research identifying what factors increase and reduce vulnerability to psychopathology in unaccompanied children has important implications for mental health screening and service provision. However, compared to the extensive documenting of the psychosocial stressors to which unaccompanied children are exposed, there has been relatively little research assessing risk and protective factors for psychopathology among these youth empirically.

Several Northern European studies have compared children migrating with and without parents and have consistently found that unaccompanied children are at higher risk for psychopathology (Bean et al., 2007a; Derluyn et al., 2008; Hodes et al., 2008). Unaccompanied children have also been shown to be at higher risk of exposure to traumatic events than other migrants (Bean et al., 2007a; Hodes et al., 2008), and there is a strong and consistent association in unaccompanied children (and other migrant youth) between increased level of exposure to traumatic events and increased distress (Bean et al., 2007a; Derluyn, Mels, & Broekaert, 2009; Hodes et al., 2008; Vervliet et al., 2014). More institutional and restrictive settings have also consistently been identified as a risk factor for psychopathology among unaccompanied children (Bean et al., 2007a; Hodes et al, 2008; Reijneveld, de Boer, Bean, & Korfker, 2005), mirroring findings from other studies looking at the impact of detention on child migrants (e.g., Lorek et al., 2009; Mares & Jureidini, 2004). Uncertain legal status among unaccompanied children has been linked to internalizing problems (Bean et al., 2007). Female sex has also been identified as a risk factor for psychopathology, especially depression and other internalizing disorders.
(Derluyn & Broekaert, 2007; Hodes et al., 2007; Reijneveld et al., 2005), a finding also true for the broader, non-migrant youth population (Fazel et al., 2012).

Two studies have looked at risk and protective factors for psychopathology in unaccompanied children in the United States. Porte and Torney-Purta (1987) compared depression and academic achievement in Indochinese unaccompanied refugee children \( (N = 82) \) resettled in the United States to different types of care. They found that children in foster care with adults who shared their ethnicity were significantly less depressed (as measured by the Center for Epidemiological Studies Depression Scale for Children) and had significantly higher grade-point averages compared to children in foster care with Caucasian families or in group homes. Geltman and colleagues (Geltman et al., 2005; Geltman, Grant-Knight, Ellis, & Landgraf, 2008; Goodman, 2004; Grant-Knight, Geltman, & Ellis, 2009) studied a cohort of several hundred children from southern Sudan, the so-called “lost boys of Sudan,” who were resettled from refugee camps in Kenya to foster care in the United States by the U.S. Unaccompanied Refugee Minors Program in the largest resettlement of unaccompanied children in history. In their initial paper (Geltman et al., 2005), they evaluated the relationship between the experience of traumatic migration experiences, PTSD symptoms, psychosocial functioning, and general health among unaccompanied Sudanese refugee adolescents living in government-sponsored foster care \( (N = 304) \). Twenty percent of participants screened positive for PTSD (as assessed using the Harvard Trauma Questionnaire), and these adolescents had significantly worse overall functioning (as assessed using the Child Health Questionnaire). Additionally, children who had experienced physical injury, particularly head injury, were more likely to experience PTSD. Children varied as to whether or not they were placed with other Sudanese refugee children, and whether they were living with a Sudanese or American family. Children
living with other Sudanese people in their household were less likely to have elevated PTSD symptoms, echoing findings from Porte and Torney-Purta (1987) regarding the protective nature of living with families who share the same cultural background. However, findings from these studies of unaccompanied refugee children from Asia and Africa resettled to the United States by the government with approved asylum cases may not be generalizable to the unaccompanied children in our study.

Several other vulnerability and protective factors have been identified in the broader literature on child migrants accompanied by parents. Fazel and colleagues (2012) analyzed data across multiple studies of migrant youth resettling to high-income countries and identified community-level vulnerability factors for psychopathology including discrimination and exposure to violence in the post-migration period and multiple changes of residence. Family-level vulnerability factors they identified included having a single parent, financial stress in the home, parental exposure to violence, and parental psychiatric problems. Protective factors included high parental support and family cohesion, support from friends, and a positive experience of school (Fazel et al., 2012). Migrant children’s integration into the host society, while maintaining their own cultural identity and values, has also been identified as an important protective factor (Fazel et al., 2012; Perreira & Ornelas, 2011; WALS, 2008). Future research should assess the impact of these factors on unaccompanied children.

Studies should also investigate the impact of other stressors and supportive factors that have received little attention in the literature on children migrants. For example, there is a lack of research on the impact of child abuse among unaccompanied and other migrant children, despite high reported rates of such violence (e.g., UNHCR, 2014) and the fact that child abuse is a well-established risk factor for psychopathology (e.g., Brown, 2003; Petersen, Joseph, & Feit, 2014).
Similarly, the protective and promotive role of secure attachments and risk imposed by disrupted attachments are well documented in the general literature (e.g., Nachmias, Gunnar, Mangelsdorf, Parritz, & Buss, 1996; Schuengel, Oosterman, & Sterkenburg, 2009) but have received little attention in the child migrant literature despite the frequent familial separations experienced by these children. Secure attachments established between children and their parents prior to separation may benefit unaccompanied children in a variety of ways. Securely attached children typically develop an internalized working model of attachment figures as available, responsive, and helpful (Bowlby, 1973, 1988); thus, unaccompanied children with secure attachments may be better able to manage physical separations from parents and continue to benefit from their support from afar. Moreover, secure attachments to primary attachment figures serve as models for close, supportive relationships with other caregivers (Bowlby, 1973); in this way, secure attachments to parents may assist in the development of close, emotionally supportive relationships with other relatives who take on parenting roles following parents’ departures. In addition, secure attachment helps facilitate the development of personal traits and abilities such as emotion regulation, behavioral inhibition, coping flexibility, and social functioning (Cassidy, 1994; Nachmias et al., 1996). For unaccompanied children, such characteristics may help protect against the many stressors to which they are exposed throughout their migration process.

Studies that have used multivariate analyses to help understand the interrelationship between factors influencing unaccompanied children’s mental health outcomes (e.g., Bean et al., 2007a; Geltman et al., 2005; Hodes et al., 2008; Lustig et al., 2004; Sourander, 1998) have provided mixed findings. For example, some researchers (e.g., Lustig et al., 2004; Sourander, 1998) have found that younger unaccompanied children are at higher risk for psychopathology, attributing this to their limited internal coping resources compared to older children. However,
other studies (e.g., Bean et al., 2007a; Hodes et al., 2008) have found that older unaccompanied children are at higher risk for psychopathology, which may be linked to factors such as increased exposure to stressors and increased fear of deportation due to loss of legal protections after the age of 18 (Fazel et al., 2012).

The mixed findings from these and other studies that have looked at risk and protective factors for psychopathology in unaccompanied and other migrant children from different cultures, age groups, and stages of migration suggest the context- and timing-specific nature of these variables in influencing mental health outcomes (Tol, Song, & Jordans, 2013). These variable results also indicate the insufficiency of additive models that assess outcome in terms of the sum total of risk and protective factors, instead suggesting a complex and dynamic relationship between them.

In general, the research on vulnerability factors for and protective factors against psychopathology in unaccompanied and other migrant youth has also been hindered by several limitations: cross-sectional designs that limit the ability to make causal inferences (Hodes et al., 2008); variation in measures of psychopathology that impede comparisons across studies; convenience samples; and study designs that limit the ability to assess complex interactions between multiple risk and protective factors (Fazel et al., 2012). Certain types of harder-to-measure variables increasingly commonly assessed in domestic child samples (e.g., biomarkers of stress such as allostatic load) are currently lacking from studies of migrant youth and other children from low- and middle-income countries (Tol et al., 2013).

One important limitation of research on risk and protective factors is that, almost by definition, it is focused on negative outcomes (or their avoidance). Unless balanced against other ways of understanding unaccompanied children’s experience, a diagnostic perspective runs the
risk of pathologizing unaccompanied children and presenting a narrative of victimization that may be very different to children’s experience of themselves (even those presenting with some mental health difficulties). Recognizing these potential pitfalls, several recent studies have focused on resilience processes in unaccompanied children, looking at factors contributing not only to psychopathology but also children’s positive adaptation and wellbeing.

**Resilience processes among unaccompanied children.** Even while documenting their vulnerability and high rates of psychopathology, researchers, clinicians, and other stakeholders have consistently remarked on the fact many unaccompanied children function well despite exposure to extreme adversity (e.g., Aldarondo & Becker, 2011; Feerick Center & Vera, 2015; Grant-Knight et al., 2009; Lustig et al., 2004). These observations reflect findings from the broader literature on responses to extreme stressors suggesting that, even in the face of violence and life-threatening events, the majority of people (including some who display transient stress symptoms) cope well in the long term (Bonanno, 2004). In recognition of the fact that many unaccompanied children fare well and response to the limitations of a singular emphasis on psychopathology, there is an increasing research focus on factors contributing to unaccompanied children’s wellbeing and healthy adaptation following adversity.

Research with unaccompanied children has focused on various aspects of resilience: adaptive personality traits and psychological constructs such as self-efficacy (Scott, 2009); effective coping strategies (Goodman, 2004); protective community values, cultural interpretations of distress, and attitudes towards migration (Maegusuku-Hewett, Dunkerley, Scourfield, & Smalley, 2007; Rousseau, Said, Gagné, Bibeau, 1998); and external factors that contribute to unaccompanied children’s wellbeing including community supports and psychosocial interventions (Derluyn & Broekaert, 2007; Kohli & Mather, 2003). This literature
has identified resilience factors including: children feeling a sense of choice and agency, often including through the decision to migrate (Kohli & Mather, 2003); making positive meaning out of their migration experience and maintaining optimism for the future (Goodman, 2004); living in a supportive environment (Derluyn & Broekaert, 2007); coping through distraction and staying busy (Goodman, 2004); engagement in school (Maegusuku-Hewett et al., 2007); and feeling part of a community and having a sense of belonging, both to the host country’s culture and through continued identification with their culture of origin (Kohli & Mather, 2003; Maegusuku-Hewett et al., 2007).

The literature on resilience processes among unaccompanied children in the United States remains limited to a very few studies. In a qualitative study of 16 children from the unaccompanied Sudanese refugee cohort, Goodman (2004) identified four coping strategies commonly used by participants: children’s collective, communal identification with their fellow Sudanese refugees, their shared hardships, and their desire to stay strong for each other and those left behind; suppression of traumatic memories and use of distraction to avoid difficult thoughts and feelings; making meaning of their experiences, particularly by interpreting their survival as God’s will and a mandate to represent lost loved ones; and hope for the future predicated on a newfound sense of stability and trust that education would provide them with new opportunities.

Scott (2009) assessed resilience in a group of unaccompanied children from Central America detained in federal custody ($N = 118$) using the Individual Protective Factors Index and identified personal characteristics and environmental factors contributing to children’s scores in the instrument’s various domains. Mean scores on the protective factors of social bonding, social competence, and personal competence all fell in the moderate range, as did scores on risk factors relating to family supervision and interactions, neighborhood environment, peer associations,
and substance use and other risk behaviors. Social bonding was linked to being raised by parents, a desire to reunify with family, and hope for starting a family in the future. By comparison, social competence was associated with children not living with family members in their home countries and being required to work. Meanwhile, personal competence was related to children going to school in their home countries, not working, and living with family (Scott, 2009). Thus, factors that contributed to risk in some domains in other ways supported positive adaptation. These findings suggest the context-specific nature of vulnerability and supportive factors among unaccompanied children, and a dynamic interaction between them.

Overall, the study of resilience in unaccompanied children has focused more on the role of individual traits, attitudes, and coping behaviors in response to adversity than environmental determinants of positive adaptation. This may reflect broader tendencies in Western conceptualizations of trauma, which have emphasized PTSD as the primary form of traumatic response—focused heavily on the individual’s emotional, cognitive, and physiological responses to specific stressors—and paid less attention to environmental determinants of stress and coping (Hobfoll, 2014). However, there is growing recognition in the trauma literature (e.g., Bracken, Giller, & Somerfield, 1995; Hinton & Kirmayer, 2013; Miller & Rasmussen, 2010) that while PTSD is found across cultures it represents just one among a variety of manifestations of trauma response. In Latino children, chronic exposure to traumatic stressors has also been linked with a variety of emotional and behavioral difficulties, including anxiety, depression, somatic complaints, recklessness, and aggressive behavior (WALS, 2008). As Hobfoll (2014) notes, multiple studies (e.g., DeSalvo et al., 2007; Ironson et al., 1997; Laban, Komproe, Gernaat, & de Jong, 2008) have demonstrated that the extent of resource loss following traumatic events is more predictive of trauma response than exposure to the actual traumatic event. Similarly, and in
the context of refugee adaptation, Ryan and colleagues (2008) draw attention to the failings of trauma-focused models of post-migration adjustment that exaggerate the role of individual coping and neglect the impact of the host society environment on migrants’ adaptation. They also point out the limitations of psychosocial stress models that overemphasize migrants’ subjective appraisal of stressors or focus narrowly on cross-cultural adjustment instead of looking at a broader range of tangible adversities (e.g., family separations) and needs (e.g., shelter, access to education, and work opportunities) (Ryan, Dooley, & Benson, 2008).

Recognizing the limitations of models of stress and coping focused on the individual, particularly as applied to non-Western contexts, increasingly the resilience literature (e.g., Betancourt & Khan, 2008; Ungar, Ghazinour, & Richter, 2013) is adopting social ecological models that characterize risk and resilience as dynamic processes involving an interaction between individual variables (e.g., gender, sense of agency, and coping flexibility) and multiple levels of intersecting environmental factors (e.g. familial, community, and institutional stressors and supports). This perspective is grounded in Bronfenbrenner’s social ecological theory (1979), which underscores the importance not only of factors directly involving the individual (the microsystem) but also broadening spheres of resources (the mesosystem, exosystem, and macrosystem) that play an indirect but nevertheless pivotal role in adaptation.

Although some differences in definitions and models of resilience persist (Panter-Brick & Leckman, 2013), there is growing consensus about several core features of the construct. These have important implications for the way in which we think about mental health outcomes and psychosocial interventions in unaccompanied and other migrant children. First, increasingly this literature defines resilience not as a personality trait residing within an individual child, nor as an outcome, but instead as a dynamic, systemic, and multi-factorial process that evolves over time
(Betancourt & Khan, 2008; Fergus & Zimmerman, 2005; Maegusuku-Hewett et al., 2007; Panter-Brick & Leckman, 2013). Second, this research moves the field beyond a narrow focus on absence of psychopathology to consider other outcomes of resilience such as educational, familial, and social functioning (Barber, 2013; Ungar et al., 2013). Resilience and distress are not considered mutually exclusive, reflecting findings that migrant children can continue to maintain positive developmental trajectories while experiencing mental health symptoms (e.g., Bean, 2006; Mollica, Poole, Son, & Murray, 1997; Sack, Clarke, Kinney, Belestos, Him, & Seeley, 1995). Third, the literature emphasizes that definitions of adaptive outcome vary across cultures, reflecting different priorities and perceptions of what constitutes wellbeing and positive functioning in different societies. In line with culture-specific definitions of good outcome, the risk and resilience processes contributing to these outcomes are also considered context-specific (Tol et al., 2013). Fourth, risk and resilience are seen as pathways that emerge over time, acknowledging the interaction of biological and environmental factors on unaccompanied children’s psychological trajectories and the differential, timing-specific impact of these depending on the migration phase and the child’s stage of development (Ager, Annan, & Panter-Brick, 2013; Panter-Brick & Leckman, 2013; Tol et al., 2013). Fifth, in many cases, the literature differentiates between protective factors (those that mitigate the impact of stressors) and promotive factors (those that facilitate positive developmental processes) (Fergus & Zimmerman, 2005; Tol et al., 2013). Sixth, this literature expands our sense of what constitutes an intervention, highlighting the importance of providing not only mental health treatment to unaccompanied children but also other psychosocial services ranging from educational support to legal representation (Feerick Center & Vera, 2015; Maegusuku-Hewett et al., 2007; Roth & Grace, 2015).
Social ecological theories of resilience provide a dynamic, culture- and timing-specific framework of risk and resilience processes. However, in and of themselves, they do not provide a predictive model of the circumstances under which different potential stressors and supportive factors have an impact. Hobfoll’s Conservation of Resources (COR) (Hobfoll, 1989), a theory of motivation and stress, provides a paradigm for understanding the interaction between exposure to adversity, access to resources, and mental health. Specifically, COR posits that the relationship between potential vulnerability and supportive factors (be they internal or environmental variables) and stress reactions is mediated by the impact of those factors on the availability of resources. COR suggests that one of people’s primary motivations is to obtain, retain, and protect resources. Within the model, resources refer to different types of things people value (or that can be used to acquire things they value), including: object resources (e.g., a home, food, and clothes); conditions (e.g., living with loved ones, being a student, and having legal immigration status); personal characteristics (e.g., a positive sense of self and good emotion regulation skills); and energies (e.g., resources such as money, time, and knowledge that can help obtain other resources). Stress occurs in response to actual or threatened resource loss or when there is no resource gain in response to an investment of resources (Hobfoll, 1989). Applied to potentially traumatic situations, the model predicts that adverse events lead to stress primarily based on whether they bring about environmental changes that threaten or precipitate resource loss (Hobfoll, 2014). Thus, resources are embedded in the local culture, informed by social ecology, and are highly context-specific, as is the experience of stress. Another principle of COR theory is that resources tend to cluster in so-called resource caravans, with acquisition or loss of certain key resources precipitating further resource gain or depletion (Hobfoll, 2012). The environmental conditions that lead to resource loss or gain are referred to as caravan
passageways (Hobfoll, 2012). In predicting the circumstances in which factors contribute to risk and resilience, highlighting the ways in which resources impact each other, and emphasizing the environment as a key factor informing the relationship between adverse events and trauma response, COR theory may also help inform context- and timing-specific, ecologically-valid interventions.

As informed by social ecological models and stress theories such as COR, a central tenet of the evolving conceptualization of resilience is that it should be a practical concept. In particular, resilience approaches seek to emphasize the promotion of strengths and capacities, to develop preventive resources in anticipation of potential stressors, to consider how factors at different systemic levels influence each other, to time interventions for critical moments in counteracting vulnerability or harnessing strengths, and to select interventions that have an outsized effect by fostering other capacities. For unaccompanied children—whose migration involves a critical period of seismic change across individual, familial, community, and broader cultural, and institutional levels—a resilience lens may be particularly helpful in identifying effective ways to meet their evolving needs.

**Psychosocial services for unaccompanied children.** Unaccompanied children in the United States experience a broad range of contexts depending on how far along they are in their migration process, whether they remain in government custody or are released to sponsors in the community, and the availability of resources such as healthcare, counseling, education, and immigration attorneys. Reflecting these different situations, they may receive an array of interventions (e.g. mental health screening, mental health treatment, and case management to assist in accessing other needed resources) in a variety of settings (e.g., during Office of Refugee Resettlement custody, from government-mandated social workers follow release, and through
community-based clinics and programs). Depending on the setting, challenges to service provision include difficulty identifying the children most in need, limited availability of services, and obstacles helping children to access available resources.

Under the terms of the Flores settlement and subsequently reinforced by the Wilberforce Trafficking Victims Protection Reauthorization Act, unaccompanied children in Office of Refugee Resettlement custody are mandated to receive medical and mental health screenings, individual and group counseling, educational programming, recreational activities, and case management in support (whenever possible) of family reunification (Byrne & Miller, 2012; ORR, 2016a). ORR completes a needs assessment for all unaccompanied children to determine whether they can be released into the community safely and the Department of Health and Human Services completes a home study for children presenting with particular vulnerabilities to determine the appropriateness and ability of sponsors to care for their needs (Byrne & Miller, 2012; Roth & Grace, 2015).

At times concerns have been raised about the consistency and quality of the psychological services provided to children while in government custody. A 2008 government audit of ORR facilities found most children’s files were missing assessments or lacked documentation of mental health and psychosocial services (HHS, 2008). Moreover, lawyers have expressed concerns about both the quality and confidentiality of services unaccompanied children receive in detention facilities (Baily et al., 2014). Although ORR guidelines stipulate the use of standardized screening tools to assess children for mental health issues (ORR, 2016a), no measures have been validated empirically for use with unaccompanied children in the United States.
Whereas children should continue to receive psychosocial services as long as they remain in custody, service provision for children released to the community is more limited. In an attempt to address this problem, since the passage of TVPRA in 2008, ORR has been required to allocate post-release services (PRS) to especially vulnerable children (e.g., children with physical disabilities, abuse or trauma histories, or high risk for future victimization) (Byrne & Miller, 2012; Roth & Grace, 2015). These services are provided by local, community based-agencies and include assistance with school enrolment (to include access to Individualized Education Plans and English as a Second Language programming), connection to community supports, referral to legal services to assist in children’s immigration cases, and mental health counseling (Roth & Grace; 2015; United States Conference of Catholic Bishops & Lutheran Immigration and Refugee Services, 2014). In 2015, ORR referred 8,618 unaccompanied children for these services (ORR, 2016d). Starting that year, ORR also initiated a national help line to assist released children and their sponsors in accessing resources and initiated its Safety and Well Being Follow-Up Call program to determine whether children were residing with their sponsors, safe, enrolled in school, and prepared for upcoming court dates. As of late 2015, 87% of unaccompanied children and 90% of their sponsors were contacted within 37 days of the child’s release (ORR, 2016b). In addition, ORR coordinates Legal Orientation Program for Custodians (LOPC) meetings at which new custodians are provided with information about navigating the immigration court process, finding a lawyer, enrolling children in school, applying for public health insurance, and accessing other services such as counseling.

Although these programming developments have improved monitoring of unaccompanied children following release from custody and communication with their sponsoring families, their impact is hindered by a lack of community resources available to
unaccompanied children. Roth and Grace (2015) conducted a qualitative study with case managers and unaccompanied children assessing the implementation of four different PRS programs. In general, children had been able to enroll in schools, although in some instances they had experienced resistance from schools unfamiliar with or even discriminatory towards unaccompanied children’s temporary residency status. However, they had considerable difficulty accessing legal services due to a dearth of affordable immigration attorneys competent in this area of practice. After legal services, case managers ranked mental health counseling as unaccompanied children’s greatest area of need, but they had difficulty accessing services, primarily due to a lack of Spanish-speaking counselors, long waiting lists, prohibitive treatment cost (with many children uninsured), and long distances to clinics. The study showed that communities with less history of receiving immigrants were particularly under-resourced. Moreover, many case managers reported that the complexity of children’s cases, the size of their caseloads, the limited availability of community resources to which to refer, and the limited, six-month time frame of PRS all hampered their efforts to support the children in their care (Roth & Grace, 2015).

Not only are ORR’s PRS programs time-limited, they are also restricted to a small minority of unaccompanied children. In the absence of government-sponsored initiatives, it may fall on other professionals involved in children’s cases to make referrals. Our survey of lawyers in NYC (Baily et al., 2014) suggested that among unaccompanied children living in the community, lawyers are one of the few sources of referral into mental health services. Although, out of necessity, many lawyers accepted this responsibility as part of their advocacy role, few had received any type of training in mental health assessment and support, and they had
difficulty finding services in the great majority of cases where they sought referrals, with an estimated 40% of referred children ultimately not receiving care (Baily et al., 2014).

Mirroring findings from Roth and Grace (2015), the lawyers in our survey study cited a lack of affordable, locally accessible, Spanish-speaking counselors as a primary barrier to mental health care for unaccompanied children. The obstacles of cost, accessibility, and availability are also frequently observed in the wider literature on immigrant mental health care access (e.g., Aguilar-Gaxiola et al., 2012). The role of stigma as a barrier to service access has also been documented extensively in the immigrant mental health utilization literature (e.g., Ishikawa, Cardemil, & Falmagne, 2010; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). However, although some instances of mental health stigma have been reported in qualitative studies with unaccompanied children (e.g., Baily et al., 2014), it does not appear to be as significant an obstacle to mental health service utilization as the limited availability and accessibility of feasible services. While open in theory to counseling, some families (and indeed case managers) prioritize other concerns such as obtaining a lawyer to represent children in immigration court (Roth & Grace, 2015). Thus, lack of access to one resource may create barriers to others. However, there is evidence that when psychosocial services are made easily accessible (e.g., to unaccompanied children in detention centers) they are often received enthusiastically (Descilo et al., 2010).

In their study of unaccompanied Sudanese refugee children, Geltman and colleagues (2008) identified a nuanced pattern of service utilization and some challenges to effective service delivery. Of the 304 children in their study, 45% had received mental health counseling (although these included psychosocial support groups offered by the Unaccompanied Refugee Minors Program that are not typically available to unaccompanied children) and 76% had sought
medical care for somatic symptoms and other complaints that appeared related to behavioral and emotional problems. While PTSD diagnosis was not predictive of mental health service use, it was predictive of seeing a medical professional, suggesting that in this sample children sought out medical help for mental health concerns. Neither counseling nor medical support were associated with improved functional health outcomes. As the authors noted, their findings indicated the challenges involved in identifying unaccompanied children in need of mental health care and directing them to appropriate, effective services (Geltman et al., 2008). Attitudes towards mental health difficulties and treatment among unaccompanied children, their caregivers, and their communities, and how these influence service access, are important areas for further study.

In recognition of the challenges in connecting children and their families to services, and the interrelationship between unaccompanied children’s medical, mental health, and legal needs, several initiatives have sought to combine different services within a single program in a manner similar to the child advocacy center and community collaborative care models commonly used with other potentially traumatized youth populations. These approaches improve service access, provide specialized, culturally informed treatment, limit the potential for retraumatization caused by children having to recount traumatic episodes multiple times to new providers, allow for better coordination between service providers, can extend support to children’s families, and frequently incorporate resilience and rights-based perspectives (Alvarez & Alegría, 2016; Baily et al., 2011; Rousseau, Measham, & Nadeau, 2013). The Bronx-based medical-legal partnership for unaccompanied children Terra Firma offers one example of a community-based, integrated care model. Lawyers, physicians, and mental health clinicians work in collaboration to provide a range of complementary services to unaccompanied children living with sponsors in NYC. For
example, sensitive assessment of traumatic exposure can not only inform medical and psychological treatment but also lead to expert testimony in children’s legal proceedings. This type of “planned synergy” (Ager et al., 2013), whereby an intervention in one domain has a positive, domino effect on others, is an important aspect of resilience-based programming. The Terra Firma program also focuses on bolstering community support through interventions such as an adolescent support group, family-cooked meals, and a soccer league (Stark et al., 2015).

Recent years have also seen some government efforts at the national and local level to improve availability of services to unaccompanied children following their release from custody, although few have targeted mental health services directly. Following the child migrant crisis, the Obama administration and Congress proposed a variety of measures to increase care for unaccompanied children (in addition to expanding immigration enforcement), and although many stalled due to congressional impasse, some additional funding was secured. For example, the Department of Health and Human Services provided an extra $9 million to fund legal representation for unaccompanied children in FY 2014 and 2015 (American Immigration Council, 2015). Despite these efforts, as of April 2015, over 38,000 unaccompanied children remained unrepresented. With federal action limited by a divided Congress, some state and city governments have taken up the mantle of increasing support for unaccompanied children. Access to public education regardless of immigration status is protected nationwide (Feerick Center & Vera, 2015). However, at the state level, New York is one of only five states (alongside Washington, D.C.) to offer government-funded health insurance to undocumented children (Alvarez & Alegría 2016). In response to the child migrant crisis, NYC took a variety of measures in support of unaccompanied children, to include: creating an interagency task force to help address unaccompanied children’s needs; sending representatives from NYC’s education
and health departments to attend immigration court in order to assist unaccompanied children in registering for school and enrolling for health insurance; and creating a fund of almost $2 million to pay for legal representation for unaccompanied children (Feerick Center & Vera, 2015).

The limited availability and challenges connecting unaccompanied children to mental health services are not exclusive to the United States. For example, in her study with unaccompanied children in the Netherlands, Bean (2006) reported that of the almost 58% of unaccompanied children with a self-reported need for mental health services, only 12% had received treatment. However, children who had received services reported significantly lower anxiety, depression, and PTSD scores than children who had not. Sourander (1998) noted a discrepancy between the psychosocial services available to unaccompanied children in asylum centers and the levels of care generally available in residential care settings in Finland, both in terms of staff ratios and levels of training. Lynch (2001) reported difficulties among unaccompanied children in Britain obtaining specialized services for mental health difficulties and in accessing other services such as housing and education. However, given variations in health care infrastructure and governments’ policies regarding unaccompanied children, it is difficult to generalize findings on the mental health care utilization of unaccompanied children across countries.

It is similarly difficult to generalize solutions to unaccompanied children’s challenges in accessing services. For example, Bean (2006) proposed a stepped-care approach to address the mental health needs of unaccompanied children in the Netherlands. This included training residential staff and guardians in emotion regulation and social skills that they could then teach to children in their care, and using mental health professionals to provide preventive and curative mental healthcare to children identified as having particular needs. However, this potentially
promising solution was proposed in the context of a system where a single guardianship organization, the Nidos Foundation, is responsible for the care of every unaccompanied child in the country, and brings together guardians, teachers, and mental health providers involved in their care (Bean, 2006). In the United States, which lacks such a coordinated infrastructure of care for unaccompanied children, such an approach might be less feasible. However, other stepped-care paradigms that have proved effective with vulnerable populations in the United States (e.g., school-based models) should be considered.

Overall, there has been more focus on improving unaccompanied children’s mental health service access and integrating this with other needed services than on the development of specific psychotherapeutic interventions tailored to their needs. However, in 2015, the National Latina/o Psychological Association published guidelines for mental health professionals working with unaccompanied children (Torres Fernández, Chavez-Dueñas, & Consoli, 2015), drawing on best practices for the treatment of other children with similar concerns such as accompanied immigrant youth and children who have experienced trauma and loss. While they note the absence of any established protocol for mental health assessment with unaccompanied children, they emphasize the importance of culturally and developmentally appropriate screening. They recommend symptom-focused treatments such as Trauma-Focused Cognitive Behavioral Therapy, systemic approaches such as family therapy, and client-led approaches such as narrative therapy that prioritize children’s beliefs, values, and culture in making meaning out of their experiences (Torres Fernández et al., 2015).

One example of a program seeking to investigate and expand best practices tailored specifically to unaccompanied children is the Immigrant Children and Legal Services Partnership (ICLASP), a collaboration between academic, welfare, advocacy, community, and treatment
professionals in South Florida. Focusing on unaccompanied children in local ORR detention facilities, ICLASP’s interventions include culturally appropriate assessments and specialized trauma-focused treatment, resilience-focused youth development programming, “Know Your Rights” orientations to the immigration process, legal representation for children’s cases, and training for detention center staff on resilience-oriented care and for juvenile and family court judges on legal provisions for unaccompanied children (Aldarondo & Becker, 2011). Their programming for unaccompanied children aims to inform children about their migration process, to help them develop strengths, and to build a sense of optimism for the future. Features of the program include an educational board game called *Toma el Paso* that teaches unaccompanied children about the complex U.S. immigration system and the development of a “book of life” to help children reassume important parts of their identity that may have been obscured during their migration and detention experiences (Aldarondo & Becker, 2011; Collier, 2015).

ICLASP has also tested a treatment for PTSD among children at the detention centers. Descilo and colleagues (2010) examined the efficacy of Traumatic Incident Reduction, an imaginal exposure therapy, in an open trial using archival data from 40 unaccompanied children ages 11 to 18. The mean length of treatment was 7.5 sessions, with transfer away from the facility being the only reason for treatment non-completion. There was a significant reduction in children’s posttraumatic stress scores (as measured on the Posttraumatic Stress Disorder Checklist) over the course of treatment, with most children’s scores dropping out of the clinical range. Girls showed greater improvements in depression (assessed with the youth version of the Center for Epidemiological Studies Depression Scale) and happiness (assessed with the Short Depression Happiness Scale) than boys, but also had higher pretreatment scores. This is, to this author’s knowledge, the first clinical study testing a psychotherapeutic intervention for
unaccompanied children. The limitations of a small open trial notwithstanding, these promising results suggest that Traumatic Incident Reduction bears further study as a treatment for PTSD in unaccompanied children. Given the current lack of treatment options for unaccompanied children outside of ORR facilities, it would be helpful to assess the accessibility, feasibility, and effectiveness of interventions for unaccompanied children in community samples.

**Human Rights-based Advocacy and Care for Unaccompanied Children**

Increasingly, researchers and advocates are applying a human rights focus to their work with unaccompanied children (e.g., Androff, 2016; Chappell Deckert, 2016). In particular, over the last few decades legal and social rights organizations have used human rights principles to advocate for better government treatment of unaccompanied children and improved access to services. However, a human rights approach also challenges stakeholders to see unaccompanied children in a new light—less as victims in need of care, and more as survivors empowered to claim the resources essential to their forward development.

The psychosocial stressors to which many unaccompanied children are exposed particularly lend themselves to a human rights perspective. Unaccompanied children are often fleeing human rights violations in their own countries from which they are entitled to international protection (UNHCR, 2014); during their journeys they are vulnerable to abuse and exploitation that further violate their rights; having arrived in the United States they may be subject to detention conditions that violate their rights to a child-appropriate environment; and they may be denied their right to adequate legal representation and due process of their claims to immigration relief (Androff, 2016). Moreover, unaccompanied children’s context is reflected in many of the principles of the United Nations Convention on the Rights of the Child (CRC) and other key international treaties confirming key children’s rights. For example, articles from the
CRC include: children’s right to be cared for by their parents; children’s right to family reunification; children’s right to protection from abuse or exploitation; children’s right to education; children’s right to health and healthcare services; children’s right to interventions to promote psychological recovery following neglect, exploitation, abuse, or maltreatment in an environment that fosters their health, self-respect, and dignity; children’s right to international humanitarian protection and assistance if these rights are being violated in their own countries; children’s right to freedom from detention except as a measure of last resort and for the shortest time possible; children’s right to legal representation; children’s right for their best interests to be a primary consideration in all welfare, judicial, administrative, or legislative actions; and children’s right to express their opinions and for these to be given due weight in decision-making on their behalf (UNICEF, 1989). Reiterating some of these principles, in 1999 UNHCR published guidelines on the detention of asylum-seekers stating that, whenever possible, children should not be detained, should participate in school, and should have access to recreation and play activities to help cope with stress and facilitate mental development (UNHCR, 1999).

Although the United States has not ratified the CRC (the only country in the world other than Somalia not to have done so), it is a signatory to this agreement and several other important children’s rights treaties. Moreover, many of the principles they contain are reflected in U.S. law, and these have been used by immigration advocates to expand the rights and protections granted to unaccompanied children. For example, the terms of the Special Immigrant Juvenile Status immigration relief provision, passed by Congress in 1990, include that the “best interests of the child” be taken into consideration in determining whether to return unaccompanied children to their home country, making it the only U.S. immigration law to contain this fundamental principle of human rights (Byrne & Miller, 2012). Similarly, the principle of minimizing the
detention of children is reflected in the 1997 Flores settlement mandating that unaccompanied children be released as quickly as possible to the least restrictive setting available and that, while in government care, they be provided access to essential developmental activities such as school and recreation.

Despite these and other changes, concerns remain regarding the U.S. government’s treatment of unaccompanied children, and these have led to a series of recent claims on human rights grounds (American Immigration Council, 2015; Androff, 2016). In 2014, a group of immigrant rights organizations filed a complaint on behalf of 116 unaccompanied children who had allegedly been denied their basic rights and subjected to abuse, neglect, and maltreatment in Customs and Border Protection (CBP) facilities (Huebner et al., 2014). In 2015, the Inter-American Commission on Human Rights documented concerns pertaining to inadequate screening of unaccompanied children (especially Mexican youth) for their need for international protection, and (despite the issuing of new Department of Homeland Security detention standards) continued inadequate conditions and treatment of children in Customs and Border Protection facilities. Meanwhile, with the majority of unaccompanied children still unrepresented in their cases, a group of legal advocacy organizations have filed a class-action law suit (JEFM v. Holder, currently pending) challenging the government’s failure to provide legal assistance to children undergoing removal proceedings as a denial of their rights (American Immigration Council, 2015).

To date, access to mental health services for unaccompanied children has rarely been a direct focus of human rights advocacy in the United States. However, in promoting children’s broader rights (e.g., to family, education, recreation, and security), human rights work has bolstered key environmental factors that play a protective and promotive role in unaccompanied
children’s resilience processes. There is also significant overlap between unaccompanied children’s legal and mental health rights. Each of the major forms of U.S. immigration relief for which unaccompanied children are eligible require evidence of psychosocial stress, and as a result psychological testimony documenting exposure to and the impact of traumatic events is frequently an important component of cases. In our study of NYC lawyers working with unaccompanied children, in almost half of cases where lawyers made referrals expert testimony was the primary reason for doing so, and the majority of participants reported that having a mental health diagnosis typically assists in acquiring immigration relief. Legal and psychological considerations may also combine. In many cases where lawyers made mental health referrals, this was at least partially due to apparent posttraumatic stress symptoms and other emotional difficulties hindering their clients’ ability to engage with their lawyer or the court (Baily et al., 2014).

Beyond petitioning for unaccompanied children’s protection following traumatic experiences, there is also a place for a human rights perspective to influence mental health treatment more directly, in asserting children’s right to psychological services, in championing an approach to care that adheres to the principles of child participation in treatment decisions and respect for children’s views, and in acknowledging that while violations of human rights can adversely impact mental health, respect for human rights can actively promote mental wellbeing. This is in keeping with a view of resilience including both individuals’ capacity to navigate towards needed resources and their capacity to negotiate for these to be given in a culturally appropriate fashion (Ager et al., 2013; Porsdam Mann, Bradley, & Sahakian, 2016). Such approaches have been adopted in a variety of settings in the United States and internationally, ranging from nationwide health initiatives to general and forensic hospitals, prisons, and
specialized mental health clinics. An assessment of mental health programs adopting a human rights-based approach by Porsdam Mann and colleagues (2016) suggested the following positive outcomes: increased patient involvement, empowerment, and investment in treatment; a better environment for staff, patients, and caregivers; reductions in distress; and low cost of implementation. A human rights-based approach to care might be particularly pertinent to unaccompanied children, not least in promoting a view of mental health focused less on victimization and more on empowerment. This perspective is typically more consistent with unaccompanied children’s own narratives about themselves (Aldarondo & Becker, 2011).

**Summary of Existing Psychosocial Research on Unaccompanied Children and Rationale for Current Study**

Although recent years have seen an exponential growth in the literature on the mental health needs of unaccompanied children in Europe, there has been little psychological research on unaccompanied children in the United States. Given considerable discrepancies in the backgrounds, migration experiences, legal context, and living situations of unaccompanied children in different countries, it is unclear to what extent findings from Europe generalize to children in the United States. Given the increasing number of unaccompanied children coming to the United States, their high exposure to stressors, and limited supports, there is an urgent need for studies assessing the psychosocial context and psychological needs of this population of youth.

The U.S. legal advocacy and social sciences literature have documented unaccompanied children’s exposure to psychosocial stressors. However, systematic analyses of these stressors from a psychological perspective and linked to mental health and functional outcomes are lagging behind. A current barrier to such analyses is the lack of standardized assessment of
unaccompanied children’s mental health presentation. To facilitate this, mental health screening measures should be validated for use with these children. Psychometric testing of current instruments would help to identify potential limitations in using U.S. psychiatric assessment paradigms with these youth and to highlight cross-cultural considerations in assessing their needs. Conversely, the availability of reliable, culturally validated screening instruments would allow researchers to document types and rates of psychopathology in unaccompanied children and test the effectiveness of therapeutic interventions, clinicians and other professionals (e.g., teachers and lawyers) to screen for mental health problems, and children’s rights organizations to advocate for greater access to services for unaccompanied children.

The research literature on unaccompanied children to date has focused heavily on children’s exposure to adversity and resulting difficulties. However, research is also required to consider the broader range of responses to migration experiences in unaccompanied children, including both risk and resilience trajectories. This research should investigate the interconnecting psychosocial factors (e.g., familial care, community support, academic opportunities, and perceived discrimination) that confer protection against and vulnerability for the development of psychological and behavioral problems and, equally, those that promote normative child development. It should also seek to identify facilitators of and obstacles to mental health service utilization encountered by unaccompanied children in the United States, focusing on both availability and accessibility of services. Furthermore, it should include assessment of structural (e.g., cost, transportation issues, and availability of bilingual service providers) and attitudinal factors in service access (e.g., the influence of psychoeducation and mental health stigma on unaccompanied children, their caregivers, and their communities).
There has been very little research on psychosocial interventions for unaccompanied children. Studies are needed to develop and test feasible, accessible, and culturally acceptable mental health interventions for these youth. This research should investigate the feasibility of a variety of pathways into care and seek to identify key moments for intervention and optimal methods of screening for need. A variety of models of care should be considered, including school-based programs and integrated models providing a range of services (e.g., mental health, medical, and legal) in one setting. In developing best practices for the care of unaccompanied children, studies should attempt to discern what is unique to the experience of unaccompanied children and shared with other immigrant children of similar heritage, borrow from and adapt existing models accordingly, and test the feasibility and effectiveness of interventions for unaccompanied children in a range of contexts and settings (e.g., living in the community versus in child shelters). This research should take a broad view of what constitutes a psychosocial intervention and acknowledge the synergistic relationship between counseling, medical care, legal representation, and other services.

To date, there has been a stark division between qualitative studies documenting unaccompanied children’s migration experience and empirical, quantitative research measuring their mental health symptoms. Mixed methodologies should be used to balance these approaches, providing a more comprehensive and nuanced understanding of unaccompanied children’s needs. This work should be informed by a human rights perspective that moves beyond narratives of victimization and need to empower children as active participants in their development. Methodologies should reflect this stance by placing children at the heart of the research process through use of data collection methods such as autoethnographies and participatory action research.
A comprehensive response to any of these areas of inquiry is beyond the scope of this small study. Rather, the goal was to develop a detailed understanding of the psychosocial context and psychological needs of a small group of children, and in particular to understand the interrelationship between children’s exposure to stressors, psychosocial supports, psychopathology, self-assessment, service utilization, and attitudes towards their migration experience. Through this approach grounded in participants’ perspectives we hoped to develop rich data to inform subsequent theory-driven research, as well as advocacy and interventions for unaccompanied children.

Aims and Hypotheses

This study aimed to investigate the mental health needs of unaccompanied children ages 10 to 18 who were in removal proceedings in NYC. Given the study’s mixed methodology and primarily inductive, exploratory nature, the aims included both open-ended research questions and testable hypotheses. The specific aims of the study were:

**Aim 1: Psychosocial context**

1. To examine the psychosocial context of unaccompanied children’s migration and identify risk and resilience processes in this population.

   *Research Questions:*

   1a. What reasons do unaccompanied children and their guardians state for children migrating to the United States?

   1b. What psychosocial stressors do unaccompanied children experience during their migration process?

   1c. What psychosocial supports do unaccompanied children receive during their migration process?
Id. How do unaccompanied children and their guardians understand and describe children’s experiences of distress and coping and their attitudes towards their migration process?

**Aim 2: Mental health diagnosis**

Aim 2a. To determine the rates and types of mental health disorders found in a sample of unaccompanied children using a structured clinical interview (the Diagnostic Interview Schedule for Children Version IV [DISC-IV]).

*Hypothesis 2a.* This sample of unaccompanied children will exhibit elevated rates of common *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) internalizing and externalizing disorders on the DISC-IV compared to U.S. community norms for the general adolescent population and immigrant youth, and similar rates to youth receiving psychosocial services.

Aim 2b. To provide initial data regarding the potential future use of child- and caregiver-report measures to screen for mental health disorders in unaccompanied children.

*Hypothesis 2b.* Results from the child-report (Hopkins Symptom Checklist for Adolescents [HSCL-37A] and Reactions of Adolescents to Traumatic Stress questionnaire [RATS]) and caregiver-report (Child Behavior Checklist [CBCL]) instruments will concur with diagnostic assessment on the structured clinical interview (DISC-IV) in this sample of unaccompanied children.

**Aim 3: Mental health service utilization**

Aim 3a. To determine the rate of mental health service utilization in a sample of unaccompanied children.

*Hypothesis 3a.* The gap between the number of children with DSM-IV diagnosable mental health difficulties and the number receiving mental health services will be greater among
this sample of unaccompanied children than estimates for both the general adolescent population and other immigrant youth.

Aim 3b. To determine obstacles to and facilitators of mental health service utilization in unaccompanied children.

Research Question 3b. What are the obstacles to and facilitators of mental health service utilization among unaccompanied children from the study referred to care?
Overview of the Research Design

This was a mixed methods study employing standardized diagnostic measures of mental health disorders, qualitative interviewing, and ethnographic procedures. In this way, we intended to investigate the interrelationship between unaccompanied children’s psychosocial context, psychiatric presentation, and mental health service utilization. The mixed methodology was also intended to assist in better understanding the migration experience of a multicultural population about whom little is currently known and whose attitudes towards mental health diagnoses and services may vary from the psychiatric models of distress and treatment dominant in American culture. Given that research on the mental health needs of unaccompanied children remains in its infancy, a main goal of the study was to gather descriptive data to develop hypotheses and inform future study, rather than organizing the study primarily around theoretical constructs such as complex trauma and resilience. Both the open-ended research questions and broad, mixed methods approach were designed to facilitate collecting this type of data. Table 1 provides an overview of the research design.
Table 1. Overview of study research design

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<th>Aim 1: Psychosocial context</th>
<th>Aim 2: Mental health diagnosis</th>
<th>Aim 3: Mental health service utilization</th>
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<tr>
<td>1a. What reasons do unaccompanied children and their guardians state for unaccompanied children coming to the United States?</td>
<td>2a. What are the rates and types of mental health disorders found in a sample of unaccompanied children using a standardized diagnostic interview?</td>
<td>3a. What is the rate of mental health service utilization in a sample of unaccompanied children?</td>
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<td>1b. What psychosocial stressors do unaccompanied children experience during their migration process?</td>
<td>2b. What is the feasibility of using child- and caregiver-report measures to screen for mental health disorders in unaccompanied children?</td>
<td>3b. What are the obstacles to and facilitators of mental health service utilization among unaccompanied children?</td>
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<td>1c. What psychosocial supports do unaccompanied children receive during their migration process?</td>
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<td>1d. How do unaccompanied children understand and describe their experiences of distress and coping and their attitudes towards their migration process?</td>
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<th>Methodology</th>
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<td>- Narrative interview</td>
<td>- Structured diagnostic interview (DISC-IV)</td>
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<td>- Autoethnography</td>
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Note. Abbreviations: SLE = Stressful Life Events questionnaire (Bean et al., 2004c), A&A = Adaptation and Attitude questionnaire (Bean, 2006), DISC-IV = Diagnostic Interview Schedule for Children Version IV (Shaffer et al., 2000), HSCL-37A = Hopkins Symptom Checklist for Adolescents (Bean et al., 2004a), RATS = Reactions of Adolescents to Traumatic Stress questionnaire (Bean et al., 2004b), CBCL = Child Behavior Checklist (Achenbach & Rescorla, 2001).
Participants

Participants were unaccompanied children living in the community in the NYC metro area with their guardians. Inclusion criteria for child participants were: the child was living in the community with a sponsor (guardian) following release from government custody and pending immigration proceedings; the child was between 10 and 18 years old; and the child was Spanish- or English-speaking. The inclusion criterion for guardians was that they were the sponsor to whom the child participant had been released. There were no exclusion criteria based on other aspects of children’s psychosocial context, psychological presentation, or mental health needs.

The study focused specifically on unaccompanied children living with sponsors in the community. Despite the fact that approximately 85% of unaccompanied children detained by the Office of Refugee Resettlement are then released to sponsors, to our knowledge no previous study has looked at the mental health needs of this group specifically. Instead, there has been more focus on the psychological needs of unaccompanied children in government custody. However, these children likely differ systematically from those who are released with regard to reasons for migration, stressors experienced, and access to formal and informal supports.

The 10 to 18 age range of child participants and Spanish- or English-speaking language criteria were chosen to include the broad majority of unaccompanied children in the United States without deviating substantially from the established age norms for the instruments used. Common mental health research exclusion criteria such as severe psychopathology and suicidal ideation did not rule children out of participation in the study. Given the study’s emphases on understanding the broad range of children’s experiences, case identification, and referral into appropriate mental health services, it was deemed appropriate to interview children at all levels of mental health need. In addition, it should be noted that unaccompanied children in the
community have already been assessed for acute risks and vulnerabilities to determine their suitability for release from ORR facilities (Byrne & Miller, 2012).

Initially, potential participants were accessed and informed about the study via two local ORR-funded programs for unaccompanied children and their families run by Catholic Charities of the Archdiocese of New York. One was the Legal Orientation Program for Custodians, which provides information to local sponsoring families on the immigration process and how to access legal, educational, health, and other community services. The other was the Safe Passages program, which gives post-release case management services to children identified through ORR as especially vulnerable. Shortly after commencing the study, we decided to discontinue recruitment via Safe Passages, in order to minimize potential sampling bias resulting from case workers selecting particular children for the study from their already by definition high-need client group. Only one child was recruited to the study via this program.

LOPC meetings are offered as a free service to families sponsoring unaccompanied children. All guardians of children newly-released in the NYC metro area are contacted by staff at the Unaccompanied Minors Project at Catholic Charities and asked to attend. Starting in August 2013 and ending in June 2014, at every orientation LOPC staff described the study, provided attendees with a copy of the study flyer, and asked attendees if they were willing to be contacted by a member of the study team about potential participation or, alternatively, wanted to take telephone details to contact the study team themselves.

This recruitment procedure was designed to inform as wide a cross-section of potential participants as possible about the study. The aim was to gather information about the full range of children’s migration experiences, including children who had suffered extreme adversity and were struggling emotionally but also children who had experienced fewer difficulties. To this
end, the study description emphasized learning about children’s migration experiences broadly rather than just their mental health needs specifically. Furthermore, the staff running the orientations presented the study to every attendee and had no specific knowledge of each family and their context, thus limiting targeted selection of participants based on perceived need.

Of the approximately 500 families notified about the study (based on records kept by Catholic Charities), the sponsors of 202 (roughly 40%) children agreed to be contacted by the study team. A further four sponsors contacted the study team directly about the study. Families who expressed an interest in the study were contacted by a study interviewer, provided with a more detailed description of the study, its potential risks and benefits, and the voluntary and confidential nature of participation, and given an opportunity to ask any questions they might have about the study. If both the sponsor and child agreed to participate in the study, a date was arranged for the study interview at Teachers College, Columbia University.

We took the issue of coercion, real or perceived, with this vulnerable population very seriously. First and foremost, for ethical reasons we did not want any family to feel to feel in any way compelled to participate in the study. Secondly, we did not want any perceived pressure to participate to create selection bias. Therefore, at every stage of the recruitment process the voluntary nature of participation was explained and emphasized. In particular, we emphasized that participation would in no way affect children’s access to legal representation or other services received from Catholic Charities (and that they would not be notified as to whether children participated in the study), nor would participation have any other bearing on children’s immigration cases. The $15 gift card (in addition to reimbursement for public transportation to and from the study interview) provided to each participating guardian and child was intended to serve as a token of gratitude without creating financial incentives or pressure to participate.
Figure 2 shows the sampling for the study. Of the 179 children for whom contact was attempted, 14.5% (26/179) participated. Of the 135 children for whom contact was made (meaning a member of the research team contacted and spoke with the family) and who were eligible for the study, 19.3% (26/135) participated. In order to have a clearer idea of sampling bias, it would have been helpful to obtain comprehensive information on families’ reasons for not participating. However, only 32 families stated outright that they did not wish to participate, compared to 77 families who expressed interest in the study but with whom contact was later lost. Some families did not return follow-up calls about interview scheduling and a number did not present for scheduled interviews after reconfirming in the days beforehand.

LOPC = Legal Orientation Program for Custodians

Figure 2. Study sampling flowchart.
Although it was not possible to collect systematic data on factors influencing families’ decision to participate, members of the research team mentioned several common themes. Logistical issues were a common barrier to scheduling. Many sponsors reported working multiple jobs with very limited time off, and balancing this with multiple childcare responsibilities. Frequently, families lived in NYC’s outer boroughs or outside the city, rendering travel to Teachers College time-consuming and challenging. In other instances, families expressed confusion or, in certain instances, suspicion about the purpose of the study. Several families alluded to fearing that information they provided might be shared with the government, especially after hearing that the study interviews would be recorded. At the same time, families also commonly seemed reluctant to decline to participate, despite reassurances from the study team that it was alright to do so. Often, it was not clear whether families genuinely wanted to participate but felt overwhelmed with other commitments, were ambivalent, did not want to participate but out of politeness did not feel they could say so, were concerned that there could be some negative implications of declining to be involved, or some combination of these. In one instance, a study interviewer called to confirm the night before a scheduled interview with a child and guardian who had enthusiastically agreed to participate, only for the phone to be answered by a man who stated that the family would not be participating and threatened the interviewer. It was not clear whether this man was articulating the wishes of the guardian and child, was anxious about the study purpose, or was in some type of coercive relationship with them (some unaccompanied children are vulnerable to ongoing trafficking concerns following their arrival in the United States). However, together these experiences from the sampling process gave some initial insight into the complex pressures, responsibilities, and challenges encountered by many families sponsoring unaccompanied children.
**Procedure**

Study interviews were completed at Teachers College, Columbia University, in counseling rooms at the Dean Hope Center for Educational and Psychological Services and (when these were unavailable) other rooms in the College booked for the interviews. Each interview was conducted by a pair of interviewers, one of whom interviewed the child and one of whom interviewed the guardian. As every study participant was predominantly Spanish-speaking, all interviews were conducted in Spanish. Following review of the study procedures and signing of the informed consent and assent forms together, children and guardians moved to separate offices. The child- and caregiver-report screening measures were completed prior to the rest of the study tasks in order to avoid potential priming effects from the diagnostic interview and recounting of children’s migration experiences. Typically, it took participants two to three hours to complete the screening measures, structured diagnostic interview, and semi-structured narrative interview. If participants were struggling to maintain their attention, interviewers encouraged them to take breaks. Snacks were provided during longer interviews.

Study interviewers were trained in all aspects of the study protocol, including administrating the computerized version of the Diagnostic Interview Schedule for Children Version IV (DISC-IV), conducting the narrative interview (with an emphasis on assisting children and their sponsors in telling their migration stories while being as non-directive as possible), and giving the semi-structured follow-up interview. Study interviews were recorded and reviewed by this author for adherence to protocols.

At the end of the study interview, children were provided with a notebook in which to complete the autoethnography in their own time. They were also given an addressed and stamped envelope in which to send the notebook back to Teachers College. In practice, some children
chose to complete their autoethnographies immediately after the interview, while others completed them at home and returned their booklets by mail. In total, we received autoethnographies from 17 of the 26 children in the study.

Children who screened positive for mental health problems on the study measures or who expressed interest in receiving psychological services were contacted by phone and mail with a list of referrals tailored to the child’s neighborhood and presenting needs. These were drawn from a master list of referrals created by a member of the study team based on location, cost, population served, and current availability of clinicians. In cases where referrals were provided, children and their caretakers were asked if they would be willing to participate in a follow-up phone interview assessing service usage and barriers. These lasted approximately 15 minutes and were scheduled for three months after the initial interview (although in some instances they were delayed, due to difficulties contacting families).

The study procedure also included a number of measures to maintain participants’ confidentiality. The survey interview did not elicit names or other identifying information from participants and potentially identifying information that subjects provided over the course of the interview (e.g., city of origin, date of arrival in the United States, and current school) were not included in the results documented. In place of their names, participants were assigned a study number to which their data were linked. Hard data (e.g., child- and caregiver-report questionnaires) were kept by this author in a locked desk and digital data were kept on an encrypted, password-protected flash drive.

The study recruitment, interview, and follow-up procedures are outlined in Figure 3.
Figure 3. Study recruitment, interview, and follow-up procedures.

Measures

The study measures were selected to capture multiple aspects of children’s presentation and different perspectives on their experience. Efforts were made to limit the length of the child and guardian interviews, such as avoiding redundancy between screening measures and eliminating certain diagnostic modules on the DISC-IV.

**Narrative interview.** In order to learn about the psychosocial context and migration experiences of children in the study (Aim 1), they and their guardians completed a narrative interview. The goal was to obtain a personal account of children’s migration experiences rather than obtain data on a highly structured and specified list of questions. To this end, interviewers
were encouraged to allow children’s account to develop naturally, keeping prompts to a minimum. This approach was also designed to minimize the impact of demand characteristics based on children trying to offer the “correct” answer to directive questions rather than reflecting on their own experiences.

Nevertheless, in order to insure that a range of core themes was covered, study interviewers were provided with a narrative interview protocol. This was developed by this author in conjunction with mental health and legal service providers working with unaccompanied children. Following an initial prompt of “Tell me about how you/your child came to be in the United States,” areas to be covered included: reasons for coming to the United States; family background and pre-migration circumstances; journey to the United States; apprehension and detention experiences; immigration process; resettlement and current circumstances; stress and coping; and health/mental health problems and service utilization. Although the protocol also included potential follow-up questions, interviewers were instructed to use these as a guide rather than following them exactly, such that the specific questions asked depended on the child, their experience, and what they and their guardian chose to disclose. This author reviewed interviews for adherence to this methodology.

**Adaptation and Attitude questionnaire (A&A).** The A&A was used to gather structured, child-report data about acculturation issues in unaccompanied children as a supplement to families’ qualitative descriptions of children’s adaptation in the United States (Aim 1). The measure was developed by Bean (2006) to assess unaccompanied children’s adaptation and adjustment to their current life in their destination country, and to this author’s knowledge is the only measure of its type designed specifically for unaccompanied youth. It has 21 Likert-type questions (with response options including *yes, sometimes, no, and I don’t know*),
one question eliciting children’s top three wishes, and another asking children to predict how their life will be in 10 years’ time (Bean, 2006). The measure has not been used extensively in research studies or undergone rigorous testing. However, in Bean’s study (2006) factor analysis confirmed a three-factor model based on general adaptation and attitudes towards work and security. However, the internal consistency of the measure was questionable, with total score $\alpha = .70$, work subscale $\alpha = .61$, and security subscale $\alpha = .68$ (Bean, 2006). In our study, it was used primarily in a descriptive capacity.

**Autoethnography.** The autoethnography provided children in the study with the opportunity to record aspects of their experiences that did not occur to them or were not covered during their study interview, and to use both writing and drawing to express themselves. The autoethnography is a research tool that aims to place the author at the center of the research (Ellis, 2004), and has been used with immigrant children (e.g., Feuerverger, 2011). The author determines which details are important, how deeply to explore them, and how the different aspects of the narrative interrelate (Ellis, 2004). This emphasis on consideration of children’s perspectives is consistent with a human-rights centered approach to understanding and attending to unaccompanied children’s needs.

In addition to the booklet in which to record their experiences, children were provided with the following autoethnography prompt: “In this booklet, please tell your story about coming to the United States and your experiences since arriving here. You can write and/or draw whatever you would like. There are no right or wrong answers. Your story can be as long or as short as you want, however much space it takes to tell your story.”

**Diagnostic Interview Schedule for Children Version IV (DISC-IV).** The DISC-IV was used to assess psychiatric disorders and diagnosis-related functional impairment (Aim 2a).
Additionally, it was used as a standard of comparison for child- and caregiver-report screening measures (Aim 2b). Researchers working with unaccompanied children (e.g., Bean, 2006) have previously proposed the use of standardized interviews as part of the validation process for screening measures used by these youth. To the author’s knowledge, this is the first study to do so.

The DISC-IV is one of the most widely used and studied structured diagnostic interviews in both clinical and community populations, including in Latino populations (e.g., Alegría et al., 2004; Canino et al., 2004; Gudiño, Lau, & Hough, 2008). The measure is designed to assess for DSM-IV psychiatric disorders in children and adolescents, and can be administered by non-clinicians after minimal training. Youth and caregivers are interviewed using parallel formats (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). The test-retest reliability of English-(e.g., Schwab-Stone et al., 1996; Shaffer et al., 2000) and Spanish-language (e.g., Bravo et al., 2001; Ribera et al., 1996) versions of the instrument have been tested using Cohen’s kappa coefficient. Reliability varied by diagnosis and reporter, as is typical for diagnostic evaluations, but overall was considered good to moderate. Validity testing for the DISC is limited (Shaffer et al., 2000), but previous versions of the instrument have shown moderate to very high concordance with clinicians’ diagnostic assessments (Fisher et al., 1993; Schwab-Stone et al., 1996). An updated version of the measure assessing DSM-5 diagnoses has not yet been developed.

Although the DISC was developed for use with children ages nine to 17, and parents of children ages six to 17, there is precedent for its use with 18-year-olds (Shaffer et al., 2000), the highest age in this study. A number of diagnostic modules were omitted due to concerns that participants, especially younger children, would lose focus if interviews became too long and
that this would compromise accuracy of reporting. These included modules assessing less common diagnoses (e.g., anorexia nervosa) and disorders that, theoretically, were less likely to be impacted by migration experience (e.g., attention-deficit/hyperactivity disorder). Even with these cuts, the administration time typically ranged from 45 to 90 minutes for each respondent.

**Hopkins Symptom Checklist for Adolescents, Stressful Life Events questionnaire, and Reactions of Adolescents to Traumatic Stress questionnaire.** The HSCL-37A, SLE, and RATS were used to provide initial data regarding the potential future use of child-report screening measures of mental health conditions and psychosocial stressors with unaccompanied children (Aim 2b). Bean and colleagues developed these measures for their research with unaccompanied and other migrant children in the Netherlands and Belgium (Bean, Eurelings-Bontekoe, Derluyn, & Spinhoven, 2004a, 2004b, 2004c). They have been translated into multiple languages and have showed strong reliability and validity (Bean, 2006). The original study population was children ages 12 to 18, as compared to the 10 to 18 age range in our study. However, the items were written for a primary reading level (Bean et al., 2004a, 2004b, 2004c) and, in accordance with use of these instruments in prior studies, interviewers provided clarification of questions to children as needed.

**Hopkins Symptom Checklist for Adolescents (HSCL-37A).** The HSCL-37A is a 37-item measure of past-month depression, anxiety, and externalizing symptoms that was designed by Bean and colleagues for their research with unaccompanied and other migrant children in the Netherlands and Belgium (Bean et al., 2004a). Each symptom is rated on a 4-point Likert-type scale ranging from *never* to *always*. It is an adaptation of the Hopkins Symptom Checklist-25, a well-known screening measure that has been used in research and clinically throughout the world with diverse populations, including refugees, to measure symptoms of depression and anxiety in
adults. The HSCL-37A adds twelve items relating to oppositional behavior, conduct problems, and substance abuse. The instrument underwent extensive psychometric testing with the large research sample for whom it was developed (Bean et al., 2004a). At the total scale level, the measure showed excellent internal consistency, with Cronbach’s alpha (α) = .91 (internalizing subscale α = .92; externalizing subscale α = .69). Test-retest reliability following a 12-month interval was considered reasonable, with a total scale stability coefficient (r_2) of .63 (internalizing subscale r_2 = .64; externalizing subscale r_2 = .55). The construct validity of the measure was strong based on correlations of children’s scores with other measures of psychosocial stress and internalizing and externalizing behaviors. Factor analysis indicated a two-factor model of internalizing and externalizing symptoms. The measure showed good criterion validity as assessed in relation to children’s number of self-reported stressful life events on the SLE, children’s perceived need for help (as assessed by the child, the child’s guardian, and a teacher), self-reported use of psychosocial services, and referral to services by the child’s guardian (Bean et al., 2004a).

Normative data for the HSCL-37A is limited to the samples of unaccompanied minors, other immigrant children, and indigenous children in the Netherlands and Belgium used in the development of these instruments (Bean et al., 2004a; Bean et al., 2007a) and several follow-up studies of migrant youth (e.g., Derluyn et al., 2008; Vervliet et al., 2014). Bean and colleagues (2004a) established cutoffs for high and very high scores based on percentile scores and criterion-referenced to children’s self-perceived need for psychosocial help. By comparison, the HSCL-25 (which forms the internalizing subscale of the HSCL-37A) has been widely used in many countries, and the clinical cutoff of two standard deviations above the mean established by Derogatis and colleagues in the community sample of American adults upon whom the test was
initially normed (Derogatis, Lipman, Rikels, Uhlenhoth, & Covi, 1974) has since been validated for use with refugee populations (Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987). However, the instrument has not been normed for use with migrant youth.

**Stressful Life Events questionnaire (SLE).** The SLE (2004c) and RATS (2004b) were also developed by Bean and colleague, to document unaccompanied children’s exposure and reactions to potentially traumatic stressors. The SLE consists of 12 dichotomous (yes/no) questions and one open-ended question inquiring whether children have been exposed to different types of stressful life events. These events fall into five categories: events concerning family; experiences of illness, accidents, and disasters; war-related events; physical and sexual mistreatment; and miscellaneous other stressful life events (Bean et al, 2004c).

**Reactions of Adolescents to Traumatic Stress questionnaire (RATS).** The RATS is a 22-item measure developed by Bean and colleagues (Bean et al., 2004b) to assess PTSD symptoms occurring over the past four weeks. It contains the DSM-IV criteria for PTSD, formulated in language designed to be comprehensible to refugee adolescents, and grouped into the intrusion, numbing/avoidance, and hyperarousal clusters. Each item is measured on a 4-point Likert-scale ranging from not to very much. The psychometric properties of the measure were tested in a similar manner to the HSCL-37A, with the same research sample. The measure showed strong total scale internal consistency, with $\alpha = .88$ (intrusion subscale $\alpha = .85$; numbing/avoidance subscale $\alpha = .69$; hyperarousal subscale $\alpha = .75$). The 12-month test-retest reliability for the total scale was moderate, with an $r_2$ coefficient of $.64$ (intrusion subscale $r_2 = .65$; numbing/avoidance subscale $r_2 = .46$; hyperarousal subscale $r_2 = .59$). The measure displayed good construct validity as assessed by correlations with other symptom measures administered and good factorial validity, with factor analysis supporting a three-factor model based on the three PTSD criteria.
clusters. The same indicators of criterion validity (exposure to stressful life events, perceived need for psychosocial help, and use of/referral to services) were used for the RATS as the HSCL-37A, with the RATS also demonstrating good criterion validity. Also like the HSCL-37A, norms for the RATS were determined by percentile scores criterion-referenced to children’s perceived need for psychosocial help (Bean, 2004b).

**Child Behavior Checklist (CBCL).** The CBCL was used to provide initial data regarding the potential future use of caregiver-report screening measures with unaccompanied children (Aim 2b). It is among the most widely used and studied screening measures for behavioral and emotional difficulties in children and adolescents ages six to 18. The CBCL is the caregiver-report form for the Achenbach System of Empirically Based Assessment (ASEBA). Respondents rate items on a 3-point Likert scale ranging from 0 (not true) to 2 (very true or often true). The CBCL has 118 Likert-type items and takes approximately 15 minutes to administer. It can be self-administered or administered orally, depending on reporters’ reading ability. Scores are based on factor analyses scaled across forms. The measure provides a total score, subscale scores for internalizing and externalizing symptoms, and scores of empirically-based syndromes (anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, and aggressive behavior) and DSM-IV syndromes (mood problems, anxiety problems, somatic problems, attention deficit/hyperactivity problems, oppositional defiant problems, and conduct problems) (Achenbach & Rescorla, 2001).

The CBCL has been translated into multiple languages and used in studies of displaced and refugee children (e.g., Mollica et al., 1997; Montgomery, 2008; Rousseau, Drapeau, & Platt, 2000; Sourander, 1998). In their research with unaccompanied and other migrant youth in the Netherlands and Belgium, Bean and colleagues used the CBCL as a caregiver-report measure.
Factor analysis confirmed a two-factor model of internalizing and externalizing symptoms, with moderate factorial validity. The measure showed excellent internal consistency, with total scale $\alpha = .94$, internalizing subscale $\alpha = .89$, and externalizing subscale $\alpha = .90$. The measure discriminated effectively between children who were and were not identified as in need of mental health services by guardians and teachers, but not based on children’s self-perceived need for help (Bean et al., 2006). However, discrepancies between child reporting of mental health concerns and caregiver-report CBCL scores have been commonly noted across studies (Achenbach, McConaughy, & Howell, 1987; Yeh & Weisz, 2001).

A number of recent studies have found the CBCL to have strong psychometric properties in Spanish-speaking populations (e.g., Albores-Gallo, Lara-Muñoz, Esperón-Vargas, Cárdenas, Pérez, & Villanueva, 2007; Lacalle, Ezpeleta, & Doménech, 2012). Perhaps of most relevance to this study’s population, most of whom were from Central America, Albores-Gallo and colleagues (2007) tested the psychometric properties of a Spanish-language version of the CBCL for children in the community and outpatients from a children’s psychiatric clinic in Mexico. The measure showed strong internal consistency, with total scale $\alpha = .97$, internalizing subscale $\alpha = .90$, and externalizing subscale $\alpha = .94$. The test-retest reliability (as measured using intraclass correlation coefficients) was .97 for the total problem scale (Albores-Gallo et al., 2007).

The CBCL **borderline** and **clinical** cutoffs are based on percentile scores in the normative sample and criterion-referenced to children referred to mental health services (Achenbach & Rescorla, 2001). Although the instrument has been researched extensively across many countries, there are no established norms for El Salvador, Guatemala, Honduras, or Ecuador (the home countries of children interviewed in our study). In scenarios where no norms exist for the
countries studied, the multicultural scoring guidelines (Achenbach & Rescorla, 2007) suggest using the standard default norms, norms established for a country with a similar heritage (e.g., Peru), or, in the case of immigrants, possibly the norms of the host country (i.e., the United States). In the case of the study population, these criteria are all fulfilled by Norm Group 2 (Achenbach & Rescorla, 2007).

**Follow-up telephone interview on service utilization.** In cases where child participants were referred to services, the child and guardian completed separate semi-structured telephone interviews about service utilization scheduled for three months after their initial study interview. This interview inquired about whether children had obtained services for mental health difficulties, barriers and facilitators to service access, impressions of services received and reasons for ending treatment (among children no longer receiving services), and whether children were currently experiencing distress.

**Human Subjects Approval**

This study was approved by the Internal Review Board at Teachers College, Columbia University (IRB protocol # 13-280). As noted previously, the voluntary and confidential nature of the study was emphasized to study participants throughout the recruitment process and prior to signing of the informed consent and assent documents. One risk associated with the study was the possibility that children could become emotionally distressed while discussing their migration experiences and any mental health difficulties they might be experiencing. To minimize this risk and its potential consequences, the interviewers in this study were masters-level clinical psychology and social work students. They were trained on interviewing techniques for potentially traumatized child immigrant populations and on the safety assessment protocol. This protocol, for use in situations where children became acutely distressed or presented as a
danger to themselves or others, included additional assessment and liaison with the study’s medical monitor, Dr. Schuyler Henderson (who was also the study’s co-principal investigator). However, as no children presented with imminent risk concerns, it was not necessary for him to be contacted in this capacity at any point in the study.

**Data Analysis**

The study generated four distinct forms of data. The narrative interview and autoethnography provided qualitative data that was reported in a narrative format. Frequencies of qualitative data were, in general, not reported due to variability in the questions asked (and hence differences in the content covered) in different interviews. The DISC-IV structured diagnostic interview provided categorical data on the frequency of different diagnoses. The child- and caregiver-report standardized screening measures (HSCL-37A, SLE, RATS, A&A, and CBCL) provided quantitative data and these were analyzed using descriptive and inferential statistics. The semi-structured care-utilization follow-up interview provided a combination of frequency and qualitative data.

**Analysis of qualitative data.** Data from the narrative interviews and autoethnographies were analyzed qualitatively. Given the primarily descriptive, hypothesis- and theory-generating aims of this research, a thematic analysis approach was chosen. The first step of the analysis was to identify themes within and across interviews in an inductive (non-theory-driven) manner and to organize them into a network of codes and sub-codes.

The coders were psychology and counseling Masters students recruited via the Global Mental Health lab at Teachers College. Some had prior qualitative research experience and some had worked in clinical contexts with vulnerable child populations (e.g., children trafficked for sex in India and child welfare work in Afghanistan). Eleven of the coders were female and two
were male. They came from a variety of countries including Australia, India, France, and the United States. Coders’ different experiences and perspectives were highlighted throughout the coding process through the use of memos, journal entries, and team discussion. In order to limit coding bias, coders were not made aware of the specific research questions posed in this study but instead instructed to code for any and all themes they identified (rather than deriving codes with the specific research questions in mind). Only once the coding process had been finished were the encoded data used to address the research questions.

Data were coded using the NVivo Version 10 qualitative data analysis software package. Applying the iterative thematic analysis process described in the qualitative methodology literature (e.g., Braun & Clarke, 2006), the coding procedure was as follows: 1) all data were transcribed and translated from Spanish into English; 2) every member of the coding team was provided with the same three pairs of child and guardian interview transcripts to read and reread for initial impressions, which were recorded in the form of memos (for ideas or queries about specific aspects of the text) and journal entries (for more general thoughts and impressions about the interviews); 3) an initial whole-team coding meeting was held to discuss impressions of the interviews, identify themes, generate initial codes based on these themes, define the codes, and organize them into an initial draft of the codebook; 4) coders reread and recoded their interviews based on this initial codebook, noting any additions to be made, redundancies between codes, and potential categorization of codes into nodes and sub-nodes; 5) a second whole-team coding meeting was held to consolidate the codebook; 6) coders were divided into four sub-teams of three, in which each coder had primary responsibility for coding two to three pairs of interviews and reviewing other team members’ interviews; 7) as coders identified new potential themes and sub-themes, they submitted them as proposed revisions to the master codebook, which was
updated on an ongoing basis by this author to reflect these additions; 8) sub-teams met to discuss their interviews, and suggestions and queries from these meetings were used for further consolidation of the codebook (e.g., new codes, clarifying definitions, code consolidation etc.); 9) this author consolidated all coded interviews into a single thematic map with narrative data nested into the various nodes and sub-nodes; and 10) themes and accompanying illustrative examples were drawn from the thematic map and used, in conjunction with other data sources (e.g., the child-report Stressful Life Events questionnaire), to address the study’s research questions. In keeping with the exploratory, inductive nature of the study, coding was designed to be conducted primarily at an explicit rather than a latent level, with a main goal of description rather than interpretation (Braun & Clarke, 2006).

Consistent with a thematic analysis approach, efforts were made to limit interpretative coding. For example, coders frequently noted their own impulse to make inferences about the psychological impact of situations (e.g., to assume that a particular event or situation was helpful or harmful regardless of whether a child mentioned how they were affected). Coders also identified situations in which interviewers appeared to be making interpretations (e.g., through the use of leading questions), in which case content was not typically coded. What constituted a theme was another common source of reflection and discussion, as the team considered whether to highlight certain low frequency but particularly striking and potentially impactful situations (e.g., witnessing the death of fellow travelers) by including them as their own sub-codes. Ultimately, potential themes were considered based both on how frequently a topic was raised and the psychosocial relevance of the content (e.g., the extent to which it appeared to contribute to children’s vulnerability or coping). Other than for a few topics about which every family provided data (e.g., reasons for coming to the United States, length of separations from
caregivers, and whether the child had acquired legal representation,), frequency data were not reported in the qualitative analyses. However, to provide a sense of the recurrence of different themes across interviews and in keeping with qualitative analysis conventions (Braun & Clarke, 2006), some frequency markers (e.g., “a few,” “many,” and “most”) were included.

Reflecting the study’s emphasis on families’ individual experience of migration, the qualitative data collection, coding, and analysis process was inherently subjective. Interviews and autoethnographies were intentionally unstructured and open-ended and conducted by a variety of interviewers, leading to differences in style and emphasis. Team members with varied backgrounds and perspectives regarding migration and child mental health issues coded the transcribed data. During the data analysis, themes and examples were drawn selectively from the coded data in response to specific research questions and ultimately at the service of the wider goal of this study, to contribute data towards a grounded theory of risk and resilience processes in unaccompanied children. Despite the intention of presenting the qualitative data in a largely descriptive, non-inferential a manner, this broader purpose inevitably had some bearing on the way in which the data was organized and shared.

**Analysis of quantitative data.** Study hypotheses had been developed before collecting the data. Prior to testing these hypotheses, descriptive statistics were calculated for sociodemographic factors and all quantitative variables to determine frequencies and data distributions. These statistics were used to inform which statistical test was appropriate for a given comparison. The small sample size led to increased risk of violation of assumptions of many common parametric tests (e.g., normality of data distributions, homogeneity of variances, and absence of significant outliers).
Normality of continuous data was tested using the Shapiro-Wilk test ($p < .05$). Presence of outliers was assessed through visual inspection of box plots (with outliers defined as data points outside the interquartile range by over 1.5 times the length of the interquartile range). For correlational analyses, the assumption of linearity was assessed through visual inspection of scatterplots. When parametric test assumptions were violated, they were replaced with non-parametric alternatives: the independent samples t-test was replaced with the Mann-Whitney U test, the one-way ANOVA was replaced with the Kruskal-Wallis H Test, the Pearson product-moment correlation was replaced with the Spearman rank-order correlation, and the Pearson point-biserial correlation was replaced with the Kendall’s tau-b coefficient test. When parametric tests were used, homogeneity of variances was assessed. When the assumption of homogeneity of variances was violated (Levene’s test $p < .05$), the Welch t-test was used for significance testing in place of the standard independent samples t-test and the Welch ANOVA was used for significance testing in place of the standard one-way ANOVA. Comparisons of categorical variables (e.g., differences in gender by nationality) were performed using the chi-square statistic. In cases where there were one or more expected cell counts less than five, chi-square tests were replaced by exact significance testing (Fisher’s Exact Test for 2x2 contingency tables and the Fisher-Freeman-Halton Exact Test for larger configurations). Despite tailoring of tests to the small sample size, the limited $N$ meant that results from many tests were susceptible to Type II error. Although only tests for which $p < .05$ are reported as significant, all tests with $p < .10$ are noted. Findings from all inferential tests should be considered tentative. Testing of statistical models involving multiple predictor variables (e.g., regression analyses) was not possible due to the small sample size (Wilson VanVoorhis & Morgan, 2007).
**Anomalous and missing data.** One child participant had diagnosed cognitive difficulties and demonstrated limited understanding during the DISC-IV interview and on child-report screening measures (where her scores were identified as outliers in multiple box-plot analyses). Her DISC-IV diagnoses were therefore assessed based on caregiver-report alone and her child-report scores were removed from all analyses. Another child’s guardian missed four modules on the DISC-IV (Hypomania, Conduct Disorder, Alcohol Abuse, and Nicotine Abuse), so diagnoses for these modules were based on child-report data alone. Based on caregiver-report, one child screened positive for schizophrenia. However, the DISC-IV manual advises that positive cases of schizophrenia be treated as “possible” diagnoses subject to further review of the perceptual and thought disturbances described. Review of the guardian’s responses suggested that these symptoms did not constitute true psychotic experiences and were better accounted for by the child’s other mood and anxiety diagnoses. As such, the schizophrenia diagnosis was removed. One child completed the child-report measures months apart from the administration of his DISC-IV and his guardian’s caregiver-report measure. Due to differences in time-frame for which symptoms were reported, these scores were removed from comparisons of child- and caregiver-report measures and of child-report measures and DISC-IV findings.

Consistent with the user’s manuals for the HSCL-37A (Bean et al., 2004a) and RATS (Bean et al., 2004b), extrapolation was used to estimate the value of missing items on these measures, calculated as the mean of the participant’s completed items multiplied by the number of items in the scale. Due to the potential for participants excluding items nonrandomly, which could thus create systematic bias in the data, scores for a given scale or subscale were omitted if more than 10% of the data were missing for that scale. In practice, there was very little missing data. One child missed two items on the HSCL-37A (both from the depression subscale,
resulting in his scores on this scale being excluded from analyses), and two children missed one item each on the RATS. Six children had missing data on the A&A, including one child with two missing items and another one with three (resulting in this latter child’s A&A total scale score and A&A work subscale score being omitted from the analyses). Two children were missing an item on the A&A Security subscale, resulting in those children’s data being omitted from analyses of that subscale.

On the CBCL, missed items, items with multiple responses, and items requiring clarification were scored according to guidelines from the instrument’s manual (Achenbach & Rescorla, 2001). Items with multiple responses were given a score of 1 and, consistent with other studies that have used the CBCL (e.g., Nakamura, Ebetsutani, Bernstein, & Chorpita, 2009) extrapolation was used to account for missing items (as with the child-report measures, using the mean of the participant’s completed items multiplied by the number of items in the scale). Six guardians had missed one item, and one had missed two items.

The presence of two pairs of siblings in the sample, with the same guardian reporting for both children in each pair, created a threat to the assumption of independence in these data analyses. Potential responses to this scenario included removing one sibling from each pair from the analyses and adjusting significance tests (e.g., Wadsworth, Olson, Willcutt, & DeFries, 2012). However, either approach would have compromised analyses in what was already a small sample. Nevertheless, these two sets of paired data present a caveat to the interpretation of findings.

**Sociodemographic characteristics.** Sociodemographic characteristics recorded included gender, age, nationality, and relationship to guardian. To assess the representativeness of the sample, these data were compared to the sociodemographic characteristics of the total population
of unaccompanied children detained in Office of Refugee Resettlement custody in FY 2014 (the period covering October 1, 2013 to September 30, 2014, the fiscal year with the greatest overlap with the study) using the chi-square goodness of fit test. Between-group differences across age, gender, nationality, and guardian relationship were also assessed.

Study Aim 1: Psychosocial context.

Research Question 1a: Stated reasons for migration. Data regarding reasons for migration were drawn from the reasons for migration node of the thematic map and its constituent push factors and pull factors sub-nodes.

Research Question 1b: Psychosocial stressors experienced during migration process. Data on psychosocial stressors came from three sources: the Stressful Life Events questionnaire, child and guardian report of psychosocial stressors in the PTSD Criterion A (traumatic event) sub-section of the DISC-IV, and the stressors nodes for each migration phase.

Research Question 1c: Psychosocial supports received during migration process. Data relating to psychosocial supports were drawn primarily from the coping nodes for each migration phase, alongside other nodes relating to structural factors in support of children’s wellbeing (e.g., the relationships and education pre-migration and post-migration sub-nodes).

Research Question 1d: Children’s experiences of distress and coping and their attitudes towards their migration process. Data on children’s experience of migration were drawn principally from two sources: the thoughts, feelings, and behaviors sub-nodes for each migration phase; and scale scores and item analyses from the Adaptation and Attitude questionnaire, which addressed children’s attitudes towards living in the United States.

Study Aim 2: Mental health diagnosis.
Study Aim 2a: Rates of mental health diagnoses. Children were assessed for 20 separate DSM-IV diagnoses using the computerized version of the DISC-IV. Consistent with the instrument design (Shaffer et al., 2000), diagnoses were assessed by combining child- and caregiver-reports, such that a given criterion for any disorder was considered met if endorsed by either the child or the guardian. Each diagnosis was assessed both including and excluding functional impairment. Using the impairment algorithms from the DISC-IV manual (Fisher, Lucas, Lucas, Sarsfield, & Shaffer, 2006), children were considered to have moderate functional impairment for a given disorder if they met criteria based on the A impairment algorithm (i.e., they had at least one associated intermediate impairment rating: *some of the time* or *bad*). Children were considered to have severe functional impairment if they met criteria based on the D impairment algorithm (i.e., they had at least two associated intermediate ratings or one severe impairment rating: *a lot of the time* or *very bad*). Child- and caregiver-reports were combined in assessing functional impairment. Rates of the different disorders were also compared by age, gender, and nationality (for diagnoses including functional impairment criteria A).

Rates of DSM-IV diagnoses from this sample were compared to rates observed in other studies that have used the DISC-IV, using chi-square goodness of fit tests and relative risk (RR) ratios (Coggon, Rose, & Barker, 1997). In each comparison, impairment criteria, diagnoses assessed were matched as closely as possible to those used in the other study.

Study Aim 2b: Reliability and validity of diagnostic screening measures. The internal consistency of the child- and caregiver-report screening measures was assessed using Cronbach’s alpha. Given that the primary purpose of including the child- and caregiver-report measures in the study was to assess their feasibility for use in their current form as screening instruments, all items were kept regardless of their item-to-total correlations. The reliability of the SLE was
assessed through comparison of children’s endorsement of events experienced on this measure and the DISC-IV PTSD module for the four equivalent items (experience of a serious accident, a natural disaster, physical abuse, and sexual abuse) using Cohen’s kappa. Interrater reliability between child- and caregiver-report on the DISC-IV was also assessed using Cohen’s kappa.

Detailed analysis of the construct validity of the measures was beyond the scope of this study. Nevertheless, bivariate correlations between the different scales and subscales were assessed to provide initial evidence for the construct validity of the measures.

To assess the association of the child- and caregiver-report measures with children’s DISC-IV diagnoses (with the DISC-IV being treated as the “gold standard” assessment for the purposes of this study), Area Under the Receiver Operating Characteristic curve (AUC) analyses were conducted. In order to evaluate the capacity of the child- and caregiver-reports to discern children with functional difficulties in addition to symptoms of distress (i.e., children more likely to want and need help), screening measures were compared to DISC-IV diagnoses including functional impairment criteria A (denoting at least moderate functional impairment).

For tests that demonstrated a significant association between screening instrument scores and DISC-IV diagnoses, follow-up analyses were conducted using goodness of fit tests to assess the convergence between children who screened positive on the screening measures and children who met diagnostic criteria on the DISC-IV. As no children screened positive for a PTSD diagnosis, the concurrent validity of the RATS could not be assessed. In the absence of established cutoff scores for the HSCL-37A among youth in the United States, the standard clinical cutoffs from the HSCL-25, with item mean = 1.75 (Derogatis et al., 1974; Mollica et al., 1987), were used to interpret scores from the various HSCL-37A scales. CBCL scores were interpreted using the norms established for children closest approximating the study population,
Norm Group 2 (Achenbach & Rescorla, 2007). Given the goal of assessing these measures for potential use in screening unaccompanied children for further clinical evaluation (rather than establishing diagnoses), it seemed appropriate to err on the side of sensitivity over specificity by using CBCL borderline rather than clinical cutoffs (Lalkhen & McCluskey, 2008).

For goodness of fit tests which indicated a significant association between screening measure and DISC-IV assessments of caseness, sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) were calculated. Additionally, Receiver Operating Characteristic curves were inspected to provide optimal cutoff scores for HSCL-37A scales balancing the highest sensitivity and specificity possible. Optimal threshold analyses were not conducted for the CBCL, which already has established age- and gender-based norms.

To provide an additional reference point for children’s scores on the child-report screening measures, these results were compared to those of the immigrant and non-immigrant samples used in the development of the instruments (Bean et al., 2004a; Bean et al., 2004b) using the independent samples t-test.

**Study Aim 3: Mental health service utilization.**

**Study Aim 3a: Rate of mental health service utilization.** Children’s mental health service utilization was operationalized two different ways: 1) children who had received any form of counseling services to include monitoring by a school counselor since their arrival in the NYC metro area; 2) children who had received mental health treatment services outside the school environment since their arrival. Unmet mental health need was defined as the percentage of children with any DISC-IV past-month diagnoses with functional impairment who had not received mental health treatment services since arriving in the NYC area. Past-month, as
opposed to past-year, diagnoses were used in order to identify children with current, ongoing needs.

*Study Aim 3b: Obstacles to and facilitators of mental health service utilization.* Data regarding obstacles to and facilitators of mental health service utilization were drawn from the three-month follow-up interviews of children identified as having mental health needs during the initial study interview. The semi-structured design of the interview facilitated the collection of frequency data about the number of children who had obtained services and about barriers to and facilitators of service access.
CHAPTER IV:
RESULTS

Sociodemographic Characteristics

The sociodemographic characteristics of the sample are summarized in Table 2. The sample consisted of 26 unaccompanied children and their guardians. Fifteen (57.7%) of the children were male and 11 (42.3%) were female. The mean age of participants was 14.69 years ($SD = 2.57$), with a range of 10 to 18 years (the lower and upper age limits of the inclusion criteria for study participation), a median of 15 years, and a mode of 17 years. Four (15.4%) of the participants were from El Salvador, six (23.1%) were from Guatemala, 13 (50%) were from Honduras, and three (11.5%) were from Ecuador. The mean length of time since arrival in NYC at the date of the study interview was 3.81 months ($SD = 1.77$), with a range of one to eight months, and a median and mode of three months. Eighteen (69.2%) of the children’s guardians were their mothers, two (7.7%) were fathers, two (7.7%) were brothers, two (7.7%) were sisters, one (3.8%) was the child’s grandmother, and one (3.8%) was a family friend. For children who had been separated from both parents and then reunited with one or both of them in the United States, the mean length of separation was 7.94 years ($SD = 2.75$), with a range of four to 13 years and a median of 8.5 years. The mean age at which children had been left was five years and eight months ($SD = 3.12$), with an age range of one to 13 years and a median age of five.

The sample did not differ significantly from the population of unaccompanied children detained in Office of Refugee Resettlement custody in Fiscal Year 2014 (the period covering October 1, 2013 to September 30, 2014) with respect to gender, age, or nationality (ORR, 2016d). However, differences approached significance with respect to nationality, ($p = .088$),
with Honduran and Ecuadorian children appearing to be somewhat overrepresented in the sample, and Guatemalans and Salvadoreans underrepresented.

The difference in mean age of boys ($M = 14.60, SD = 2.77$) and girls ($M = 14.82, SD = 2.40$) in the sample was not statistically significant. However, differences in mean age of children from El Salvador ($M=16.50, SD =1.73$), Guatemala ($16.50, SD = 1.38$), Honduras ($M=13.62, SD = 2.40$), and Ecuador ($M =13.33, SD = 3.51$) were statistically significant, $H(3) = 8.73, p = .033$. However, pairwise comparisons using a Bonferroni correction for multiple comparisons did not reveal statistically significant differences. Mean age of children living with mothers ($M = 13.61, SD = 2.35$), fathers ($M = 16.50, SD = 0.71$), sisters ($M = 17.50, SD = 0.71$), brothers ($M=17.50, SD = 0.71$), a grandparent or a family friend (singles cases, in both of which the child was aged 17) differed significantly, $F(5) = 2.91, p = .039$. Post hoc pairwise comparisons were not performed due to two groups with fewer than two cases. Gender by nationality, gender by guardian relationship, and nationality by guardian relationship comparisons did not indicate significant differences.
Table 2. Demographic characteristics of the sample

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>El Salvador (n = 4)</th>
<th>Guatemala (n = 6)</th>
<th>Honduras (n = 13)</th>
<th>Ecuador (n = 3)</th>
<th>Between-group differences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD) or n (%)</td>
<td>M (SD) or n (%)</td>
<td>M (SD) or n (%)</td>
<td>M (SD) or n (%)</td>
<td>M (SD) or n (%)</td>
<td></td>
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<tr>
<td>Mean age (SD)</td>
<td>14.69 (2.57)</td>
<td>16.50 (1.73)</td>
<td>16.50 (1.38)</td>
<td>13.62 (2.40)</td>
<td>13.33 (3.51)</td>
<td>H(3) = 8.73 .033</td>
</tr>
<tr>
<td>Median</td>
<td>15</td>
<td>17</td>
<td>17</td>
<td>14</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Mode(^a)</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Exact .469</td>
</tr>
<tr>
<td>Male</td>
<td>15 (57.7)</td>
<td>1 (25.0)</td>
<td>3 (50.0)</td>
<td>9 (69.2)</td>
<td>2 (66.7)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>11 (42.3.)</td>
<td>3 (75.0)</td>
<td>3 (50.0)</td>
<td>4 (30.8)</td>
<td>1 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Guardian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Exact .117</td>
</tr>
<tr>
<td>Mother</td>
<td>18 (69.2)</td>
<td>2 (50.0)</td>
<td>3 (50.0)</td>
<td>11 (84.6)</td>
<td>2 (66.7)</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>2 (7.7)</td>
<td>0 (0.0)</td>
<td>1 (16.7)</td>
<td>1 (7.7)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td>2 (7.7)</td>
<td>1 (25.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td>2 (7.7)</td>
<td>1 (25.0)</td>
<td>2 (33.3)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Grandparent</td>
<td>1 (3.8)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>1 (7.7)</td>
<td>0 (0.0)</td>
<td></td>
</tr>
<tr>
<td>Family friend</td>
<td>1 (3.8)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
<td>1 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Length of separation(^b)</td>
<td>7.94 (2.75)</td>
<td>8.67 (4.04)</td>
<td>11.00 (2.83)</td>
<td>7.00 (2.32)</td>
<td>9.00 (1.41)</td>
<td>H(3) = 4.24 .236</td>
</tr>
<tr>
<td>Child’s age at separation(^b)</td>
<td>5.67 (3.12)</td>
<td>7.33 (5.13)</td>
<td>4.00 (1.41)</td>
<td>6.09 (2.74)</td>
<td>2.50 (.71)</td>
<td>F(3) = 1.29 .317</td>
</tr>
</tbody>
</table>

Note. \(^a\)Age was broadly distributed for Honduran children, with five modal scores. Each Ecuadoran child was a different age.
\(^b\)Calculated in years and only for children separated from both parents prior to migration (n = 20).
Aim 1: Psychosocial Context

Research Question 1a: What reasons do unaccompanied children and their guardians state for children migrating to the United States? The reasons for children’s migration provided by families (either the child, their guardian, or both) suggested a number of patterns: all families mentioned multiple reasons for migration; these reasons could be divided into push factors (variables motivating children to leave their home countries) and pull factors (variables drawing children to the United States); push factors included exposure to both extreme (e.g., gang violence) and chronic (e.g., poverty) social adversities, along with domestic stressors (e.g., abuse, loss of caregiver); family reunification was the most common pull factor, often accompanied by opportunities to study and work as secondary motivations; children mentioned pull factors more than push factors, whereas the opposite was true of guardians; and reasons for coming to the United States were offset against the dangers of the journey, with the decision to come often finally being triggered by some extreme event placing the child’s wellbeing in immediate jeopardy.

Figure 4 provides data on children’s reasons for migration as stated by children, their guardians, or both during the narrative interviews and in children’s autoethnographies. Overall, 60/104 (57.7%) of reasons families provided were pull factors and 44/104 (42.3%) were push factors. Whereas 53/76 (69.7%) of children’s responses corresponded to pull factors, push factors accounted for 29/52 (55.8%) of guardians’ responses.
Figure 4. Stated reasons for children’s migration to the United States (combining child and guardian data).

**Pull factors.** Reunification with family was the most commonly stated pull factor for migration, reported by 73.1% (19/26) of families. Among other pull factors, 69.2% of families (18/26) mentioned better educational opportunities, 30.8% (8/26) mentioned work opportunities (either immediately or following study), and 15.4% (4/26) stated earning money to support family in the child’s home country. Older children were more likely to state finding work as one of their reasons for migration, $r_{rb}(26) = .46$, $p = .009$. The frequency with which families mentioned economic pull factors varied by nationality, $p = .025$, with 75.0% of families (3/4) from El Salvador mentioning work opportunities as a pull factor, compared to 50.0% (3/6) of Guatemalan families, 33.3% (1/3) of Ecuadoran families, and 7.7% (1/13) of Honduran families.
**Push factors.** Push factors clustered into six categories: lack of appropriate support for the child; gang-related violence; abuse of the child; limited opportunities in the child’s home country; concern about the child’s behavior or emotional wellbeing; and inability to support the child financially.

In total, eight families (30.8%) mentioned some form of gang violence as a reason for migration. Five families (19.2%) stated general concerns about violence in the child’s home county as a reason for migration, with four (15.4%) mentioning specific gang threats to the child or household and three (11.5%) stating that the child personally witnessing gang violence was a catalyst for migration. Fifty percent of families (2/4) from El Salvador and 46.2% of families (6/13) from Honduras mentioned gang violence as a reason for migration, compared to no families from Ecuador or Guatemala. However, these between-country differences were not statistically significant.

Six families (23.1%) reported some form of abuse of the child as contributing to the decision to migrate. Three families (11.5%) reported that caregiver abuse of the child was a reason for migration. One family (3.8%) cited partner violence, one (3.8%) listed suspected sexual abuse, and one (3.8%) reported harassment by an estranged parent as contributing to the decision to come to the United States.

Nine children (34.6%) lacked an appropriate caregiver to look after them (due to abandonment, death of the caregiver, or otherwise). Five (19.2%) were exhibiting behavioral or emotional problems that led families to believe the child needed to be reunited with parents in the United States in order to receive the necessary support. Six families (23.1%) included lack of opportunities in the home country among reasons for migration, and five families (19.2%) mentioned inability to support the child financially.
Children’s motivations for migration were complex, with every family interviewed reporting multiple reasons. One 16-year-old boy explained his reasons for leaving Honduras and coming to the United States, including escaping the violence in his home country but also a desire for family reunification and a better life:

Well, because in Honduras, life is really hard. There are a lot of deaths and so on. It is really dangerous. I wanted to see my dad. I haven’t seen him in many years. I wanted a better life. I want to study . . . I want to be a lawyer. I want to be someone in life, you know?

Other families also mentioned a combination of push and pull factors that contributed to the decision to migrate. There were also frequently differences in emphasis between the explanations provided by children and their guardians. One 14-year-old boy from El Salvador whose mother came to the United States when he was three years old suggested succinctly, “The first reason is because I wanted to meet my mother… And because there isn’t a future for you and here I think that there could be.” His mother added considerable contextual detail, explaining the complex set of reasons that had caused her to bring him to the United States:

One is because I missed him a lot… I needed to see him… Second, because my country is very dangerous, with the gangs, and as he is already growing up, he is already almost a young man… and he’s at great risk there… the gangs, they’re looking for the young people to get them into stuff, because if they get caught, the [authorities] can’t do anything so they release them quickly, so the gangs get them into trouble… So that was my worry, that he’d be pushed into something like that, because where we live … it’s the worst place in the country… And also because my mom is already pretty old to be taking care of him, she can’t anymore… and my dad the same… Here in this country there are
more opportunities for him, for his studying and everything, there my mom and dad don’t know how to read, so, … [they] couldn’t help him with his homework, with anything.

For many families, there were multiple longstanding and compelling reasons for children to migrate but the dangerous journey had previously prevented them from attempting to do so. Often, it took some urgent, triggering event to tip the balance and to risk children coming. One 16-year-old Guatemalan girl, who had suffered chronic physical abuse from the grandmother who had been her primary caretaker since her mother left 13 years earlier, had wanted to reunite with her parents for many years. However, once she found herself in a dangerous, abusive romantic relationship, the family decided to act. Her mother described their difficult decision:

We had been longing for it for quite a while but it hadn’t been possible. Yes, because people are at risk when taking that journey, it’s not easy. Many people die… So, it’s hard for one, as a parent, to have your kids brought over that way, but considering the situation, we decided to take the chance.

Several children had finally made the decision to migrate in response to escalations in gang violence. One family agreed for their 17-year-old son to come from Honduras despite their misgivings after he narrowly escaped a shoot-out at a party where two of his friends were killed. Another family decided to send their 16-year-old son to the United States after they inadvertently witnessed a gang murder and were worried, in the words of the boy’s father, that the attackers “could go back and kill them, because those people are like that.” In other instances, children who were being threatened by gangs eventually disobeyed their family members’ pleas not to undertake the journey and came of their own accord. A 17-year-old Salvadoran girl who had long been the victim of gang threats, in addition to abuse by her caregivers, found a coyote to bring her shortly after gang members broke into her home and, in an apparent act of intimidation,
left a razor. As she stated simply, “I wanted to be with my mother. I didn’t want to be over there, I was scared.”

For several children, the trigger for departure was the loss of a caregiver. A 17-year-old Honduran boy explained that, after the death of his grandmother, “The person who took care of me was no longer there . . . I was practically alone and my mother didn’t want that. I didn’t want that either.” In other instances, the trigger was a concern about the child’s emotional state or behavior. One mother had been working on getting a visa for her 13-year-old Honduran son but decided to bring him with a coyote instead when her son, who had recently been abandoned by his grandmother, refused to cooperate with living with his aunt, was getting into trouble at school, and threatened to come to the United States on his own. The mother of a 14-year-old Honduran girl whose behavior at home and school had apparently deteriorated after an alleged sexual assault by her sister’s boyfriend recounted the circumstances that led her to send for her daughter:

I sent my daughter to my mother’s house, but when she was there, a boy was visiting her too much and she was going out with him . . . I started the process of bringing her here immediately. I didn’t even have money, I had to borrow some money. It was necessary to take her out of there before something worse happened. I didn’t want that person to leave her pregnant or to harm her.

**Research Question 1b: What psychosocial stressors do unaccompanied children experience during their migration process?** Figure 5 shows stressors experienced by children in the study at any point during their migration process, as reported on the SLE and DISC-IV PTSD section. Based on these data, the majority of children had been exposed to violence, injury, and/or death: 65.4% (17/26) of children had been threatened with serious injury or death,
or had experienced such a threat to a loved one; 34.6% (9/26) had personally been threatened
with a weapon; 61.5% (16/26) had witnessed someone else’s murder, serious injury, or death;
73.1% (19/26) reported distress after seeing the body of someone they knew well; and 53.8%
(14/26) reported having lost someone they really cared about. Many children had been exposed
to abuse: 23.1% of children (6/26) had been physically abused and 34.6% (9/26) had witnessed
physical abuse. Suspected sexual abuse of one child (3.8%) was reported by her guardian.

Children had also frequently been exposed to other dangers: 38.5% (10/26) had experienced a
natural or man-made disaster, 23.1% (6/26) had been involved in a serious accident, and 15.4%
(4/26) had experienced military conflict. Not a single child reported being separated against his
or her will.

Figure 5. Stressors reported on Stressful Life Events questionnaire and Diagnostic Interview
Schedule for Children Version IV (data combined).
In order to obtain a more detailed understanding of the challenges experienced by children at various stages of their migration process, data on stressors from the narrative interview and autoethnography were analyzed qualitatively. Reflecting findings from other studies documenting stressors associated with child migration (e.g., Lustig et al., 2004; Pumariega & Rothe, 2010), these qualitative analyses supported a phasic model whereby different phases of migration were associated with distinctive challenges. These included: a long pre-migration phase characterized by chronic instability and insecurity (inside the home, outside the home, or both); an acutely dangerous journey running a gauntlet of potentially lethal stressors; a brief period in frequently cold and hostile conditions in immigration (Customs and Border Protection) detention; a typically more grounding but sometimes still stressful experience in an Office of Refugee Resettlement-sponsored child shelter; and a post-migration process involving reacquainting with family members after long separations, acculturating to a new environment, and in many cases grieving the absence of loved ones left at home. The findings on psychosocial stressors experienced by children in the sample are summarized in Table 3.
Table 3. Summary of results on psychosocial stressors experienced by children during their migration process

<table>
<thead>
<tr>
<th>Pre-migration stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessed or victim of gang violence; threat of political violence; ineffective policing; long separations from parents; multiple changes of home; abusive or neglectful caregivers; abandonment by caregivers; illness or death of loved ones; poverty; natural disasters; limited educational access; cognitive or learning difficulties</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Journey stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threats, robberies, and kidnappings by gangs; apprehension, threats, and extortion by Mexican authorities; threats, neglect, and abandonment by coyotes; shortage of food and water; dangerous and uncomfortable modes of transport; witnessing injuries and violence towards other travelers; physical hazards (e.g., crossing rivers and deserts); illness or injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Apprehension stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent apprehension (among children who resisted arrest); being handcuffed/restrained; being mistaken for an adult and threatened with adult detention and rapid deportation; separation from of-age travel companions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immigration detention stressors (Customs and Border Protection facilities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold and uncomfortable conditions; overcrowding; poor or inadequate food; removal of possessions; lack of communication; hostile treatment by some officials</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Child shelter stressors (Office of Refugee Resettlement facilities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty locating loved ones; uncertainty over whether sponsorship application would be accepted; delayed release to family due to administrative obstacles; restrictive/institutional setting; separation from opposite-sex siblings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-migration stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending immigration cases and the threat of deportation; difficulty accessing legal representation and psychosocial services; rebuilding relationships with family members after long separations; missing/concern about loved ones left at home; financial difficulties; adjusting to a new culture, language, and lifestyle; bullying by peers; unsafe neighborhoods</td>
</tr>
</tbody>
</table>
Pre-migration stressors. During the period in their home countries prior to migration, children were frequently exposed to dangers and insecurity both inside and outside the home. Many families described children living against a permanent backdrop of gang violence, and at times this punctuated their lives more directly in the form of personal threats or violence towards loved ones. Long separations from parents were another pervasive stressor, and in some instances this had left children exposed to abusive or neglectful relationships with other caregivers. Poverty was also a common, chronic stressor, denying children educational opportunities and leaving them exposed to health- and safety-related stressors.

The majority of families reported that children had been exposed to gang-related violence in their home countries. Children reported both direct and indirect exposure to violence. Many children described a general climate of insecurity related to gang violence. One 17-year-old boy described the atmosphere in his community in Honduras:

I felt unsafe. I was scared because almost every day you could listen to someone saying that something bad happened, like someone robbed someone or someone killed another person. It is almost every day… It was very hard to leave the house without knowing if I was returning back.

Families expressed little confidence in the ability of the police to keep them safe in the face of such dangers. The mother of a 14-year-old Honduran girl explained, “There were murders even in daylight… The policemen get there when everybody is dead already… the dead body stays there until it is day again and the forensic team has not arrived there to pick up the body.” A Honduran boy, aged 15, described, “In the city where I lived, there was … a river, but it was dirty. When there was a murder, they threw the bodies in that river.” Far from feeling protected
by institutions such as schools, some children described these as centers of gang activity. One 17-year-old girl explained the situation in her neighborhood in El Salvador:

In schools, they kidnap girls and kill innocent people. They try to draft boys around my age… And they ask for “rent” for houses and other places… There are a lot of kidnappings and disappearances if you don’t give them your money… They rape and kidnap girls, and sometimes they’re found dead… Or maybe if you are wearing earrings… they take them from you and they can kill you for that… It is very dangerous. That is why I was scared to take the bus, because if I wore earrings or stuff like that something could happen to me.

In some instances, children reported direct experience of intimidation and violence. Two mothers spoke about their sons being harassed, assaulted, and robbed by gang members in their neighborhoods and outside school and a number of children had seen the bodies of family members, friends, and neighbors killed by gangs. A 15-year-old Honduran boy recounted a murder he witnessed:

They killed people where I lived, every day. I went to buy something at the corner store and they killed like five people, with five shots. . . . It was dangerous and bad, a bad environment. They kill you in your own house. I couldn’t take it anymore and I came here.

The mother of a 14-year-old from El Salvador reported that gang members had cut the phone lines to the home where her son lived with his grandparents, “so that if [the gang members] wanted to do something to a house, they couldn’t be warned.” She further described the gang violence that had caused her to send for her son:
The truth is that yes, every little while there are deaths . . . they killed my cousin like that, in front, in front of everyone, of my little nephews. And the police don’t say anything, and, they don’t do anything. There you look and stay quiet and that’s it, because if you say something, they come for you in the night, not just for you, but your whole family . . . I worried a lot. I mean, he’s an only child, I’m a single mom. He’s all that I have.

In addition to gang violence, several children mentioned being affected by the political instability that has plagued Central America following years of civil war and their aftermath. An 18-year-old boy from Guatemala explained, “I was like five years old when they started with rumors about war, ‘This and that is going to come.’ All the people were afraid . . . They could take the land away from us. They could kill the entire family.”

Abuse and neglect were also commonly reported pre-migration stressors. Several guardians reported that their children were beaten physically by the family members entrusted with their care after the parents had left the country. A 17-year-old Salvadoran girl whose father was in jail in for murdering his ex-girlfriend had gone to live with her paternal grandmother after her mother, fearing for her own life, had fled the country. Her grandmother subjected her to repeated abuse including beatings and even tying her up and burning her feet. Her mother secured a court order for the child to be removed from her grandmother’s care and to go and live with her maternal aunt. However, the child continued to be mistreated:

My aunt didn’t beat me up but still she treated me badly and she used to kick me out of the house very often, she used to do it very often and I didn’t know what to do because I didn’t have any other place to go. Later on, with time, I spoke to my mother but I never told her all the things that used to happen to me because I was scared that she would say something to my aunt and my aunt would take revenge.
In some instances, caregivers neglected to take care of children’s basic needs. One mother reported that her sister spent the money she was sending home to Honduras to pay for her 13- and 15-year-old children’s private school tuition, clothes, and food on cosmetic surgery and other items for herself. The aunt, who was also physically abusive, threatened to beat the children if they told their mother, and the children had to drop out of school due to unpaid bills. Another mother reported that she was sending money to her sister in El Salvador to look after her 17-year-old daughter, only to find that she was suffering extreme neglect:

There was no one looking after her. I mean she was little, she suffered a lot, without food; there was no one to pick her up after school. . . . She even got to the point where she had no shoes because they wouldn’t give her the money. She was always barefoot and she had no underwear either. I sent a person to go and see how she was and she told me that her bra had created a sore on her skin, her breast. . . . She was using toilet paper to contain the blood. It was the only bra she had and she said her socks were torn and she lived in a room where they stocked firewood. . . . And she said that there were rats, bugs, and it didn’t have a door. They would tell her off if she took any food. Such things she went through.

Every child interviewed denied having been the victim of sexual violence when asked during the interview. However, several guardians reported fearing that their children either had been abused or were at risk for sexual abuse or violence, either by relatives or gang members. Frequently, fears of sexual abuse were accompanied by other forms of abuse or negligence. One mother reported that her 14-year-old daughter claimed that she had been molested by her older sister’s boyfriend. When the child told her sister, her sister beat her and threw her out of the house. She went to live with her grandmother, while her younger sister, aged 10, remained in the
home. The mother of a 16-year-old Salvadoran boy stated that, when he was 10 years old, she had heard rumors via his aunt that he had been sexually molested by an older boy. When his mother asked him about this directly, the boy denied the story. A 17-year-old Salvadoran girl was being harassed by her physically abusive father despite a restraining order, and she reported being scared that “he could do something to me or force me to do something I don’t want to do.” This same girl reported that a friend had confided in her that she had been raped by gang members, and suggested, “I feel her pain seeing her like that . . . you feel that way too.” Her mother suspected that she may have been sexually abused herself.

For many children, poverty was a major stressor with a significant impact on their lives. Several families spoke about stressors such as cramped living conditions and lack of food. Some children had been forced to leave school due to secondary education not being publicly funded and the need for the children to be earning money to help support their families. Poverty also contributed to other, health- and safety-related stressors. Several children had lost parents and other family members to illness, and one child reported witnessing a man being run over and killed while out working in rural Guatemala. One 17-year-old boy from Ecuador wrote in his autoethnography about the impact of the poverty in his community:

In my village, poverty consumes everyone. We fight to be able to survive. Sometimes we eat what we have and there is nothing left for another time, and if sometimes there is something for the morning there is not for the afternoon, and if there is something for my brothers there is nothing for me. . . . They say that money is not happiness, but in my case it was because without money we did not eat and we could not study.

Poverty was also largely responsible for another stressor that impacted every child in the study, family separations. Parents interviewed repeatedly stated that they had come to the United
States in order to work and send money back to their home country to support their children (e.g., to fund secondary education and to buy basic necessities such as food and clothing). For some children, being separated early in life and over a long period appears to have created complicated feelings about their parents. For example, one mother who left her daughter in Ecuador in the care of her grandparents when the girl was three years old explained that for a long time her daughter refused to speak to her and apparently told her grandmother, “You’re my mom, that’s not my mom. She left me looking for something else.” Although many children had managed to create strong attachments to replacement caregivers, a number had been passed between multiple relatives and this appeared to have left them vulnerable to abuse. The mother of one 16-year old boy from El Salvador whose uncle disciplined him by beating him with a hose explained her concerns about her son’s disrupted parenting as follows:

I know that my son’s childhood was rough. First he was in someone’s hands and then he changed to someone else’s hands and all that. . . . He was with different people, with different personalities and a different way of raising kids. I know that he had a difficult childhood.

In several instances, as they grew up children no longer had a caretaker capable of looking after them appropriately and were, effectively, abandoned. A 13-year-old-Honduran boy and his older brother were abandoned by their ailing grandmother after she left the house, apparently to take herself away to die alone in accordance with her *santería* faith. In other instances, where children had high levels of need, aging caretakers were no longer able to care for them appropriately. The grandparents of a 10-year-old boy from Ecuador contacted his mother in NYC to inform her that he was becoming increasingly defiant, had started spending time with children who were “not a good influence,” and had recently been found with
cigarettes. His mother decided to have him brought to the United States and planned the journey without telling him, such that he did not have the opportunity to say farewell to any of his family or friends in Ecuador. The child’s aunt, who accompanied him on the journey, informed him they were coming to the United States only once they had boarded the bus to start their journey. His mother recounted their conversation:

He asked her why they were leaving his grandparents, [saying] they are already so old, and that he will be sad. My sister told him that he was going to meet his mother and that it'll be much better with his mother. This helped him calm down.

The mother of a 14-year-old girl with significant cognitive difficulties, a seizure disorder, and at times hyperactive and aggressive behavior, explained how her daughter had become too difficult for her aging grandmother to manage:

My mother is an old person . . . [she] could not take care of the girl because of the girl’s problem. She could not understand her. She used to get frustrated with her…. I have to deal with her because I am her mother and I am the person who is going to have more patience with her.

**Journey stressors.** The majority of children reported being exposed to danger, hardship, and other stressors during their journeys to the United States. These included threats, kidnapping, and other abusive behavior by coyotes and gangs controlling the migration routes through Central America and Mexico to the United States; risk of extortion, detention, and deportation by Mexican police and immigration officials; dangerous or uncomfortable travel conditions; and physical dangers such as crossing the Rio Grande into the United States and becoming lost in harsh conditions in the Texas desert.
Families described exposure to gangs as an almost inevitable consequence of the journey to the United States. The coyotes many hired were working directly with gangs or using part of the fees they charged for children’s safe passage to pay off the gang members patrolling the migration routes. One boy aged 17 explained the monitoring system used by the Zetas gang:

The Zetas . . . they ask for money. . . . The coyote sends photos to them . . . if they have your number and your photo with them, they check your photo, and they let you pass. If they don't have your photo and number with them, they kill you.

Children traveling without coyotes across Mexico on top of the freight trains, the typical mode of transport for children attempting the journey on their own, also faced regular threats and demands from gangs. A 17-year-old boy recounted having to give up all his possessions, including his clothes, to gang members from *Mara 18* who boarded the train on which he was traveling with machetes: “The gang members were threatening each of us. They were saying, ‘Give me your things. If not, I will kill you.’” Another boy aged 17 who traveled north by train described seeing the bodies of migrants murdered by the gangs:

When you get on that train you see a lot of dead people and all of that . . . the bad part is the tunnels from Mexico, where the train goes by. A lot of people get thrown off. When we came here, in every tunnel, there were a lot of dead people underneath the train. . . . It is dark but we had lamps and so a friend of mine lit underneath the train. We saw heads and bodies. They had been thrown off because I tell you if you get on and you don’t have money and you oppose the Zetas, then they throw you off the train. . . . Every time they ask you for a rate, it is 100 dollars . . . if not, they kill you or throw you off the train.

Even when families had managed to afford some degree of safety by paying for coyotes to bring children as far as the U.S.-Mexican border, many were held for ransom by gangs before
crossing into the United States. A 14-year-old boy who had come with his uncle guided by a coyote explained how they were kidnapped by members of the Zetas at the border: “When you enter that house you have to pay, whether you leave for the other side or to return. They threatened us there.” He also described witnessing other travelers being beaten and abused during his three-week kidnapping and mentioned talking with a woman who had been held for three months because “those men liked her.” A 17-year-old boy wrote in his autoethnography about his experience being kidnapped in the Mexican border town of Reynosa:

I don’t know how to describe that house in Reynosa but it was the most disgusting place. We fought over water and beans if there were any and otherwise had nothing. Sometimes people cried from hunger or from being sick, fearful, depressed, wanting to arrive already. . . . I spent a month there. . . . A lot of us there got sick with bites . . . I got sick with scabies and I lost a lot of blood from the nose. . . . They told me to give them [my family’s] phone numbers because they said I'm worth a lot of money since I came from so far away. They were armed men, they said from a group called the Zetas.

For some children, their ordeal at the hands of gangs continued after crossing into the United States. An 18-year-old girl described being passed into the hands of a second smuggler once she had crossed the border into Texas who tried to force her to smoke marijuana and threatened to rape her. He then sold her on to other smugglers who demanded a ransom from her sister in NYC. The girl described her experience in her autoethnography:

They kept me there many days, they didn’t give me anything to eat, they went to ask for money from my sister and it was only to buy things, food for them, and they spoke to my sister and they threatened that if she did not answer the phone they wouldn’t hear any more from me.
After three weeks, U.S. immigration authorities raided the house where she was being kept and she was taken into custody.

As well as the dangers presented by gangs, children feared being captured by Mexican *federales* (police, military, and immigration authorities) during their journeys north. Children described being sent by coyotes to hide in the undergrowth to avoid capture, being chased by police with dogs, and evading apprehension by pretending to be Mexican at police checkpoints. Three of the children interviewed were detained by Mexican immigration and sent back to their home countries before successfully crossing Mexico at the second attempt. One 17-year-old boy described being threatened by a Mexican policeman who mistook him for a coyote:

> So a federal thought that I was the guide and took us off the train. . . . And he told me that if I got on the train again with my people, he´d kill me and he loaded the gun and he told me, “You heard that right? Or do you want me to kill you now?” And then I started crying because I thought that was it for me.

In addition, many children reported being robbed by Mexican authorities or having to pay bribes to officials in order to continue their journeys. One mother described how Mexican authorities extorted money from her 10- and 14-year-old daughters:

> They would take [the older daughter] out, question her, and tell her, “Give me all you have.” They would take all her money, and they would ask her, “Who are you with?” “With my sister.” “Go to the bus and take x amount of money from your sister and bring it to me.” She would go and take the money from her sister and give it to them. When they had taken all their money, then they would put her back on. The same thing would happen at the next stop. . . . The buses stop so that people can get off and that’s where they wait. Once they have taken everybody’s money, then they can get back on.
Whoever they want gets back on, and those they don’t want to, that have no money, they leave them there. They do whatever with them.

Dangerous or uncomfortable travel conditions were another common stressor on children’s journeys. A 17-year-old boy described seeing a fellow traveler fall from underneath their bus and being crushed to death, after which he was threatened by the coyote: “The guide called me over because nobody had seen what happened except me, as it was just the two of us down there. And he told me not to tell anyone or I’d be in big trouble.” Several children described the particular dangers of traveling on top of trains. Some recounted seeing other travelers knocked off the train by low-hanging tree branches and one boy aged 17 mentioned meeting a fellow traveler who had his foot cut off after he slipped under the train. Many children complained of being given little to eat or drink by the coyotes transporting them or being concealed in cramped, overcrowded spaces in buses, trucks, or trailers. One 10-year-old boy used an annotated drawing in his autoethnography to describe, among other aspects of his migration, some of the hardships he endured on his journey to the United States from Ecuador. This is shown in Figure 6.
Figure 6. Annotated drawing from autoethnography by 10-year-old boy describing journey stressors.
Children also frequently commented on the dangers imposed by the challenging geographical conditions of the journey. Several children stated that crossing the river into the United States was for them the most stressful part of their journeys. They described coming across without life jackets on rafts, inner tubes, swimming or wading. Depending on the time of year they crossed, some encountered very cold water and strong currents. Some had to dive into the water to evade being seen by immigration helicopters flying overhead. One 10-year-old boy who had heard about other children drowning in the Rio Grande described “trembling with fear,” and a 17-year-old girl, who was almost six months pregnant at the time of her journey, described feeling scared as she barely managed to keep hold of the inner tube she used to cross. One 18-year-old girl reported having to jump into the water despite the fact that she could not swim because she had been seen by immigration officials. Several children mentioned losing possessions in the mud as they struggled along the banks of the river trying to avoid being captured.

Children who were not apprehended immediately after crossing into the United States described walking for up to three days before being captured. One 17-year-old boy fell climbing over a wall and injured his ankle; he struggled on walking and running for several hours until he “couldn’t bear the hunger and thirst anymore” and was apprehended by immigration. One 17-year-old girl described spending three days in the desert without food and drink and being “scared of dying there;” after she was apprehended, she had to be hospitalized and rehydrated intravenously. Another 17-year-old described his experience in the desert after he and his group were abandoned by their coyote:

We crossed the river and then we started to walk. We had to go across the desert… Well, we just had to walk. . . . We walked like two days . . . we didn’t sleep. . . . The guide left
us. . . . The guide told us, “Stay here,” and he never came back. He left us alone at night. We waited and he never arrived. . . . Well, they told us that a van was going to meet and take us. . . . We were thinking that we could get to the place where the man told us, but we never got there . . . we were walking. . . . We could not stand the thirst and we were hungry. . . . We lost our strength. There were many cacti with thorns . . . we had to go through the thorns. We had to go through bushes . . . I had cuts here, here, and here. . . . There was another man who got even more hurt than the rest. He wasn’t able to walk anymore. . . . No, we said that if we could not find a solution, we would turn ourselves in because we could not find the way out.

Apprehension stressors. Children’s apprehension experiences typically differed starkly based on whether they attempted to resist being caught by U.S. immigration authorities or whether they gave themselves up voluntarily, with those children who tried to evade capture frequently being chased and forcibly apprehended.

In a number of cases in which families had a clear idea that their children would be sent to them once detained on U.S. soil, they had arranged with coyotes to see that the children made it into U.S. custody. In a few instances, children were aware of this arrangement, while others had not been told. One 14-year-old girl explained the circumstances in which the coyote gave her and her 10-year-old sister over to U.S. authorities: “The guide didn’t come with us. It was just us walking. He just said, ‘Go through there . . . so you can see your mothers.’ We thought our mom was going to be there, but immigration caught us.” In other instances, children gave themselves up after becoming separated from their fellow travelers. One 17-year-old boy explained, “The group started to fall apart near the bridge where the customs officers are. . . . Since the others had left, the younger ones had to turn ourselves in because we didn’t know where to go.”
By contrast, children who tried to evade capture once in the United States frequently experienced multiple stressors. Several recounted being pursued by helicopters and dogs and being cut and scratched by thorns as they ran through the scrub or hid in holes and thickets. Some children who were part of groups who tried to escape once confronted by U.S. immigration described aggressive treatment by officers. One 14-year-old girl reported, “Our guide, they hit him on forehead with something, like a stick. They were pointing guns at [the other migrants’] heads and I got nervous because I thought they were going to kill them.” The mother of a 14-year-old boy traveling with his uncle described her son’s experience:

When they apprehended them, they handcuffed them, but before they handcuffed them, they had them, they held them at gunpoint. Yes, they treated them badly. “Mom,” he told me crying, “they treated me like I was a delinquent . . . they threatened us with guns and after they handcuffed us.

Separation from loved ones was another common apprehension stressor. Many children had traveled with siblings, uncles, aunts, cousins, or friends over the age of 18 who were sent to adult detention, and from there often deported. A 10-year-old boy described his experience of being apprehended and separated from the aunt who had accompanied him from Ecuador in his autoethnography:

I started to cry and was very afraid because the agents spoke very loud and I did not understand any English. That was when I was separated for the first time from my aunt and I was crying not knowing what would happen to me.

The 17-year-old girl who was pregnant had traveled to the United States with her husband. Being of age, after being apprehended at the border he was deported back to Guatemala, leaving his young wife to have and take care of their baby without his support.
**Detention stressors.** Immediately after apprehension, children were sent to Customs and Border Protection immigration detention facilities for periods ranging from a few hours to four or five days before being transferred to the care of the Office of Refugee Resettlement and sent to specialized child shelter facilities for unaccompanied children. The majority of families reported that children were kept in uncomfortable conditions while in CBP detention, in particular: being locked in very cold cells without sufficient clothing and blankets; not having access to daylight or bathing facilities over multiple days; being unable to sleep due to a lack of floor space and mattresses and insufficient, aluminum blankets; receiving poor or insufficient food; and, in some instances, hostile treatment from officials.

Almost half the children reported being kept for long periods in very cold cells, in some instances with fans and air conditioning turned up and their sweaters and other warm garments having been taken from them (apparently for security reasons). One 17-year-old boy noted: “They had us in a hielera [icebox], that’s what they called it. It was so, so cold. . . . It was way too cold. . . . And I trembled and everything, and, like, there were 14-year-olds there.” A 14-year-old boy described his experience at the CBP facility where he was detained for several days:

When they caught me they took off all my clothes, the long-sleeves that I brought, my sweater, and they left me with a short-sleeve shirt. That room was so cold that I couldn’t stand it and they left me locked up there. You couldn’t see the Sun, or anything. You could go crazy there, with everything white, and nothing to look at.

Other children also described vividly the impact of being kept in cold, permanently lit rooms without access to sunlight. One 14-year-old girl described her experience as follows:
Then they put us in a really cold place. It was a really pale color and it was weird. I was there like four days but I didn’t know if it was day or night because it was a really strong light. Then I didn’t know how long we had been there. I don’t know, a girl asked someone and they told her it was one date. And the day we left it was another date and we realized we had been there like four or five days.

Several children reported that their cells were overcrowded, with no space to lie down and sleep and no mattresses. Several children and their families commented on the lack or poor quality of food the children were given. One mother described the conditions in the CBP facility where her 10- and 14-year old children were detained as follows:

The two days in immigration, they were sleeping on the floor there. They gave them aluminum paper to cover themselves. The food was terrible, they were sick to their stomach. They would only give them sandwiches with, with I don’t know what raw things and they are not used to that. The bathrooms were open, without a door. They used the bathroom there and they felt really embarrassed, because everyone could see them. And well, the time they were there they suffered a lot. At the place they were, they didn’t let them sleep because they would call them for whatever information at 10, 12 at night.

Several children commented on being treated poorly by staff at the detention facilities. One 10-year-old boy complained that guards shouted orders at him. A 14-year-old boy reported being frightened by guards whom he felt were making fun of him and who apparently told him that he would be staying in detention longer in order to upset him. One 14-year-old girl described the prison-like experiences to which she was subjected (although, as one of the younger children, she was spared being physically restrained):
They took away our shoe laces. . . . Then when we arrived at the cells . . . they took away our scarves and sweaters . . . because they were scared that we would attack them . . . because with a scarf you can strangle someone and also with the shoe laces. . . . My sweater had a lace . . . and they cut it with a knife. . . . I was scared because I thought, “How can I attack them with this?” . . . They put handcuffs on people, but they didn’t put handcuffs on my sister or me. . . . They would put manacles on people’s feet and they would put a chain that would go from their hands to their stomach and they would put handcuffs on their hands. . . . I was scared because I thought that they were going to handcuff me too.

Lack of communication was also a commonly cited stressor during CBP detention. Most families reported that they were called and notified when their children were taken into immigration custody, but in general they were not granted access to speak to their children directly until they reached child shelters.

*Child shelter stressors.* By contrast with their descriptions of inhospitable conditions in CBP immigration detention facilities, children universally had more positive experiences in the child shelters managed by the Office of Refugee Resettlement to which they were transferred pending their release to guardians. Many reported that they were treated well by staff who seemed genuinely to care for them and to want to help, that they were able to contact family in the United States and back home on a regular basis, and that they enjoyed the school program provided and leisure activities such as watching films, playing sports, and being taken out to buy new clothes. However, this was still a stressful period for many children. Children reported different types of uncertainty: whether their U.S. family members would be located, if their resettlement applications would be accepted, how long the reunification process would take.
Also, the shelters inevitably provided a restrictive, institutional environment with rules and consequences.

Uncertainty about if and when they would be released to guardians was the most commonly reported child shelter-related stressor. A number of children reported meeting other minors who had been stuck in shelters for many months because no guardian had been found to whom they could be released, and worrying that the same thing could happen to them. One 16-year-old boy explained his concern:

I was worried there because they said that well, if your parents didn’t claim you, then you had to stay there until you turned 18. Sometimes they took a long time on the paperwork and it was hard for you to get out of there.

It took two weeks to locate the mother of one 10-year-old boy after he forgot his mother’s telephone number. In his autoethnography, he described that uncertain period:

They took me to a child center until they found my mom and it was many days before they could find my mom and I continued crying desperately until I got to the point where I thought I would stay there forever and the social worker told me to calm down as whatever it took they were going to contact my mother.

Even when social workers at shelters had managed to locate guardians and were working actively to secure children’s release, being detained was nevertheless stressful for many children. Some children reported worrying that their applications for temporary resettlement in the United States would be delayed or denied and that once they turned 18 they would be deported as adults. A brother and sister who had traveled all the way up from Honduras together on their own without a coyote were separated due to the unisex policy of child shelters. Other children described the inevitable rules associated with any institution. For example, one 15-year-old boy
reported an incident in which the director of the shelter threatened to take away television and play privileges after someone pulled a fire alarm. Several children mentioned that shelter staff had told children that their behavior there could have a bearing on their immigration cases. One 17-year-old boy reported:

Some [children] are spoiled and the [counselor] advised them. She said they can give you a paper because of your behaviors and we shouldn’t get one because it affects your case.

I never got one . . . she motivated me to not to mess up.

**Post-migration stressors.** The predominant post-migration stressors mentioned by families were: pending immigration cases and the threat of deportation; difficulty accessing legal representation and other needed resources; rebuilding relationships with family members after long periods apart; mourning separations from loved ones left at home; and adjusting to a new language, culture and lifestyle.

The threat of deportation was a universal stressor faced by all children in the study. Children who had just been reunited with parents after long absences faced the possibility of being separated from them again permanently. One 14-year-old girl with developmental difficulties who had been separated from her mother for the previous eight years and had grown up in a violent Honduran city stated simply to her mother, “I don’t want to go over there, I want to be with you.” Other children who had come to the United States not to be reunited with parents but to work and send money home to their families were afraid of the financial consequences of deportation. A 17-year-old boy who had come to the United States to support his impoverished family in Ecuador described his anxiety about adding to his family’s financial burden if he was deported and unable to work off the debts they had incurred paying for his journey. His guardian, a family friend, commented on the child’s predicament:
He’s very afraid that suddenly immigration will seize him and deport him, and with the debt he has he doesn’t know what to do. That’s the one thought that’s always in his head and he really suffers a lot with it.

Limited access to legal support compounded children’s stress about their immigration situation. At the time of their interviews, only five families (less than 20%) had managed to obtain a lawyer. The importance of obtaining legal representation had been impressed upon many families, but cost of hiring attorneys privately and the very limited availability of pro bono lawyers created stressful obstacles to representation. Several families reported that they had been provided with lists of pro bono attorneys but either their calls were not returned or the lawyers they spoke to already had full caseloads. The guardian of one 17-year-old boy recounted the advice he had been given:

They explained to me that if I hire a lawyer myself it would cost $5,000 or more. But I don’t have that money. I don’t have somewhere to get it from. It’s difficult. Now I don’t know what to do . . . they have told me that there are some lawyers who work for free but in reality I have not been able to contact them.

Separation from family and friends in their home countries was a common post-migration stressor. Some children had left their mothers, fathers, and siblings behind at home to come to the United States, while those migrating to be with their parents had often had to say goodbye to grandparents and other relatives who had raised them for the majority of their lives. Additionally, several children who had been separated from aging or ailing grandparents expressed concern about whether they would ever see them again. One 14-year-old girl described her predicament:

It was a little difficult because I left my grandparents who for me are everything. They have always been with me, they have never abandoned me, they trust me and me them.
For me it is difficult to be without them because I lived with them for 10 years, and it is hard to leave a loved one who has been present your whole life and suddenly you separate from them . . . and on top of that they are very ill, and I don’t want anything to happen to them.

A number of families reported that children were having difficulty reacquainting with parents who they had not seen for many years. The mother of a 10-year old boy who was raised by his grandparents and aunt in Ecuador after she came to the United States when he was two explained, “He is more trusting with my sister than with me, he grew up with her. . . . Whatever he wants to say, first he tells her so that she can tell me.” Another mother explained that her 13-year-old daughter relied on her younger, U.S.-born sister to make requests on her behalf:

Whenever she wants to express something, she tells her sister to say it: “[Child’s name] has a field trip, you have to sign here and she needs this much money,” and I ask her, “Why don't you ask me directly?” She just stares at me smiling. “You have to tell me, why are you ashamed? You don't have to hide, if you need something at school, tell me so I know.”

Some children were adjusting not only to seeing their parents after long separations but also to new family configurations, such as parents having separated since their arrival in the United States, new step-parents, and younger siblings they had never met before. One mother described her 11-year-old son’s difficult adjustment process following his arrival:

It wasn’t easy at first. . . . It’s logical. He wanted attention from us . . . he had been without us for a long time and it was hard for him to understand that there were two baby brothers and that he was the oldest one . . . so maybe he saw the attention I paid to the
little ones. But I explained to him, they are toddlers and that is why I had to pay attention to them.

Another mother described her 10-year-old son’s sadness and disappointment that his father, from whom she had separated after arriving in the United States, had not come to see him in the three months since her son’s arrival:

Sometimes he tells me, “I want to meet my dad.” I tell him, “I don’t know, that’s not up to me, he has to come to visit you.” And sometimes he says, “But why doesn't he love me, why?” I don't know what to say, I can't tell him, “He doesn't love you.” I say I don't know, that he might not have time, I give him excuses so he doesn't feel bad, but I think he knows.

In some instances, there had been tension between parents and their children over parenting and disciplinary styles. The mother of a 14-year old boy described differences in parenting style between her and her son’s grandparents as a source of conflict:

[Child’s name] talked back to me, I scolded him . . . there they spoil them, grandparents spoil their grandkids you see, she didn’t scold him, so he resents the scolding. He says, “My grandma told me, ‘Don’t leave.’ But I begged, I said, ‘No, I want to go and meet my mom,’ and now I meet you and you only scold me.” . . . I told him, “But it’s for your own good.” . . . I told him he doesn’t know me. Sometimes people give advice and it seems like scolding, right? So he doesn’t know that, and sometimes he doesn’t like my manner.

Many children reported challenges adjusting to their new living environment in NYC. Children were frequently transitioning from lives in their home countries centered on social activities with family and friends to a more work- and school-driven, hurried, individualistic lifestyle in the United States. In addition, a number described finding the cold weather,
complicated transit system, and high-rise NYC neighborhoods restrictive and many reported missing the freedom to go out and play in their communities. Several children reported initially having difficulty meeting people and making friends and some reported being afraid to go out on their own for fear of getting lost. One 14-year old Salvadoran boy commented, “There you go out wherever you want because there everybody knows you and … here you can’t go out alone, because I’m not familiar with it, I could get lost.” A 16-year-old girl from Guatemala reported that for her one of the most challenging aspects of being in NYC was that “one has to be in doors all the time and I don’t have too much time to spend with my parents, they are always working.” The mother of a 15-year-old boy from Honduras described his difficult acclimation:

At the beginning . . . it was different to what he thought it would be. . . . Over there in our country, you can be free . . . you can go out onto the street . . . he could play more. You see the neighbors and they know you. . . . It’s very nice because every morning you say hello to the neighbors. . . . Here, there are many buildings. You don’t know who your neighbors are and you barely see anybody… Everyone is always inside. He came in the winter, so he couldn’t go out. . . . So he felt frustrated. All that frustrated him.

Financial hardship was a stressor for many families in the post-migration period. One mother had been sending money back to Honduras to pay for her three children’s schooling and other needs and was not prepared to support them financially when they made their way to NYC unannounced. She explained how she had adjusted her living environment since their arrival:

I don’t have an apartment . . . I rent a room. When my kids got here, I was living alone, so, well they charged me a bit more for rent . . . I asked for a loan, and I am paying it. . . . And I bought a bunk bed and the two boys sleep on the lower bed and the girl sleeps up
above and I sleep next to them in my bed. . . . I live in a room. I don’t have an apartment. I don’t have help. It isn’t easy, but I am trying.

The father of a 17-year-old boy described the financial and resulting emotional strain having his son in the home had created:

I feel the burden because he doesn’t work. He is studying, there are expenses . . . so I feel it now. . . . He is seeing, well we don’t have enough . . . the situation is kind of hard. Sometimes he tells me, “Well, just get the tickets ready, I will go back.” I tell him, “No, you can’t go back. Someday you can help when I get older.”

Several children described learning English as the most challenging aspect of their acculturation process. Some commented on the difficulty of moving forward academically or professionally until they had learned the language. As one 17-year-old boy commented, “I would really like to learn, that’s my wish, to learn, because I know that without that I’m nothing here.”

A number of children were struggling to keep up academically due to language difficulties. A 14-year-old girl described her situation:

It is hard for me to understand [English], and then I feel really confused . . . I am not the only one. There is a girl that has been here for a year, and she still hasn’t learned it. That makes me nervous, it makes me panic.

Although almost all children had managed to enroll in school somewhere, several had been placed in schools mismatched to their age, grade level, level of English, and years of education.

A 17-year-old boy described his experience:

I am at a school where they only speak English. They only had space in that school. . . . In Honduras I had already finished tenth grade, I was going to go into eleventh grade . . . they sent me to tenth grade. . . . It has been hard . . . I don’t understand English, and at my
school, they only speak English. It is not bilingual. It is only English. . . . It is hard because all the textbooks and everything are in English. It is easier when I am seeing numbers . . . it is easier because . . . I can see the exercise and do it. I know the subject already. The rest is very hard. The part that tells you how to do the exercise is in English and I don’t understand.

One mother explained that her 15-year-old son had initially been failing all his classes due to the language barrier, suggesting, “He didn’t even want to participate because he didn’t understand.” However, after she contacted the school district, his school arranged for him to be placed with a Spanish-speaking teacher.

Although many children reported that peers, especially other Spanish-speaking students, had been supportive in helping them integrate into school in NYC, several had been picked on by other students. The mother of a 12-year-old boy described how his language difficulties had initially contributed to altercations with peers after he arrived in NYC six months previously: “He is now doing better with the language. He doesn’t speak it very well, but he can defend himself. Before, when he didn’t defend himself, he would react by fighting with his classmates.”

Several other children had also experienced bullying by peers. A 14-year-old girl noted that some girls at her school had been harassing her with racist comments: “They tell me many things. They tell me that they don’t like black people. I don’t know. They tell me that I am a monkey and many other things.” One 14-year-old boy had been picked on by a classmate and pushed to the ground when he refused to fight.

A number of children commented on feeling safer from crime in NYC than they had in their home countries. However, a couple of children reported feeling scared. A 10-year-old boy from rural Ecuador reported that NYC was not as he expected because “there is a lot of crime . . .
I saw in the news that they found just a part, the leg of a boy here . . . that's why I come home quickly from school, I come home running.” Given limited resources, families frequently lived in NYC neighborhoods with crime and security issues, even if these issues were less pronounced than in their home countries. One 12-year-old Honduran boy explained why he did not feel safe in his building: “[People] smoke a lot . . . drugs . . . and they knock at people’s doors. . . . When I see them, I start running. . . . The people in the street fight . . . you see fights.”

**Research Question 1c: What psychosocial supports do children receive during their migration process?** In keeping with social ecological models of development and response to adversity (e.g., Betancourt & Khan, 2008; Bronfenbrenner, 1977), thematic analyses investigating psychosocial supports identified multiple levels of intersecting resources—at the familial, community, and broader cultural, institutional, and structural levels—that promoted children’s wellbeing and protected them in the face of the many stressors to which they were exposed across the various stages of their migration. Family members were a vital source of wellbeing for children throughout their migration process, from separated parents supporting their children emotionally and physically from afar to grandparents, siblings, aunts, and uncles who took on parenting roles at home, and siblings helping each other through difficult journey and detention experiences. Community factors included friends and neighbors in children’s home communities who helped mitigate the impact of disjointed families and peers helping children negotiate the language barrier in NYC schools. Cultural factors ranged from local people on the migration routes through Mexico who offered children traveling on their own food, lodging, and kindness to children’s access to close-knit Latino communities in NYC. At the broader, institutional and structural levels, factors such as government and nonprofit organizations providing basic aid to children on migration routes, access to counseling in child shelters
following children’s apprehension in the United States, and easy enrollment in medical and educational services for undocumented children in NYC all counteracted potential migration stressors. The supports received by children at different systemic levels are summarized in Table 4.

Table 4. Summary of results on psychosocial supports received by children during their migration process

<table>
<thead>
<tr>
<th>Familial factors</th>
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<tbody>
<tr>
<td>Loving caregivers in home country; supportive extended families; regular contact with parents in U.S.; financial support from family in U.S.; accompaniment on journey by family members; telephone communication during journey and detention; close relationship/rebuilding connection with parents in U.S. following reunion; participating in fun activities together; ongoing emotional support from loved ones in home country</td>
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<table>
<thead>
<tr>
<th>Community factors</th>
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<tbody>
<tr>
<td>Presence of caring neighbors and friends in home country; attentive teachers; engagement in community activities; support from fellow migrants during journey; shared educational and recreational activities in child shelters; school engagement in NYC; supportive peer group (e.g., helping with language difficulties in school); participation in church and extra-curricular activities (e.g., sports, dance, theater)</td>
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<thead>
<tr>
<th>Cultural factors</th>
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<tr>
<td>Economic assistance from family remittances; culture of migration from Latin America and network of trusted coyotes; support from local churches and people along route; pro-reunification stance of Office of Refugee Resettlement child shelters; access to immigrant community in NYC</td>
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<tr>
<th>Institutional factors</th>
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<tbody>
<tr>
<td>School-based and other psychosocial services in home countries; protection and care from migrant-support organizations during journey; integrated case management, counseling and legal education in child shelters; easy school enrollment in NYC; access to school-based counseling; legal orientations and other advocacy programs to increase resource access</td>
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<table>
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<tr>
<th>Structural factors</th>
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<tr>
<td>Government-sponsored migrant safety initiatives in Mexico; separation of U.S. government’s prosecutorial and caretaking roles; legal provisions for releasing unaccompanied children to undocumented family members; access to public education and government-funded healthcare</td>
</tr>
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</table>
**Familial factors.** Family members, both in children’s home countries and the United States, were identified as important coping resources throughout children’s migration process.

For many children, the potentially damaging effect of long parental separations had been mitigated by close, parent-like relationships with other relatives who had stepped in to raise them. A 10-year-old Honduran girl described her relationship with the older sister who had cared for her since her mother came to the United States when she was a one-year-old:

My older sister raised me, since I was small it was her who was with me for everything. She celebrated all my birthdays, she put me in school, and helped me with my homework, and much more . . . and then she had two babies and I loved them like my sisters because I loved her like a mother and I loved her very much because she helped me a lot.

The child’s mother suggested that the fact she had left when her daughter was so young may have been protective: “She practically didn’t know me when I came. . . . She didn’t know me, so I don’t think she missed me as much. And well, that helped for her to be okay over there.”

In addition to important individual caregiver relationships, children frequently described enjoying growing up in their home countries surrounded by relatives in large, supportive families. One 11-year-old boy described his family life in Honduras:

I liked living with my aunt because we used to go out everywhere. We used to go to my grandmother’s house. . . . Sometimes we would go to the funfair. I’d buy tickets so that my cousins and I could play . . . bumper cars, roller coasters, and the wheel of fortune.

Although the majority of children interviewed had been separated for long periods from their biological parents, many parents had managed to maintain close relationships from afar and to provide both emotional and financial support. In some cases they had managed to maintain almost daily contact with their children via telephone or internet over the span of many years.
One mother described her efforts from NYC to support her 17-year-old daughter in El Salvador in the face of her aunt’s neglectful treatment:

For nine months she had nothing, no shoes, nothing. . . . After that I did wire her a little money and she started to eat a little better, but they wouldn’t give her the money. They would take it from her. . . . She spent a lot of time by herself. My sister would go on vacation or somewhere else and they would leave her by herself at home. [We spoke] by phone . . . almost every day. . . . She cried a lot. . . . They denigrated her and she’d call and tell me, “Mom, I can’t stand living here.” . . . Then I paid someone else to give her money. . . . I enrolled her in a private school so she could study, a better one, but no one would show up to the parent meetings. She didn’t have anyone to support her . . . she told me, “I'm leaving.” And so I told her, “No, my child, you have to finish school first.” But she couldn’t take it anymore and she came here.

Parents’ financial support from the United States took a variety of forms, from paying for basic commodities such as food and clothing to funding private education. The mother of two Honduran girls aged 10 and 14 was paying a private driver to take her children to and from school every day due to the dangers of taking public transport in their gang-patrolled neighborhood. The mother of a 17-year-old Salvadoran girl who had wanted her quinceañera (coming of age fifteenth birthday party) to be the “party of the year” had paid for her to have a big celebration that “was her happiness, it was something she really wanted.”

In some cases, the potential hurt of separation appeared to have been mitigated by parents clearly communicating the reasons for separation. The mother of an 11-year-old Honduran boy who had come to the United States when he was three years old explained:
He is a child that always knew why he stayed behind and why we were here. . . . Every
time I called, I spoke to him and I explained. . . . He would say, “Mom, why are you there
and I am here?” He’d say, “I want to be with you and live with you. Why don’t you pick
me up? Why do I live with granny?” And when I got those questions I explained
everything to him, and I guess that is why it wasn’t so hard for him when he got here,
because he thought everything was normal. There were certainly changes, but 70 percent
was positive with him. . . . We didn’t have problems.

Familial support was also important for many children during their journey to the United
States. The majority of children interviewed were accompanied by at least one family member,
typically siblings, uncles, aunts, or cousins. Several children explained how traveling with
relatives helped them to stay positive and keep their spirits up during the long and dangerous
journey to the United States. For example, a 16-year-old boy who had traveled north on train
tops with his cousins aged 17, 12, and eight explained that “the best part [of the journey] was that
we laughed a lot because we were family and we told jokes.” In other cases, children relied on
family to help them keep going at particularly challenging points in their journeys. The 17-year-
old boy who had witnessed a fellow traveler being crushed to death explained how the older
cousin who accompanied him on his journey supported him:

Although I didn’t tell her what I saw, I said, “I feel bad,” and she was the only one who
said, “I support you.” She was the only one, and at this point I love her more than as a
cousin, I love her more like my mom . . . those days that I felt bad she was the one who
held me. She was the only one who said, “Keep your head up, you’re not like this. I don’t
want you to cry.” She was the only one who was there. When I couldn’t do it, she would
say, “You have to be able to, never say you can’t, yes, you can.”
Most children were in contact with family members in the United States by phone, text, or email during the journey to inform them of their progress and to receive emotional support. The father of a 16-year-old boy who came accompanied by his older brother explained how, despite his own fears, he encouraged his children after they called frightened to say that their coyote was going to conceal them in a trailer to evade capture by the Zetas:

I said it was for the best. I said, “I think you better keep on going, son. Because it is better for you to get across the border instead of being stranded there where they could kill you. . . Little boys have gone through and woman and everything, so I don’t think you and your brother will have the bad luck of failing. . . So just get in the trailer and fall asleep. Close your eyes and sleep. Come like that.” . . So he said, “Ok Dad, we will try.” And they got into it. I think that they were in [the trailer] for like 22 hours.

Many coyotes carried cell phones and would put the children on the line when their parents called. In most cases, children were in contact with their families for support once or twice over the course of their journeys. However, two parents described having daily contact with their children. One mother who was in contact with her children multiple times daily explained that this was part of the deal she had negotiated with the coyote:

I was really worried, calling them very often to see if they had eaten, if they had taken a bath, and if they had brushed their teeth. Daily and often, whether it were in the morning, lunchtime, or during dinner. I would add credit to the phone of the person that was bringing them so that he wouldn’t tell me, “Look, I don’t have credit. I don’t know.” He would pick up and say, “Mrs. [mother’s name], I’ll pass you to your daughters.” “How do you know it’s me?” “Because you are the one that worries the most about your daughters.” . . But, that was the condition. “If you are going to give me a telephone
number where I can communicate with them at all times, you bring them. And if you are not going to do that, it’s best if you tell me.” If I didn’t have communication one day, I wouldn’t stop calling and calling.

Calls appeared to help not only children but also their loved ones deal with the stress of the journey. As one mother of a 17-year-old girl explained:

[The coyote] would lend her his phone and she would call me. The days she called me, I was happy. There were times when she would not call for one or two days and during those days I felt as if I was going to die. When she called me, I felt peace because I knew I could listen to her voice.

Family support also appeared important in helping children to cope with the stress of apprehension and detention by U.S. immigration officials. A 14-year-old boy explained how his uncle, who had also helped his nephew through a grueling kidnapping experience by gangs in Mexico, decided that it was time to stop running from U.S. immigration despite the fact he would face certain deportation:

My uncle told me, “Let’s put down here, if they catch us, oh well.” . . . And my uncle told me not to sign [the deportation papers] because for me they were going to let me stay here, but for him he was going to get sent back.

Similarly, one 17-year-old boy explained how his older cousin supported him through the process of being apprehended:

Even when she was caught, she hugged me. They took her because she was of age, but she told me, “I want you to carry on, to help your family go forward although they’re sending me back.” Because she only allowed herself to be caught for me.
During the stressful period following apprehension when children were kept in often harsh, uncomfortable conditions in CBP immigration detention facilities, several children were comforted by the support of their siblings. A mother described how her younger daughter, aged 10, had received support from her 14-year-old sister during their stay in immigration detention: “When she arrived at immigration she had to sleep for two days on the floor. She had never done that and she cried. Her sister put her legs down so that she could sleep on her.”

Once in child shelters, children were able to make calls to family members, typically one per week to their future guardians in NYC and one to relatives in their home country. This appeared to help some children cope with the stress of their continued detention and uncertainty about when they would be released. The older brother (and sponsor) of an 18-year-old recounted how he reassured his brother during their calls:

He was somewhat scared. . . . I told him not to worry because he was here [in the United States] and I was going to get him out. . . . He said something like that, that they could send him [back to Guatemala]. . . . I told him that nothing was going to happen, that it would be fine. . . . But I did hear him and he was a little scared, but that is normal.

Guardians also used calls to reassure their children that they were completing the necessary paperwork to secure their release and that they would see them soon. A 10-year-old boy who was separated from his accompanying, adult aunt after they were apprehended recalled the moment he was first able to speak to his mother after several days in U.S. immigration, by which point he feared he would never see his family again:

The next day the lady who was looking after me arranged for me to talk to my mom. I could not believe it and I began to cry, but out of emotion. I talked to her and asked her to
please get me out of that place soon. She told me to calm down because she had to do some paperwork to prove that she was my mom.

Family support was also an important emotional resource for children following their arrival in NYC. After years of being under the care of other relatives, several children described feeling reassured to once again be with their parents. A 17-year-old girl who had suffered abuse and neglect at the hands of her aunt in El Salvador in addition to being harassed by gangs explained how it felt to be reunified with her parents:

And over here, I feel calm. I feel alright like nothing will happen because I have my parents and they look after me . . . a mother knows how to take care of her kids. Well, I feel safe with her. I feel well here.

The mother of another Salvadoran described her efforts to support her daughter after she disclosed that she wanted to die:

I tell her, “Life is very beautiful. We have to continue with our lives until God tells us that it is time to go. We all know that this world is not ours, we are all going to leave sooner or later but it is not going to be until God allows it. We can’t decide that. My life has been hard and destiny has not smiled upon me but God willing you won’t suffer what I have suffered.”

Family members also helped reassure children worried about their upcoming immigration cases. One mother explained how she responded to her 10-year-old daughter’s anxiety that she was going to be deported:

“Daughter,” I tell her, “don’t ever think that, you just keep moving forward. Think that you are going to make it. I have faith that you will make it and you have to do the same. So, relax be calm, walk calmly, and that’s it.” And my daughter goes on her way, calmly.
In addition to offering advice, family members provided support by listening and bearing witness to children’s often harrowing stories. The mother of a 13-year-old girl explained that her daughter “talks about [her journey] in full . . . she explains how she came here, what she did, what she went through, and I just listen.” The sister of the 18-year-old girl who was kidnapped and held for ransom in Texas explained:

I tell her, “Tell me everything. Tell me. We are sisters and we need to trust each other.”

[So] she told me the truth about how she suffered when they held her in the house and how it was for her and everything.

Family members also played an important role in supporting their children in more typical, adolescent matters. As one 17-year-old girl explained, “I tell my mom, ‘Well look, this and that happened in school’ . . . And she listens to me . . . because she is my mother and she understands me. . . . She is my mother and she knows me well.” Similarly, a 16-year-old boy described how his mother was supporting him in his career aspirations:

I decided I want to be an actor and told my mom. She told me she would support me and everywhere we go, we ask if there’s a place for acting so I can go and learn, because it’s hard when you do castings.

Several children had come to their parents regarding difficulties they were having in school. Two parents had contacted school administrators due to their children being bullied by other students. The mother of a 14-year-old boy who was being picked on by another student explained that she continued to monitor the situation and to encourage him to open up to her:

I tell him, “If they keep bothering you, say, tell me, because they’re going to keep bullying you if you don’t say anything . . . you always have help available.” . . . I always
tell him to trust me and that he can tell me anything. . . . “I am going to try to understand you,” I say, “I am going to look for help, to help you, however that may be.”

Family members also supported children during the post-migration period by providing a supportive home environment and sharing family activities together. A 10-year-old boy suggested that when he is feeling sad, “I play with my brother because he makes me feel better.” Other children described enjoying a variety of activities with their families: going out to eat with their families, going into Manhattan from the outer boroughs, visiting tourist sites such as Times Square, going shopping or to the park, and going to church.

Many children reported that family members in their home countries had remained an important source of support following their arrival in NYC. A 14-year-old girl commented on how her older sister in Guatemala, who had taken on a parenting role after her parents left when she was four, remained her go-to person when she was feeling anxious or overwhelmed: “Sometimes I call my sister and I talk to her and she says I have to calm down and be patient. And she has given me advice since I was a girl and I always call her.” Sometimes, when children were worried about family members they had left behind, telephone or video calls also helped provide reassurance. One 17-year-old boy who had left Guatemala to get away from gangs, study, and earn money to send his impoverished family at home noted, “I feel a little bit sad [being away from home], but I call [my mother] over the phone and hear how she is doing. She is fine. She says, ‘Don’t worry because I am fine.’” In other instances, children found reassurance in being kept up to date with familial events going on at home.

Community factors. In addition to family relationships, having broader support in the community prior to, during, and following migration was an important resource for many children.
A number of parents mentioned that they had taken advantage of community support to help care for their children from afar. One mother noted the reciprocal caregiving arrangement among friends back home: “I had many friends back in Honduras . . . that’s what helped my kids. . . . That if I could help someone, I would. So when I had to move here, those people helped my kids.” In addition to adults in their communities, many children relied on their friends for support during the pre-migration period. A 17-year-old girl was concerned for her safety in El Salvador because her abusive father had been following her to school but noted feeling some security because “I had friends I hung out with and who took care of me.” Another, 18-year-old, girl whose father had killed himself when she was six years old and whose mother was ill with chronic medical problems reported how she relied on friends to help her finish school: “You may be alone, but you have friends. . . . I went to them and they helped me with homework. We all helped each other out. Like that, I kept going, and I graduated the ninth grade”.

School, church, and participation in sports teams were among the primary sources of community for many children. In addition to academics, children mentioned playing sports and being involved in other extra-curricular activities such as dance and making and selling food and crafts in raffles. One 16-year-old boy from El Salvador was part of a dance troupe that toured the country putting on performances for tourists. Many of the boys in the study mentioned playing soccer as one of their main social activities, both in school and outside. One 17-year-old boy who came from Honduras to the United States after his grandmother passed away, leaving him without a caregiver, noted:

Since I was little, I was always studying. I never flunked a school year, thank God. My mother supported me in playing soccer. I was always studying or playing soccer. . . . When she was over there, she enrolled me in different teams so that I could play. . . .
When she came here, I continued. Right now, I have been playing for a year with one of the professional leagues in my country. . . . I had many friends because of soccer and school. . . . Every person who plays soccer hopes for the best, which is to make it to the national league . . . I was already there. . . . It was a dream. I was just starting to live my dream.

A number of children described going to local festivals in their home countries and being actively involved in their local church communities. Others reported simply enjoying the freedom of spending unstructured time outside with friends in close-knit communities. One mother described that back in El Salvador her 14-year-old son had friends “from church, from school . . . there in the towns it’s different from here, you know everybody, you’ve been with everyone since you were little, since you were kids you’ve had your friends, everyone.”

Community support was also an important coping resource for children during their journey to the United States, both for children traveling with coyotes in organized groups and perhaps particularly for those making the challenging journey on their own. A 17-year-old boy who traveled up through Central America on trains and buses with his cousin described the sense of community among migrants he met along the route: “The nice thing is that you meet a lot of people and you socialize with them . . . people from other countries. They tell you their story and why they had to come here and everything. That is nice, that part.”

Children traveling with coyotes described coming in heterogeneous groups of males and females, including infants, young children, adolescents and adults of all ages, and ranging in size from just a few travelers to 40 or more. Children described the close attachments they formed in these groups as travelers supported each other through the dangerous journey. A 10-year-old boy described the encouragement he received from an adult after the group he and his aunt were
traveling with were held by a gang in a safe house for weeks prior to crossing into the United States:

I had a friend who was from Guatemala . . . people called him “policeman” because he was a policeman . . . he knew how to do everything, like a hundred chest [exercises] . . . he was teaching me how to exercise. . . . I liked him, and I said goodbye when our group left [the safe house] without him.

A 14-year-old girl described striking up a friendship with another girl during the journey: “There were some kids that were my age. . . . And well, I grew fond of them because my father’s family friends were older. . . . And there was a girl that was my age and she grew fond of me.”

Having a sense of community also appeared important to children in helping them through the uncertain period in child shelters under the care of the Office of Refugee Resettlement prior to their release to guardians. In contrast to the bleak conditions of Customs and Border Protection immigration detention, child shelter facilities seem to have purposefully fostered a sense of community. Children described enjoying communal activities to include attending classes, watching movies, playing soccer and baseball, and being taken out to the park, pool, zoo, movies, and restaurants. Many children referred to the friends they had made while in their child shelters, and how they had told jokes, shared their journey experiences, and supported each other while waiting for their release paperwork to be processed. One 12-year-old Honduran boy made friends with another boy who spoke his regional language, Garifuna. Another, 16-year-old, boy described the routine he enjoyed with his peers at his shelter:

We went . . . to the shelter where there were children our age and they took us to the park and to school. . . . We prayed and we had fun. There was a kid who played the guitar and we sang. There was a counselor that gave us paper to draw and there were word puzzles.
We cleaned, there was a laundry machine, and it was by shifts.

Many children also mentioned the role of community supports in NYC. For some children, making friends through school and the local immigrant community helped them with the process of acclimating to life in a big, foreign city. In addition, some children spoke more specifically about how confiding in friends had helped them to cope with the stresses of the post-migration period. For many children, school provided a ready-made community, source of friends, and social support. In particular, several children mentioned that other Spanish-speaking children had helped them adapt. A 17-year-old boy described how his peers supported him: “The ones that speak Spanish have become close to me, they look out for me. They ask me, ‘Do you know which class you have to go to? How is it going?’ We have a good relationship.” A 16-year-old boy who had been bullied and threatened by gang members at his school in El Salvador compared that experience to the supportive school friends he had made in NYC and described how they had helped him acclimate after his arrival:

My Dominican classmates told me that it was a bad time for me to come because it was colder. . . . When I don’t understand something in English, they help me. . . . I haven’t had problems like I had back there. [There] they told me I was gay, but I don’t think about it anymore because I am who I am. And here it’s different . . . when I don’t understand something they help me with my homework.

Some children mentioned how Spanish-speaking peers had helped them deal with the language barrier. One 17-year-old girl commented:

I go to a school where a lot of people speak Spanish. And they help me with my English classes. . . . Or they help me with my homework or projects in English, because my school books are in English. . . . And I think, “How am I going to understand this?” So I
go to see them. Or they come to my house . . . and they help me . . . they help me translate things . . . they are nice. They invite me over to their places and I’ve gotten to know their parents too.

Several other families also described how friends made at school had formed the basis of children’s social networks outside of school. The mother of a 17-year-old girl reported that two of her daughter’s school friends had taken her to their church. The mother of a 10-year-old boy mentioned that he took himself to play with a school friend who lived down the block.

In addition to school, for many children the immigrant community provided an important source of support. A 17-year-old boy from Ecuador who had not yet enrolled in school described the friends he had made in the local Ecuadorian community via the family friend serving as his guardian: “I’ve made friends [from Ecuador]… There are times I haven’t even met people and they come up to me and say hello… they call me and say, ‘Do you want to go out?’ I say, ‘Okay’ and they take me out, they take me to the field to watch games, to get to know people, stuff like that.” Others mentioned playing soccer or baseball with other children in the neighborhood and several families described attending local churches. A number of families described going to local restaurants serving favorite foods from children’s home countries. One 17-year-old girl had joined a dance group and a couple of the older children had started dating other children in the NYC Latino community. In some cases, children had been able to maintain contact with other children who had recently migrated. One mother reported that her daughters were in contact via Facebook with children they had befriended in the child shelter prior to their release. One 13-year-old girl had reconnected in NYC with a friend from back home in Ecuador who came to the United States a few months before her. In a couple of cases, families had been able to find lawyers for their children’s cases through relatives and friends in the immigrant community.
In addition to helping children to acclimate and feel more at home in NYC, friends were also an important source of emotional support for many of the children interviewed. Several children described confiding in new friends that they had made in the United States when they were feeling distressed. In other instances, children relied on friends from their home countries for support, maintaining contact via social networks or Skype. A 17-year-old boy who did not have any family in NYC described how speaking to a friend from home in Ecuador had provided an important outlet:

I don’t tell [my family] anything. What for? I know that worrying them puts another burden on them too. So for that reason I try to console myself on my own. Sometimes I tell a friend that lives over there, he knows everything too. He gives me advice and tells me all sorts of things. And so he tells me not to think about what has happened, because it keeps distressing you, it keeps making things worse for you, it keeps hurting you and your body.

**Cultural, institutional, and structural factors.** An entire culture and institutional infrastructure has developed around the migration of unaccompanied children from Central America to the United States, bringing with it both informal and formal supports for children. Families mentioned different aspects of this culture, from money sent from the United States back to Central America to compensate for the limited educational infrastructure to the network of coyotes bringing children north, government and non-government organizations to support travelers en route through Mexico, U.S. legal accommodations for unaccompanied children, and access to educational and health services in the post-migration period.

Prior to their migration, education appeared to provide an important source of structure and support for many children and offset living in unstable or chaotic home environments or
dangerous neighborhoods. Frequently, children described going to school as one of their favorite aspects of their lives back home. When they encountered structural obstacles to accessing appropriate schooling (such as lack of funding or transport problems) families were sometimes able to provide their own solutions. Several parents had sent money earned in the United States to pay for their children to attend private schools back in their home countries due to poor public education or a lack of availability in the more advanced grades. One father explained how, due to a lack of space in the local school, he paid for his 17-year-old son to be bused back and forth to another Guatemalan city so he could continue his studies.

Although guardians described limited resources in their home countries for children with special educational needs, several suggested that schools had made efforts to communicate their concerns and accommodate their children. One mother noted that when her 12-year-old son started displaying attention and behavior problems in school in Honduras and began falling behind in reading and writing, his school referred him to a psychologist and contacted her in the United States expressing concern about the care he was receiving from his aunt. The psychologist attributed the child’s symptoms to a lack of parental attention, and this feedback and the aunt’s neglect were important factors in the mother’s decision to bring him to NYC. The mother of the 14-year-old girl diagnosed with cognitive deficits described the process by which her daughter’s difficulties were identified and the supports she received:

When I was over there [in Honduras] I didn’t accept she had problems . . . I came here and she started going to pre-kinder. The kids at that age only go to school to play, to know people and to make friends. When she started first grade, they noticed more. She could not pay attention . . . she was always hyperactive. She got angry easily . . . She went to a psychologist over there. . . . They used to take her to a foundation over there
once a week or at the most twice if she was lucky. Over there, there is only that foundation that offers help.

Parents’ engagement in their children’s lives from afar, either through financial support or direct engagement with teachers and other professionals involved in their care, was one part of a larger migratory culture that they described in which separations were common and many institutions were dependent on support from family members living and working abroad. This culture they described in which everyone knew others who had migrated to (and sometimes subsequently back from) the United States may have helped normalize separations that would otherwise have been harder for children to understand. For some children living in challenging circumstances separated from family, the possibility of traveling to the United States also appeared to have provided a sense of hope for a better future. A number of the children interviewed mentioned that they knew other children from their communities who had successfully made the journey to the United States, and that this had inspired them to do the same. A 15-year-old boy who came with his siblings aged 13 and eight described their decision to leave their abusive and neglectful aunt and travel to the United States to reunite with their mother:

We could not take the bad life that we had in Honduras... And people used to tell us that they were letting children across here in the United States... So little by little I organized everything until the day arrived. I got up early in the morning, got some clothes for my siblings and I, and we escaped from the house.

For some families who could afford to pay, the potential danger and hardship of the journey appears to have been mitigated by employing coyotes from highly organized and professional people-trafficking networks. Wary of leaving their children in the hands of
exploitative coyotes who might hurt rather than protect them, several parents used guides who had already brought other family members and friends. In other cases, families asked around in their communities for recommendations. One 14-year-old girl whose family had paid a high premium to bring her with a trusted coyote described the conditions of her journey: “[Our guide] would give us food . . . sandwiches, chicken, everything. . . . Sometimes they would take us to hotels so that we could bathe . . . [we slept] in hotels.” An 11-year-old boy whose mother had arranged for a “highly recommended person to bring him” described his relationship with the coyote who brought him: “When we were on our way, he bought me many things and I was not too scared anymore. We used to laugh a lot.”

A culture of informal supports from local communities has developed along the migration routes to help unaccompanied children traveling without coyotes. Several children mentioned receiving assistance from local people during their journeys to include money, food, shelter, and advice. A 15-year-old boy who made the journey with his younger siblings wrote in his autoethnography:

We passed through Guatemala, with people helping us and they helped us to cross the river to get into Mexico. We were in Chiapas for five days in a house where they looked after us a lot better than my aunt, I felt like I was at home. And then they told us that there was a train heading to Veracruz. So we carried on asking the whole journey and people gave us food.

Children traveling without coyotes were, in some cases, able to access support from organizations designed to limit the dangers of the journey. For example, some children mentioned receiving assistance from Grupos Beta, the Mexican government initiative designed
to provide basic protections to migrants. One 16-year-old boy described his interaction with the organization:

We were walking and they called us over. We got scared and we were deciding whether to run or what, but they told us that they were not going to arrest us. They gave us food and water, then we continued on our way. They gave us cookies and water for us to take, so we only had to ask for money to find a place to sleep.

The same child also described receiving assistance through Casas del Migrante, a Catholic organization with a network of shelters on the migration route:

We stayed at the Casa del Migrante. . . . We slept in berths and there was food, books, and we could watch TV. I found out that you couldn’t stay for more than 24 hours. It was like a rest. But thank God we only needed a night, because the train was going to be there in the morning.

Other, legislative factors also helped mitigate the stress of apprehension and detention by U.S. immigration authorities. As a result of U.S. immigration law’s provision of special forms of immigration relief for many unaccompanied children, in some cases families had arranged for their children to be passed directly to U.S. immigration authorities, and as a result the children avoided the dangers and uncertainties of trying to evade capture on the U.S. side of the border. One mother who had arranged for her 10- and 14-year-old daughters to be handed over to U.S. authorities explained:

They put them in the water to hand them over, in a raft, they call it a boat. They put them in there so that on the other side the U.S. police can grab them. There they become responsible for them, when they apprehend them. The smugglers are watching that they pick them up. They call us, “Look, your daughters are in the hands of the U.S. police.”
They are waiting there, for the police to be there, so that the police can see them. If they are not there, it is dangerous for the girls. They have to see that the police are there at the end, you understand me? If they put the girls there and no one receives them, it’s a problem. The girls can drown or anything can happen to them.

The mother of a 12-year-old boy from Honduras who had made a similar arrangement with a coyote reported that five to 10 minutes after the coyote watched her children being apprehended, she received a call from a U.S. border patrol official verifying that she was their mother, explaining the resettlement process, and reassuring her, “They are in good hands. We will keep you posted with everything.” In three other cases, children gave themselves up shortly after crossing the border. A 15-year-old boy and his 13-year-old sister who made the journey to the United States without a coyote and without telling their mother surrendered themselves to U.S. authorities because they had heard back home in Honduras that if they made it to the United States and handed themselves over they would be released to family. In all these cases, children reported being treated well by the officers who apprehended them.

Separation of the U.S. government’s prosecutorial and custodial roles and streamlining of the detention and release processes meant that most unaccompanied children were quickly moved from uncomfortable, stressful Customs and Border Protection immigration detention facilities to more child-appropriate shelters run by the Office of Refugee Resettlement where their needs could be more appropriately addressed. Only two children described being kept in immigration detention more than three days, and a number reported that they were moved to child shelters within 24 hours of being apprehended at the border. Social workers and other staff at the child shelters helped mitigate the impact of the migration process in a variety of ways: by providing a grounding, structured environment at a moment of acute stress; by giving individual
counseling to children suffering with trauma symptoms and other specific needs; by supporting families through the often anxiety-provoking process of applying for guardianship; and by providing information and helping orient families to the challenges of the post-migration period.

The structured, supportive environment of classes and other activities provided at child shelters appears to have served a particularly important, grounding function. This appeared particular true for children who had been subjected to traumatic experiences either in their home countries or en route to the United States. An 18-year-old girl who had been kidnapped and held for ransom in Texas for weeks reported:

They took me to the juvenile center. And I showered there, it is like they really care about you there. They check your health, and they give you shots . . . and they feed you. Well, first of all they feed you, then you bathe, everything is ready. They give you shoes and clothes, everything that you should have . . . and they give you classes. I adapted well there. I really liked it because it was a nice environment. We went out to the pool and everything. But the main thing was that the teachers were taking care of us. We were really cared for there.

As part of their mandated procedures, children all received a psychosocial assessment upon entering ORR child shelters. In some cases where children presented with particular distress, this led to ongoing support from counseling staff throughout children’s stay. Children frequently reported feeling anxious about telling their stories to a stranger, but described feeling less sad and anxious after talking to their counselors. One 17-year-old boy described the care he received:

In that place I was staying, there were psychologists. And thanks to them I'm a little better. They talked to me about everything. They told me I have to leave all that behind
me, that’s in the past, not to wear myself down with that same stuff . . . try to smile at life, I know life is hard, and that’s the way it is. . . . I spent 27 days there in Texas, and [the psychologist] visited me constantly . . . she gave me all sorts of advice . . . and thanks to her . . . I’ve come out better. . . . I got there in the worst state, scared, as if someone was doing something bad to me. But it was just, like she said, it’s just psychologically that you’re thinking that. It’s not real, it’s because of what you’ve seen that you feel like that. . . . She gave me a book to draw everything I was feeling and to write everything I was thinking, so I started to do that. When I arrived there, every night I’d wake up startled 10 or 11 times, but then I started to sleep.

One of the primary roles of staff in children’s shelters was to locate their families or other potential sponsors and to help them prepare and submit the background check and release paperwork. Many families spoke about the care and support they received through this stressful process. The sister of an 18-year-old girl described how the social worker helped process her application as quickly as possible before her sister’s eighteenth birthday so that she would still be eligible for release as a minor, which they managed with two days to spare. One undocumented father of a 17-year-old Guatemala boy described how he was reassured by shelter staff that he could come forth and claim his son safely:

Because he is 17 they sent him to [the child shelter] and then they called me. From San Antonio, Texas, they called me and they said, “Do you know [child’s name]?” “Yes, he is my son.” “Well, we have him, but this has nothing to do with immigration . . . it is something legal allowed in this country. We can send him to you, but he has to study.”

Child shelter staff also helped orient families to the demands of the post-migration period. Some shelter shelters brought in legal advocacy groups to inform children about the
immigration process. One 17-year-old boy described the legal orientation he received:

Some people came from ProBAR, that’s what the group was called, and they explained some things about what we have to do in court, about what court is like and all that. . . .

And they told us that that when we get here we had to get a lawyer to be able to stay.

Child shelter staff also informed families about the importance of enrolling their children in school rather than allowing them to work. The mother of a 12-year-old boy who had been having academic and behavioral problems at school in Honduras noted the advice he had been given by the social worker at his shelter:

But it seems like . . . they explained it to them very well. If they behave in school, their school behavior . . . goes to court. How can I say it? The social worker explained to them that they needed to show their best behavior here . . . the government can see how they are doing in school. Because there are times that they fight in school and I tell them, “Remember what they told you.” What was his name? Luis. “Remember what Luis told you, in this country your behavior is what counts.”

Families also referred to a number of factors at the institutional level that appeared to support their children’s wellbeing in the post-migration period: easy enrollment in public schools; access to free and government-sponsored healthcare programs; and availability of legal orientations and other nonprofit immigrant advocacy programs. An additional, implied supportive factor was that children could be released to family members regardless of their migration status. Not only did this allow for children to benefit from the loving care and support of their immediate family, these family members were often very proactive in helping their children to access other educational, medical, and community resources. Placement with family also provided children with access to NYC’s Latino immigrant community and associated
resources (e.g., restaurants, churches, sports, and other recreational activities) to ease their acculturation process.

Almost all the children interviewed had been enrolled in school by the time of their interviews. Guardians typically described a simple school enrollment process, although entering mid-year sometimes their first choice (typically bilingual) schools were full. With the exception of one child who had to wait more than a month for the beginning of a new semester, families typically reported that their children were enrolled in school within a week or two of their arrival. Children’s temporary immigration status did not appear to pose an impediment for any families.

For many children interviewed, school was not only an important source of structure and community but also the main means of accessing other services. In some cases, children had been seen by school counselors. This appeared to provide an accessible, non-stigmatizing therapeutic setting, and allowed for monitoring of children’s symptoms over time with the possibility of further care. The mother of a 14-year-old boy who had been apprehended at gunpoint by U.S. immigration officials in Texas described speaking with his school counselor:

I talked with the counselor, to see if the trauma of what happened in [Texas] when he came . . . if he needed psychological help . . . he went to talk with [my son], he went to see him, to see how he was acting.

At the time of their interviews, three children were being monitored by school counselors and receiving support on an ad hoc basis. The 14-year-old Honduran girl with cognitive deficits was being monitored by her school counselor due to her learning difficulties and racist bullying from peers A 16-year-old boy who had witnessed gang violence in El Salvador and had been bullied by peers at school was being monitored by his school counselor after a teacher found a
note stating that he was missing his grandparents and his home country and no longer wished to live. One 14-year-old boy had been to speak with his school counselor because another child was bullying him.

Access to free medical care through school and government insurance programs such as New York State’s Child Health Plus and Medicaid also served to support children’s physical and mental health. Children interviewed received medical care in a variety of contexts and settings: medical exams and vaccinations for school at local community health centers; visits to school nurses for routine problems; consultation with pediatricians for physical and emotional concerns; gynecological appointments; and hospital visits for urgent care (e.g., food poisoning and panic symptoms). However, some families described difficulty accessing care and limitations in the services they had received. Two guardians had taken their children to see pediatricians since their arrival in NYC due to mental health concerns, but these encounters had not resulted in referral to mental health treatment. One mother had taken her 17-year-old daughter to the hospital due to her difficulties breathing and breaking out in rashes “when I think about something or when I am sad about something.” However, she was cleared medically and not provided with any additional follow-up or referrals. Another mother had taken her 14-year-old daughter children to see her pediatrician “because she was sad and I thought he might be able to help her.” However, the mother suggested that the visit had not been productive:

She used to cry every day. Well, she still cries a little. I thought [the pediatrician] could help her in some way. I have to take her to a doctor that can help her. He is not going to help her at all. She doesn’t trust him. Trust is the most important part. If a patient doesn’t trust a doctor, nothing can be done.
In other cases where families had not known of the existence of free or government-assisted programs, they had not received services. The mother of a 13-year-old boy with knee problems had been given conflicting advice about whether he qualified for Medicaid and as a result her son had not received treatment. Another mother who was worried about her 17-year-old daughter’s mood did not know her daughter was eligible for subsidized care and as a result had not sought services.

Immigrant advocacy organizations had helped a few of the families interviewed access legal services, either through direct assistance or by providing them with information on how to access services. Families recruited to this study had attended a Legal Orientation Program for Custodians meeting, where they received information about how to access legal, educational, and health resources in the NYC area. One mother described being reassured about her 15-year-old son’s immigration case following the LOPC meeting and discussions with a lawyer:

They gave us a guide . . . so that we know how it is going to be. . . . Well, they told him that he qualifies because he doesn’t have a father. . . . There is a law that covers him so that he can get his visa and his residency at the same time. . . . But it is going to be a process . . . I have to go to the family court and ask for the kid’s full custody. . . . That is what they explained to me.

Another child had been able to obtain a lawyer with assistance from a case manager at Safe Passages, whose nonprofit program includes training and mentoring volunteer attorneys to represent unaccompanied children in immigration court. However, overall the capacity of legal advocacy organizations to provide services was very limited compared to the number of families needing help.
Research question 1d: How do unaccompanied children and their guardians understand and describe children’s experiences of distress and coping and their attitudes towards their migration process? Participants described a variety of manifestations of distress, some of which they regarded as normative and non-pathological and some of which they presented as cause for greater concern. Alongside the support received from others, children noted a variety of personal beliefs, attitudes, and behaviors that had helped them cope. They had complex and nuanced attitudes towards their migration, reflecting both the challenges and opportunities coming to the United States had presented. These results are summarized in Table 5.

Table 5. Summary of results on children’s experiences of distress and coping and their attitudes towards their migration process

<table>
<thead>
<tr>
<th>Experience of distress</th>
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<tbody>
<tr>
<td>• Distress typically regarded as normative: missing family in home country; loneliness; regret/ambivalence about leaving home; difficulties adjusting to living with parents</td>
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<tr>
<td>• Distress regarded as more problematic: somatic complaints; re-experiencing and hyperarousal symptoms; suicidal ideation; behavioral difficulties</td>
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<tr>
<th>Personal coping factors</th>
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<tr>
<td>• Coping attitudes: belief in mental fortitude and capacity to overcome obstacles; sense of agency; close emotional attachments to family; internalization of cultural values from home country; religious faith; identification with U.S. values regarding self-determination; achievement orientation</td>
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<tr>
<td>• Coping behaviors: prayer; emotional suppression; emotional expression; distraction</td>
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<tr>
<th>Attitudes towards migration process</th>
</tr>
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<tbody>
<tr>
<td>• Sadness about leaving family in home country versus excitement at family reunification in United States</td>
</tr>
<tr>
<td>• Desire to get an education and move forward with life in United States</td>
</tr>
<tr>
<td>• Anxiety about legal uncertainties but even-handed view of immigration process</td>
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Children’s experience of distress. Children described distress they were experiencing in a variety of ways. Many reported feeling sad and missing family members and other loved ones left at home. Several children had somatic complaints that appeared to be linked to their migration experience. Other children appeared to be having re-experiencing and hyperarousal symptoms consistent with trauma. A number of children were preoccupied with ruminative thoughts such as regret or guilt about family members left in their home countries, and some had experienced suicidal ideation. Others were troubled by memories of their journeys or experiences in their home countries. A few children had found it difficult to adjust to living with parents in the United States after long absences and had exhibited behavioral problems. Some were trying to hide their distress from loved ones in order not to worry them.

The majority of children reported feeling sadness about family and friends they had left behind in their home countries. One 17-year-old boy from Honduras came to the United States to be with his mother after his grandmother, who had been his primary caregiver for the past 10 years, died. He described what this transition had been like for him:

I was leaving everything that I was used to and I had to start all over in another country.
It is hard . . . you feel sad. . . . To tell you the truth, I miss [my family in Honduras]. . . . How can I explain to you? I lived with them since I was little. I was used to talking to them, joking around, or just saying whatever.

The mother of a 14-year-old Salvadoran boy described her son’s feelings about being separated from his grandmother, who had been his primary caregiver since he was three years old:

When he looks at her photo or whatever, I can’t control him, he starts to cry and cry and he tells me, “It would be better to buy me a flight, I will leave, I want to be with my
grandmother, I’ll leave.” . . . That is the most difficult thing right now, not being with my mother, he misses her so much, so much.

Children reported particularly missing family and friends around holidays or other important events such as the death of loved ones. A 16-year-old Salvadoran boy noted, “I felt the worst at Christmas because it’s so different. There in El Salvador you hear fireworks and here it’s so different, with no music or people. Here it is really different.” A number of children reported feeling lonely having exchanged large families and friend groups at home for one or two relatives or acquaintances in the United States. One 17-year-old Salvadoran girl noted, “Over there I used to have many friends and here I only have my mother and my cousin. I feel lonely. Well, I just started school and I don’t know anyone.” Others spoke about missing small, routine aspects of daily life. A 17-year-old boy commented on missing the young relatives he had lived with in his aunts’ home:

Well, right now, I am happy being with my mother. What makes me sad is talking to my nephews and [when] they ask me when I am going back. One is three years old and the other one is six. They are little and they ask me. Every time they ask me, I feel sad. I was always with them. When I used to get home from school, they even ran to hug me. The same when I used to return from my soccer practices. Well, I miss them very much, that is what makes me sad.

For several children, contact with family at home was at times painful. The family friend serving as a guardian to a 17-year-old Ecuadoran boy who had left his entire family at home described their internet calls:

There are times when he loses hope, or rather, I always make sure he can see his parents over there, I give him my computer so that they see each other in a video call . . . he cries
a lot, his mom too; when they see each other, I feel a pain in my soul and I feel very sad listening because he has a little brother who, when he sees him in the computer, he wants to pick up his brother.

In some instances, children emphasized the normative nature of their sadness about missing home. One 16-year-old boy from Honduras clarified, “But really, sometimes I worry because, well, not because of problems, but . . . because of my mother. Because she is over there, and sometimes I feel sad because of that, but not because I have problems or any of that.” Other children described their sadness in more impairing terms. One 14-year-old girl expressed her anguish at being separated from her ailing grandparents in Honduras, including a sense of guilt and difficulty feeling motivated to go about her daily life here in the United States:

Sometimes I think that if something happens to [my grandmother] it would be my fault because at night she would get nervous attacks and my aunt taught me to take her blood pressure. . . . Sometimes I feel depressed. I don’t want to do anything. I don’t want to go to school. I just want to see my grandmother.

Other children also expressed feeling regret about family members they had left at home. A 16-year-old boy described his feelings about his grandfather: “My grandpa is always sick. He criticized me and as they say, you never value what you have until you lose it.” A 10-year-old boy whose grandparents had sent him to be with his mother in NYC due to his increasingly unruly behavior lamented the loss of his life with them in Ecuador: “I liked helping them, because I like living in the country, not in the city. . . . So here I am regretful. . . . Over there . . . everything was fine, fine.”

In addition to feelings such as sadness and guilt, three children had experienced suicidal ideation. One 16-year-old Salvadoran boy, who had been harassed by gang members and other
peers in his home country and had initially struggled to adjust to living with his mother and stepfather in NYC, had written a note found by a teacher at school expressing that he missed his grandparents and no longer wanted to live. An 18-year-old girl, whose father had suffered from alcoholism and depression and killed himself when she was six years old, reported that at the age of 11 she started to take some pills because “I wanted to be with my father.” She denied any recent suicidal thoughts. Another, 17-year-old, girl had ongoing suicidal ideation dating back to her life in El Salvador, where her family had been threatened by gang members and she had suffered physical and emotional abuse at the hands of her grandmother and aunt. Her mother described her suicidal ideation as follows:

I knew it since she was over there. My sister told me, “She says that she doesn’t want to live anymore.” I told her, “Daughter why do you say that? I want to see you with your diploma. I want you to be someone in life. I want you to do what you like.” She tells me, “No, mommy, sometimes I feel alone. Sometimes I feel alone. I feel as if nobody loves me.” I tell her, “How can you believe that nobody loves you? I have not done anything for you?” And she tells me, “Yes, mommy. I know you are doing a lot for me. I am fighting and powering through to be someone in life for you but sometimes I feel sad.”

Several children reported somatic complaints associated with their distress. The 18-year-old girl who had been kidnapped and held for ransom for two weeks in Texas after crossing the border reported that when she thought about her experience, “I get a headache. My head hurts and I think a lot.” A 14-year-old girl who had to stop speaking to her grandmother over the phone because it was too upsetting reported that following their calls, “I would get sick… I would get painful headaches.” The 17-year-old Salvadoran girl with recurrent suicidal ideation described her physical experience of anxiety:
When I am nervous or when I feel something, I get like spots, well, not spots but I get allergies on my skin. My entire body itches and my chest hurts. I can’t breathe and I feel cold so I start trembling. At the beginning when I start feeling nervous, I start talking a lot and I start laughing. Later on, I feel pain on my chest and the allergies appear.

Her mother recounted that her daughter also complained of feeling muscular pain, tiredness, blurred vision, and difficulty sleeping, and also that she had starting scratching herself:

She scratches her face. I tell her, “Daughter, you are going to become wrinkled very fast. If you are going to scratch your body, look for a gentler way to do it. Don’t harm yourself.” She tells me, “I feel better when I scratch.” I tell her, “No, don’t harm yourself.” Her skin is damaged. It is because of her anxiety. I tell her, “Don’t do it.” She tells me, “It makes me feel better” . . . The rash goes away after two or three hours. She says that sometimes she sees blurry.

Several children experienced distress in the form of traumatic memories. Another 17-year-old Salvadoran girl described feeling “traumatized” by her experiences living in a violent neighborhood where friends had been victimized by gang members. She reported being reminded of bus robberies in El Salvador while riding the bus in NYC:

I remember, but then I realize I am somewhere else . . . like both places are in my vision, but then I realize I am here, I am far away. I remember and I say to myself, “Poor people over there, that might be getting mugged or something.” And I think, “Thank God I am on this bus,” and I go back to the moment I am living and I feel fine.

Other children described being troubled by memories of abusive experiences in their home countries. A 16-year-old girl who had been physically abused by her grandmother over many years reported, “Sometimes I feel sad. I feel sad because . . . I remember the things I went
through . . . in Guatemala . . . what I went through with my grandmother my entire life, all the difficult moments.” The mother of a 17-year old girl who had witnessed her father’s attempted suicide and had been sent to live with a grandmother who abused her described the ongoing impact of these traumas: “She can’t get rid of all those feelings . . . she has lived a hard life. She has things in her mind that she can’t erase.”

Children also described re-experiencing traumatic episodes from their journeys to the United States. The 17-year-old boy from Ecuador who had seen a fellow traveler fall off a bus and be crushed to death described his response to this traumatic incident:

When I arrived in Texas . . . sometimes, I couldn’t sleep, I wasn’t hungry, just thinking about that . . . I was afraid . . . I wanted to lock myself away alone, to be alone. Sometimes when someone came up to me I would be really startled.

He reported that although these symptoms had improved in the three months since his arrival in NYC, “There are times when I start thinking about it . . . there are times when thinking about it scares me.” A 17-year-old girl who described being mistreated while detained in a Customs and Border Protection facility explained that following her release to her mother in NYC “I didn’t want to see any police officers because it reminded me of that.” Her mother reported that her daughter had nightmares about her immigration experience and “she doesn’t want to go out because she thinks something might happen and she could get deported.”

Children frequently reported hiding their distress from others, particularly in cases where their closest loved ones were back in their home countries. One 14-year-old who wrote at length in her autoethnography about her anguish at missing her family in Honduras stated in her narrative interview, “I don’t like to talk about things that have happened in my life because, for me, nobody else has to know . . . I don’t trust too much and I don’t show my feelings.” Another
14-year-old girl also described keeping her emotions to herself:

I do feel, like, the only way out is to be quiet. So let’s say I do feel really sad a lot of times and I lie in bed. Or sometimes I don’t feel like talking to anyone and then I just stay quiet.

In some cases, children were experiencing tension in their relationship with their parents and having behavioral problems at home or in school. The 10-year-old Ecuadorian boy who had been brought to the United States because he was misbehaving with his grandparents back home reported that he did not yet trust his mother and did not get on with his stepfather. His mother noted that he was not behaving himself or taking responsibility, particularly with regard to his school work. The mother of a 13-year-old boy reported that initially she had to take a very firm stance with him after he tried to stand up to her authority:

I had to stand up to him and I told him, “Look, sweetie, I have never gone to jail here and I will not go to jail because of you. I will call the police on you and the one that is going to go to jail here is you.” I stood up to him. I stood up to him in a strong way, so then he packed his things and he was going to leave the house.

Although his behavior at home had improved, he was continuing to have problems academically and socially at school. His mother described the situation:

He doesn’t pay attention. It seems that the other kids bother him . . . they called me first telling me that he used to fall asleep in school. Then they said that he plays too much at school. Then he got into a fight with a kid that used to bother him. It seems that he even ripped his schoolbag and [child’s name] responded. They fought and I had to go there.

*Children’s experience of coping.* In addition to psychosocial supports in their environment, children identified a variety of ways in which, at the individual level, they were
Several children described a belief in their own courage, mental toughness, ability to endure hardship, and capacity to overcome obstacles that had been reinforced by difficult journeys and had helped them continue to cope with the ongoing stress and uncertainty of their lives in NYC. One 17-year-old boy wrote in his autoethnography, “We have dreams and we just have to achieve them, not allow ourselves to be defeated by obstacles. I know that although we fall we have to get up. It doesn’t matter if it hurts, we have to fight.” Some children described their resolve in terms of self-determination connected to a belief in America as a place where one could shape one’s own future by working hard. One boy aged 17 stated:

What I like the most is that there are more opportunities. If one puts effort into things, I know that one can power through. For example, I know that if I study hard and I do my best, things can go well. This is a country with many opportunities and I like that. I know that it will go well because I have a good plan.

For other children, an attachment to their cultural heritage and loved ones back home was an important aspect of their mental fortitude. One boy from Ecuador reported that despite being from “a corrupt country that does not allow us to study . . . even so we carry our homeland in our hearts.” A 14-year-old girl wrote in her autoethnography that the grandparents who raised her in Honduras “will always be in my heart” and suggested that in difficult moments she thinks of her grandmother and her advice “that I should become successful so we can see each other again.”

A number of children spoke about specific coping strategies they had found to regulate distressing thoughts and feelings. Several children described using distraction as a coping strategy. One 17-year-old boy explained how he dealt with traumatic memories from his journey:
When I’m really bad, sometimes when all that comes to mind, what happened and what I saw, and it starts to scare me, I go out or read the Bible and it passes, or when I start thinking about other things or when I’m talking to someone, I don’t think about it.

Another 17 year-old boy suggested that in response to feeling sad about being away from his family he purposefully tried to create different emotions: “[I] talk about good things, tell jokes, that makes me happy. Yes . . . telling a joke, chatting about good things, that makes me happy. Telling a story, that makes me happy.” The 17-year-old girl who appeared to be experiencing stress-related skin problems suggested that she tried to replace sad or anxious rumination with positive thoughts:

It helps me to think that I have to calm down and that I don’t have to think about the problem. When I am sad, I think about something positive that makes me happy. When I start thinking like that the itchiness goes away, it disappears.

Several children mentioned using relaxation strategies such as listening to music and, in the case of one 15-year-old boy, practicing meditation. For some children, allowing themselves to experience emotions seemed an important coping strategy. The mother of a 10-year-old girl reported:

What happens is that she is a crier. She cries a lot about everything. . . . She likes to cry a lot. . . . Sometimes I tell her to cry, because if I tell her not to, she cries anyway. I think crying is good for you, even healthy. If she doesn’t cry and she doesn’t say what she is feeling, she can even get sick. I tell [her], “Cry because sometimes it’s good and it’s healthy.” . . . It’s good therapy, she cries and then feels better.

Faith was another important means of coping with the dangers and uncertainties of the migration process, mentioned by almost half the families. Several children mentioned praying for
God’s protection before and during their journeys, be it from gangs, the physical dangers of the journey, or immigration authorities. One 17-year-old male reported that despite stories of the drug gangs patrolling the route he had summoned the courage to undertake the dangerous journey north from Honduras by “trusting in God.” Another 17-year-old boy who had a particularly difficult journey riding atop trains reported, “My mom gave me a rosary when I left, and before I got on the train we prayed.” The mother of a 14-year-old recounted how her son coped after he was incarcerated by Mexican immigration officials and there were complications in the paperwork required for his release back to his family in El Salvador: “He says that he started to pray and asked God… he promised . . . something to God, he didn’t tell me what, but he told me, ‘I made a pact with God, I promised him something, if I [get released].’” One 17-year-old boy described how prayer was integral to the culture of migration, such that even the gang members controlling the route participated: “We went to a church. Those people from the gangs took us to church to get a rosary, they were giving them out and they handed out one for each person. They respect that. They are very religious.”

A number of children spoke about praying to cope during the stressful, uncertain time spent in detention following their apprehension by U.S. immigration authorities and prior to their release. One 17-year-old boy described how prayer had helped him through this process:

They submit your case under evaluation . . . from the government. So sometimes they accept them, sometimes they reject them. . . . And some boys get sent back to their country, and I was unsure. I felt bad because I didn’t know and I started praying a lot . . . it took me a month, my case.

A 13-year-old boy explained that he and the other children in his child shelter asked God for an end to their long migration process: “We prayed so that we could be at home now and so that
nothing would happen to us anymore.” Several children mentioned having the opportunity to read the Bible and go to church while in child shelters and that they found this comforting.

Faith and prayer remained important coping strategies for many children following their arrival in NYC. One 17-year-old boy noted that listening to Christian music helped him to relax and get through hard moments such as missing his family back in Honduras. Another 17-year-old boy who was in NYC without family and being sponsored by a family friend noted, “There are times that I feel really bad, and thanks to Him, I tell him some things that are making me feel bad and then I feel better.” In a drawing from his autoethnography, he referred to the strength he derived from his religious faith through the ongoing challenges of the post-migration period.

This is shown in Figure 7.

![Drawing from autoethnography by 17-year-old boy referencing role of religious faith in his coping.](image)

**Figure 7.** Drawing from autoethnography by 17-year-old boy referencing role of religious faith in his coping.
The 18-year-old girl who had been kidnapped in Texas closed her autoethnography by describing the hope and fortitude her faith provided:

Today I am with my sister. I feel very happy because I am no longer with bad people.

Today I want to study and I want to learn English. I want them to give me permission to be here in the United States and to be able to go and come back again. I have faith in God that everything is going to turn out well, with God nothing is impossible!

**Children’s attitudes towards their migration process.** Children described complex feelings about their migration and current lives in the United States. Often they had left home with regret about loved ones and aspects of the lives they were leaving behind, but at the same time excitement at the prospect of longed-for reunions with family members in the United States. For many, their journeys were a time of fear but also adventure, and an exhilarating realization of their own courage and self-determination. Apprehension and detention by U.S. immigration officials often brought great disappointment and, for some children with traumatic journeys, simultaneously a sense of relief. Many children felt initial joy at being reunited with loved ones followed by some ambivalence about their lives in the United States. While hoping for successful outcomes in their immigration cases, many were experiencing acculturation difficulties and were unsure whether they wanted to stay. Despite distress and anxiety about their detention and immigration processes, the great majority reported finding their treatment by the government fair.

Many children described mixed feelings about the countries they were leaving behind. One 17-year-old boy discussed the tension between an idyllic relationship with his family and the extreme poverty they endured in Ecuador:
I had my family, I had everything. They were my happiness, although we did not have anything, like I said, at times we did not have anything to eat. But for me they were everything, and that’s why I came here, for them, because I did not want to see my brothers suffering what I had already suffered so much. I wanted to help.

Another 17-year-old boy described his contrasting sense of danger and community in Honduras:

“The hard thing is that you don’t know when you will die, when they will kill you. The nice thing is that you can go out with your family and as long as you are not in danger, that is fine.”

A 16-year-old Salvadoran boy noted the tension between longing to see his mother after a nine-year separation but not wanting to be separated from the grandparents who had looked after him for the past decade: “I felt bad but at the same time positive about coming here. Leaving my grandparents and not knowing if I’d see them again or not was hard.”

In keeping with these contrasts, children described experiencing a variety of emotions as they undertook their journeys, including sadness about separations from loved ones, relief about leaving bad situations, anxiety about the dangers ahead, and excitement for the future. One 15-year-old boy described his contrasting feelings about escaping unannounced with his little brother and sister from his aunt’s abusive care: “I felt nervous . . . because I had never done that. And at the same time I felt proud of myself . . . because I had saved my brother and sister from harm.” Another, 17-year-old, boy also described mixed thoughts and feelings about his decision to leave home:

To tell you the truth, when you are young, you take those things as new experiences. Yes, when you are traveling, you think a lot. You think about many things. You think about what you are leaving behind, and about the future and what could happen. When you are
thinking about all that, you feel excited and sad because you are leaving your loved ones
behind.

Children also experienced their journeys in a variety of ways. A 15-year-old boy who
traveled up through Mexico on the trains described the range of emotions he experienced during
his journey:

“[The journey] affected me and helped me. It helped me because I got the chance to
Mexico. I always wanted that . . . and I got the chance to do it. It affected me because I
had to beg for money. It was helping us, but I felt embarrassed. And I met really bad
people. . . . In Mexico . . . the gang members were scary. They were really, really scary.”

Another, 16-year-old, boy who also rode the trains north wrote in his autoethnography about his
journey in a way that evoked his sense of adventure:

My experience of coming to the United States was to learn about new things because I also
had the opportunity to get to know two countries, Guatemala and Mexico, where I was for
two weeks, despite the risks, which were being caught by immigration or suffering
injuries, such as assaults, illnesses, or death. . . . [One] of my experiences was going to a
park in Mexico where they make the telenovela (TV soap) La Mujer de Judas, and while
we were asking for money I saw the Univision vehicle go by, which I went mad for
because that is the channel where I watch telenovelas. I also had the opportunity, although
I only saw it from a long way off, to see where they record the videos for Laura, which I
never imagined I would see.

One 17-year-old boy who came in a group with a coyote but was kidnapped by Zeta gang
members just south of the U.S.-Mexican border described the horror of his experience in his
autoethnography:
It was a struggle to survive on a journey of death. One imagines the journey up here is ugly, but it’s not just ugly, it’s like something out of a horror movie wondering whether you will die or not. It’s as if we were given scripts and one suffers without a clue of what the script is.

Some children reported having second thoughts about making the decision to leave their home countries during the journey. An 18-year-old Guatemalan boy reported, “I felt bad. Sometimes when I was on my way I would feel regretful about coming. I’d think, ‘What am I doing here? I could be over there in my country.’” A 14-year-old Honduran girl described similar misgivings during her journey:

We were already in Guatemala and I wanted to go back to Honduras. . . . It was my grandmother’s birthday. . . . I was thinking a lot about whether something was happening to my grandmother or my grandfather. I don’t want anything to happen to them.

Children in the study responded to being apprehended in a variety of ways. For children whose plan was to hand themselves over to U.S. immigration in anticipation that they would be sent on to family in NYC, apprehension often brought relief that their stressful journeys had come to an end. However, many children assumed that being caught meant they would be sent back to their own countries. One 17-year-old boy described how he felt when he was apprehended:

I felt bad because well, you went through a lot on the way and to think that you will have to go back and you try so hard to come. I felt really bad because my intention wasn’t for them to catch me.
For some children, disappointment at the thought they were going to be deported was juxtaposed against comfort that traumatic ordeals from their journeys were over. A 16-year-old boy Honduran boy described his mixed emotions after his apprehension:

I actually felt better being in immigration, because I was done with the trip. I was done with that so I felt a little calmer. But also I felt depressed because I was there, you know? . . . I felt like dying when I was in the jail and I said to myself that I would go back to my country disappointed about not getting to my destination. But I told myself I would come back and cross another time and that time nobody would stop me, that’s what I thought.

The 17-year-old boy who had been abandoned by his coyote and spent days lost in the Texas desert with four adult travel companions before—exhausted, dehydrated, and cut up by cacti thorns—they decided to turn themselves in, used his autoethnography to depict their mixture of sadness and relief at the moment of their apprehension. This is shown in Figure 8.

Figure 8. Drawing from autoethnography by 17-year-old boy portraying his experience of apprehension by U.S. immigration authorities.
The sister of the 17-year-old girl who had been kidnapped and held for ransom in Texas commented on her reaction to being rescued by immigration authorities in Texas:

When immigration got her, she was happy, she was glad. . . . She told me, “Thank God they caught me. If I go to El Salvador, that is fine. Thank God. If you can do something, then thank God too.” I said, “I will try to do something for you, if we can.” . . . We came here because we are poor, not because we want to be here.

Several children reported feeling criminalized by the uncomfortable conditions and treatment they received in Customs and Border Protection detention facilities. One 14-year-old boy commented:

I was incarcerated there three days . . . waiting for them to take me away from there. And three days passed and I couldn’t take it anymore and I was becoming desperate. I just wanted to sign to go back [to El Salvador], and I cried because I couldn’t even talk to or call anyone. I asked the Immigration people and they told me I was going to sleep where I was, but I couldn’t sleep because, even though I was so sleepy, I was having nightmares, I saw my family, everything. . . . I felt weird being imprisoned because I had never been locked up before, because I have never done anything bad. And they had me there as if I was a criminal.

Children frequently described a stark contrast between the austere, prison-like conditions in CBP facilities and their treatment in child shelters overseen by the Office of Refugee Resettlement, where they felt cared for and as though they were being supported in their immigration process. A 17-year-old boy commented, “[The child shelter] is where they help kids continue with their trip. . . . They have nothing to do with immigration, they help us stay here.” A 14-year-old Honduran suggested the staff at her ORR shelter “didn’t seem like they were
employees, more like they were our family.” The mother of one 17-year-old girl who had been subjected to gang threats and persistent and severe physical and emotional abuse back in El Salvador recounted how her child described the experience of finally being safe and knowing that she would soon be reunited with her mother:

She said, “Nobody has treated me like they treated me there.” It made me very happy. She told me that they gave her a bed and clothes. . . . She took a shower; she slept because she was tired. They took care of them there. She told me, “Mommy, I was like a queen there. I just wanted to see you. I was dreaming about seeing you.”

Although children in the study reported being well looked after in child shelters, meeting other children there who had been detained for long periods left many anxious about whether and when they would be released to guardians. The guardian of one 17-year-old, boy described his surprised when he was released after almost a month at a shelter:

One night, they pulled him out of bed and said, “Get up, you’re going.” He says he never even imagined [that] because there are people there for six months, one year, without leaving. He never thought that he was going to leave, but luckily he got out and came here.

In their accounts of their migration process, children and their guardians often recounted emotional reunions at the airport after long separations. One 14-year-old girl described her journey from her child shelter in Chicago to meet her mother in NYC after nine years apart:

When they told me that I was leaving [the child shelter] in Chicago at three in the morning I felt like I was dreaming. On the flight I thought that I was still dreaming because I was so happy that I was going to see my mom. When I saw her I thought that it was a dream.
A 16-year-old boy, who had also been separated from his mother for nine years, described their reunion at the airport in NYC: “It was nice. I cried so much and so did she. I told her that she looked thinner than in the pictures and she told me I was taller.” The mother of an 11-year-old boy described her reunification with her son, whom she had last seen at age four:

That moment doesn’t even have a name or anything. I don’t even know how to explain it to you. After all that time without seeing my son, imagine that, he was the first to recognize me. And he was little, he was a baby when I left him, but when he came down, hey, that kid screamed. I hadn’t seen him, he saw me first. Imagine that. That’s amazing! Blood bonds are amazing. He had only seen pictures of me, but he knew. It was a joyful moment, it was a joyful moment for me and for him.

In her autoethnography, a 13-year-old girl drew several images depicting her experience of her release from her child shelter facility in Texas, journey to NYC, and reunification with her mother. These are displayed in Figure 9.

Figure 9. Drawing from autoethnography by 13-year-old girl depicting her experience of the process of reunification with her mother.
Following the initial joy of their reunions, many children reported some ambivalence about their lives in the United States. Some described the distressing dilemma of having exchanged separation from family in the United States for separation from family in their home countries. A 10-year-old girl whose mother left her in Honduras when she was a year old reported, “Being with my mom, going to school, having math class, and being with my family makes me happy. Having family in Honduras that didn’t come with me is the saddest.” One 14-year-old girl from Guatemala who had been raised primarily by her sister after her mother came to the United States when she was five years old described her feelings:

I used to feel sad because my mom wasn’t there. I got sad sometimes. But I feel sad because of my sister all the time. . . . I feel between a rock and a hard place because I have the choice to go back, but then I would be away from my mom, so I am sad. . . . If I get one thing then I don’t get the other one. . . . And sometimes I feel that, well, it was bad [to leave Guatemala]. If I choose to go back, then send me back to my country.

The 17-year-old girl who had traveled to the United States while almost six months pregnant was unsure whether she wanted to stay in the United States after being separated from her 30-year-old husband whom she had married the year before. One 17-year-old boy who had left his parents in Guatemala to come and live with his older brother in NYC and send money back to support the family appeared to express his contrasting excitement at being in New York with his brother and sadness about being away from home in two pictures he drew in his autoethnography. These are presented in Figure 10.
“I love you New York. Together forever.”

“I miss you so much...”

Figure 10. Drawings from autoethnography by 17-year-old boy expressing mixed feelings about being in New York City.

Some children suggested they were better off being in the United States but wanted to have the option to visit family at home. One 14-year-old girl from Honduras reported, “I would like to go back to visit [my grandparents] . . . but not to stay because life is very difficult over there . . . there is too much evilness. It is very dangerous and nobody finds jobs.”

A number of children and their guardians mentioned a gap between children’s expectations about life in the United States and the reality of being in NYC. For example, one mother explained that because she had always sent money back to Honduras for her daughters and consequently they had always been able to afford certain luxuries there, they had assumed they would be fairly affluent in the United States. After arriving, they were surprised to see the
sacrifices their mother had made to send money home and to find themselves living together in a single-room of a shared apartment. One 16-year-old Salvadoran boy noted, “In reality, New York doesn’t compare to what people told us. They said that everything was cheaper and that I would be happier.” Some children contrasted the family- and community-orientated life in their home countries with a more rushed and isolative experience in NYC. One 14-year-old Guatemalan girl wrote in her autoethnography:

> What I liked in my country was going to my sister’s work, taking my dog out for walks, I loved spending time with my family, I loved getting together with my family to get to catch up, I loved being with my cousins, nephews and nieces, and brothers to be able to play games, and also my whole family liked to go to swimming pools, and some of the family liked to get together in pretty places to take photos. But having come here I don’t do the same things. Things here are very different and very difficult to understand, but what I like least is that time passes very quickly, which does not give me the time to do the same types of things that I did in Guatemala.

Additionally, some children were having difficulty acclimating at school. The father of one 17-year-old boy reported his son’s difficulties integrating academically had been so demoralizing that he had considered dropping out of school:

> He is learning but sometimes he feels discouraged and I tell him to move on. One day we will be able to resolve things, of course. . . . But now things are kind of complicated. He feels desperate, he has told me twice that it would be best to go back.

Although some children had mixed feelings about being in NYC, many expressed relief about being somewhere safe, happiness to be reunified with family, and excitement over the possibilities life in the United States might provide. A 15-year-old boy who was sharing a single
room in the Bronx with his mother and siblings after fleeing from a dangerous neighbourhood and abusive and neglectful aunt in Honduras reported:

In New York we have a different life with my mom. It’s better. We sleep well, we eat well, we bathe in hot water, and I thank God for giving me the opportunity to be with my mom and to know good things.

The mother of a 17-year-old Salvadoran girl who had also been exposed to both personal abuse and gang violence recounted her daughter’s words: “She says, ‘Mommy, my dream has been to be in this country with you, in a country where there are no dangers. [Here] we don’t have personal dangers.’”

Some children suggested that the hardships they had endured during their migration, even if worse than anticipated, had ultimately been worth it. One 16-year-old boy stated, “The journey was very difficult but the best thing is that now I am with my father, and that is what matters.”

One 18-year-old boy described himself in his autoethnography as “an immigrant who fought for his dream and who found it but who suffered finding it. But he found it and he is happy.”

Another, 17-year-old, boy reflected on his migration process as follows:

Things didn’t go as I expected them, but they turned out for the best. . . . I know that over here you can become someone and study and that makes me feel good because I think that it is an opportunity to move on.

Several children reported having learned and grown as a result of their migration experiences. A 14-year-old boy commented, “I learned that although over there I was small, I had bravery in coming here.” One 17-year-old boy suggested, “[Before] I didn’t have courage. I set a goal for myself, to get here and, thank God everything went fine. I learned I can do that.”

Echoing a number of commonly held sentiments, one 16-year-old boy commented:
Leaving my family in El Salvador was a little painful, but now I am here in this land of opportunities, where I hope to achieve my goal of being a soap actor, of being someone in this life, and helping my family to get ahead, especially my mom and little sister . . . And my dream is also to get my papers and to be able to travel to El Salvador to see my family who I miss so much, my two grandfathers… One of them is ill but I know I will see him again.

Families varied in their understanding and experience of the U.S. government’s immigration process. The majority appeared to have been unaware of provisions for children to be resettled to family members awaiting their court cases. The mother of one 14-year-old girl initially declined to provide her details when she was contacted about sponsoring her daughter, due to her own undocumented status and fear of deportation. She then contacted an attorney who reassured her that she could go forward safely with the reunification process, but it took her 15 days of calling around different shelters to locate her daughter. The mother of a 15- and 13-year-old brother and sister who had come together without telling her explained how her understanding of the law had changed:

Now, after my kids came, I noticed other children were coming, but not before. I didn’t know that immigration would hand them over. I didn’t know . . . I thought it was the same [as for adults]. If they caught someone, they’d deport them. I didn’t know Immigration let minors stay in the country.

Children’s attitudes towards their upcoming court cases varied. Some children reported feeling optimistic about their cases, such as one 15-year-old boy who suggested, “I trust I will be able to stay. I am calm. I am confident.” However, most children expressed some anxiety. One 16-year-old boy reflected many children’s nervousness (and apparent tendency for
understatement) regarding their cases: “I am a little bit frightened because I don’t know how things are going to work out. I don’t know if I am really going to stay here. I don’t know.” One 14-year-old girl commented on her anxiety about the judicial process:

I’m scared because . . . in the children’s home I had an interview with a woman from the immigration department . . . and she told me that the judge decides depending on the appointment. He decides if you stay here or if you leave.

Children and guardians who did not have attorneys to provide advice and reassurance and to guide them through the legal process often expressed particular anxiety about immigration court. For example, one 14-year-old girl had heard a rumor that if she lost her case, her mother could be deported and she could be sent to live in foster care and separated permanently from her family:

I don’t know who told me this but someone told me that if I didn’t win the case, then it was possible that the judge would send me to another family and I felt panic about being taken away from my mom.

Several guardians voiced concerns that, having come forward to sponsor their children, if the children’s cases were unsuccessful, they too could be sent back to their home countries. One mother explained, “I don’t want to go back to my country. I don't know how to support my children there, and here I have a job.” The mother of a 14-year-old boy expressed similar worries:

It scares me because as I am illegal here too, I don’t know what consequences that could have . . . it scares me that as I am illegal they are not going to help me with my son . . . I don’t know how they make someone legal too in that case. . . . I don’t know if they are going to leave me here, if it’s going to have any benefit or not, because I am illegal. . . . It makes me scared, but at the same time it makes me feel good, like if, it could be possible.
I feel pretty good to be able to do this for my son and to help him to be able to be okay in this country, it doesn’t matter that I don’t get anything.

Children were typically very measured in their attitudes towards the immigration process. Often they alluded to faith in the fairness of the system and a belief that their compelling reasons for coming would be heard and result in them being allowed to stay. An 18-year-old girl articulated her hope that being apprehended and going through the legal process would help her regularize her situation:

I think maybe there is something good about immigration finding me. I think there are better opportunities than coming without papers or anything…. I think that coming here without papers or anything doesn’t help me at all, right? Well, I want to be here and work. But, I think it is in immigration's hands.

One 17-year-old girl linked her faith in the immigration process to her belief in God:

Supposedly, coming here is illegal and they caught us, I think it is fair what they have done because they are right, it is not our country and we came here illegally. They have to do something about it. They have to take control over that…. I just want this to get resolved and be able to stay here. Well, I think that everything in life happens for a reason and every sacrifice has its own reward. I believe a lot in religion and all that. When they caught me, I said that if God didn’t want me to come to this country it was for a reason. God knows why I am here and he has a reason for me being here. I just have to have patience and faith that something good is going to happen.

Several children articulated beliefs that not only the adverse circumstances compelling them to leave their home countries but also their potential contribution in the United States could and should be considered in their immigration cases. One 16-year-old boy commented, “Actually
I can’t complain about what you are doing with the immigrants. That is something good and they say that if you study you get papers and stuff, if you study. I don’t know, I like that.” Another, 17-year-old, boy suggested, “I think that they should support kids that come with a good purpose in life. The ones that don’t come here to ruin the country, but to help improve it. That would be good.” By contrast, one 17-year-old boy (the same one who referenced his religious coping in the drawing and quotation displayed in Figure 7) alluded to perceived injustices and discrimination in the immigration system and broader culture, as shown in Figure 11.

![Drawing and statement from autoethnography by 17-year-old boy alluding to his experience of discrimination.](image)

If only they realized that God made us equal the one difference is the color of our skin but we are equal so why do they block the dreams of people like me...

*Figure 11. Drawing and statement from autoethnography by 17-year-old boy alluding to his experience of discrimination.*

In the few instances in which children did have suggestions for changes to the immigration system, these largely concerned children’s treatment in Customs and Border Protection detention facilities prior to being moved to child shelters. One 10-year-old girl stated, “I would have liked if there were beds and not to have to sleep on the floor, and if there had been
blankets… and that they would let us bathe.” A 14-year-old boy commented, “What they could change is that they hardly let people have any clothes on in those cold rooms.”

The Adaptation and Attitude questionnaire provided an additional, standardized measure of how children were adjusting to life in the United States and their attitudes towards their immigration process and current living situation. The response frequencies for the Likert-type items are presented in Table 6.
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<th>Sometimes (%)</th>
<th>No (%)</th>
<th>Uncertain (%)</th>
<th>Did Not Answer (%)</th>
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<td>12.0</td>
<td>0.0</td>
<td>4.0</td>
<td>0.0</td>
</tr>
<tr>
<td>3. I think that living in the USA is difficult.</td>
<td>20.0</td>
<td>28.0</td>
<td>32.0</td>
<td>20.0</td>
<td>0.0</td>
</tr>
<tr>
<td>4. I want to live in the USA.</td>
<td>84.0</td>
<td>4.0</td>
<td>4.0</td>
<td>8.0</td>
<td>0.0</td>
</tr>
<tr>
<td>5. I want to go back to my own country.</td>
<td>8.0</td>
<td>28.0</td>
<td>28.0</td>
<td>32.0</td>
<td>4.0</td>
</tr>
<tr>
<td>6. I want to move to a different country.</td>
<td>4.0</td>
<td>8.0</td>
<td>84.0</td>
<td>4.0</td>
<td>0.0</td>
</tr>
<tr>
<td>7. I think that I will be able to stay in the USA.</td>
<td>40.0</td>
<td>16.0</td>
<td>0.0</td>
<td>40.0</td>
<td>4.0</td>
</tr>
<tr>
<td>8. I am afraid that I will be sent back to my own country.</td>
<td>56.0</td>
<td>8.0</td>
<td>20.0</td>
<td>16.0</td>
<td>0.0</td>
</tr>
<tr>
<td>9. I feel safe where I am living (in my home).</td>
<td>84.0</td>
<td>12.0</td>
<td>4.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>10. I feel safe at school.</td>
<td>84.0</td>
<td>8.0</td>
<td>0.0</td>
<td>0.0</td>
<td>8.0</td>
</tr>
<tr>
<td>11. I feel safe when I am walking around outside.</td>
<td>52.0</td>
<td>28.0</td>
<td>16.0</td>
<td>4.0</td>
<td>0.0</td>
</tr>
<tr>
<td>12. I am satisfied with the way in which child immigrants are cared for in the USA.</td>
<td>88.0</td>
<td>4.0</td>
<td>0.0</td>
<td>8.0</td>
<td>0.0</td>
</tr>
<tr>
<td>13. I am satisfied with the way in which I am cared for in the USA.</td>
<td>80.0</td>
<td>12.0</td>
<td>0.0</td>
<td>8.0</td>
<td>0.0</td>
</tr>
<tr>
<td>14. I want to work in the USA.</td>
<td>76.0</td>
<td>16.0</td>
<td>8.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>15. I already have a job in the USA.</td>
<td>4.0</td>
<td>0.0</td>
<td>96.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>16. I am learning a trade/going to school in the USA.</td>
<td>84.0</td>
<td>0.0</td>
<td>16.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>17. I want to get an education.</td>
<td>88.0</td>
<td>0.0</td>
<td>0.0</td>
<td>12.0</td>
<td>0.0</td>
</tr>
<tr>
<td>18. I want to learn a trade.</td>
<td>76.0</td>
<td>4.0</td>
<td>0.0</td>
<td>16.0</td>
<td>4.0</td>
</tr>
<tr>
<td>19. I think that I am going to learn a trade.</td>
<td>76.0</td>
<td>12.0</td>
<td>0.0</td>
<td>12.0</td>
<td>0.0</td>
</tr>
<tr>
<td>20. I would leave my country again if I knew that I would end up in the same situation.</td>
<td>36.0</td>
<td>8.0</td>
<td>32.0</td>
<td>24.0</td>
<td>0.0</td>
</tr>
<tr>
<td>21. I would come to the USA again if I knew that I would end up in the same situation.</td>
<td>44.0</td>
<td>8.0</td>
<td>12.0</td>
<td>36.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Children expressed mixed attitudes towards being in the United States. Eighty-four percent (21/25) reported wanting to live in the United States and the same number reported liking living here. However, 48.0% (12/25) acknowledged that living in the United States is at least sometimes difficult for them, while another 20.0% (5/25) were uncertain. Children also expressed ambivalence about staying in the United States. Although only 8.0% (2/25) stated categorically that they wanted to go back to their own country, 28.0% (7/25) acknowledged that they sometimes wanted to, and another 32.0% (8/25) were uncertain. Similarly, only 36% stated definitively that they would leave their country again if they knew that they would end up in the same situation, while 44% stated definitively that they would come to the United States again if they knew that they would end up in the same situation.

Many children had uncertainty about the future. Forty percent (10/25) endorsed thinking consistently that they would be able to stay in the United States, and 64% (16/25) reported some fears that they would be sent back to their own country. However, none of the children reported feeling dissatisfied with the way unaccompanied children are treated in the United States on the A&A. With regard to day-to-day security concerns, 16% (4/25) endorsed having some safety concerns relating to their living environment and 8% (2/25) endorsed sometimes feeling unsafe at school. By contrast, 28% (7/25) reported only sometimes feeling safe while walking around outside and 16% (4/25) reported not feeling safe.

Regardless of their other reservations about being in the United States, in their overwhelming majority children appeared to want to progress with education and, ultimately, work. Every child (25/25) wanted to learn to speak English, 88.0% (22/25) endorsed wanting to get an education and 80.0% (20/25) reported wanted training in a profession. Children aspired to a range of careers including becoming a doctor, lawyer, teacher, computer programmer, actor,
fireman, mechanic, and construction worker. When asked how their lives will look in 10 years’ time, 64% (16/25) of children made a positive prediction. One 17-year-old boy encompassed several common responses with his prediction: “Be here legally working having finished school, help my mother and aunts, have my own home.” A 17-year-old girl answered simply, “Much better than today.” Twenty-four percent of children (6/25) reported that they were unsure, 12% (3/25) did not respond, but no children made a negative prediction about their future.

Children were also asked on the A&A to list three wishes. These were then clustered into categories. The most common wish was to be successful in school and work. For example, one 13-year-old girl wished “to be able to carry on studying without any problems in order to have my desired profession [doctor]”. A 15-year-old boy stated that he wished “to be ‘someone’ in life.” The second most frequent wish was for children to be unified with family from whom they were now separated. One 15-year-old boy wished “to have my grandparents here with me.” A 14-year-old girl who had expressed ambivalence about staying in the United States wished “to be reunited with my whole family, including my dog.” Third, children wished for successful resolution of their immigration cases. One 17-year-old boy stated that he wanted to “stay in this country to help my parents move forward.” Fourth, children wished for better circumstances or wellbeing for loved ones. One 17-year-old boy wished “for my mom to have her papers.” The 17 year-old girl who was pregnant wished for “a better education for my baby when she is born.”

The lack of established norms for the A&A limits the interpretability of quantitative analyses. However, children’s A&A total scores did not differ across age group, gender, and nationality categories. In comparisons between children’s scores on the A&A and the other child-report measures, the only significant A&A total score correlation was to the Stressful Life Events questionnaire, $r_s (25) = .43, p = .034$, suggesting that increased number of past stressors
experienced was associated with more positive attitudes towards being in the United States. A&A total scores and A&A work subscale scores were not associated with presence of a past-month diagnosis with functional impairment on the structured diagnostic interview (DISC-IV), but A&A security subscale scores were, $r_{tb}(25) = -.41, p = .039$, with lower sense of security linked to increased rates of diagnosis. On analyses of the association between A&A item responses and presence of a past-month DISC-IV diagnosis, the only tests approaching significance both involved items from the security subscale: “I feel safe where I am living (in my house)”, $p = .081$ and “I feel safe when I am walking around outside,” $p = .097$. Thus, it appeared that security-related concerns had a greater impact on children’s mental health presentation than other dimensions of adjustment.

In summary of the results on unaccompanied children’s psychosocial context, Table 7 summarizes the main stressors and supportive factors (either promotive or protective) described by children, arranged by migration phase and systemic level. It includes individual level stressors and supportive factors identified through analyses of children’s experiences of distress, coping, and attitudes towards their migration processes. The matrix format is designed to reflect the potential differential effect of stressors and supportive factors depending on the migration phase.
<table>
<thead>
<tr>
<th>Pre-migration</th>
<th>Journey</th>
<th>Apprehension</th>
<th>Immigration detention</th>
<th>Child shelter detention</th>
<th>Post-migration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stressor</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessed traumatic events; cognitive or learning difficulties; behavioral problems</td>
<td>Planned without caregiver</td>
<td>Delayed apprehension (following exposure to desert, kidnapping etc.); fear of being deported</td>
<td>Feeling criminalized; clothing removed; subjected to cold/ uncomfortable conditions</td>
<td>Fears about delayed release; freedoms restricted; desire for reunification</td>
<td>Threat of deportation; loneliness and missing loved ones; difficulty learning English/adjusting to U.S. culture; academic difficulties; desire to return home; traumatic memories; discomfort sharing feelings</td>
</tr>
<tr>
<td>Good school engagement/ performance; athleticism; religious faith; close emotional attachments</td>
<td>Good school engagement/ performance; athleticism; religious faith; close emotional attachments</td>
<td>Voluntary submission to authorities at U.S.-Mexican border</td>
<td>Religious faith/prayer; internal coping strategies (e.g., distraction and meditation)</td>
<td>Religious faith/prayer; internal coping strategies (e.g., distraction and meditation)</td>
<td>Educational/professional aspirations; religious faith; sense of agency/fortitude; attachment to cultural identity; identification with U.S. values</td>
</tr>
<tr>
<td>Long separation from parents; abusive/ neglectful caregiver; witnessing domestic violence; alleged sexual abuse; abandonment by caregiver; multiple changes of home; death of loved one; aging/ailing caregiver</td>
<td>Separation from accompanying family members; deportation of offspring family members</td>
<td>Loss of contact with family; guardian’s misgivings about claiming child due to own undocumented status</td>
<td>Delayed release to family (e.g., due to paperwork problems)</td>
<td>Delayed release to family (e.g., due to paperwork problems)</td>
<td>Emotional distance from parents after long separations; separation from loved ones in home country; concerns/guilt about old/ill relatives at home; new family configurations; arguments with guardian over limit-setting; guardian’s own deportation fears</td>
</tr>
<tr>
<td>Loving caregivers; regular contact with parents in U.S.; strong extended family network</td>
<td>Support of accompanying family members; adult relatives surrendering selves to protect children’s safety</td>
<td>Support of accompanying siblings/cousins</td>
<td>Phone communication with family in U.S. and home country; rapid completion of sponsorship application</td>
<td>Close relationship/ rebuilding connection with parents in U.S.; close relationships with siblings with whom migrated; support in accessing psychosocial services; emotional support from family at home</td>
<td></td>
</tr>
</tbody>
</table>

**Support**

[Table 7. Matrix of migration stressors and supports organized by migration phase and systemic level]
<table>
<thead>
<tr>
<th>Stressor</th>
<th>Pre-migration</th>
<th>Journey</th>
<th>Apprehension</th>
<th>Immigration detention</th>
<th>Child shelter detention</th>
<th>Post-migration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Gang violence and intimidation; high crime rates (e.g., robbery, kidnapping); gang recruitment; sexual violence; bullying in school; delinquency among peers; poverty</td>
<td>Threats/robberies/kidnappings by gangs; abusive/neglectful coyote; abandonment by coyote; witnessing injuries and violence towards other travelers</td>
<td>Separation from travel companions</td>
<td>Overcrowding; lack of privacy</td>
<td>Restrictive/institutional shelter conditions</td>
<td>Victimization in school; grade-age mismatch due to educational/language gap; living in dangerous neighborhood</td>
</tr>
<tr>
<td>Support</td>
<td>Caring neighbors; supportive friend groups; strong community identity</td>
<td>Accompanied by friends; bonding with other travelers; supportive coyote</td>
<td>Joint decisions to surrender in treacherous conditions</td>
<td>Shared experience/information</td>
<td>Educational and recreational program; caring shelter staff</td>
<td>Supportive friend group; enrollment in extra-curricular activities (e.g., soccer, dance); church attendance; connection to local Latino community</td>
</tr>
<tr>
<td>Stressor</td>
<td>Natural disasters; threat of political violence; child labor</td>
<td>Dangerous modes of travel; physical hazards (e.g., crossing rivers and desert)</td>
<td>Aggressive treatment from some immigration officials (e.g., pursuit and exposure to guns, use of physical restraints on some older children)</td>
<td>Hostile treatment from some facility staff</td>
<td>Guardian concerns about claiming child due to own undocumented status</td>
<td>Financial pressure to start working and sending money home; ongoing debts to coyote; cultural adjustment; lack of knowledge/stigma about mental health help-seeking; discrimination against immigrants; wariness of official institutions within immigrant community</td>
</tr>
<tr>
<td>Cultural</td>
<td>Normalization of migration/familial separations; culture of sending remittances from U.S. to support family at home</td>
<td>Support from local churches and people on migration route</td>
<td>Children surrendering voluntarily treated well by immigration officials</td>
<td>Latino cultural norms rejecting criminalization of migration</td>
<td>Culture of support for migrants and reunification process</td>
<td>Access to immigrant culture in NYC and associated resources (e.g., referrals to lawyers, help accessing healthcare)</td>
</tr>
<tr>
<td>Stressor</td>
<td>Pre-migration</td>
<td>Journey</td>
<td>Apprehension</td>
<td>Immigration detention</td>
<td>Child shelter detention</td>
<td>Post-migration</td>
</tr>
<tr>
<td>----------</td>
<td>---------------</td>
<td>---------</td>
<td>--------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Institutional</td>
<td>Ineffective policing; corruption; gang presence in schools</td>
<td>Extortion by corrupt officials; gang-controlled child-trafficking networks</td>
<td>Children mistaken for adults threatened with adult detention/rapid deportation</td>
<td>Poor conditions (e.g., cold, overcrowded, uncomfortable environment); lack of communication</td>
<td>Long stays for children without sponsors; separation from opposite-sex siblings</td>
<td>Long waiting lists for legal representation and backlog of court dates; large medical bills (e.g., prior to child’s health insurance enrollment)</td>
</tr>
<tr>
<td>Support</td>
<td>School-based and other psychosocial services in home countries</td>
<td>Migrant community support organizations (e.g., Casas del Migrante)</td>
<td>Deliberate handoff to U.S. immigration by coyotes</td>
<td>Rapid release to Office of Refugee Resettlement care</td>
<td>Integrated case management and counseling; legal advocacy education</td>
<td>Access to healthcare services; school counseling services; easy school enrollment; legal orientation and other advocacy programs to increase access to available resources</td>
</tr>
<tr>
<td>Stressor</td>
<td>Under-resourced education system; limited mental health services; weak economy</td>
<td>Deportation of minors seized in Mexico back to countries of origin</td>
<td>Limited legal protections for migrants ≥ 18 years</td>
<td>Prioritization of enforcement over caretaking role by Department of Homeland Security; underfunding of immigration system leading to overcrowding and poor conditions</td>
<td>Delays in reunification process caused by sponsor background checks</td>
<td>Long delays in immigration case processing; no legal right to representation in immigration cases</td>
</tr>
<tr>
<td>Structural / policy</td>
<td>Child protective legal system</td>
<td>Mexican government initiatives for migrant safety (e.g., Grupos Beta)</td>
<td>Laws protecting unaccompanied children against deportation without due process of child protection claims</td>
<td>Laws requiring expedited transfer of care to Office of Refugee Resettlement and rapid release to child shelters</td>
<td>Separation of government’s prosecutorial and caretaking branches</td>
<td>Legal provision for releasing unaccompanied children to undocumented family members; right to public education; eligibility for NY State public health insurance</td>
</tr>
</tbody>
</table>
Aim 2: Mental Health Diagnosis

The qualitative exploration of unaccompanied children’s psychosocial context, stressors, and supports from Aim 1 provides a background for the quantitative data collected for Aim 2, in which the Diagnostic Interview Schedule for Children Version IV, Hopkins Symptom Checklist for Adolescents, Stressful Life Events questionnaire, Reactions of Adolescents to Traumatic Stress questionnaire, and Child Behavior Checklist were used to consider questions about mental diagnoses and the assessment of psychopathology in unaccompanied children.

Study Aim 2a: To determine the rates and types of mental health disorders found in a sample of unaccompanied children using a structured clinical interview (DISC-IV). Taken together, the results of the DISC-IV analyses suggest very high rates of past-year internalizing disorders in this sample: 75.0% of children met criteria for at least one anxiety or mood disorder based on symptoms alone, and 53.8% with inclusion of criteria for moderate functional impairment. Rates of past-year disruptive and substance use disorders were much lower: 11.5% with or without inclusion of impairment criteria. Past-month rates were lower, but still high: 46.2% met criteria for at least one diagnosis, and 34.6% with the inclusion of moderate impairment criteria.

Compared against other studies that have used the DISC-IV in the United States, this sample showed significantly elevated levels of internalizing but not externalizing disorders. Rates of past-year anxiety and mood disorders were over twice as high in this study as in community studies of the general and Latino adolescent populations and over one-and-a-half times higher than those observed in service-receiving Latino and immigrant youth.

Table 8 presents rates of the various mental health disorders assessed in detail, based on the combined child- and caregiver-report DISC-IV data.
Table 8. Rates of diagnosis on Diagnostic Interview Schedule for Children Version IV (DISC-IV)

<table>
<thead>
<tr>
<th>Diagnosisa</th>
<th>Past-year n (%)</th>
<th>Past-month n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Symptoms only</td>
<td>Impairment A²</td>
</tr>
<tr>
<td>Any anxiety disorder</td>
<td>18 (69.2)</td>
<td>14 (53.8)</td>
</tr>
<tr>
<td>Separation anxiety disorder</td>
<td>13 (50.0)</td>
<td>12 (46.2)</td>
</tr>
<tr>
<td>Agoraphobia without panic</td>
<td>10 (38.5)</td>
<td>4 (15.4)</td>
</tr>
<tr>
<td>Panic disorder with agoraphobia</td>
<td>1 (3.8)</td>
<td>1 (3.8)</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>3 (11.5)</td>
<td>3 (11.5)</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>3 (11.5)</td>
<td>1 (3.8)</td>
</tr>
<tr>
<td>Any mood disorder</td>
<td>8 (30.8)</td>
<td>5 (19.2)</td>
</tr>
<tr>
<td>Major depression</td>
<td>6 (23.1)</td>
<td>5 (19.2)</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
<td>1 (3.8)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Hypomania²</td>
<td>2 (7.7)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Any disruptive disorder</td>
<td>2 (7.7)</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>Oppositional defiant disorder</td>
<td>1 (3.8)</td>
<td>1 (3.8)</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>2 (7.7)</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>Alcohol abuse³</td>
<td>1 (3.8)</td>
<td>1 (3.8)</td>
</tr>
<tr>
<td>Any internalizing disorder</td>
<td>18 (69.2)</td>
<td>14 (53.8)</td>
</tr>
<tr>
<td>Any externalizing disorder</td>
<td>3 (11.5)</td>
<td>3 (11.5)</td>
</tr>
<tr>
<td>Any diagnosis</td>
<td>18 (69.2)</td>
<td>14 (53.8)</td>
</tr>
</tbody>
</table>

Note. Several disorders were assessed but had zero rates: panic disorder without agoraphobia, mania, schizophrenia, alcohol dependence, nicotine dependence, marijuana abuse, marijuana dependence, other substance abuse, and other substance dependence.

¹Diagnoses based on combined child- and guardian-report. Impairment A criteria include at least one associated moderate functional impairment rating. Impairment D criteria include at least two associated moderate functional impairment ratings and/or one severe functional impairment rating.

²DISC-IV does not calculate hypomania with impairment.

³DISC-IV substance use diagnoses are past-year only.
Past-year diagnostic rates. Figure 12 shows past-year diagnostic rates for children in the study sample by disorder type.

Assessing past-year rates based on symptom criteria alone, 18 (69.2%) of the children in the sample had one or more diagnoses. Eighteen children (69.2%) met symptom criteria for an anxiety disorder, eight (30.8%) for a mood disorder, and three (11.5%) for an externalizing disorder (including two children for a disruptive disorder and one for alcohol abuse). Every child with a past-year mood, disruptive, or substance use disorder also had at least one comorbid anxiety disorder (for this reason, the number of children with any disorder and any anxiety disorder are the same). The most frequent diagnoses were separation anxiety disorder (SAD) \((n = 13, 50.0\%)\), agoraphobia (without panic, \(n = 10, 38.5\%\); with panic, \(n = 1, 3.8\%\)) and major depression \((n = 6, 23.1\%)\), followed by generalized anxiety disorder \((n = 3, 11.5\%)\) and PTSD \((n = 3, 11.5\%)\). Even when discounting SAD and agoraphobia, the two most common and perhaps
most context-specific diagnoses, 11 children (42.3%) met symptom criteria for at least one past-year diagnosis.

Assessing past-year rates based on symptom criteria with functional impairment, the number of children presenting with any diagnosis was reduced to 14 (53.8%) with at least moderate functional impairment and 12 (46.2%) with severe impairment. With the inclusion of impairment criteria, the number of children presenting with agoraphobia reduced by more than half to five (19.2%) presenting with at least moderate functional impairment and only three (11.5%) presenting with severe impairment, and the number of children with PTSD was reduced from three to only one (3.7%). Including functional impairment criteria had less impact on the rates of other diagnoses. Removing SAD and agoraphobia from analyses, eight children (30.8%) met criteria for at least one diagnosis with moderate impairment and seven children (26.9%) met criteria for at least one diagnosis with severe impairment. Past-year diagnostic rates by disorder are displayed in Figure 13.

![Diagnostic Interview Schedule for Children Version IV (DISC-IV) past-year diagnostic rates by disorder.](image)

**Figure 13.** Diagnostic Interview Schedule for Children Version IV (DISC-IV) past-year diagnostic rates by disorder.
Despite the low rates of PTSD diagnosis compared to other disorders, based on the combined reports of children and their guardians on the DISC-IV, 23 children (88.5%) had experienced at least one type of stressor meeting criteria for a potential PTSD diagnosis. Families were asked to identify the child’s most prominent stressor, defined as the stressor that the child had thought or talked about most during the last year. In 21 cases (80.8% of the total sample) the stressor related to the pre-migration period, for one child (3.8%) the stressor related to the child’s journey, and for one other (3.8%) the stressor related to the child’s experience of apprehension. In 13 instances (50.0%) children’s PTSD stressor related to gang violence in their own countries, including 10 children (38.5%) who had experienced a loved one’s murder.

**Past-month diagnostic rates.** Figure 14 shows past-month diagnostic rates by disorder type based on symptoms alone and inclusion of moderate functional impairment.

![Bar chart showing past-month diagnostic rates by disorder type.](image)

*Figure 14.* Diagnostic Interview Schedule for Children Version IV (DISC-IV) past-month diagnostic rates by disorder type.

Based on symptom criteria alone, 11 (42.2%) of the children in the sample had one or more past-month diagnoses. Ten children (38.5%) met past-month symptom criteria for an
anxiety disorder, one (3.8%) for a mood disorder, and two (7.7%) for a behavioral disorder. As in the case of past-year assessment, the most frequent diagnoses were SAD (n = 7, 26.9%) and agoraphobia (without panic, n = 3, 11.5%; with panic, n = 1, 3.8%). However, past-month rates of these disorders were markedly lower than past-year rates: the prevalence of SAD fell by more than a third, from 13 (50%) to eight (30.8%); the number of agoraphobia cases fell by more than half, from 11 (42.3%) to four (15.4%). The number of major depression cases fell from six (23.1%) to one (3.8%) and the number of PTSD cases fell from three (11.5%) to one (3.8%). However, the frequency of generalized anxiety disorder (n = 3, 11.5%), oppositional defiant disorder (n = 1, 3.8%), and conduct disorder (n = 2, 7.7%) all remained the same across past-year and past-month assessment. Discounting SAD and agoraphobia, five children (19.2%) met symptom criteria for at least one past-month diagnosis.

When taking into account functional impairment, the number of children presenting with any past-month diagnosis was reduced to nine (34.6%) with at least moderate functional impairment and six (23.1%) with severe impairment. With the inclusion of impairment criteria, the number of children with a past-month agoraphobia diagnosis with either moderate or severe impairment reduced from four (15.4%) to one (3.8%) and no children met criteria for PTSD. The number of past-month SAD cases reduced from eight children (30.8%) based on symptom criteria only, to seven (26.9%) with at least moderate functional impairment, and five (19.2%) with severe impairment. Inclusion of functional impairment criteria had no impact on rates of panic disorder (n = 1, 3.8%), major depression (n = 1, 3.8%), and conduct disorder (n = 2, 7.7%). Excluding SAD and agoraphobia, five children (19.2%) met criteria for at least one past-month diagnosis with moderate impairment and four children (15.4%) met criteria for at least
one past-month diagnosis with severe impairment. Figure 15 shows past-month diagnostic rates by disorder.

![Bar chart showing past-month diagnostic rates by disorder.](chart.png)

**Figure 15.** Diagnostic Interview Schedule for Children Version IV (DISC-IV) past-month diagnostic rates by disorder.

**Past-year diagnostic rates by gender, age, and nationality.** Table 9 presents rates of different past-year DISC-IV diagnoses (with moderate functional impairment) based on children’s age, gender, and nationality. The only statistically significant association found was between age and agoraphobia without panic, $r_{pb}(26) = .40$, $p = .025$, with older children appearing more prone to this diagnosis. Although these tests may have been limited by the small sample size, descriptive review of the data largely bore out the results of significance testing, with few apparent differences in diagnostic rates across groups. However, younger children appeared less likely to have major depression and possibly more likely to have disruptive disorders than older children (although cell counts for these diagnoses were very low).
Any anxiety disorder 7 (46.7) 7 (63.6) $\chi^2(1) = 0.74$ .391 2 (40.0) 5 (55.6) 7 (58.3) $r_{pd}(26) = .22$ .273 3 (75.0) 3 (50.0) 6 (46.2) 2 (66.7) Exact .792
Separation anxiety disorder 6 (40.0) 6 (54.5) $\chi^2(1) = 0.54$ .462 2 (40.0) 3 (33.3) 7 (58.3) $r_{pd}(26) = .24$ .247 3 (75.0) 3 (50.0) 4 (30.8) 2 (66.7) Exact .410
Agoraphobia without panic 2 (13.3) 2 (18.2) Exact 1.000 0 (0.0) 1 (11.1) 3 (25.0) $r_{pd}(26) = .40$ .025 2 (50.0) 1 (16.7) 1 (7.7) 0 (0.0) Exact .190
Panic disorder with agoraphobia 0 (0.0) 1 (9.1) Exact .423 0 (0.0) 0 (0.0) 0 (0.0) $r_{pd}(26) = .17$ .342 1 (25.0) 0 (0.0) 0 (0.0) 0 (0.0) Exact .269
Generalized anxiety disorder 1 (6.7) 2 (18.2) Exact .556 1 (20.0) 1 (11.1) 1 (8.3) $r_{pd}(26) = .07$ .713 1 (25.0) 0 (0.0) 2 (15.4) 0 (0.0) Exact .700
Posttraumatic stress disorder 1 (6.7) 0 (0.0) Exact 1.000 0 (0.0) 0 (0.0) 1 (8.3) $r_{pd}(26) = .17$ .342 0 (0.0) 0 (0.0) 0 (0.0) 1 (33.3) Exact .115
Major depression 2 (13.3) 3 (27.3) Exact .620 0 (0.0) 3 (33.3) 2 (16.7) $r_{pd}(26) = .10$ .633 0 (0.0) 1 (16.7) 3 (23.1) 1 (33.3) Exact .810
Any disruptive disorder 1 (6.7) 1 (9.1) Exact 1.000 1 (20.0) 1 (11.1) 0 (0.0) $r_{pd}(26) = .25$ .155 0 (0.0) 0 (0.0) 1 (7.7) 1 (33.3) Exact .360
Oppositional defiant disorder 1 (6.7) 0 (0.0) Exact 1.000 1 (20.0) 0 (0.0) 0 (0.0) $r_{pd}(26) = .27$ .118 0 (0.0) 0 (0.0) 0 (0.0) 1 (33.3) Exact .115
Conduct disorder 1 (6.7) 1 (9.1) Exact 1.000 1 (20.0) 1 (11.1) 0 (0.0) $r_{pd}(26) = .25$ .155 0 (0.0) 0 (0.0) 1 (7.7) 1 (33.3) Exact .360
Alcohol abuse 0 (0.0) 1 (9.1) Exact .423 0 (0.0) 0 (0.0) 1 (8.3) $r_{pd}(26) = .05$ .786 0 (0.0) 1 (16.7) 0 (0.0) 0 (0.0) Exact .500
Any internalizing disorder 7 (46.7) 7 (63.6) $\chi^2 (1) = 0.74$ .391 2 (40.0) 5 (55.6) 7 (58.3) $r_{pd}(26) = .22$ .273 3 (75.0) 3 (50.0) 6 (46.2) 2 (66.7) Exact .792
Any externalizing disorder 1 (6.7) 2 (18.2) Exact .556 1 (20.0) 1 (11.1) 1 (8.3) $r_{pd}(26) = .18$ .307 0 (0.0) 1 (16.7) 1 (7.7) 1 (33.3) Exact .580
Any diagnosis 7 (46.7) 7 (63.6) $\chi^2 (1) = 0.74$ .391 2 (40.0) 5 (55.6) 7 (58.3) $r_{pd}(26) = .22$ .273 3 (75.0) 3 (50.0) 6 (46.2) 2 (66.7) Exact .792

Note. Several disorders were assessed but had zero rates: panic disorder without agoraphobia, dysthymia, mania, schizophrenia, alcohol dependence, nicotine dependence, marijuana abuse, marijuana dependence, other substance abuse, other substance dependence. Functional impairment is not assessed in relation to hypomania on DISC-IV.

*Functional impairment assessed using DISC-IV impairment criteria A (including at least one associated moderate functional impairment rating).
Association of DISC-IV diagnoses with psychosocial stressors and pre-migration vulnerabilities. Preliminary analyses were conducted investigating the relationship between children’s presentation on the DISC-IV (i.e., whether they met criteria for at least one diagnosis with moderate functional impairment) and their exposure to migration stressors, including: physical abuse or neglect in country of origin; exposure to gang violence in country of origin; age at time of separation (for children whose primary caregiver had left to come to the United States, $n = 18$); travel without a coyote; exposure to violence or threat to life during journey; length of time since arrival in United States; length of separation (for children reunifying with a primary caregiver, $n = 18$); child bullied in school in United States; and immigration lawyer not yet obtained. Analyses were conducted with both past-year and past-month DISC-IV diagnoses.

The total number of different types of traumatic experiences children had experienced (as assessed on the Stressful Life Events questionnaire) was correlated with past-year-DISC-IV diagnosis, $r_{pb}(25) = .47, p = .010$, with higher exposure to stressors associated with greater instances of psychopathology. Children who had been subjected to physical abuse or neglect during the pre-migration period were significantly more likely to have at least one past-year DISC-IV diagnosis with functional impairment, $p = .014$, with eight of the nine children with an abuse history meeting criteria for at least one disorder. Age at time of separation was also correlated with past-year DISC-IV diagnoses, $r_{pb}(26) = .49, p = .039$, with mean age of separation higher for those with diagnoses ($M = 7.00, SD = 3.40$) than those without diagnoses ($M = 4.00, SD = 1.77$). However, there was also a strong association between age at time of separation and abuse, $r_{pb}(26) = .59, p = .011$, with children who were abused left at an older age ($M = 7.44, SD = 3.17$) than those who were not abused ($M = 3.89, SD = 1.90$). Past-year DISC-IV presentation was not significantly associated with any of the other migration stressor
variables examined. Tests using past-month DISC-IV diagnoses did not yield any significant results.

The association between DISC-IV presentation and pre-existing vulnerabilities (defined as guardian-stated concerns about the child’s emotions or behaviors dating back to the pre-migration period) was also assessed. Past-month DISC-IV diagnosis was associated with presence of a pre-existing vulnerability, \( p = .010 \), with five of the six children with noted pre-migration concerns meeting criteria for at least one disorder with functional impairment.

**Hypothesis 2a:** This sample of unaccompanied children will experience elevated rates of common DSM-IV internalizing and externalizing disorders on the DISC-IV compared to U.S. community norms for both the general adolescent population and other immigrant youth, and similar rates to youth receiving psychosocial services. Table 10 compares rates of DSM-IV past-year disorders in the study sample to two large epidemiological studies that have examined adolescent psychiatric diagnoses using the DISC-IV (Garland et al., 2001; Roberts, Roberts, & Xing, 2007). Compared against community (Roberts, Roberts, & Xing., 2006; Roberts et al., 2007) and service-receiving (Garland et al., 2001; Gudiño et al., 2008; Hough et al., 2002) samples representing the general population as well as Latino and immigrant youth, rates of any disorder and internalizing disorders ranged from one-and-a-half to over 10 times higher in the sample study.
### Table 10. Comparison of diagnostic rates between current study and other Diagnostic Interview Schedule for Children Version IV (DISC-IV) studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Reference</th>
<th>Past-year diagnosis</th>
<th>Disorder rate (%)</th>
<th>Cross-study comparison</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Without impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any diagnosis</td>
<td>17.1</td>
<td>42.3</td>
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<tr>
<td></td>
<td></td>
<td>Anxiety disorder</td>
<td>6.9</td>
<td>19.2</td>
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<tr>
<td></td>
<td></td>
<td>Mood disorder</td>
<td>3.0</td>
<td>30.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disruptive disorder</td>
<td>6.5</td>
<td>7.7</td>
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<tr>
<td></td>
<td></td>
<td>Substance use disorder</td>
<td>5.3</td>
<td>3.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>With impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any diagnosis</td>
<td>11.1</td>
<td>30.8</td>
</tr>
<tr>
<td></td>
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<td>Anxiety disorder</td>
<td>3.4</td>
<td>15.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mood disorder</td>
<td>2.0</td>
<td>19.2</td>
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<tr>
<td></td>
<td></td>
<td>Disruptive disorder</td>
<td>3.6</td>
<td>7.7</td>
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<tr>
<td></td>
<td></td>
<td>Substance use disorder</td>
<td>2.7</td>
<td>3.9</td>
</tr>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Mexican American sub-sample</td>
<td>Roberts et al., 2006</td>
<td>Any Disorder w/o Imp.</td>
<td>17.9</td>
<td>42.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any Disorder with Imp.</td>
<td>10.7</td>
<td>30.8</td>
</tr>
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</tr>
<tr>
<td>Patterns of Care (POC) study</td>
<td>Garland et al., 2001</td>
<td>Anxiety disorder</td>
<td>9.9</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mood disorder</td>
<td>7.0</td>
<td>19.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oppositional defiant disorder</td>
<td>17.4</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conduct disorder</td>
<td>24.9</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino sub-sample ages 12-18</td>
<td>Hough et al., 2002</td>
<td>Anxiety disorder</td>
<td>8.3</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mood disorder</td>
<td>8.5</td>
<td>19.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immigrant sub-sample ages 11-18</td>
<td>Gudiño et al., 2008</td>
<td>Internalizing disorder</td>
<td>17.7</td>
<td>53.9</td>
</tr>
</tbody>
</table>

**Note.**
- aOnly child-report DISC administered in TH2K study.
- bObsessive-compulsive disorder and social anxiety assessed in POC Study and included in anxiety and internalizing disorder rates (these disorders not assessed in current study). Guardian-report DISC only administered for adolescent anxiety and mood disorders. Child- and guardian-report DISC administered for adolescent disruptive disorders. Gudiño and colleagues also included Child Behavior Checklist and Youth Self-Report scores (T $\geq 70$) in assessment of diagnoses.
- cAgoraphobia excluded from current study rates due to often transient and journey-related nature of symptoms endorsed, which may have inflated rates of this disorder. Separation anxiety disorder excluded from comparison between current study and TH2K study rates, as separation anxiety disorder DISC module was not included in TH2K study.
The percentage of children in the study with any DISC-IV diagnosis was over twice as high as in a representative community sample (Roberts et al., 2007) and this difference was statistically significant both when considering symptom criteria alone, \( RR = 2.47, \chi^2 (1, N = 26) = 11.65, p = .002 \), and including functional impairment criteria, \( RR = 2.77, \chi^2 (1, N = 26) = 10.14, p = .006 \). Diagnostic rates for any disorder were also over twice as high in the study sample as in a Mexican American subsample (Roberts et al., 2006), with differences in symptom impairment only, \( RR = 2.36, \chi^2 (1, N = 26) = 25.55, p < .001 \), and including functional impairment, \( RR = 2.88, \chi^2 (1, N = 26) = 10.96, p = .005 \), both significant.

Analyses by disorder type provided a more varied picture. Anxiety disorders were significantly more prevalent in the study sample than in the community sample (Roberts et al., 2007), both when considering symptom criteria alone, \( RR = 2.79, p = .030 \) and including moderate functional impairment, \( RR = 4.50, p < .001 \). Similarly, mood disorders were more common in the study sample, both excluding impairment, \( RR = 10.30, p < .001 \), and including impairment, \( RR = 9.65, p < .001 \). However, there were no significant differences between the study sample and the community sample with regard to rates of disruptive disorders.

Differences in rates between the study sample and a high-risk sample of youth (Garland et al., 2001) receiving services in one or more public care sectors (including mental health, drug/alcohol, child welfare, juvenile justice, and public school services for serious emotional disturbance) varied based on disorder type. Internalizing disorders were significantly more common in the study sample than the full high-risk sample (Garland et al., 2001), the Latino subsample (Hough et al., 2002), and the immigrant subsample (Gudiño et al., 2008), with relative risk ratios for anxiety and mood disorders ranging from 2.26 to 5.05. By contrast, higher rates of disruptive disorders were observed in Garland and colleagues’ sample, although only the
difference in rates of conduct disorder was statistically significant, \( RR = 0.31, \chi^2 (1, N = 26) = 4.12, p = .042. \)

Taken together, these results provide evidence to support the hypotheses that unaccompanied children experience higher rates of internalizing disorders than the general adolescent population and immigrant youth. However, they do not suggest that unaccompanied children experience higher rates of externalizing disorders than these populations. The results also provide some evidence to suggest that unaccompanied children experience higher rates of internalizing but not externalizing disorders than service-seeking youth.

**Study Aim 2b: To provide initial data regarding the potential future use of child- and caregiver-report measures to screen for mental health disorders in unaccompanied children.** The Hopkins Symptom Checklist for Adolescents (HSCL-37A), Stressful Life Events checklist (SLE), and Reactions of Adolescents to Traumatic Stress questionnaire (RATS) child-report instruments and the Child Behavior Checklist (CBCL) caregiver-report measure were assessed as possible screening instruments for use with unaccompanied children and their guardians. Following preliminary psychometric analyses, the association between scores on these measures and DISC-IV diagnoses was tested. Table 11 presents descriptive data from the self-report measures, including tests of internal consistency and between-group differences based on gender, age, and nationality.
Table 11. Child- and caregiver-report measure descriptive statistics and between-group differences

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Gender M (SD)</th>
<th>Age M (SD)</th>
<th>Nationality M (SD)</th>
<th>Test</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M (SD)</td>
<td>Male</td>
<td>Female</td>
<td>Test</td>
<td>p</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>n(23)=</td>
<td>n(23)=</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSCL-37A&lt;sup&gt;a&lt;/sup&gt;</td>
<td>.85</td>
<td>52.99</td>
<td>(8.90)</td>
<td>(9.29)</td>
<td>(6.73)</td>
<td>.473</td>
</tr>
<tr>
<td>Internalizing</td>
<td>.86</td>
<td>39.56</td>
<td>(8.31)</td>
<td>(8.40)</td>
<td>(8.32)</td>
<td>.432</td>
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<tr>
<td>Anxiety</td>
<td>.68</td>
<td>15.68</td>
<td>(3.34)</td>
<td>(3.45)</td>
<td>(3.20)</td>
<td>.397</td>
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<tr>
<td>Depression</td>
<td>.77</td>
<td>23.65</td>
<td>(5.25)</td>
<td>(4.96)</td>
<td>(5.67)</td>
<td>.366</td>
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<tr>
<td>Externalizing</td>
<td>.33</td>
<td>13.44</td>
<td>(1.45)</td>
<td>(1.73)</td>
<td>(0.97)</td>
<td>.683</td>
</tr>
<tr>
<td>SLE&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.56</td>
<td>2.67</td>
<td>(2.16)</td>
<td>(2.12)</td>
<td>z = 34</td>
<td>.765</td>
</tr>
<tr>
<td>RATS&lt;sup&gt;c&lt;/sup&gt;</td>
<td>.66</td>
<td>33.92</td>
<td>(5.36)</td>
<td>(6.04)</td>
<td>(4.66)</td>
<td>.813</td>
</tr>
<tr>
<td>Intrusion</td>
<td>.66</td>
<td>8.36</td>
<td>(2.16)</td>
<td>(2.50)</td>
<td>(1.53)</td>
<td>.396</td>
</tr>
<tr>
<td>Numbing/Avodance</td>
<td>.26</td>
<td>14.72</td>
<td>(2.65)</td>
<td>(2.36)</td>
<td>(2.95)</td>
<td>.181</td>
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<tr>
<td>Hyperarousal</td>
<td>.51</td>
<td>10.86</td>
<td>(3.17)</td>
<td>(2.66)</td>
<td>(2.44)</td>
<td>.925</td>
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<tr>
<td>CBCL&lt;sup&gt;d&lt;/sup&gt;</td>
<td>.96</td>
<td>36.43</td>
<td>(25.30)</td>
<td>(21.48)</td>
<td>(20.15)</td>
<td>.439</td>
</tr>
<tr>
<td>Internalizing</td>
<td>.89</td>
<td>13.36</td>
<td>(8.79)</td>
<td>(7.57)</td>
<td>(10.11)</td>
<td>.83</td>
</tr>
<tr>
<td>Externalizing</td>
<td>.89</td>
<td>7.64</td>
<td>(7.15)</td>
<td>(6.65)</td>
<td>(7.34)</td>
<td>.464</td>
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<td>AKA&lt;sup&gt;e&lt;/sup&gt;</td>
<td>.79</td>
<td>14.33</td>
<td>(4.03)</td>
<td>(2.93)</td>
<td>(3.36)</td>
<td>.215</td>
</tr>
<tr>
<td>Security</td>
<td>.29</td>
<td>3.87</td>
<td>(1.01)</td>
<td>(1.13)</td>
<td>(0.76)</td>
<td>.295</td>
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<tr>
<td>Work/Health</td>
<td>.82</td>
<td>4.04</td>
<td>(1.52)</td>
<td>(1.21)</td>
<td>(1.57)</td>
<td>.07</td>
</tr>
</tbody>
</table>

Note:
<sup>a</sup> Hopkins Symptom Checklist for Adolescents (Bean et al., 2004a).
<sup>b</sup> Stressful Life Events questionnaire (Bean et al., 2004c).
<sup>c</sup> Reactions of Adolescents to Traumatic Stress questionnaire (Bean et al., 2004b).
<sup>d</sup> Child Behavior Checklist (Achenbach & Rescorla, 2001).
<sup>e</sup> Adaptation and Attitude questionnaire (Bean, 2006).
Reliability of measures.

HSCL-37A. Cronbach’s alpha for the HSCL-37A indicated high internal consistency for the total scale ($\alpha = .85$) and the internalizing subscale ($\alpha = .86$) but poor internal consistency in the externalizing subscale ($\alpha = .33$). Within the internalizing cluster, the internal consistency of the depression subscale was acceptable ($\alpha = .77$), but the reliability of the anxiety subscale was questionable ($\alpha = .68$). Excluding items with zero variance, eight of 30 total scale items had an item-total correlation under 0.3, as compared with three of 24 items on the internalizing subscale, six of nine items on the externalizing subscale, four of 10 items on the anxiety subscale, and three of 14 items on the depression subscale.

SLE. On the four SLE items comparable to DISC-IV stressors, there were six inconsistencies across 100 response comparisons, with one participant’s responses accounting for three of these inconsistencies, $\kappa = .59$, (95% CI, .30 to .89), $p < .001$. This provides evidence to suggest that children’s SLE responses were largely consistent with information gathered during the structured diagnostic interview.

RATS. Cronbach’s alpha for the RATS demonstrated questionable internal consistency for the total scale ($\alpha = .66$) and the intrusion subscale ($\alpha = .66$), and poor internal consistency on the numbing/avoidance ($\alpha = .26$) and hyperarousal ($\alpha = .26$) subscales. Total scale consistency remained almost identical ($\alpha = .67$) when children who did not endorse any stressful life events on the SLE were removed from the analyses. When items with zero variance were excluded, 13 of 22 total scale items had an item-total correlation under 0.3, three of six intrusion subscale items, eight of nine numbing/avoidance subscale items, and four of seven hyperarousal subscale items.
CBCL. Cronbach’s alpha for the CBCL indicated excellent internal consistency for the total scale (α = .96) and high internal consistency for the internalizing (α = .89) and externalizing (α = .89) subscales. Excluding items with zero variance, 33 of 97 total scale items had an item-total correlation under 0.3, nine of 32 internalizing subscale items, and eight of 25 externalizing subscale items.

DISC-IV. None of the comparisons between child and guardian diagnoses using Cohen’s kappa test of interrater reliability yielded significant results, reflecting the fact that discrepancies between child and guardian report on the DISC-IV were common. Even when criteria were expanded to include full or intermediate diagnoses, the only area of significant agreement was Panic Disorder, κ = .65 (95% CI, .014 to 1.280), p < .001. Based on children’s report alone, 15 children (57.7%) had at least one past-year diagnosis and four (15.4%) had at least one past-month diagnosis. Based on guardians’ report alone, 11 children (42.3%) had at least one past-year diagnosis and five (19.2%) had at least one past-month diagnosis.

Construct validity of measures. Correlations between the child- and caregiver-report mental health screening measure scores are presented in Table 12. These analyses provided initial data on the construct validity of the measures and further support for the consistency of participants’ responses.
Table 12. Child- and caregiver-report mental health screening measure correlations

<table>
<thead>
<tr>
<th></th>
<th>1</th>
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<td>1. HSCL-37A&lt;sup&gt;a&lt;/sup&gt;</td>
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Note.
<sup>a</sup>Hopkins Symptom Checklist for Adolescents (Bean et al., 2004a).
<sup>b</sup>Stressful Life Events questionnaire (Bean et al., 2004c).
<sup>c</sup>Reactions of Adolescents to Traumatic Stress questionnaire (Bean et al., 2004b).
<sup>d</sup>Child Behavior Checklist (Achenbach & Rescorla, 2001).
†Pearson product-moment correlation.
‡Spearman rho correlation.
*p < .05, **p < .01, ***p < .001.
HSCL-37A total scores were significantly associated with RATS total scores, $r(25) = .72, p < .001$, and RATS intrusion, $r_s(25) = .47, p = .018$, numbing, $r(25) = .42, p = .036$, and hyperarousal, $r(25) = .66, p < .001$, subscale scores. HSCL-37A internalizing subscale scores followed the same pattern, showing significant associations with RATS total scores, $r(25) = .72, p < .001$, and RATS intrusion, $r_s(25) = .42, p = .038$, numbing, $r(25) = .43, p = .034$, and hyperarousal, $r(25) = .67, p < .001$, subscale scores. HSCL-37A anxiety subscale scores were associated with RATS total scores, $r_s(25)= .65, p < .001$, and hyperarousal subscale scores, $r_s(.25) = .71, p < .001$, and marginally associated with RATS intrusion scores, $r_s(25) = .39, p = .055$, but not with RATS numbing subscale scores. HSCL-37A depression subscale scores were associated with HSCL-37A anxiety scores, $r_s(24) = .83, p < .001$, RATS total, $r(24) = .73, p < .001$, numbing, $r(24) = .44, p = .032$, and hyperarousal scores, $r(24) = .64, p < .001$, and marginally associated with RATS intrusion scores, $r_s(24) = .38, p = .064$. HSCL-37A externalizing scores were marginally associated with HSCL-37A anxiety subscale scores, $r_s(25) = .36, p = .076$, but not with any other measures. SLE scores were associated with RATS total, $r_s(25) = .53, p = .006$, intrusion, $r_s(25) = .48, p = .016$, and numbing scores, $r_s(25) = .52, p = .007$, but not with RATS hyperarousal scores or any other measures.

CBCL externalizing scores were associated with CBCL internalizing scores, $r_s(24) = .68, p < .001$, and with HSCL-37A anxiety subscale scores, $r_s(24) = .41, p = .048$. However, CBCL scores were not associated with any of the other child-report measures.

**Between-group differences on measures.** Between group differences by gender, age, and nationality were assessed for each of the child- and caregiver-report measure scales and subscales. No differences were observed across measures by gender and nationality. However, the correlation between SLE scores and age approached significance, $r_s = .38, p = .059$, with
older children appearing to have experienced more traumatic stressors. Older children also appeared to have higher scores on the RATS intrusion, $r_s = .38, p = .059$, and hyperarousal, $r_s = .47, p = .017$, subscales. On the A&A, differences in total adaptation scores by age approached significance, $r_s = .36, p = .088$, with older children reporting higher levels of adaptation. Older children also scored higher on the security subscale of the A&A, $r_s = .44, p = .038$.

**Hypothesis 2b:** Results from the child-report (HSCL-37A and RATS) and caregiver-report (CBCL) instruments will concur with diagnostic assessment on the structured clinical interview (DISC-IV) in this sample of unaccompanied children. Results on the association between children’s screening measure scores and DISC-IV diagnoses lent mixed support to the above hypothesis. HSCL-37A and CBCL total scale scores were significantly associated with whether children met criteria for DISC-IV diagnoses. However, whereas the HSCL-37A screened more effectively for DISC-IV internalizing disorder diagnoses than externalizing diagnoses, the opposite was true of the CBCL. Overall, existing CBCL norms provided effective cutoffs for discriminating between DISC-IV cases and non-cases. However, current HSCL norms did not, with children appearing to underreport their symptoms relative to cutoffs from other studies (including those with unaccompanied children). Analyses of RATS scores were not possible as no children met DISC-IV criteria for a past-month diagnosis of PTSD with functional impairment.

Table 13 presents the relationship between child- and caregiver-report screener scores and children’s DISC-IV diagnoses (including functional impairment criteria A), assessing screening accuracy using Area Under the ROC Curve (AUC) analyses and goodness of fit with norm-based cutoffs using chi–square and Fisher’s Exact Test analyses. These analyses were limited by the small cell counts (e.g., only one child met criteria for past-month major
depression or dysthymic disorder on the DISC-IV and no children reached cutoff criteria for an externalizing disorder on the HSCL-37A) and the questionable internal reliability of some HSCL-37A subscales (e.g., the externalizing subscale). They were also based on the assumption that the DISC-IV provided accurate diagnostic information against which to compare, including past-month diagnoses (which are, by definition, less stable than past-year prevalence). It was not possible to test the screening properties of the RATS, as no children in the study met criteria for a past-month diagnosis of PTSD with functional impairment. However, it should also be noted that none of the children in the study screened positive for a PTSD diagnosis based on cutoff scores for the normative sample of unaccompanied and other migrant minors in the Netherlands and Belgium with whom the measure was developed.
Table 13. Concurrent validity between Diagnostic Interview Schedule for Children Version IV (DISC-IV) diagnoses and child- and caregiver-report screening measure scores

<table>
<thead>
<tr>
<th>DISC-IV diagnosis</th>
<th>Measure</th>
<th>Association using ROC curve analyses</th>
<th>Association using norm-based clinical cutoffs&lt;sup&gt;a&lt;/sup&gt;</th>
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<tr>
<td></td>
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<td>Area under curve</td>
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<td>Any PM&lt;sup&gt;c&lt;/sup&gt; Disorder</td>
<td>HSCL-37A&lt;sup&gt;b&lt;/sup&gt; Full scale</td>
<td>.81 .014</td>
<td>Exact .091</td>
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<td>Any PM internalizing</td>
<td>Internalizing scale</td>
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<td>Exact .608</td>
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<td>Any PM anxiety</td>
<td>Anxiety subscale</td>
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<td>Exact .552</td>
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<td>Depression subscale</td>
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<td>Exact .304</td>
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<td>Externalizing scale</td>
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<tr>
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<td>$\chi^2(1) = 2.35$ .126</td>
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<td>Any PY externalizing</td>
<td>Externalizing scale</td>
<td>.92 .020</td>
<td>Exact .008</td>
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<sup>a</sup>Clinical cutoffs for HSCL-37A based on item mean = 1.75 (Derogatis et al., 1974; Mollica et al., 1987). Clinical cutoffs for CBCL from Norm Group 2 borderline range (Achenbach & Rescorla, 2007). Hopkins Symptom Checklist for Adolescents (Bean et al., 2004a). Past-month. <sup>d</sup>No participants reached clinical cutoff score on the HSCL-37A externalizing subscale, so norm-based prediction was not possible for this subscale. <sup>e</sup>Child Behavior Checklist (Achenbach & Rescorla, 2001). <sup>f</sup>Past-year.
**HSCL-37A screening properties.** Children’s HSCL-37A total scale scores were significantly and strongly associated with whether they met criteria for a past-month diagnosis on the DISC-IV, \( AUC = .81, p = .014 \). The relationship between children’s HSCL-37A internalizing subscale scores and DISC-IV internalizing diagnoses was weaker and marginally significant, \( AUC = .75, p = .057 \). Within the internalizing subscale, children’s anxiety subscale scores were significantly related to presence of a DISC-IV anxiety diagnosis, \( AUC = .80, p = .024 \), but their depression subscale scores did not significantly identify children with a DISC-IV depressive disorder diagnosis. The HSCL-37A externalizing subscale did not accurately screen for DISC-IV disruptive or substance use disorders. Given the high rates of SAD in the sample and the fact that SAD symptoms were not included on the HSCL-37A, exploratory analyses were also conducted with this diagnosis removed from the DISC-IV data. However, this led to an increase rather than a reduction in \( p \) values.

Using the HSCL-25 cutoff scores established by Derogatis and colleagues (Derogatis et al., 1974), scale/subscale item mean = 1.75, the association between children who screened positive on the HSCL-37A total scale and children who met criteria for a past-month DISC-IV diagnosis approached significance, \( p = .091 \). Sensitivity was 37.5%, specificity was 93.8%, and PPV and NPV were both 75%. Inspection of ROC curves suggested an optimal cutoff point of 51.5 (sensitivity= 87.5%, specificity = 75%, \( PPV = 63.6\% \), \( NPV = 92.3\% \)), corresponding to approximately the 58th percentile of scores (as compared to Derogatis and colleagues’ cutoff score of 64.75, which corresponded to approximately the 92nd percentile). Testing of the relationship between the HSCL-37A internalizing and anxiety subscales using the same 1.75 item mean cutoff and DISC-IV anxiety and depression diagnoses did not yield significant results. ROC curve inspection suggested an HSCL-37A internalizing subscale optimal cutoff point of
41.5 (sensitivity = 71.4%, specificity = 82.4%, PPV = 62.5%, NPV = 87.5%), corresponding to approximately the 65th percentile (whereas the normed cutoff score of 43.75 coincided with approximately the 80th percentile). The optimal cutoff point for the HSCL-37A anxiety subscale was 15.5 (sensitivity = 85.7%, specificity = 64.7%, PPV = 50%, NPV = 91.7%). This coincided with approximately the 73rd percentile of scores (whereas the normed cutoff score of 17.5 corresponded to approximately the 86th percentile).

Children’s HSCL-37A and RATS scores were, for the most part, significantly lower than those of the Dutch and Belgian minor cohorts on whom the measures were validated and normed (Bean et al., 2004). Study children’s scores were significantly lower than those of the Dutch unaccompanied child cohort across the HSCL-37A total scale, \( t(1016) = 4.52, p < .001, d = 0.92 \), HSCL-37A internalizing subscale, \( t(1011) = 4.36, p < .001, d = 0.88 \), and RATS total scale, \( t(1016) = 6.51, p < .001, d = 1.32 \). The children’s scores did not differ significantly from those of the Belgium migrant minor cohort from Bean and colleagues’ work (2004a) on either the HSCL-37A total or internalizing scales, but their scores were significantly lower than those of the Belgium migrant minors on the RATS total scale, \( t(947) = 2.35, p = .019, d = 0.48 \). Study children’s scores were significantly lower than those of the Belgian indigenous sample on the HSCL-37A total scale, \( t(639) = 3.85, p < .001, d = 0.79 \), and approached significance on the internalizing subscale, \( t(639) = 1.92, p = .056, d = 0.39 \); however, the difference in RATS total scores between the two samples was not significant. Similarly, study children’s scores were significantly lower than those of the Dutch indigenous cohort on the HSCL-37A total scale, \( t(1048) = 2.29, p = .022, d = 0.46 \), but differences in scores were not significant on the HSCL-37A internalizing subscale and RATS total scale. Due to the non-normality of study children’s scores on the HSCL-37A externalizing subscale, \( t \) test comparisons with the Dutch and Belgium
minor cohorts were not conducted. However, their scores on this subscale appeared very low: compared to a minimum score possible on the scale of 12, the mean HSCL-37A externalizing score for the sample was 13.44, ($SD = 1.45$).

CBCL screening properties. There was a significant and moderate association between CBCL total scale scores and whether children met diagnosis for a past-year diagnosis on the DISC-IV, $AUC = .76, p = .027$. Children’s CBCL externalizing subscale scores were strongly associated with presence of a past-year DISC-IV externalizing disorder, $AUC = .92, p = .021$. The internalizing subscale did not significantly discriminate between children with and without past-year DISC-IV anxiety and mood disorders. However, in exploratory analyses with SAD and agoraphobia removed, the CBCL internalizing score appeared to screen more effectively, although this association was only marginally significant, $AUC = .71, p = .069$.

Using standard CBCL cutoff scores for the borderline range (Norm Group 2), there was a significant and strong association between children who screened positive on their total scale scores and those who met criteria for a past-year DISC-IV diagnosis, $\chi^2(1, N = 26) = 6.00, p = .014$ (sensitivity = 64.3%, specificity = 83.3%, $PPV = 81.8\%$, $NPV = 66.7\%$). Similarly, positive screens on the externalizing subscale were closely associated with past-year DISC-IV disruptive and substance use disorder diagnoses, $p = .008$ (sensitivity = 100%, specificity = 87.0%, $PPV = 50\%$, $NPV = 100\%$). Children with DISC-IV anxiety and mood disorders were not identified significantly by those screening positive on the CBCL internalizing subscale. However, with SAD and agoraphobia removed from the analyses, the association approached significance, $p = .051$ (sensitivity = 81.8%, specificity = 60.0%, $PPV = 60.0\%$, $NPV = 81.8\%$). Exploratory analyses were also performed using the CBCL cutoff scores for the clinical range (again, using Norm Group 2). For each of the CBCL total, internalizing, and externalizing scales this
weakened the association with past-year DISC-IV diagnoses, with only the results for the total scale reaching significance, \( p = .036 \) (sensitivity = 50.0%, specificity = 91.6%, PPV = 87.5%, NPV = 61.1%).

**Aim 3: Mental Health Service Utilization**

During the study interview, data were obtained about children’s current mental health diagnoses and mental health service usage since arriving in NYC. For those children who presented with mental health needs or requested mental health referrals at the time of the interview, a brief telephone follow-up interview was conducted, providing data on facilitators and obstacles to mental health service access and usage.

**Study Aim 3a: To determine the rate of mental health service utilization in a sample of unaccompanied children.** At the time of the study interview, three children (11.5% of the sample) were being monitored by school counselors for learning difficulties or emotional concerns on an ad hoc basis. This compared to 14 children (53.8%) with a past-year diagnosis with functional impairment on the DISC-IV (two of whom were among those being monitored by school counselors), and nine (34.6%) with a past-month diagnosis on the DISC-IV (one of whom was among those being monitored). Based on a broad definition of receiving services (i.e., any contact with a mental health professional) and a strict definition of need (past-month psychiatric diagnosis with functional impairment) the unmet need of the sample was 88.9%. Not a single child was receiving consistent, regular services (e.g., therapy sessions, support group, medication management etc.), either through school-based services or in a specialized mental health treatment setting. Based on this narrower definition of receipt of services, the unmet need of the sample was 100%.
Hypothesis 3a. The gap between the number of children with DSM-IV diagnosable mental health difficulties and the number receiving mental health services will be greater among this sample of unaccompanied children than estimates for both the general adolescent population and other immigrant youth. Unmet need in the sample was compared against data from a study of mental health service utilization combining three large nationally representative surveys (Kataoka, Zhang, & Wells, 2002). Based on a broad definition of receiving services (i.e., to include monitoring by a school counselor on an ad hoc basis), goodness of fit testing using Fisher’s Exact statistic did not yield any significant differences in unmet need in our sample (88.9%) compared to the general adolescent population (77%), Latino youth with U.S.-born parents (88%), and Latino youth with non-U.S.-born parents (93%). On this basis, the study did not provide evidence to support the hypothesis that this sample of unaccompanied children has a higher level of unmet need than the very high levels also observed in the broader child immigrant and general adolescent populations.

Based on a narrower definition of receiving services involving receipt of regular, scheduled counseling or other mental health treatment services, no children in our sample had received treatment since arriving in NYC, indicating a 100% unmet need. Statistical comparisons with other studies based on this metric were not possible due to the zero value for children in our sample.

Study Aim 3b: To determine obstacles to and facilitators of mental health service utilization in unaccompanied children. Factors influencing service utilization were assessed primarily based on data from follow-up phone interview with children in the sample who were identified as having mental health needs and referred to services. Figure 16 summarizes the data
on services received and services wanted at the time of the follow-up telephone interview. The reasons why families had or had not received services are then discussed below.

![Diagram showing mental health service utilization]

**Figure 16.** Mental health service utilization of children interviewed at follow-up.

**Mental health referrals following study interview.** Of the 18 children who screened positive for one or more DISC-IV diagnoses, 17 were provided with a list of mental health referrals. The other child, who met criteria for past-year and past-month separation anxiety disorder but no other diagnoses, and was not provided with referrals as the child and his guardian did not feel a need for services. Two children who did not receive diagnoses on the DISC-IV were provided with referrals due to elevated child- and caregiver-report screening measure scores and because their guardians requested referrals for them.

**Use of mental health services following referral.** One of the 19 children provided with mental health treatment referrals after the study interview could not be contacted at follow-up. Of the 18 children contacted (three or more months after the study), seven (38.9%) had received
some form of counseling. Two of the three children who were being monitored by school counselors prior to the study had continued to receive school-based counseling services only. Five children (27.8%) had received formal mental health treatment outside school. Among the eight children with acute current mental health needs (defined as having one or more past-month DISC-IV diagnoses with functional impairment) who were referred to services, three (37.5%) had received formal mental health treatment outside school.

Research Question 3b: What are the obstacles to and facilitators of mental health service utilization among unaccompanied children from the study referred to care? Most children provided with mental health referrals experienced some obstacles to accessing services. The most common structural barriers cited were not yet having insurance for the child and not knowing where to access free or low cost mental health services. A third of the families provided with referrals did not seek services because the child, the guardian, or both felt that the child was doing well and did not require assistance. In several other cases, the child acknowledged some distress but did not want formal help. The mother of one of these children expressed concerns about stigma relating to seeking mental health treatment. Two of the three children who were being monitored by school counselors at the time of their study interviews had continued to use these services alone rather than seeking formal mental health treatment. Some children were attending church as a form of psychosocial support in place of formal counseling. All five families who sought treatment were ultimately successful in finding therapists. Some experienced obstacles to service access, including treatment cost, language-barrier, and having to wait for an appointment. However, with assistance they were able to navigate these.

Reasons for not pursuing mental health services. 13 families (72.2% of the families interviewed at follow-up) had not pursued any additional services following their study
interviews. In five cases, guardians stated that they did not know where they could access free or low cost services for their child. In four (30.7%) of these instances, guardians specifically mentioned lack of insurance as an initial impediment to seeking services, although three of them had subsequently applied for and enrolled their children in government healthcare programs. In three cases where insurance had imposed an obstacle, families were still interested in seeking treatment at follow-up. For several families anxious about children’s upcoming court dates, concerns about finding a lawyer appeared to take precedence over seeking counseling services. One guardian articulated the competing stresses and demands on the family’s time, suggesting that a counseling referral for his 17-year-old child could be helpful “depending on the day. Sometimes there is no time, but it would be good. I would like to have a lawyer’s number.” He further explained, “The immigration appointment is soon and he is nervous because he does not know what will happen.”

In six cases (33.3%), the family had not sought out mental health services because the guardian and child felt that the child did not need this support. Four of these children had received only SAD and/or agoraphobia diagnoses on the DISC-IV, and three of them had not met functional impairment criteria for any diagnosis. Another child received multiple DISC-IV diagnoses with functional impairment based on his self-report, but none based on caregiver-report. During the follow-up interview, his mother suggested, “I think that if sometimes he becomes rebellious it is part of his development.” In one other case, the child was being seen by a school counselor and this was seen by both the child and his guardian as sufficient to the child’s need.

In three cases (16.7%), guardians expressed concern about their child and wanted to take them to a therapist, but the child did not want to go. Two of these children who were reluctant to
see a therapist, reported that, as an alternative to mental health treatment, they were going to church. They suggested that this was providing them with the support they needed, and they were now feeling better. However, in both cases the guardians had continued concerns. One 17-year-old who presented with considerable distress during the study interview and multiple diagnoses on the DISC-IV suggested at follow-up that “[t]here are days when, like anybody, I feel bad. All that happened has been forgotten. It was a dark time and now I am better. I have God and nobody else. He is my only hope.” However, his guardian suggested, “He is suffering a lot and is quite desperate, but time is passing here.” The 15-year-old boy who had several sessions with a school counselor after expressing suicidal ideation suggested during the study interview that he was not interested in seeing a therapist because “I’m not crazy.” At the follow-up interview he, emphasized that had never intended to hurt himself, was feeling better, and that going to church helped him cope. However, his mother reported, “He seems sad and irritable . . . all the changes have been difficult for him.”

One mother whose 14-year-old son was being seen by a school counselor also expressed stigma-related concerns. She reported that he was “normal,” and emphasized that he was receiving help for school work rather than any emotional difficulties (although the child’s account contradicted this). She subsequently stated, “I don’t want people to take him for a crazy person.” She also reported that her neighbor had advised her that “if you go to a psychologist you have to take medication and if you stop taking it the government looks for you.”

The decision whether or not to seek specialized mental health services outside school was associated with caregiver-report CBCL total scores, $r_{tb}(26) = .47, p = .020$, but not with child-report HSCL-37A total scores, $r_{pb}(25) = .07, p = .796$. Within the CBCL, externalizing scores were associated with the decision to seek services, $r_{pb}(26) = .71, p = .001$, whereas internalizing
scores were not, \( r_{pb}(26) = .18, p = .470 \). However, neither presence of externalizing diagnosis on the DISC-IV nor impairment on the DISC-IV was significantly associated with the decision to seek services. Children’s gender did not predict treatment-seeking, nor did the guardian’s relationship to the child. (Although every guardian who sought services for her child was a mother, 15 of 18 guardians who completed follow-up were mothers). The relationship between child’s age and seeking services approached significance, \( r_{pb}(26) = -.44, p = .065 \), with guardians seeking services more for younger children (\( M = 12.20, SD = 2.05 \)) than for older ones (\( M = 14.77, SD = 2.59 \)). However, younger children were also more likely to have their mothers as guardians, potentially confounding the relationships between guardians’ relationship to the child, child’s age, and treatment-seeking.

Facilitators and barriers to treatment among children who accessed mental health services. Children using school-based counseling reported ease accessing these services. One child who was receiving help for both emotional and academic difficulties stated that he talked to his school counselor for about 30 minutes almost every day and explained that all he had to do to facilitate this was tell his teacher. A second child, the one whose note expressing suicidal ideation had raised concern, had apparently only seen the school counselor on two or three occasions and was no longer receiving counseling due to the school year ending. In both these cases, either the child or guardian mentioned stigma-related concerns about seeking formal mental health services outside the school. A third child, the 14-year old with cognitive deficits, was in the process of applying for an Individualized Education Plan in school with the help of a psychological evaluation obtained from a nonprofit organization that works with children with intellectual and developmental difficulties. She had also started working with a psychologist outside the school.
In all five cases (100%) where the child received formal counseling outside school, the family received assistance in obtaining the referral. Two families (40%) had used the lists of referrals provided to them by the study team to access low-fee/free treatment at community mental health centers. One of these children was placed on a waiting list for two months before being seen, but otherwise accessing these services was reportedly easy. The other three children were referred to psychologists via a medical doctor. In two instances, the child’s pediatrician referred the child to a psychologist. In the third instance, the child’s mother took her to the hospital because “she was not feeling well, and she was like sad and depressed.” According to the mother the child initially felt uncomfortable because she was seen by a doctor who was male and did not speak Spanish. As a result, he referred her to a Spanish-speaking female psychologist with whom she apparently had a good rapport. However, the mother, who had not yet applied for insurance for her child, did not realize that she had to pay for services and at the time of the follow-up interview owed the hospital $650.

Families’ impressions of services received. Two families whose children had been seen by school counselors had favorable impressions of the services they had received. One, a 14-year-old boy, explained that he had initially felt sad and resentful after coming to the United States. However, he reported that “speaking with the counselor I feel different…I’ve become used to things” and noted that he now has friends both at home and at school. The other, a boy aged 16, suggested, “I liked talking to a person that you can say anything to. I feel that is good.” His mother also commented on how the school counselor had been helpful to him:

As a mother one doesn’t know what to ask and perhaps it makes it easier to speak with someone outside the family who knows what to ask . . . when he went to speak with someone at the school he liked it.
Four of the five families whose children had been seen by therapists outside school were positive about the experience. A 10-year-old boy who had been referred for a mix of emotional and behavioral concerns suggested that his therapist “helps me, she is good with me” and his mother suggested that he was behaving better. Another mother who had been concerned that her 13-year-old son was not paying attention or doing his homework suggested that he was now “doing his part more,” and the child reported liking going to his weekly appointments. Another mother reported that she had taken her daughters for treatment because one was sad and anxious and the other was lonely and missing family back in Honduras. She reported that after several sessions they had both been helped so treatment was ended. By contrast, the mother whose child had cognitive difficulties expressed frustration with her daughter’s apparent lack of progress in treatment: “I don’t see any progress, I ask the girl what they talk about and she cannot tell me.”

*Children’s mental health presentation at follow-up.* Ten of the 18 families contacted at follow up (34.6% of the total sample) indicated that the child was still experiencing distress, based on child-report, guardian-report, or both. Three of these children were continuing to receive mental health services outside school while one was being seen by a school counselor regularly. Perceptions of the children’s distress varied, with guardians appearing to focus more on problematic behavior and children on internal experience. For example, one 10-year-old boy commented that “sometimes I have nightmares,” while his mother remarked, “What’s difficult is that he doesn’t take responsibility for his behavior, and he doesn’t pay attention when you tell him to do something.” In two cases where the family had not sought services, the child and guardian were still interested in treatment and provided with additional referrals. One 15-year-old boy who was waiting for his insurance to be approved before seeking counseling explained how his distress persisted nine months after arriving in NYC: “I think a lot about the journey,
about immigration, bad people on the journey.” One mother who had not sought services for her 17-year-old daughter due to a lack of insurance described her daughter’s ongoing difficulties:

She is like hysterical, non-compliant, not social. Yes, I would say she is depressed. She had a court appearance and they summoned her for next March. She is very afraid of going back. I think everything that happened to her in El Salvador affected her.

Among the eight children (44.4% of those referred to services) for whom no mental health concerns were reported at follow-up, two were doing better after receiving counseling outside school and one after receiving counseling in school. The other five families had never regarded the children as needing services.
CHAPTER V: DISCUSSION

The aim of this study was to examine the mental health needs of unaccompanied immigrant children living with guardians in the NYC area following release from government custody and pending resolution of their immigration cases. Specifically, the goals were to obtain data on children’s psychosocial context, their mental health presentation, and their use of mental health services.

Children in the study presented with complex reasons for migration, typically involving a variety of push factors (e.g., gang violence, physical abuse in the home, poverty, and lack of an available caregiver) and pull factors (e.g., family reunification, better study opportunities, and to support family in their home countries). Their departure was often triggered by a specific, acute stressor which tipped the relative risk analysis for staying versus leaving in favor of attempting the dangerous journey to the United States. Most children had been subjected to multiple traumatic stressors prior to and during their migration processes, including almost two-thirds who had been exposed to violence, injury, or death. These were counterbalanced by familial, community, and other cultural, institutional, and structural resources that served as a buffer against stressors and helped promote children’s wellbeing. While many children acknowledged how hard their migration process had been, they typically identified with narratives of resilience rather than victimization.

Children interviewed had exceptionally high rates of psychiatric diagnoses as assessed using the DISC-IV. Almost 70% of the sample met criteria for one or more past-year diagnoses based on symptom criteria alone, and even with the inclusion of functional impairment criteria
over half the children had at least one past-year diagnosis. Past-month diagnoses, while lower, were still high, with over one-third of children meeting criteria for at least one diagnosis even when functional impairment criteria were applied. Children in the sample had high rates of anxiety and mood disorders compared not only to community norms for the general adolescent population, but also to other immigrant youth and service-seeking samples. By contrast, they presented with low rates of externalizing disorders. Child-report measures screened better for internalizing disorders, whereas caregiver-report measures screened better for externalizing disorders. However, overall children appeared to understate their symptoms on child-report screening instruments.

Children in the sample had a large unmet need for mental health services. At the time of the study interview, none had received any formal mental health treatment, although several were being monitored by school counselors. Of children referred to treatment centers, at follow-up several months later less than a third had pursued and received additional services. Facilitators of service provision included availability of school counseling and referral by a pediatrician to mental health treatment services in the community. Stated barriers included lack of knowledge of available services, lack of insurance, and the child not perceiving a need for help. Mental health stigma concerns were rarely expressed. The study findings are summarized in Table 14.
Table 14. Summary of study findings on mental health needs of unaccompanied children

Aim 1: Psychosocial context

- **Stated reasons for migration (1a):** Children frequently had multiple reasons for migration, involving both push and pull factors, with departure often triggered by a specific, acute stressor

- **Psychosocial stressors (1b):** Among other stressors, children were frequently exposed to gang violence, domestic abuse, and abandonment in their home countries, exploitation during their journeys, poor treatment during U.S. immigration detention, and long separations from caregivers and other loved ones

- **Psychosocial supports (1c):** Factors at multiple systemic levels both protected against the impact of stressors and helped promote normative developmental processes

- **Distress, coping, and attitudes towards migration (1d):** While frequently acknowledging hardship and distress, children’s migration narratives emphasized overcoming rather than victimization

Aim 2: Mental health diagnosis

- **Rates of mental health diagnoses (2a):** Unaccompanied children had very high rates of past-year internalizing but not externalizing disorders compared to general community, immigrant, and service-seeking samples; rates lower with inclusion of functional impairment criteria and when assessing past-month diagnoses, but still elevated compared to other populations

- **Feasibility of using screening measures (2b):** Child-report measure screened better for internalizing disorders, guardian-report measure screened better for externalizing disorders; children appeared to understate symptoms on screening measures

Aim 3: Mental health service utilization

- **Rates of service utilization and unmet need (3a):** Large discrepancy between children presenting with diagnoses and minimal receipt of care; however, differences in unmet need compared to other populations not statistically significant

- **Obstacles to / facilitators of service utilization (3b):** Common obstacles included lack of knowledge of available services, lack of insurance, and child resistance to treatment (stigma concerns rarely overtly expressed); principle facilitators of service provision were availability of school counseling and pediatrician referral
The exploratory nature of this small study and the cross-sectional design—involving interviews shortly after children’s arrival in the United States and with their long-term immigration status still unresolved—limit the conclusions that can be drawn. However, broadly speaking, the results suggest that the mental health presentation, functioning, and wellbeing of the children sampled were informed by an ongoing interaction between: the type, severity, and chronicity of the stressors to which they had been exposed; the level of individual and social promotive and protective resources available to them; and the extent to which environmental conditions facilitated or negated development and maintenance of these resources.

Social ecological models of risk and resilience (e.g., Betancourt & Khan, 2008; Panter-Brick & Leckman, 2013; Ungar et al., 2013) and Hobfoll’s Conservation of Resources (COR) theory (Hobfoll, 1989, 2012, 2014) provide models that may help explain these findings. In this section, the results are reviewed through these lenses and tentative conclusions drawn, with an eye to more targeted testing of theory-informed hypotheses in future studies. This discussion is followed by several illustrative case examples. Finally, limitations of the current study and implications of its findings for future research, psychosocial intervention, and advocacy with unaccompanied children are presented.

**Sociodemographic Characteristics**

Before discussing the study findings, it is important to note that this sample represents a particular subset of unaccompanied children: those released to family members (or, in one case, a family friend) in the community after relatively short periods in immigration detention. It does not include the 15% of unaccompanied children who remain in some form of government-sponsored foster care, detention, or treatment facility pending their immigration cases (HHS, 2014). It also does not include children who enter the country undetected, who often do not have
access to services such as education and health care and may be at increased risk for trafficking and exploitation (Ijadi-Maghsoodi et al., 2016). Additionally, it does not include unaccompanied children who do not make it as far as the United States because they are caught and deported back to their home countries, nor of course those who die attempting the journey.

The ability of the children in the sample to navigate their way from their home countries to the United States and then through the immigration system to their loved ones may be evidence of their particular internal resourcefulness, as well as the external supports available to them. The sample is also made up exclusively of children settled to the New York City metro area, which has a thriving Latino population, less aggressive immigration enforcement policies than some other parts of the country, and government initiatives to help access education, medical, and legal supports. Further, the study recruitment process through optional legal orientation meetings, resulting in a convenience sample made up of families willing and able to participate in the study, likely selected for children whose caregivers were taking a particularly active interest and role in their health and wellbeing. Thus, with respect to their post-migration circumstances and the internal and external resources available to them, the sample of unaccompanied children interviewed in this study may represent something of a best-case scenario. Children who do not make it as far as the United States, who remain in government custody, or are released to environments with fewer supports likely experience even more challenging circumstances and even higher rates of distress than those reported in this sample. Potential selection bias, demand characteristics, and limits to the inferences drawn and generalizability of the study findings will be discussed in depth in the limitations section.

Despite the particularities of the sample, it was broadly reflective of government statistics (ORR, 2016d) on the population of unaccompanied children apprehended in FY 2014, with
regard to both age and gender. Specifically, it was representative of the recent trend whereby children are coming unaccompanied at younger ages and the proportion that are female is rising. With regard to nationality, Honduran children (50% of the sample) and Ecuadorian children (11.5%) appeared somewhat overrepresented compared to the overall population of unaccompanied children (ORR, 2016d). Although differences were not in all cases statistically significant, even this small sample was suggestive of several demographic patterns. Children from Honduras were frequently younger than youth from other countries and fleeing gang violence. Children from El Salvador and Guatemala were often older and included earning money to support family at home (as well as fleeing societal and domestic violence) as a reason for migration. Children from Ecuador had been less exposed to violence in their home countries than other children in the study. Younger children typically were reuniting with mothers, whereas older children were more likely to be reuniting with other family members. Older children were also more likely to state working to support family at home among their reasons for migration.

**Aim 1: Psychosocial Context**

**Stated reasons for migration (Research Question 1a).** Many of the reasons families in the study gave for children’s migration matched those cited in other recent studies looking at unaccompanied children’s motivations for coming to the United States (Kennedy, 2014; KIND, 2013; UNHCR, 2014): push factors including societal violence, abuse in the home, lack of opportunities, and poverty; and pull factors including family reunification and educational and work opportunities. Echoing the UNHCR study (2014), in which 21% of children reported abuse in the home as a reason for migration, in our study 23.1% of families mentioned abuse. Gang violence was mentioned less often as a reason for migration (by 30.8% of families in our study,
compared to 48% of children in the UNHCR study), although many participants in our study described exposure to gang violence during their interviews without stating it as a reason for children leaving home. Families in our study also mentioned additional push factors not stated as explicitly in these other reports, to include lack of available caregivers and concerns about children’s mental health.

Children’s reasons for migration can have implications for whether they are eligible for immigration relief or will be deported back to their home countries. As in the studies by Kennedy (2014) and UNHCR (2014), children in the sample often reported multiple reasons for migration, combining factors that lend themselves to U.S. immigration protections (e.g., fleeing domestic and societal violence, abuse or neglect in the home, and abandonment by caregivers) and factors that do not (e.g., economic reasons for migration). The fact that many children included economic opportunities among their reasons for migration should not obscure the fact that these co-occurred alongside other reasons such as gang and domestic violence warranting legal protections. Furthermore, while “family reunification” is often not characterized as a reason for immigration relief (e.g., Rosenblum, 2015), a number of children in the study were reuniting with family because they no longer had anyone available to take care of them properly in their home countries, as in the case of the 13-year-old Honduran boy whose grandmother left their home unannounced one day leaving him and his brother to fend for themselves. Such circumstances can render children eligible for immigration relief, for example under the abandonment and neglect clauses of Special Immigrant Juvenile Status (Byrne & Miller, 2012).

Echoing findings by Kennedy (2014), even when children in our study had faced chronic stressors over long periods of time, the decision to depart when they did was frequently precipitated by an acute danger or crisis that tipped the balance in favor of attempting the
dangerous journey north. For several children in the study, like the Honduran boy who narrowly escaped a shoot-out at a party and the Salvadoran girl who found a razor left as a warning sign by gangs who had broken into her home, these stressors constituted direct and immediate threats to their lives. In other words, the decision to leave was a last resort and act of desperation. Although, for most children in the sample, family reunification and increased opportunities in the United States were happy consequences of surviving the journey, it was clear that they would not have risked their lives to achieve these things unless it was more perilous to stay at home.

In many cases, it appeared that children’s stated rationale for coming to the United States did not include all their reasons for migration. For example, the majority of families reported at some point during their interviews that children had been exposed to gang violence in their own countries, but less than a third stated this as a reason for migration. In particular, children were prone to emphasize pull factors attracting them to the United States rather than the negative circumstances pushing them to leave. This may in part be due to the fact that this violence is so normative in these children’s home countries that it did not feel relevant to raise it until asked directly. Children’s focus on pull factors for migration may be psychologically beneficial, consistent with optimistic, forward-thinking narratives of resilience. However, children may also find it uncomfortable to bring up past traumas, avoid doing so unless asked specifically, or even deny traumatic experiences altogether. However, reluctance to discuss pre-migration traumas may unwittingly cause some children to undermine compelling claims for immigration relief (Baily et al., 2014). This is likely especially true for the large proportion of children who go through removal proceedings without lawyers to prepare them for court by asking important questions about their pre-migration stressors (Rosenblum, 2015).
Overall, the study findings suggested that unaccompanied children have complex reasons for migration, involving a combination of threats, demands, fears, hopes, and aspirations. This fact can be obscured by a tendency to frame children’s migrant identity from particular perspectives: from a legal perspective, as a refugee fleeing persecution; from an economic stance, as a breadwinner coming to the United States to earn money to send home; from a familial point of view, as a son or daughter being brought back into the parents’ home; or from an intrapsychic perspective, as a young person motivated to build a better life for himself or herself. Each perspective may serve a particular function. However, each misses part of children’s experience, impedes seeing them as fully-rounded people, and hinders our ability to consider the full range of their strengths, needs, and rights.

Psychosocial stressors experienced during migration process (Research Question 1b). Children in the sample had experienced extraordinarily high levels of adversity. Based on their reporting on standardized measures, almost 90% had been exposed to one or more potentially traumatic stressors, including two-thirds who had experienced a threat of serious injury or death to themselves or a loved one, and over 60% who had witnessed an actual death or serious injury. Over a third had witnessed domestic violence and almost a quarter had been physically abused themselves. Despite these findings, the data from these instruments may in fact underestimate children’s exposure to stressors. In several instances, children and guardians described traumatic experiences during their narrative interviews they had not categorized as stressors in the structured assessment. In addition, several guardians noted that their children had chosen not to talk to them about the details of their journeys.

Many of the stressors children described were all too familiar from the extant literature on unaccompanied children, with each stage of the migration process bringing distinct types of
adversity (e.g., Fazel et al., 2012; Lustig et al., 2004; Pumariega & Rothe, 2010): during the pre-
migration period, pervasive gang violence (Hiskey, Malone, & Orcés, 2014), high levels of abuse
and neglect in the home (UNHCR, 2014), extreme poverty (Kennedy, 2014), long separations
from parents (Rosenblum, 2015), and loss of replacement caregivers charged with children’s care
(Bhabha & Schmidt, 2006); during children’s journeys, kidnappings by gangs and abusive or
neglectful behavior from coyotes (Chavez & Menjívar, 2010), threats and bribes from
government officials (Casillas, 2006), sometimes deadly accidents on the roads and railway
tracks (Chavez & Menjívar, 2010), and risk of death through exposure in the desert and
drowning while traversing rivers (Eschbach et al., 1999); while in U.S. immigration custody,
being exposed to uncomfortable and at times prison-like conditions (Women’s Refugee
Commission, 2009); and in the post-migration period, language and other acculturation
difficulties (Portes, 1999), discrimination (Feerick Center & Vera, 2015), financial stress
(Feerick Center & Vera, 2015), difficulty accessing needed resources (Baily et al., 2014),
missing family at home (Derluyn & Broekaert, 2008), and a tense period of legal uncertainty
(Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997).

However, some stressors commonly noted in the literature on unaccompanied children
were mentioned rarely in this study, such as sexual violence perpetrated by gangs against teenage
girls in their countries of origin (e.g., Bhabha & Schmidt, 2006; UNHCR, 2014) and during their
journeys to the United States (e.g., Jones & Podkul, 2012). Although several guardians expressed
worry that their children had been assaulted or molested either prior to migration or during their
journeys, the children had all denied these concerns. These discrepancies highlight the challenge
for children in disclosing this type of trauma, not least in the type of one-off research interview
in which they participated in this study. In future research, one potential way to obtain accurate
information about the types of stressors experienced by unaccompanied children without them having to make uncomfortable self-disclosures is the free listing qualitative interviewing technique commonly used in rapid ethnographic assessment (e.g., Betancourt, Speelman, Onyango, & Bolton, 2009). In this approach, informants are asked to comment on the typical experiences of people in their communities rather than to describe their own personal experiences.

Consistent with findings from other studies on the compounding effect of exposure to successive traumatic experiences during migration (e.g., Bean, 2006; Ellis, MacDonald, Lincoln, & Cabral, 2008; Hodes et al., 2008; Sinnerbrink et al., 1997), exposure to multiple stressors was associated with increased likelihood of mental health difficulties. A number of the specific migration stressors families mentioned in this study have been linked with psychopathology in previous research on displaced children (for a detailed review of this literature, see Fazel et al., 2012): exposure to pre-migration violence; pre-existing psychological difficulties prior to migration; restrictive, stressful detention experiences; financial concerns in the post-migration period; uncertain legal situations; limited family cohesion; bullying at school; and difficulties learning English. However, many of these effects have not been replicated across studies. This is likely indicative of the complex, transactional relationship between multiple vulnerability and protective factors—co-varying and exerting a differential impact based on both context and timing—in determining mental health outcomes (Fazel et al., 2012). The variable impact of stressors in this study appeared to be reflected in the fact that most bivariate analyses did not indicate direct associations between specific stressors and children’s mental health outcomes.

One of the more robust predictors of psychopathology in migrant children, identified in multiple studies (e.g., Berthold, 2000; Derluyn & Broekaert, 2007; Geltman et al., 2005), is
exposure to violence in the pre-migration period. This study echoed those findings. Even following often terrifying journeys, harsh detention experiences, and stressful acculturation processes, for 21 of the 23 children who endorsed PTSD stressors on the DISC-IV, the most prominent stressor dated back to pre-migration. In 10 instances, these related to the murder of a friend or loved one by gangs. Gang violence appeared to serve as both a chronic and acute stressor in children’s lives. Through practices such as cutting neighborhood phone lines, loitering around schools, and leaving dead bodies out in public for all to see, gang members managed to exert a daily, pervasive influence. Prior research has found that chronic exposure to violent neighborhoods can lead to a constant sense of danger (Overstreet & Braun, 2000) and chronic emotional and physiological hyperarousal (Schell, Marshall, & Jaycox, 2004). This threatening atmosphere was reinforced by children’s direct experience of gang violence, such as being assaulted outside school, having a relative or neighbor killed, being caught in the crossfire of a shooting, and through targeted attacks that left family and friends dead. Families’ awareness that institutions such as their schools and even the police were not equipped to keep them safe likely added to their chronic sense of insecurity and helplessness (Booth, Ayers, & Marsiglia, 2012).

Physical abuse has, compared to gang violence, received limited attention in the literature on unaccompanied children. However, over a third of children in the sample had been subjected to this form of violence prior to migration. Even compared to the other extreme stressors to which children were commonly exposed, physical abuse appears to have been particularly destructive, reflecting the broader literature on the impact of abuse on children’s mental health (e.g., Brown, 2003; Petersen et al., 2014). In bivariate analyses, it emerged as one of the only individual stressors predictive of past-year psychopathology; in eight of the nine cases in which the child had a history of physical abuse, they had a past-year diagnosis. Moreover, the impact of
this abuse often extended into the present. Of the six children in the sample identified on the DISC-IV as having past-month diagnoses with severe functional impairment, four had been physically abused. Consistent with diathesis-stress models (e.g., Monroe & Simons, 1991), unaccompanied children who are abused or neglected frequently suffer multiple risk factors, to include exposure to high levels of violence outside as well as inside the home and the absence of a supportive caregiver to provide emotional support and help them access other protective resources. However, the literature suggests a multifactorial relationship between childhood abuse and other contextual factors in determining mental health outcomes (Petersen et al., 2014), and some children who were abused in our sample also had access to a range of supports.

The age at which children were separated from their parents was also associated with psychopathology in our sample, with children whose parents left when they were older at greater risk. By contrast, length of separation was not associated with psychopathology. The relationship between separation age and psychopathology was likely partially explained by the strong, potentially confounding relationship between abuse and separation age. When children were left later, they were more vulnerable to poor treatment by the adults who took over their care, whereas children separated at a young age seemed to enjoy close, parent-like relationships with their replacement caregivers. Moreover, these children whose parents left when they were older likely also experienced a greater sense of loss, as well as other psychological sequelae of disrupted attachments (Schuengel et al., 2009).

Overall, it appeared that the chronic, distal stressors that children endured in the pre-migration period were more impactful than the acute, proximal stressors that they experienced during their journeys, following apprehension, and during the post-migration period. However, this should not obscure the severity of the migration stressors to which the children in this
sample had been exposed and the urgent need to address the issues they presented. Speaking about children’s journeys, families described a migration route so dominated by gangs that some level of exposure to them was practically inevitable and along which threats, kidnappings, witnessing violence against other travelers, and bribery by corrupt officials were almost routine. Potentially lethal trains and perilous walks through the desert were also all too common hazards. Although the U.S. and Mexican governments have put some measures in place to address these dangers (Dominguez Villegas, 2014; Selee, Arnson, & Olson, 2013), families’ accounts suggests that current protections are insufficient. Further work is also required to improve the treatment of children in CBP detention. The poor conditions children described with alarming regularity were also disturbingly similar to those mentioned in media reports (e.g., Redden, 2014) and legal complaint documents by human rights organizations (e.g., Huebner et al., 2014), including being kept in cold conditions so common that the cells are collectively referred to as hieleras (iceboxes), overcrowding, withholding of information and rights to communication, and hostile treatment by some officials. Less than a fifth of children in the study had found lawyers, reflecting low rates of representation observed in the broader population of unaccompanied children in immigration proceedings (TRAC, 2014). This finding is even more striking given that so many of the children in the study appeared to have endured the types of abusive experiences and exposure to violence that might make them eligible for immigration relief (UNHCR, 2014) and the very low rates of successful immigration claims observed in unrepresented children (TRAC, 2014). Unless they found immigration attorneys, many of the children in our sample with strong potential claims for relief might nevertheless have been deported.

The particular impact of pre-migration stress in this sample may also partially be a function of the study sampling process, which selected predominantly for children reunified with
family members in the United States after relatively short periods of detention. This reunification sample may have been more likely to experience certain pre-migration stressors (e.g., long separations from parents prior to migration and associated risk of abuse by replacement caregivers) but they also appeared less susceptible to many post-migration stressors. Unaccompanied youth who remain in detention for longer periods, who are not resettled to family members, or who are over the age of 18 may experience a variety of factors such as homelessness, discrimination, and restricted access to education (Feerick Center & Vera, 2015) that were rarely mentioned by families in our study. However, even if family reunification represents a best case scenario for unaccompanied children, this sample faced considerable post-migration challenges, many of which have been linked with psychopathology in migrant children (see review by Fazel et al., 2012): reestablishing relationships with family after long separations, adjusting to life in a foreign culture, academic disparities, learning a new language, establishing a new friend group, discrimination, financial pressures, and managing a stressful and uncertain legal process. Moreover, children navigated these difficulties while coming to terms with separation from loved ones at home and with no way of knowing if and when they would see them again.

The study design and small sample size precluded the possibility of investigating mediating and moderating factors in the relationship between psychosocial stressors, supports, and mental health outcomes in this sample. However, the findings on stressors experienced by children in the study were suggestive of a risk pathway whereby exposure to certain pre-migration stressors that impact children’s internal coping resources may have compromised their ability to navigate later, external forms of adversity and to access supportive resources. Chronic exposure to stress, physical abuse, and disrupted attachments of the type commonly reported in
the sample are all associated with neurological, physical, and psychological changes that impact many aspects of children’s development and wellbeing: their ability to regulate their emotions and other executive functioning capacities such as attention, planning, and behavioral inhibition; their ability to trust and relate to others; and their physical and emotional responses to subsequent stressors (Margolin & Gordis, 2000; Putnam, 2006; Schuengel et al., 2009). Children impacted in this way would likely have more difficulty coping with the acute stressors reported by unaccompanied children, such as negotiating journeys to the United States through areas patrolled by gangs and acclimating to new schools in NYC. They would also have more difficulty accessing supports such as counseling in child shelters and peers in their new communities. Hobfoll’s resource caravans concept (2012) provides a model for this cascading effect, whereby acquisition or loss of certain key resources (in this case the emotional and interpersonal regulation skills associated with attachment relationships and trauma) informs subsequent resource gain and loss. It is also consistent with a social ecological perspective, whereby multiple factors at different layers of influence, from the personal to the institutional, appear to combine in influencing risk and resilience pathways in unaccompanied children.

**Psychosocial supports received during migration process (Research Question 1c).**

Analyses of children’s psychosocial supports reflected a social ecological model with protective and promotive resources arranged by familial, community, and broader cultural, institutional, and structural levels. Social ecology paradigms have been applied in the literature on children’s responses to extreme stressors in both domestic (e.g., Luthar, 2003; Masten, 1994) and global mental health (e.g., Betancourt & Khan, 2008; Tol et al., 2013) settings, and several principles of this literature were particularly apparent in the supports received by children in the study. Factors at different systemic levels interacted with each other to create a web of supportive resources
(e.g., the changes in U.S. immigration policy that have facilitated the release of children to family members pending their immigration cases, who in turn help their children access other needed resources such as school and healthcare). Supports played not only a protective role in mitigating the impact of stressors (e.g., organizations like Grupos Beta who try to assist children’s safe passage along the dangerous migration routes through Mexico) but also a promotive role in helping children maintain or resume normative experiences to facilitate their healthy development (e.g., extra-curricular programs providing children with access to sports, dance, and theater). The impact of potential supports was frequently context-specific (e.g., children’s experience of child shelters varied based on their journey and apprehension experiences) and time-specific (e.g. the changing nature of child-parent relationships while separated and following reunification). Certain supports at critical junctures in children’s migration process (e.g., counseling in child shelters following difficult journeys) or which helped access other resources (e.g., enrollment in school in NYC) appeared particularly significant in assisting children.

Statistical analyses investigating the role of specific psychosocial supports in protecting against psychopathology and promoting positive outcomes were beyond the scope of this small study. However, some supports observed in our sample echoed protective factors identified from previous research with displaced children (Fazel et al., 2012): high levels of parental support and family cohesion; supportive peer relationships; positive experiences and sense of belonging at school; living in a community with people of the same ethnic origin; and feeling safe in one’s environment. In addition to these supports common to migrant children, a number of policies and resources have been put into place in recent years to address the specific needs of unaccompanied children coming to the United States. Although to date there has been little
research assessing the impact of these initiatives, families repeatedly alluded to the importance of factors including: Mexican programs to protect children during their journeys such as Casas del Inmigrante and Grupos Beta; rapid transfer of children from enforcement-oriented Customs and Border Protection detention to protection-focused shelters under the auspices of the Office of Refugee Resettlement; psychosocial programming in child shelters (e.g. counseling, educational service, and legal orientations by advocacy organizations like ProBAR); release of children to community settings (including parents, regardless of their immigration status); and access to public education and health insurance. Future research is needed to assess the ways in which these resources facilitate positive outcomes in unaccompanied children.

Multiple studies have identified parental support as a key supportive factor for displaced children (e.g., Berthold, 2000; Kovacev & Shute, 2004; Rousseau, Drapeau, & Platt, 2004). These studies have tended to focus on the role of parents as a protective factor against psychopathology in the post-migration period. However, our study underscored the importance of support from parents throughout children’s migration process, and in promoting children’s development and wellbeing as well as protecting them from the impact of psychosocial stressors.

One particularly important way in which parental support may have served a promotive function for children in the study is by facilitating positive attachment relationships. Although this study did not include a formal, standardized measure of attachment, qualitative analyses suggested that the quality of children’s relationships with their parents played an important role in their wellbeing. Many children who had formed strong attachments to their parents as young children had been able to maintain these close relationships remotely over many years following their parents’ departures. This emotional support from afar frequently helped children navigate the daily adversity to which they were exposed in their home countries, allowed them to retain
hope for eventual reunions and better futures, and eased the adjustment to living with parents again following reunification in NYC. In other instances when children’s parents had left when they were very young, children appeared to have formed primary attachment relationships to the other family members who assumed responsibility for their care. These relationships often provided a vital source of support, security, and stability to children both prior to migration and then from afar following their reunification with parents in the United States. Whether parents or other family members served as primary attachment figures, and in keeping with attachment theory (Bowlby, 1988), primary attachments appear to have facilitated secondary ones, facilitating children's multiple transitions between caretakers. Children in the study with close relationships—to parents, replacement caregivers, or both—appear to have possessed other, individual characteristics associated with secure attachment such as strong emotion and behavior regulation, flexible coping, and good social skills (Cassidy, 1994; Nachmias et al., 1996). These qualities likely served an important protective function in response to the types of chronic stressors many children described, where either acting out or internalizing reactions in response to gang provocation, domestic violence, and other challenges children faced would likely have carried grave consequences. In addition, the strong emotional, social, and behavioral functioning associated with secure attachments may have facilitated other promotive and protective factors such as high academic motivation and achievement and close relationships with extended family and peers.

Children in the study appeared to benefit from parental relationships not only as a source of emotional support but also structure, not least in protecting them from becoming involved in the gang activities to which they were frequently exposed. Parental control has been identified as a factor than can either be protective or contribute to behavioral issues depending on other
variables such as whether the children live in areas with high levels of crime (Sameroff, Gutman, & Peck, 2003). Several parents in the study reported having concerns prior to their children’s migration that they might be recruited into gangs and acted quickly to bring them to the United States when disciplinary problems became apparent. It is also possible that the authoritarian parenting displayed by some replacement caregivers, although at times it became abusive, was at least partially intended to help keep children out of trouble. It is hard to disentangle the impact of internal characteristics (e.g., strong self-regulation and behavioral inhibition) and external supports (e.g. high parental involvement) in this sample of children who presented with low rates of externalizing disorders. They also represent a selective cohort of children who fled rather than joining the gangs who court and threaten young people in equal measure. Likely, the support and structure children received from parent figures combined in protecting children and promoting adaptive, prosocial responses to the violence they experienced.

Parents also provided a critical role in supporting their children by helping them access other needed resources; indeed, it was this need to provide for their children that had driven many parents to separate from their children in the first place. Previous research (e.g., (Betancourt & Khan, 2008) has identified the complementary roles provided by emotional, instrumental, and informational support for children in high-risk, resource-poor settings. With regard to instrumental support, parents sent money home to their children to pay for basic, tangible commodities such as food and clothing. They also used financial assistance to bypass obstacles to resource access, such as the mother who paid a driver to take her children to school safely through their gang-afflicted neighborhood so that they could continue their education. In addition, parents provided informational support from afar, such as parents who liaised with children’s teachers, psychologists, attorneys, and other local advocates in their home countries to
support children’s wellbeing. In other instances, different forms of support were combined, such as the mother who paid for her daughter to have a large quinceañera, a symbolic gesture that appeared very meaningful for her child. In these different ways, parents remained actively present and supportive in their children’s lives, mitigating the potential disruptions in attachment caused by long separations.

Beyond the support received from parents and other caregivers, and in keeping with social ecology theory and its application to the global mental health context (e.g., Betancourt & Khan; 2008; Tol et al., 2013; Ungar et al., 2013), children in the study benefited from a network of interacting resources at the wider familial, community, cultural, institutional, and structural levels throughout their migration processes. For many children, the fragmentation caused by their parents’ departure appeared to have been mitigated by growing up with siblings and surrounded by large, extended families. At the community level, and echoing other research with immigrant children (e.g., Berthold, 2000; Kovacev & Shute, 2004), support from peers and engagement in school, church, sports, and other local activities appear to have been promotive in fostering a sense of community in both the pre- and post-migration periods. Participating in prosocial activities with peers may also have been protective against children becoming involved with gangs (Fergus & Zimmerman, 2005). For children negotiating disjointed home lives, uncertainty about the future, and dangerous communities, investment in school appeared to provide a welcome focus, structure, and sense of forward movement. Given the particular importance of education as a protective factor for migrant children (Fazel et al., 2012), future studies with unaccompanied children should seek to understand the factors underpinning this relationship in more detail.
At the cultural level, the normalization of migration from Latin American to the United States and the culture that has grown up around this was an important support for children: it gave a context to help them understand separations from their parents; it generated a culture of support from extended family and community networks in their home countries; it included assistance from local people and churches on the migration route; and it eased the acculturation process for unaccompanied children arriving in NYC. Some institutional resources, such as the governmental (e.g., Grupos Beta) and non-governmental (e.g. Casas del Migrante) organizations supporting children during their journeys through Mexico, served a protective function for unaccompanied children. Others institutional resources, such as the schools in which children enrolled in NYC, served a promotive function in providing children with normative educational and social experiences, while at the same time providing access to protective resources such as health, mental health, and academic support through their counseling programs. At the structural level, improvements in the treatment of unaccompanied children in the U.S. immigration system brought about by the Flores Agreement, the Wilberforce Trafficking Victims Protection Reauthorization Act, and other legislative and policy changes over recent years—in particular laws protecting children against deportation without due process, separating the government’s prosecutorial and caretaking responsibilities, and mandating the release of children as quickly as possible to the least restrictive setting possible (Byrne & Miller, 2012)—had a profound, multi-level supportive impact.

There is increasing focus in the global mental health intervention research on harnessing cultural, institutional, and structural resources in intentional ways to foster wellbeing, focusing both on critical moments for intervention in children’s risk and resilience pathways and factors that can be leveraged to foster additional resource gains (Ager et al., 2013). Rutter (2013) has
used the term *turning points* to describe key moments in children’s developmental trajectories when the availability of a resource (or lack thereof) has a particular impact on subsequent outcomes. For many children in our study, their transition from Customs and Border Protection immigration detention facilities to Office of Refugee Resettlement child shelters appeared to represent one such turning point, when they began to put harrowing pre-migration and migration experiences behind them and started the process of reunion with their parents and adaptation to life in the United States. Over and above removing children from the stressful and frequently adversarial conditions in immigration detention, ORR shelters appear to have provided an opportunity for psychological triage after difficult journeys and CBP detention experiences. Educational and recreational programming reintroduced normative childhood activities, allowing unaccompanied children to begin to act like children again. Counseling provided children with some symptom relief and coping skills, and in some cases might have helped to remove stigma and lay the groundwork for continuing mental health services following release. Legal orientations and close communication and coordination with family members may have served to buffer the acculturation challenges of the post-migration period. Future research should seek to assess the contribution of child shelter programming to unaccompanied children’s risk and resilience processes and these findings should be used to develop and disseminate best practices for this critical juncture in children’s migration processes.

Another key concept in social ecological models of intervention, related to Hobfoll’s notions of resource caravans and caravan passageways (Hobfoll, 2012), is the fostering of environmental conditions that assist in the accumulation of additional supports and protect against further resource loss (Ager et al., 2013). In the context of unaccompanied children’s post-migration adjustment, changes in government policy allowing the release of children to family
members irrespective of their immigration status has opened up access to a variety of resources previously unavailable to the majority of unaccompanied children. In the short term, the possibility of release to undocumented family members meant that some families in our sample opted to have their children surrender themselves to U.S. immigration authorities at the border, so avoiding the perilous walk through the desert or ongoing exploitation by traffickers that befell some children who attempted to continue their journeys undetected. In the longer term, release to family members protected children from the potentially harmful impact of prolonged immigration detention (Bhabha & Schmidt, 2006; Women’s Refugee Commission, 2009), allowed them to start the process of adjusting to living with their parents again, and meant they were able to go through their stressful immigration process with the support of family. It also assisted children’s acculturation process by placing them in a developmentally normative environment in which they could take advantage of community resources such as school, extracurricular activities, and new friend groups and participate in NYC’s large Latino community. Parents were also ideally placed to act as advocates for their children in facilitating access to other needed services such as healthcare and English-language learning programs. In this way, release to parents helped children acquire additional protective and promotive resources.

Taken together, and consistent with the child refugee resilience literature (e.g., Betancourt & Khan, 2008; Maegusuku-Hewett et al., 2007), many of the most important psychosocial supports identified by children in the study (e.g., family, school, peers, and extracurricular activities) are only psychosocial interventions in the broadest sense. Access to such resources is also a fundamental human right enshrined in domestic and international law (Androff, 2016). Moreover, at the point when children had been provided access to an appropriate environment (i.e., resettled to family in the community), most key psychosocial
resources were available to them with minimal need for additional accommodations, infrastructure, or public policy burden: children were able to enroll in school and public health insurance through existing processes for undocumented youth, to participate in English language programs, to join Latino church communities, and to participate in established extra-curricular activities. Future research and policy should continue to identify and promote key gateways to these and other important psychosocial resources. These efforts should be combined with targeted policies to improve the availability of supports more specific to unaccompanied children’s needs, such as legal representation and, potentially, specialized mental health interventions focused on the particular migration challenges faced by these youth.

**Children’s experience of distress and coping and their attitudes towards their migration process (Research Question 1d).** The children in our survey presented with varied, frequently complex thoughts, feelings, and reactions regarding their migration. Often, children reported distress about separations from family, but also derived comfort and meaning from attachments to absent loved ones. Some indicated that they had been deeply impacted by traumatic experiences prior to and during their migration, while at the same time stressing their mental fortitude and ability to overcome hardship. At times children opted to acknowledge and address feelings, and at other times they distanced and distracted themselves from them. Many children were highly ambivalent about being in the United States, but also were committed to making a success of being here.

Many of the characteristics children presented in describing their personal responses to their migration experiences have been identified with good outcomes in the resilience literature: self-esteem (Fergus & Zimmerman, 2005; Tol et al., 2013), planning capacity (Rutter, 2013); decision-making skills (Fergus & Zimmerman, 2005), internal locus of control (Betancourt &
Khan, 2008; Luthar, 1991), sense of agency (Rutter, 2013; Tol et al., 2013), optimism (Goodman, 2004; Tol et al., 2013), self-control (Fergus & Zimmerman, 2005), positive attachment relationships (Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003), psychological flexibility (Bonanno & Diminich, 2013; Tol et al., 2013), positive attitudes towards school (Fazel et al., 2012), academic achievement (Fergus & Zimmerman, 2005), social competence (Luthar 1991), attachment to one’s cultural identity (Maegusuku-Hewett et al., 2007), and religious beliefs and practices (Carlson, Cacciatore, & Klimek, 2012; Tol et al., 2013).

Frequently children described culturally informed attitudes towards distress that appeared highly adaptive. For example, most children described feeling sad about family left at home, but even when they reported intense distress about missing relatives they tended to see this as normative rather than pathological. Familial closeness and interconnectedness, sometimes referred to as familismo (WALS, 2008), are widely accepted and prized in Latino families. While values such as familismo may have helped normalize children’s feelings about separations, other Latino cultural values, such as prizing emotional stoicism, may have influenced their expression of these feelings. For example, marianismo refers, among other qualities, to the prizing of women’s forbearance and carrying the burden of their own distress (Vasquez & Rosa, 2011), while, machismo encourages males to show strength, protect family, and not display vulnerability (WALS, 2008). In keeping with these values, several children acknowledged feeling considerable distress to the study interviewers but reported that they hid their feelings from family members in order not to be a burden. Expressive flexibility, the ability to increase or limit emotional expression based on the context, has been identified as protective in the resilience literature (Bonanno & Diminich, 2013). For unaccompanied children, many of whom
move repeatedly between supportive and threatening environments, flexible expression of emotion may be particularly protective.

Some families reported more evidently pathological experiences of children’s distress. Several children described somatic complaints such as rashes and headaches in response to distress, in keeping with other studies that have documented elevated rates of somatization in Latino migrant populations (APA, 2012). Others reported trauma symptoms such as intrusive memories and hyperarousal in response to reminders of past stressful events. Several younger children were having behavioral problems at home or in school. Some children acknowledged depression symptoms such as rumination or suicidal ideation. All of these symptoms have been observed in prior research with unaccompanied children (e.g., Baily et al., 2014; Bhabha & Schmidt, 2006; Women’s Refugee Commission, 2009). In some cases where children had more severe symptoms, they were reluctant to talk about their distress with loved ones. In several instances, this appeared related to children’s history of abusive relationships and associated difficulties trusting others. However, even in situations where children were suffering with significant psychiatric symptoms, they appeared to continue to make progress at school, in developing family and peer relationships, and in acculturating to life in NYC. This ability to stay engaged in developmentally normative activities even while symptomatic, and to derive one’s identity from these activities rather than mental health problems, are important facets of resilience (Barber, 2013; Bean, 2006; Ungar et al., 2013).

Children described coping with their migration process in a variety of ways. Some emphasized attitudes and personality traits that had enabled them to cope, others described specific cognitive, behavioral, and emotional strategies they had employed, while a number emphasized the role of faith in their migration process. For many children, the decision to take
control of their lives by leaving environments where they had repeatedly been victimized, their
navigation of the journey to the United States, and their successful reunification with parents and
other loved ones all appear to have provided them with evidence of their own fortitude and
confidence in their ability to endure and overcome further, post-migration challenges. Children’s
belief in their ability to marshal their internal and external resources and achieve their goal of
coming to the United States is closely aligned to Bandura’s concept of self-efficacy (Bandura,
1997), a personality trait that has frequently been linked with resilience in the literature (e.g.,
Hamil, 2003; Rutter, 1987).

At the same time, children’s belief in their own resourcefulness often appeared to be
rooted in a strong, internalized sense of their cultural heritage. Prior research (e.g., Berkel et al.,
2010; Umaña-Taylor et al., 2014) has identified the important role played by identification with
cultural values and ethnic pride in Latina/o youth in the United States. Children also described
feeling empowered by ongoing attachments to loved ones in their home countries. Previous
research with unaccompanied children (Goodman, 2004; Ressler et al., 1988) has examined how
internalization and idealization of relationships with loved ones left at home can provide a sense
of purpose and be an important, ongoing source of inspiration and motivation. For many children
in our study, internalization of cultural values and relationships from home appeared allied with
identification with American culture. In particular, several children articulated a belief that the
United States is a country that provides opportunities to people with the type of courage,
determination, and agency they had demonstrated through their migration experiences. This
likely contributed to the optimism expressed by many children, another trait frequently linked
with resilience in the literature (e.g., Karademas, 2006; Riolli, Savicki, & Cepani, 2002), as well
as contributing to behaviors associated with resilience, such as academic endeavor and achievement orientation (Radke-Yarrow & Brown, 1993; Richardson, 2002).

Children in the study also described incorporating a variety of behavioral coping strategies. These included distracting from distressing thoughts and feelings, intentionally replacing painful thoughts and emotions with more positive ones, relaxation strategies, and prayer, and reflect previous findings on coping in unaccompanied children (e.g., Goodman, 2004; Maegusuku-Hewett et al., 2007). Often, children used different strategies at different times, a phenomenon termed coping flexibility that has been shown in multiple studies to contribute to resilience (Bonanno & Diminich, 2013). Children’s faith appeared protective in a variety of ways: as a reassuring presence during dangerous journeys; through the use of prayer as a distracting, anxiety-reducing activity; to provide a sense of predictability and control during uncertain detention and legal processes; to assuage children’s loneliness in dealing with distress on their own; and to help overcome hardships with the thought that things happen for a reason and based on a divine plan. Previous research with unaccompanied children in the United States (Carlson et al., 2012; Goodman, 2004) has found prayer and faith to be protective against the adversities of the migration process.

Consistent with a “migration of the fittest” hypothesis (Escobar, 1998) unaccompanied children may represent a subset of exceptional children who not only make the bold decision to leave their home countries but also succeed in navigating the perilous journey north (Baily et al., 2011). Certainly many of the children in this sample displayed remarkable coping resources (e.g., courage, self-possession, agency, planning skills, and intelligence) that might support such a claim. However, sometimes unaccompanied children’s remarkable survival skills may obscure other psychological, social, and emotional difficulties with which they may be struggling and
require assistance (Piwowarczyk, 2006). Moreover, when considering children’s adaptation, there can be a tendency to overemphasize children’s individual coping and attitudes and neglect the importance of environmental resources in contributing to acculturation (Ryan et al., 2008). A social ecological perspective blends these views, suggesting that an individual’s personal attitudes and coping resources are informed by the availability of environmental resources at the familial, community, and broader systemic levels (Ager et al., 2013). Reflecting such a model, many children’s mixed feelings about their migration appeared closely linked to their conflicting experience of resources lost (e.g., the support of de facto parents in their home countries, extended familial and social networks, and sense of community) and resources gained (e.g., reunification with loved ones, safety, access to school, future opportunities). This may explain apparently contrasting views expressed on the A&A, on which the great majority of children reported that they like and want to live in the United States, every child wanted to learn English, and almost all aspired to getting an education and training in a profession, but at the same time almost half acknowledged life here is sometimes difficult and most acknowledged some desire or uncertainty about whether they wanted to return home.

A resource-focused perspective also helps understand children’s attitudes towards their treatment within the U.S. immigration system and their deportation proceedings. With the exception of their experiences in Customs and Border Control detention facilities, children in our sample expressed largely positive views of the U.S. government and its treatment of immigrant children. The possible influence of demand characteristics in relation to this sensitive topic should not be discounted. However, a variety of structural factors may have served to make this particular subset of unaccompanied children feel protected and cared for by the government: rapid release from detention facilities to more child-friendly shelters where they invariably had
more positive experiences and typically trusted their needs were being advocated for; reunification with loved ones in the community; and easy enrollment in schools with supportive peers and English language programs for predominantly Spanish-speaking students. These largely positive perspectives differed starkly from those of the NYC unaccompanied youth from the participatory action research study (Feerick Center & Vera, 2015), many of whom were older, without family, had been unable to access education and healthcare, and felt discriminated against. Thus, unaccompanied children’s coping and perspectives on their immigration processes appear closely linked to the impact of government policies on the availability of resources at other levels of children’s social ecology.

At the same time, deportation proceedings presented a devastating threat to the resources that children in our study were beginning to acquire in the post-migration period. Most children in the sample had intended to come to the United States undetected. However, per Hobfoll’s concept of resource caravan passageways (2012), many spoke about the ways in which regularizing their immigration status might help them access additional resources, in particular the right to visit family back home, work legally in the United States, and pursue further education after finishing high school. Furthermore, and in keeping with their focus on resilience and reasons for coming to the United States rather than victimization and factors causing them to leave home, some children alluded to a belief that their cases would be judged as much on the children’s willingness and capacity to contribute to U.S. society as on their need for protection, often leaving children optimistic about their outcomes.

**Aim 2: Mental Health Diagnosis**

The dynamic interrelationship between children’s high level of exposure to stressors, varying access to supportive resources, and personal narratives of resilience evident from
findings on children’s psychosocial context were also reflected in the sample’s mental health presentations. Their traumatic experiences and distress were apparent in the extraordinarily high rates of anxiety and mood disorders found in the sample. At the same time, many of these children’s symptoms appeared to be improving following reunification with family and resumption of normal childhood activities. Many children’s distress appeared focused on separations in ways that, even when quite severe, felt normal and non-pathological to them and did not impede their ability to engage in important functional activities like going to school and making new friends. Reflecting a stoicism that in many ways appeared protective, children appeared to understate their symptoms when presented with a self-report format. Their guardians were frequently not aware of their distress but more likely than the children themselves to report behavioral problems, in some cases perhaps reflecting a common concern that their children could assume the delinquent behaviors to which they had been exposed.

To this author’s knowledge, no previous study has assessed psychopathology in migrant children from El Salvador, Guatemala, Honduras, or Ecuador using a standardized diagnostic interview such as the Diagnostic Interview Schedule for Children. While this represents a new contribution to the literature, it also means it is difficult to ascertain the validity of our findings on unaccompanied children’s mental health presentation. In addition to the very high rates of diagnosis observed, the relative frequency of different diagnoses was also very different from typical U.S. samples. For example, whereas almost half the sample met full criteria for a separation anxiety diagnosis, only one child met criteria for a diagnosis of PTSD. These discrepancies are likely associated with variety of contextual factors: unaccompanied children are exposed to extreme levels of adversity compared to most U.S. youth populations; the particular life experiences of unaccompanied children may have increased their vulnerability to
certain diagnoses such as separation anxiety disorder; given cultural differences between the United States and Central America, some mental health problems may manifest in different idioms of distress (e.g., cross-cultural variations in the presentation of traumatic responses); and some normative distress related to aspects of children’s journeys (e.g., fear during their journeys through Central America) may nevertheless lead to endorsement of diagnoses in a decontextualized, structured interview. In the future, criterion validity testing of the DISC-IV for use with Central American youth, for example through comparison with clinician ratings of psychopathology including consideration of local presentations of distress, would greatly increase confidence in findings.

In addition, the reliability and validity of the study’s mental health assessment data may have been affected by other instrument- and participant-related artifacts and confounding factors. In some instances, participants’ engagement and comprehension on the DISC-IV may (especially in the case of younger children) have been limited by the lengthy administration time and a lack of familiarity with the mental health concepts being assessed. However, where there was overlap with other instruments (e.g., stressors repeated on the DISC-IV PTSD module and the Stressful Life Events questionnaire), reporting was extremely consistent. Children and guardians’ responses may also at times have been influenced by impression management and demand characteristics, although participants appeared very conscientious in answering questions as accurately as possible. The reliability of guardians’ reporting of children’s symptoms may have been limited by the typically short time since reunification, averaging less than four months. This may explain why, on the DISC-IV, children self-reported past-year but not past-month diagnoses more than their guardians. Overall, discrepancies between child and caregiver reporting of diagnoses were very common, reflecting findings from research using the DISC-III (Jensen et al.,
(Kramer et al., 2004) and suggesting the importance of interviewing both children and their guardians when assessing unaccompanied children for mental health difficulties. These methodological caveats should be kept in mind while considering the results on children’s mental health diagnoses.

**Rates of mental health diagnoses (Aim 2a).** The results from the DISC-IV partially supported the study hypotheses on diagnostic prevalence: children in the study had elevated rates of internalizing disorders compared to both the general adolescent population and other immigrant youth (including service-seeking adolescents). However, they did not show significantly higher rates of externalizing disorders compared to a general sample of youth in the community, and demonstrated lower levels of conduct problems than service-seeking youth. Reflecting common findings from the epidemiological and cross-cultural mental health literature (e.g., Bird et al., 1990; Kirmayer, 2001; Shaffer et al., 1996; van Ommeren, 2003), diagnostic rates varied depending on inclusion of functional impairment criteria, examination of past-year versus past-month prevalence, and consideration of cultural variations in the manifestation of normative and non-normative distress. However, at every level of comparison, rates of diagnosis in this sample remained extremely high.

Children in the sample presented with exceptionally high rates of diagnosis on the DISC-IV: based on symptom criteria alone almost 70% of the sample had at least one past-year diagnosis and even when including criteria for moderate functional impairment over 50% of the sample presented with one or more diagnoses. This closely mirrored findings from our previous research (Baily et al., 2014), in which lawyers expressed mental health concerns about approximately half of their unaccompanied child clients (based on the last three children observed by each lawyer). Large epidemiological studies that have used the DISC-IV (e.g.,
Canino et al., 2004; Garland et al., 2001; Roberts et al., 2007) and other measures (e.g., Merikangas, He, Brody, Fisher, Bourdon, & Koretz, 2010) to assess psychopathology in youth in the United States typically estimate past-year prevalence rates for any disorder to be 10 to 25%, depending on the population surveyed (e.g., community versus service-receiving) and the inclusion of functional impairment criteria. The much higher rates of diagnosis observed in our sample were driven by particularly elevated levels of internalizing disorders, whereas rates of externalizing problems were comparable to or lower than those observed in U.S. comparison groups. They are similar to diagnostic prevalence rates observed among child survivors of conflict in some of the world’s most troubled regions (e.g., Attanayake, McKay, Joffres, Singh, Burkle, & Mills, 2009; Betancourt et al., 2012; Murthy & Lakshminarayana, 2006).

Separation anxiety disorder was both very common in our sample and frequently impairing. Half the sample met criteria for a past-year diagnosis based on symptom criteria alone, all but one of these children had associated functional impairment, and SAD was equally common in younger and older children. SAD diagnoses frequently persisted into the post-migration era, with over a quarter of the sample retaining a SAD diagnosis with associated impairment in functioning. By contrast, lifetime prevalence of SAD in the United States is estimated at approximately 3 to 8%, with the majority of cases occurring in children under the age of 12 (Beesdo, Knappe, & Pine, 2009). Many aspects of unaccompanied children’s situation likely place them at risk for the development of symptoms associated with SAD: long periods of separation from parents combined with living in dangerous pre-migration environments; children’s often sudden departures in response to acute threats; a state of legal limbo curtailing any possibility of children seeing family left at home in a foreseeable future; the continued perilous situations faced by many loved ones in their home countries; and the ailing health of
older relatives who were no longer able to take care of children. In addition to these contextual factors, the particular cultural value placed on family relationships in many Latin families may have increased separation-related distress. Familismo is typically presented as a protective factor against psychopathology in Latino families (e.g., Ayón, Marsiglia, & Bermudez-Parsai, 2010). However, for some unaccompanied children, suddenly finding themselves separated from families with whom they are very interdependent may constitute a psychological crisis almost akin to a loss of self. As one girl with a SAD diagnosis wrote about the ailing grandparents she had left in Honduras: “I don’t want anything to happen to them, because I don’t know what I would do, what I would think. I think that if something happens to them I’ll die, my life will no longer have meaning.” Regardless of whether the presentation of SAD symptoms in our sample matched the typical syndrome profile seen in U.S. children and adolescents, they caused considerable amounts of distress.

Given the extraordinarily high rates of exposure to extreme stressors in our study, the relatively low rates of PTSD diagnosis are surprising. Whereas almost 90% of the sample endorsed one or more PTSD Criterion A stressor items on the DISC-IV, only three children met symptom criteria for a past-year PTSD diagnosis on the measure. With the inclusion of functional impairment, only one child had a past-year PTSD diagnosis and none had a past-month diagnosis. These rates are similar to those observed in U.S. adolescents, among whom the lifetime prevalence of PTSD is approximately five percent (Merikangas et al., 2010b). By comparison, the point prevalence of PTSD in refugee children displaced to Western countries has been estimated at seven to 17% (Fazel, Wheeler, & Danesh, 2005).

One potential explanation for the low rates of PTSD observed in our sample is that their trauma responses manifested in different ways. Reflecting the growing literature that suggests
that trauma responses are often culturally informed and typically predicted less by exposure and reaction to specific noxious events (the PTSD model) and more by resource loss associated with adverse events (e.g., DeSalvo et al., 2007; Ironson et al., 1997; Laban et al., 2008), it is possible that the types of chronic stress and resource loss children in our sample had experienced lent themselves less to PTSD than other forms of psychopathology. In this way, they may differ from other populations of unaccompanied and other refugee children whose migration was prompted by a specific, defined act of violence or some similarly acute stressor that is more likely to provoke a PTSD-type response. For example, many of the children in the study by Geltman and colleagues on Sudanese unaccompanied refugee youth in the United States had fled their country after their villages were burned down and their parents murdered. In their sample, 20% of children screened positive for PTSD (Geltman et al., 2005), and in qualitative interviewing many children linked their symptoms to specific memories of those traumatic events (Goodman, 2004). Similarly, in the study of unaccompanied asylum-seeking youth in Norway by Jacobsen and colleagues, in which the majority of participants were fleeing war in Somalia and Afghanistan, PTSD was the most common diagnosis, with a prevalence of 30.6% (Jakobsen et al., 2014).

Linking trauma response to resource loss, Hobfoll (2014) has argued that because resources are environmentally embedded, expressions of trauma will be culturally-influenced and reflect local idioms of distress. Given the emphasis on family in Latin American culture and the familial separations and violence that were such a consistent stressor, it is not surprising that children felt losses (actual or threatened) in this domain particularly keenly. This constellation of fears is represented by many of the criteria contained in the SAD module (e.g., distress about being separated from attachment figures, fear of loss or harm to them, nightmares about
separation, and somatic symptoms following separation). From this perspective, the SAD diagnoses so frequently endorsed by children in the study may perhaps be viewed as a culturally specific trauma response.

Some types of psychopathology appear largely to have resolved in the post-migration period. For example, almost 20% of the sample met symptom and functional impairment criteria for past-year major depression on the DISC-IV, compared to just one child with a past-month major depression diagnosis. Children faced with multiple pervasive stressors in their own countries might have been susceptible to feelings of helplessness and hopeless, mental states strongly linked with depression (Abramson, Metalsky, & Alloy, 1989). By contrast, making the decision to come to the United States, successfully completing their journeys, reunifying with family, and engaging in school and other new opportunities likely provided a strong sense of agency and mastery and thus a powerful anti-depressant effect.

In some instances, normative distress may have presented as psychopathology in the sample’s DISC-IV responses. For example, based on symptom criteria alone, over 40% of the sample met criteria for a past-year agoraphobia diagnosis, compared with the three to four percent 12-month prevalence estimates in the general adolescent population (Beesdo et al., 2009). However, the rate of agoraphobia in the sample more than halved with the inclusion of impairment criteria, and only one child met criteria for a past-month diagnosis of agoraphobia with functional impairment. This suggests the transient and largely non-imparing nature of the symptoms children endorsed in the agoraphobia module of the DISC-IV. Item analyses provided further clarity, suggesting that the majority of children’s fear were journey-related (e.g., concerning fear of traveling on buses and trains, going through tunnels and crossing bridges, and fearing being away from home alone). These “symptoms” mapped onto children’s accounts of
their harrowing journeys, traveling far from home on their own, evading capture by officials and gang members, witnessing fellow travelers fall to their deaths off trains and buses, and seeing the dead bodies of fellow migrants in train tunnels. The association of agoraphobia with older age in the study (the only statistically significant age by disorder relationship in the study) is likely explained by the fact that older children in the sample typically had less support during their journeys than younger children and thus were more exposed to, and impacted by, stressors along the route. Although these experiences were frequently terrifying, children’s fear typically dissipated quickly following removal of the stressors. This example also indicates the potential for pathologizing children’s experience and underestimating their resilience if one takes diagnoses derived from a structured interview at face value and without considering the triggering events and longitudinal context. However, it should also be noted that, owing to comorbidities with other disorders, removal of agoraphobia from analyses did not alter the total number of children in the sample who met criteria for at least one DISC-IV diagnosis.

The relatively low rates of externalizing disorders observed in the study, especially compared to internalizing diagnoses, match the low rates of behavioral problems observed in some other studies with unaccompanied children (e.g., Bean et al., 2007a; Sourander, 1998). As noted previously, unaccompanied children may represent a particular subset of youth from their countries, those who internalized rather than externalized their difficulties. Given the widespread delinquency in their countries, one self-evident response to stressors such as threats from gangs, abusive domestic relationships, and poverty is for children to act out behaviorally, join the gangs, and stay in their home countries. Delinquent behavior may also stem from PTSD, such as the angry and aggressive outbursts that can be a manifestation of hyperarousal and the substance use that may be a type of avoidance behavior (Perrin, Smith, & Yule, 2000). By
contrast, children in this sample tended to have internalized their distress (including their trauma reactions), sometimes leaving themselves targets for further victimization, and eventually driving them to seek a life elsewhere. In other instances, caregiver interventions rather than individual temperament may have helped reduce behavioral issues. In both instances where children met criteria for a behavioral disorder this was based on the guardian’s reporting of symptoms, and these guardians noted that their children’s behavioral problems were an important factor in their decision to bring them to the United States before they got into more trouble.

Although one child met criteria for past-year alcohol abuse based on her own reporting on the DISC-IV, no other child self-reported an externalizing disorder. Given the sensitive legal context, it is possible that some families may have avoided endorsing items relating to problematic behavior or substance use out of fear that admission of certain less favorable behaviors could have implications for their immigration cases (Baily et al., 2014). This fear may have been reinforced by children’s child shelter experiences, where some were told that their behavior and school performance would be taken into consideration by judges. While this may be motivating for some children, it may in some cases prevent families from coming forward to get needed help. However, there was little overt sign that children were engaged in impression management.

These inferences drawn from the DISC-IV results bear further examination with a larger cohort of unaccompanied youth. In addition to other methodological limitations mentioned previously, the accuracy of overall diagnostic rates and patterns was likely limited by the small sample size. This was perhaps especially true for between-group comparisons of diagnostic rates by gender, age, and nationality, where the small group sizes increased the likelihood of Type II error. For example, although the rate of past-year major depression in girls (27.3%) was more
than double the rate in boys (13.3%), consistent with epidemiological studies of depression in the general literature (e.g., Merikangas et al., 2010a), this difference was not statistically significant in our small sample. Similarly, it appeared that younger children may have been more prone to disruptive disorders (of the two children in the sample with such difficulties, one was aged 10 and the other 14) and less prone to mood difficulties (the youngest child with a mood disorder was aged 14), reflecting the established epidemiology of these disorders (Cohen et al., 1993). However, in statistical testing, age was not associated with either behavioral or mood disorders. However, a lack of clear moderating effect for variables such as gender and age in our sample may also in part be due to the complex interplay of multiple resources in determining children’s outcomes (Fazel et al., 2012). For example, younger children in the sample may have had less internal resources to cope with their journeys than some older children, but they had also typically experienced shorter separations and were more likely to be settled to parents, a strong protective and promotive resource.

These methodological considerations notwithstanding, taken together the very high rates of psychopathology observed in this study are reflective of unaccompanied children’s exposure to extreme adversity. However, in keeping with Conservation of Resources theory (Hobfoll, 1989, 2012) the patterns of diagnosis observed for disorders such as SAD, depression, agoraphobia, and PTSD suggest a mediating role for resource loss in determining the relationship between stressors and psychopathology. When distress (e.g., fear induced by terrifying journey experiences) was not associated with losing other valued resources, children tended to maintain good functioning in areas of their lives such as engagement with school and social activities. This also suggests that psychopathology, and in particular functional deficits associated with
psychopathology, may be limited by interventions to assist in the maintenance and restoration of children’s key resources (e.g., sense of security, parental support, and access to education).

**Reliability and validity of diagnostic screening measures (Aim 2b).** Analyses of data from the child- and guardian-report measures provided mixed support for their potential future use as screening instruments for use with unaccompanied children. The child-report Hopkins Symptom Checklist for Adolescents appeared to screen more effectively for internalizing than externalizing diagnoses (as assessed on the DISC-IV), although across all diagnoses children appeared to understate the severity of their symptoms relative both to their DISC-IV assessments and clinical cutoffs from other studies. The screening properties of the Reactions of Adolescents to Traumatic Stress questionnaire could not be assessed as no child met criteria for a past-month DISC-IV PTSD diagnosis. However, the internal consistency of children’s scores on the measure was poor. In contrast with the HSCL-37A, the guardian-report Child Behavior Checklist appeared to screen more effectively for externalizing than internalizing diagnoses, and established norms for caseness appeared appropriate for use with this sample. However, due to the constraints of the study design, all these findings on the reliability and validity of the screening measures should be considered exploratory and preliminary: this was a small sample; the DISC-IV, against which the screening measures were compared, has itself not been validated for use with Central American youth; and the DISC-IV data used to establish diagnoses were provided by the same children and guardians completing the screening measures.

Based on their reporting on the HSCL-37A, children showed themselves to be reliable reporters of internalizing symptoms. Although alphas for the internalizing, anxiety, and depression subscales ranged from .86 (good) to .68 (borderline acceptable), much of this variation is likely due to differences in the number of subscales items (Tavakol & Dennick,
2011), with scales with fewer items showing poorer internal consistency. A larger sample would likely address this apparent statistical artifact. Children’s reporting of internalizing symptoms on the HSCL-37A broadly concurred with diagnoses received on the DISC-IV. The one exception to this finding was the depression subscale where, as mentioned previously, the analysis was limited by the fact that only one child met criteria for a past-month DISC-IV depressive disorder diagnosis.

Although children’s reporting of internalizing symptoms on the HSCL-37A was generally internally consistent and correlated with DISC-IV diagnoses, children underreported symptoms compared to the established clinical threshold norms for the measure (Derogatis et al., 1974). As a result, many children with DISC-IV diagnoses screened negative on the HSCL-37A and children’s scores on the measure more closed resembled those of community samples than the other unaccompanied and migrant youth on whom the measure has been tested (Bean et al., 2004a; Derluyn et al., 2008). There are a number of reasons why children might have understated their symptoms on a self-report measure compared to the DISC-IV. As the first activity in the study (intentionally, to better approximate the conditions in which screeners are normally administered), children were perhaps unaware of mental health language and had not been primed to think about their symptoms. Additionally, some children may have been reluctant to disclose their difficulties until they developed a rapport with their interviewers. However, children’s apparent understatement of their symptoms on screening measures compared both to other child samples and their own DISC-IV presentation may also relate to Latino cultural values regarding stoicism in the face of distress (WALS, 2008). Thus, children might have endorsed certain symptoms based on categorical yes/no questions on the DISC-IV, and at the same time have been more likely to rate these symptom as occurring sometimes than often or always in the
HSCL-37A’s Likert format. Reflecting our findings on children’s attitudes towards migration, this mentality that acknowledges distress and at the same time downplays the impact of symptoms might often be highly adaptive, reinforcing narratives of survivorship over victimization. However, it may also make it challenging to screen unaccompanied children for mental health services using instruments that rely on their own subjective ratings of their levels of distress.

In contrast with the HSCL-37A internalizing subscales, the HSCL-37A externalizing subscale showed poor reliability and validity. Children’s mean score of 13.44 on the HSCL-37A externalizing subscale (compared to the measure’s lowest possible score of 12) is below average scores observed in both other unaccompanied and community samples (Bean et al., 2004a). The poor internal consistency of the scale (.33) may reflect the lack of variation in responses (Goodwin & Leech, 2006). It is also possible that the combination of symptoms of oppositional defiant, conduct, and substance use disorders on this 12-item subscale did not support a single-factor model in the study sample, particularly given that the lower age limit for the measure was reduced from 12 to 10 years (an age at which some of the conduct and substance use behaviors assessed on the measure are rare). Even accounting for the possibility that unaccompanied children may be more likely to present with internalizing than externalizing problems, their very low scores suggest that some children may have underreported problematic behaviors on the HSCL-37A, echoing findings from the DISC-IV.

Whereas children in our sample may have underreported externalizing symptoms, they appeared not to relate to PTSD symptoms as presented on the RATS. The poor internal consistency of the measure’s total and subscales (with Cronbach’s alpha statistics ranging from .66 to .26) and children’s low mean scores on the instrument both provide evidence, alongside
the low rates of PTSD on the DISC-IV, that PTSD was not a typical trauma response for children in our study. The close association between children’s scores on the RATS and HSCL-37A internalizing subscale suggests that, at least in this sample, the measure may have been more indicative of distress generally than of trauma specifically.

The CBCL showed strong internal consistency, consistent with previous research findings on the use of the teacher-report version of the measure with unaccompanied children in the Netherlands (Bean et al., 2007). In contrast with the HSCL-37A, the CBCL was a stronger predictor of DISC-IV externalizing than internalizing diagnoses. The borderline cutoffs (based on Norm Group 2 for the measure) were more effective than the clinical cutoffs in identifying children with diagnoses, and overall appeared to function well with this sample. This was particularly true of the externalizing subscale, for which the sensitivity was 100%, the specificity was 87%, and the positive and negative predictive values were also strong (although it should also be noted that there were only three children with DISC-IV externalizing diagnoses in the sample). The weaker screening properties of the total scale, for which sensitivity was less than 65%, reflect the finding also observed on the DISC-IV that guardians were often unaware of children’s internalizing distress. Likewise, guardian ratings of psychopathology correlated little with children’s reporting on the HSCL-37A and RATS.

Parents and other adults involved in children’s lives may be more cognizant of children’s externalizing than internalizing difficulties due to the visibility of behavioral problems and their sometimes more evident impact on children’s functioning (Alegría et al., 2004; Jensen et al., 1999). These findings from the general literature may be particularly pronounced in the case of parents and other guardians of unaccompanied children, who have typically spent very little time living with their children in recent years and who, given their own frequent unauthorized migrant
status, may have had limited access to information on mental health problems and accessing treatment. One way to counteract the discrepancy in screening of externalizing and internalizing difficulties on the CBCL might be to use the measure in conjunction with the Youth Self Report (YSR) version of the same questionnaire.

Considering the limited availability of clinicians to provide in-person assessments, child- and caregiver-report measures may be an effective means of screening unaccompanied children who might benefit from further follow-up. The study findings suggest a need for further development and evaluation of potential screening batteries: to improve sensitivity of child-report measures; to establish appropriate clinical cutoffs; to enhance screening of trauma symptoms; to include measures of strengths and functioning in assessment of children’s mental health needs; and to balance child and caregiver evaluations. Although it would be possible to lower the clinical cutoff scores on the HSCL-37A to account for children’s apparent understating of symptoms on the measure and increase its sensitivity, in practice having optimum threshold scores so close to the bottom of the scale would likely create floor effects, limiting data variance and increasing the risk of chance results. One alternative might be use a different instrument that assesses a broader spectrum of wellbeing. For example, the Strengths and Difficulties Questionnaire combines the assessment of emotional symptoms, behavioral problems, and prosocial behaviors (Goodman, 1999), and has been used in multiple studies of refugee and other migrant youth (Birman & Chan, 2008). Inclusion of a measure of children’s functioning across a variety of domains would also help provide a more balanced assessment of children’s overall psychological presentation.

One challenge in evaluating the effectiveness of screening measures for use with unaccompanied children and determining clinical cutoff scores is the lack of an established,
culturally validated instrument against which to compare results. Other studies (e.g., Bean, 2006; Bolton et al., 2007) have addressed this problem by comparing screener results against other indicators of mental health need. For example, in their criterion validation of screeners for use with unaccompanied children in Northern Europe, Bean and colleagues (2004a, 2004b) included children and caregivers’ report of need for mental health care, utilization of care for psychosocial symptoms, and referral to mental health services by children’s guardian as categorical markers. In their research with internally displaced adolescents in Northern Uganda, Bolton and colleagues (2007) assessed the concurrent validity of their depression measure by comparing scores among children identified by caregiver-child pairs as having or not having local depression-like syndromes. Including child and caregiver perspectives in this way in the development of screening measures for unaccompanied children could help establish their validity, both in identifying culturally specific manifestations of psychopathology and in determining what types and levels of distress are seen as requiring formal mental health treatment.

Aim 3: Mental Health Service Utilization

The study findings on mental health service utilization are derived from two distinct sources: rates of mental health service utilization and unmet need in the full sample at the time of the initial study interview, and obstacles to and facilitators of care in the subsample of children referred to services and interviewed at follow-up. These findings need to be understood in the context of the population sampled. On average, the children interviewed had been in NYC less than four months at the time of the study interview and despite efforts to avoid a selection bias towards children in need, it is likely that some families may have volunteered to participate in
the study at least in part because they were in the process of looking for mental health resources for their children.

**Rates of mental health service utilization and unmet need (Aim 3a).** As predicted, there was a large gap between the number of children with current DISC-IV diagnoses (past-month, with functional impairment) at the time of the study interview and those receiving services. Not a single child had been seen for formal, ongoing counseling or other mental health treatment services since arriving in NYC, compared to the more than a third of the sample with current diagnoses (and the more than half with past-year diagnoses). The only psychosocial services being provided were by school counselors, who were monitoring (but not providing regular sessions to) three children.

The mental health gap in this sample was comparable to some of the most underserved immigrant and minority populations in the country. Population estimates of adolescent mental health service utilization and unmet need (e.g., Alegría et al., 2004; Flisher et al., 1997; Garland et al., 2005; Gudiño et al., 2008; Kataoka et al., 2002; Merikangas et al., 2010a) typically vary between approximately 50% and 90% based on the characteristics of the sample (e.g., variations in age range, ethnic diversity, and inclusion of at-risk populations), how psychiatric need is assessed (e.g., through use of structured diagnostic interviews like the DISC-IV, self-report screening measures, with or without inclusion of criteria for functional impairment, and based on different time periods for presence of disorders), and how service use is defined (e.g., to include any receipt of care including via pediatricians and informal counseling in school or limited to receipt of treatment in specialized mental health treatment settings). Combining a stringent definition of need (past-month psychiatric diagnosis with impairment) and broad definition of services (to include monitoring from school counselors), this study’s 88.9% estimate of unmet
need can be considered conservative. Employing a narrower definition of care as receipt of regular, formal mental health services, the unmet need was 100%.

Unmet need is challenging to define in this sample of unaccompanied children, due to considerable ambiguity about what constitutes need and, relatedly, what constitutes an intervention. Several researchers (e.g., Aldarondo & Becker, 2011; Derluyn & Broekaert, 2008) have noted that the high rates of distress observed in unaccompanied children do not necessarily translate to a need for formal psychological services. In our sample, many children both met criteria for mental health diagnoses and were functioning well in most aspects of their lives. In many cases their psychosocial needs (e.g., for security, emotional support, and education) had been met by access to resources (e.g., family and peer support and enrolment in school and extracurricular activities) that would not be considered formal therapeutic interventions but that nevertheless had a significant effect on their mental health and functioning. One, more child-centered, approach to assessing the treatment gap might be to ask unaccompanied children and their families their perception of the children’s need for mental health services (as in the research by Bean and colleagues, 2004a, 2004b) and compare this with their service use. However, as our findings at follow-up suggested, perceived need is itself complicated by a variety of factors including discrepancies in need reported between children and their caregivers, prioritization of certain needs over others (e.g., for legal representation versus counseling), and varied attitudes towards mental health and seeking treatment.

**Obstacles to and facilitators of mental health service utilization (Aim 3b).** The study subsample interviewed about treatment obstacles and facilitators at follow-up was far from naturalistic. These were families who had volunteered to participate in the study, had received a diagnostic screening indicating mental health difficulties, and had been provided information on
available, accessible, low-cost, Spanish-speaking services. However, even with these study-related facilitating factors less than 30% of children from these families had gone on to receive additional, formal mental health services after the study. On the one hand, this is suggestive of the need to provide ongoing support in accessing services to a highly stressed population who face multiple obstacles to care. On the other hand, it suggests that some unaccompanied children and their families may regard their distress as normative and choose alternative means of coping than mental health services.

Reflecting findings from our study with lawyers representing unaccompanied children (Baily et al., 2014), the most common barrier to help-seeking stated by families was that they did not know where to find accessible and appropriate services. The paucity of mental health services in low resource communities, the often prohibitive cost of treatment, and the limited availability of Spanish-speaking therapists are all common barriers to service access for Latino (Aguilar-Gaxiola, Loera, Méndez, & Sala, 2012) and other immigrant communities (e.g., APA, 2012). In some instances, families had not been aware of the availability of resources. For example, several families had not sought out services because they did not realize their children qualified for government-funded health insurance, other uninsured families had stopped children’s treatment after unwittingly incurring large out-of-pocket costs, while others had delayed obtaining services while completing the insurance application process. The post-release services provided by the Office of Refugee Resettlement are designed to address this problem by allocating case workers to assist families in accessing services following their release from detention (Roth & Grace, 2015). However, PRS are time-limited and available to only a small percentage of families (ORR, 2016d; Roth & Grace, 2015). Furthermore, measures designed to facilitate service access cannot always address limited availability of resources. For example,
PRS caseworkers frequently describe difficulty finding counselors for their clients (Roth & Grace, 2015) and even when unaccompanied children have Medicaid or Child Health Plus coverage it can be challenging to find therapists who accept these insurance plans (Baily et al., 2014).

Although mental health stigma is commonly cited as a barrier to care among Latino immigrants in the United State (WALS, 2008), it was rarely mentioned in our study. Some researchers (e.g., Guarnaccia, Martinez, & Acosta, 2005) have noted a distinction between more heavily stigmatized conditions classified as locura (frequently involving psychotic and antisocial behaviors, and often perceived as heritable, chronic, and severe) and less stigmatized difficulties termed nervios (which may manifest as anxiety, depression, or somatic symptoms and are frequently attributed to stressful life events). Given study children’s frequent exposure to adverse events and their typical symptom presentation, it is likely many families understood their difficulties in the latter, nervios category and as a result their difficulties were less stigmatized.

The limited reporting of stigma in this sample may also have been a function of selection bias, with families who were willing to participate also having less negative perceptions about discussing and seeking help for psychological concerns. Demand characteristics could also have been a factor, with families feeling uncomfortable discussing stigma in a study with a psychological focus. Concerns about seeking help may be exacerbated for families living in communities where many people are undocumented and understandably wary about becoming involved with professional institutions (Aguilar-Gaxiola et al., 2012). Unaccompanied children’s complicated guardianship status may further accentuate such concerns, as evidenced by one mother in our study whose mother was concerned not only that he would be considered “crazy” if he saw a mental health professional but also that that the government would intervene if she
refused to give her child psychotropic medication. (Due to the association with locura, taking psychotropic medication is often more stigmatized than seeking therapy in Latino culture [Guarnaccia et al., 2005].) Conversely, for some children concerns about speaking to a counselor seemed to have been quelled by their positive interactions with social workers in child shelters. Although this appeared to have given several children a positive attitude towards counseling, it was not clear to what it extent it contributed to children seeking services following their release to the community. For unaccompanied children with stigma-related fears, alternative forms of help such as attending church might be helpful. However, for some children in the study, attending church appears to have been inadequate to their needs and possibly prevented them from seeking more specific mental health care. Unaccompanied children might benefit from counseling services integrated into church programming, a means of service provision that has proved effective in other under-resourced populations with mental health stigma concerns (Hankerson & Weissman, 2012; Villatoro, Dixon, & Mays, 2016).

Other attitudinal factors also impacted children’s help-seeking. Some families concerned about children’s upcoming immigration cases were prioritizing finding an attorney over a therapist, a pattern also observed in other studies with unaccompanied youth (e.g., Roth & Grace, 2015). Maslow’s hierarchy of needs theory has been used as a frame to discuss challenges facing overstressed immigrant communities in accessing health services (e.g., Kaltman, Pauk, & Alter, 2011), and for some families in our sample the very real threat of deportation may have eclipsed mental health concerns. Thus, difficulties in accessing legal representation may not only have a negative impact on unaccompanied children’s mental health by increasing anxiety about their immigration cases but also by impeding their mental health service access. Conversely, therapists can play an important role in helping unaccompanied children to disclose traumatic experiences...
vital to their immigration cases and supporting them through stressful immigration court experiences (Baily et al., 2014). In two instances where the guardian wanted their child to receive help but the child did not, the child had an extensive history of pre-migration physical and emotional abuse. For children who have been abused, difficulties with trust and reticence to talk about past traumatic experiences may pose particular barriers to care and extra support may be required to engage them in services.

Some families did not seek out treatment services because they did not think children needed them. In most of these cases, the child’s diagnoses on the DISC-IV had been limited to separation anxiety disorder or agoraphobia, without functional impairment, and the family noted that the child had begun to feel better over time. Families’ ability to acknowledge normative distress based on children’s traumatic migration experiences and to provide a developmentally-appropriate environment for recovery may be very adaptive, especially if they are also willing to seek out more specialized services in the case of problems that are intransigent and have an enduring impact on children’s functioning and wellbeing. This attitude may also allow children to articulate their feelings and receive emotional support from loved ones without fear of being stigmatized. However, there may also be a tendency in cultures that value interpersonal harmony and family relations (as enshrined in Latino culture in the familismo concept) over autonomy and assertiveness to see internalizing symptoms such as withdrawal, timidity, and depressed mood as less concerning than acting out behaviors (Gudiño et al., 2008). In our study, the majority of children whose emotional difficulties had remained internalized had not received support, and this may present a particular barrier to services for unaccompanied children compared to other populations given their apparent tendency to minimize their distress. By contrast, when guardians were concerned about their child’s behavior, they were more likely to seek services.
The association between caregiver-report (CBCL) externalizing difficulties and treatment-seeking, but not other child and guardian reporting of distress, reflects a common finding in the literature: most children are referred to services based on guardians’ concerns about their children’s behavior rather than emotional concerns observed by guardians or reported by children themselves (Gudiño et al., 2008; Zwaanswijk, Verhaak, Bensing, van der Ende, & Verhulst, 2003). Similarly, when teachers had identified children as needing assistance, this was brought to their attention by external manifestations of distress such as the child being bullied, academic difficulties or, in one case, the discovery of a suicide note.

For children who had received counseling, families in the study reported two main routes into care: referral to a school counselor based on behaviors observed in school and referral to therapists in the community via a medical doctor. There are a number of reasons why Latino families may be inclined to seek help for psychological problems through medical doctors: children from Latin America frequently present with somatic complaints in response to distress (WALS, 2008); immigrant parents with limited experience or stigma regarding mental health treatment may be more comfortable consulting a medical doctor; and immigrant families may not know where to access mental health services. However, for primary care to serve as an effective route into psychological services medical professionals need to be educated about the particular challenges facing unaccompanied youth and services need to be coordinated effectively. Several families were referred by pediatricians to mental health services that were prohibitively expensive and were not made aware of their children’s eligibility for free health insurance, while the child who presented at the emergency room with panic symptoms and an extensive trauma history was not referred for psychological follow-up. One potential solution to such problems is a collaborative care model whereby medical, psychological, legal and other
needed services are grouped together within a single setting (Rousseau et al., 2013). However, programs such as the medical-legal partnership Terra Firma in NYC (Stark et al., 2015) are currently few and far between and unlikely ever to have the capacity to serve all the many unaccompanied children requiring services. One way to address this disparity is through health initiatives leveraging existing medical, psychological, and other psychological services by connecting them into a network of care for unaccompanied children. The ICLASP inter-organizational network of service providers working with unaccompanied children in South Florida (Aldarondo & Becker, 2011) demonstrates the feasibility of such an approach.

For children in our study, their schools played an important role in identifying needs and providing services. School-based psychosocial services offer a number of benefits over other treatment settings for immigrant children and other multi-stressed, low-resource communities (Birman & Chan, 2008; Garrison, Roy, & Azar, 1999; Kataoka et al., 2003). While not unique to unaccompanied children, these benefits may be of particular relevance to them: schools provide a naturalistic setting in which to identify children’s mental health needs, unlike other potential screening venues such as court where children may be presenting with acute stress that is not as reflective of their daily functioning; schools allow observation of children’s development over time, which may help screen out children who present with initial acute distress following difficult migration experiences and acculturation challenges but whose distress subsides steadily over time; schools provide a low-stigma setting in which to receive services among children and families who may be concerned with the potential ramifications of a mental health diagnosis for the child’s guardianship and immigration case; schools can combine educational and emotional support to children dealing with both traumatic migration experiences and acculturation into a
new language and culture; and schools can cluster multiple psychosocial services under one roof, assisting families of unaccompanied children in accessing a range of needed resources.

However, for school-based services to work effectively for unaccompanied children, schools need to be sensitive to the specific needs of this group, to monitor children accordingly, to provide appropriate services, and where necessary facilitate access to additional treatment. In our study, unless children’s emotional needs had been brought to the school’s attention due to educational or peer difficulties, typically they had gone unnoticed. When school counselors had identified a need for specialized mental health treatment, they had difficulty finding available services. To address these gaps, schools with large censuses of unaccompanied children and other immigrant youth might be able to incorporate low-threshold psychoeducational and coping skills programming tailored to their needs (Bean, 2006). However, as suggested above, such programs will likely need to be combined with a broader effort to connect different types of providers across a variety of settings.

Taken together, the study’s findings on unaccompanied children’s mental health service utilization underscored the fact that formal treatment services need to be provided as part of a wider web of psychosocial resources. Children’s varied, complex pathways through an immigration process combining multiple steps, governmental agencies, and other institutions (Byrne & Miller, 2012) also requires multiple routes into mental health services: through schools and primary care, as was the case for families in this study, but also via case managers, lawyers, judges, ministers, and other stakeholders involved in these children’s care (Baily et al., 2014; Feerick Center & Vera, 2015). A comprehensive infrastructure addressing unaccompanied children’s varied psychological and other psychosocial needs will undoubtedly require the provision of resources to address unaccompanied children’s particular needs (e.g., integrated
mental health and legal services for children with trauma histories who require support in preparing their immigration cases). However, the study findings suggest that for many children improving access to and connection between existing resources will suffice. For example, for many children in our sample government policies such as open school enrolment and access to free child health insurance provided the necessary conditions to access mental health treatment. Expansion of programs like ORR’s post-release services can help further leverage these resources. Non-governmental initiatives improving children’s access to pro bono mental health services (e.g., psychological assessments in support of children’s immigration claims) may also help breach the services gap (Baily et al., 2014). Future research and advocacy should investigate and promote ways to leverage and scale up available services, as well as key areas for the development of additional psychosocial interventions.

**General Discussion: Risk and Resilience Processes in Unaccompanied Children**

The research questions and hypotheses presented in this dissertation were largely descriptive and designed to document the stressors and supports experienced by a sample of unaccompanied children, their mental health presentation and service utilization, and other aspects of their psychosocial context without theorizing about the relationship between these different variables. These modest aims reflect the exploratory nature of this study, the small sample size, cross-sectional design, and inductive data analytic approach. They were also designed to provide data to inform theory about unaccompanied children’s psychosocial needs that could be investigated in future research.

Taken as a whole, the study findings suggest that the mental health status and needs of unaccompanied children in our sample were multi-determined, resulting from a complex interplay of stressors and supportive factors at multiple ecological levels and evolving over time.
The contemporary literature on risk and resilience in response to adversity, and in particular social ecological models (e.g., Betancourt & Khan, 2008; Panter-Brick & Leckman, 2013; Ungar et al., 2013) and Conservation of Resources theory (Hobfoll, 1989, 2012, 2014), presents a potential paradigm for understanding this pattern of results. In particular, several concepts from this literature provide a lens to understand key findings from the study.

**Expanding the definition of resilience beyond current symptom presentation.** In our study, the majority of children presented with diagnoses, and diagnosis-specific impairment in functioning. However, all were maintaining engagement in key developmental tasks: attending school, acculturating into new family constellations, social groups, and communities, learning English, attending to their immigration cases, and planning for the future. This apparent paradox highlights a methodological limitation of the study common in the literature. The mental health impact of psychosocial stressors such as migration has often been assessed cross-sectionally, using categorical metrics of psychopathology (presence/absence of disorders) based on Western models of psychopathology, and without incorporating measures of functioning and healthy adjustment (Bonanno & Diminich, 2013; Tol et al., 2013). However, increasingly resilience researchers are acknowledging that many children demonstrate a trajectory towards good overall functioning even while demonstrating symptoms during this process (e.g., Bonanno & Diminich, 2013). Furthermore, they argue that a singular focus on psychopathology misses other domains of experience and functioning (e.g., engagement in school, family, religious, and community life) that may be at least as central to many cultures’ valuation of wellbeing (e.g., Mollica et al., 1997; Sack et al., 1995; Ungar et al., 2013). In our sample, children’s self-identification with narratives of strength and fortitude while acknowledging hardship and suffering was primarily rooted in their engagement with several culturally informed and migration-specific functional tasks: their
seizing the initiative to come to the United States, their successful navigation of their journeys and reunification with family, and their pursuit of educational and career goals. For many, it appeared that their current experience of distress was a normative part of this process of overcoming, rather than contradicting it.

**Widening the focus from the individual to the environment.** Our findings suggested that, rather than an emphasis on individual-level resourcefulness, multiple interacting factors at different ecological levels combined in influencing children’s mental health and psychosocial functioning. These included direct influences on children’s adaptation such as availability of family and strong community support and also indirect ones such as the institutional policies and laws that either increase or limit children’s exposure to stressors and access to protective and promotive resources. There has been a tendency in Western mental health research and treatment to emphasize individual level factors such as personality traits, emotion regulation, and other internal coping resources as determinants of wellbeing and psychopathology. However, social ecological models conceptualize risk and resilience as a dynamic process of harnessing multiple interacting internal assets (e.g., sense of agency, coping flexibility) and external resources (e.g. family support, educational resources, legal protections) to protect against psychopathology, foster children’s positive adjustment, sustain wellbeing, and facilitate development (Betancourt & Khan, 2008; Fergus & Zimmerman, 2005; Panter-Brick & Leckman, 2013; Ungar et al., 2013). This type of ecological model places less emphasis on the individual’s capacity to cope in response to stress and more on how the individual’s environment enables healthy development (Ungar et al., 2013). Within such a paradigm, stressors and supports are evaluated not only based on how they impact the individual directly but also on how they affect the availability of environmental resources (Hobfoll, 2014). In the context of unaccompanied children, this expands
our conceptualization of service provision beyond providing direct psychological services to children to broader psychosocial interventions that promote normative adjustment such as access to family, education, and community activities.

**Emphasizing timing and cultural context.** Factors that contributed to stress and adaptation in our sample varied considerably depending on children’s specific context and the phase of migration. For example, for some children emotional suppression may at times have been adaptive, particular during parts of their migration process when they did not have access to supportive friends and family or expressing emotion may have placed them in danger (e.g., during interactions with gangs). However, in other instances concealing emotions may have been detrimental, depriving children of available help. Similarly, strong relationships with replacement caregivers were often an important protective factor during long separations from parents prior to children’s migration, but also contributed to separation anxiety and other forms of distress for many children in the post-migration period. Contemporary resilience research stresses the timing- and context-specific nature of risk and resilience processes, such that variables that may contribute to vulnerability in one child or one stage or migration may be protective against adversity or promotive of wellbeing in others (Tol et al., 2013). This has important implications for the targeted provision of psychosocial services for unaccompanied children.

**Understanding the relationship between psychosocial stressors and supports, access to resources, and children’s mental health and wellbeing.** Children in our sample were exposed to extreme adversities throughout their migration processes. However, and as predicted by Conservation of Resources theory (Hobfoll, 2014), generally it was not adverse events themselves but their impact on the availability of needed resources that led to distress in our
sample. Although many had experienced life-threatening, violent events during their journeys and harrowing apprehension and detention experiences, almost every child identified their pre-migration stressors as the most troubling. Their experiences of abuse, poverty, and gang-violence often eroded familial and broader social structures underpinning key personal-level resources such as attachment, security, calmness, efficacy, and hope, whereas stressors in subsequent phases of migration were time-limited and place-specific, and typically did not lead to long-term resource loss. Indeed, although these migration experiences led to some losses (e.g., separations from friends and family left at home), typically they led to net increase in resources, in the form of re-acquaintance with family, access to school and other community resources, and a new sense of safety and possibility. The primary manifestation of traumatic stress in our sample was separation anxiety disorder, reflecting the tremendous value placed on familial relationships in Latino culture and the actual or threatened loss of family (whether through gang-related violence, migration to the United States, or potential deportation) so central to unaccompanied children’s experience. One important consequence of COR theory as a model for understanding traumatic stress is that the impact of stressors can be mitigated by supportive factors limiting their impact on children’s access to resources. Thus, the presence of a caring replacement caregiver helped maintain emotional support resources for many children following parental separations, and positive child shelter experiences frequently bolstered a sense of hope and stability threatened by children’s immigration detention experiences.

**Identifying key moments and areas for intervention.** A systemic mapping of the factors influencing unaccompanied children’s risk and resilience processes identifies multiple areas of potential intervention. These interventions should be orchestrated as “planned synergies” (Ager et al., 2013) to benefit from the positive additional effects – and avoid
potential inadvertent negative ones – changing one resource can have on other resources over time and across multiple layers of the child’s social ecosystem. This requires the pinpointing of critical turning points (Rutter, 2013) in unaccompanied children’s migration processes, such as transfer of children’s care away from enforcement-oriented Customs and Border Protection to the protection-oriented Office of Refugee Resettlement. It also requires identification of resource caravans (Hobfoll, 2012) such as reunification with family in the community, whereby provision of one resource leads to accumulation of others. However, the fostering of these resources requires the establishment of environmental conditions, or caravan passageways (Hobfoll, 2012), such as the laws that have permitted unaccompanied children to be reunified with undocumented parents, protect their right to public education, and provide access (at least in New York and a few other states) to government-funded health insurance. Environmental interventions that promote access in this way are an efficient and effective way of providing needed resources to unaccompanied children, which can then have enormous implications for their mental health and wellbeing.

Case vignettes. The following case vignettes apply these concepts to the stories of a few of the children in the study. Together, they demonstrate some of the myriad ways in which different resources within children’s social ecology may interact over time to contribute to unaccompanied children’s risk and resilience processes. Cases were chosen to reflect different trajectories of migration adaptation, echoing aspects of Bonanno and colleagues categorization of trauma response ranging from recovery following acute stress experiences to chronic disruptions in functioning and emergent resilience in response to chronically stressful circumstances (Bonanno, 2004; Bonanno & Diminich, 2013). However, it should also be noted that these children had only recently arrived in NYC at the time of their interviews and all had long
deportation cases with enormous ramifications for their futures ahead of them. As such, their migration processes were still in progress. Names have been changed to protect the confidentiality of participants.

**Ongoing difficulties following history of chronic stress.** Ana, a 17-year-old girl from El Salvador, grew up in an abusive home and dangerous neighborhood. Her father was involved with gangs, had psychotic episodes while high on drugs, and had attempted suicide several times. He had frequent physical altercations with Ana’s mother and had threatened to kill her on multiple occasions. Ana’s mother fled to the United States when Ana was five years old, leaving her in the custody of her paternal grandmother. Ana’s grandmother abused her severely, including regular beatings and sometimes even inflicting burns. Following a custody battle, Ana was sent to live with her aunt, who was also abusive towards her. Ana’s father subsequently murdered a woman he was dating, and had been in prison since she was 12 years old. Her mother explained during the study interview that Ana had adored her father as a young child. When asked about him during the interview, she retorted that she “feels nothing.” In addition to the multiple stressors she endured within the home, Ana also lived in a neighborhood with a heavy gang presence. She described robberies by gang members on the local buses. When asked to state Ana’s most stressful experience, her mother recounted several different traumatic incidents: an occasion from when Ana was a young child when her father arrived home covered in blood after cutting his neck and Ana was upset that she was not allowed to accompany him in the ambulance to the hospital; Ana witnessing the murder of a cousin by gang members; and Ana seeing the body of her deceased grandmother after she passed away. When asked the same question, Ana mentioned simply her fear that someone would hurt her mother.
The immediate trigger for Ana to come to the United States was gang members breaking into her home one night and leaving a razor in an apparent act of intimidation against her family. Without telling her mother, who was anxious about the dangers of the journey, Ana and her older cousin found a coyote to guide them. They came as part of a large group of migrants who appeared to be very supportive of one another along the route. The journey was apparently largely uneventful until the group crossed into the United States and became lost in the Texas desert. After several days of walking and increasing concern about whether she would make it to safety, Ana was apprehended by U.S. immigration authorities, at which point she was having stomach problems and required IV treatment. Her cousin, being of age, was deported. After a couple of days in a Customs and Border Protection detention facility, Ana was transferred to the care of the Office of Refugee Settlement and a child shelter. She reported being well cared for there, and having the opportunity to sleep and be looked after in a safe, secure environment for the first time in many years. However, she was also excited to be released to her mother, with whom she had maintained a close relationship over the years via phone. Following her arrival in NYC, Ana was relieved to be with her mother and away from her dangerous, precarious environment in El Salvador. However, she was also feeling lonely separated from the friends and cousins to whom she was close back home. At school, she was finding lessons in English a challenge and relying on classmates to translate for her. Her upcoming court case and difficulty finding a lawyer were adding to her stress. Ana’s mother reported that she would return to El Salvador with her daughter if she was deported, despite having no way to support Ana there. Through all these pre-migration and migration challenges, Ana had retained her dream of becoming a doctor. At the same time, she was experiencing significant somatic symptoms, to include headaches, fatigue, and hives.
At Ana’s study interview, four months after her arrival in the United States, on the DISC-IV she met criteria for both past-year and past-month separation anxiety disorder, panic disorder with agoraphobia, and generalized anxiety disorder, all with severe functional impairment. She also endorsed chronic thoughts of not wanting to live that had started back in El Salvador and were based on the belief that nobody loved her. However, she described not liking to talk to other people about her problems due to difficulties with trust, adding, “I am a quiet person; when I am feeling something, I don’t like anyone to know about it.” However, on the Adaptation and Attitude scale she reiterated her wish to pursue a career in medicine and predicted that in 10 years’ time her life would be “much better than today.” She was provided with a list of referrals and shortly after the study interview went to the emergency room following a panic attack during which she reportedly had chest pain and fainted. She was cleared medically but not presented with any additional mental health referrals. At follow-up four months after the study interview, Ana had not received services and denied needing help. Her mother reported that although Ana was calmer in the day-to-day, she was still affected by her experiences in El Salvador. She suggested she would like Ana to receive therapy, but did not think she would be able to persuade her to go.

Commentary. Ana was one of several children in the study with a more severe mental health presentation and associated functional difficulties who had been exposed to the dual adversities of domestic and community violence in the pre-migration era. One way to understand the particular risk conferred by these combined factors is simply to see them as cumulative stressors. However, this type of additive model does not explain why for Ana, and other children in the study who endured similar circumstances, these chronic pre-migration stressors seem to
have been especially impactful (e.g., compared to her near-death experience when she got lost in the Texas desert).

By contrast, a resource-focused perspective such as Conservation of Resources theory (Hobfoll, 1989) offers a way of understanding the specific, interactive effect of these stressors on various aspects of Ana’s social ecology. Ana’s childhood experiences of domestic violence and separation from her parents may have led to a loss of her internal sense of the world as a secure, safe, and stable place. Like several children in the study, separation at a later age appears to have left her more susceptible both to the psychological impact of disrupted attachments and also to abuse at the hands of replacement caregivers. These domestic stressors likely left her more susceptible to being impacted by the community violence surrounding her, leaving her without either internal coping resources (e.g., strong self-esteem and emotional flexibility) or a caring home as protections against gang-related stressors. The effects of this downward spiral of lost resources can be seen in Ana’s increasing desperation, sense that nobody cared about her, and suicidal ideation. Her family history of mental illness may have conferred an additional, biological vulnerability.

Ana’s case also underscores the importance of context and timing in informing risk and resilience processes. Even prior to migration, she had access to resources at various ecological levels that together, and under different circumstances, may have helped promote her healthy development: personal characteristics including intelligence and academic and professional ambitions; an ongoing relationship with her mother, who offered her emotional support and tried to protect her from afar (e.g., through the legal proceedings that had Ana removed from her grandmother’s care); cousins to whom she was close; and friends at school. However, these resources were not sufficient to protect her from the toll of the traumatic stressors to which she
had been exposed. Furthermore, these adversities had left Ana with an emotionally avoidant coping style, mistrust of showing vulnerability, and scepticism about seeking help which all presented barriers to accessing and fully utilizing potential supportive resources. While this may have been an adaptive form of self-protection prior to migration, Ana’s ongoing difficulties with trust and reticence to seek treatment following her arrival in NYC and reunification with her mother were likely less helpful.

Ana’s case is also indicative of the ways in which context informs manifestations of distress, in keeping with the concept that trauma response is often more closely tied to the impact of stressors on the availability of resources than their direct effect on the individual. The most stressful aspect of the violence to which she was exposed as a child was, according to Ana, not these events themselves but rather the threat they posed to her mother and the separation they precipitated when her mother was forced to flee the country. Like many children in the sample who had experienced chronic stressors that had led to family disruptions, she met criteria not for PTSD but separation anxiety disorder, which appeared to represent a context-specific manifestation of her migration trauma. At the same time, the neurophysiological toll of her chronic exposure to traumatic stressors and her emotionally avoidant coping style were perhaps reflected in her somatic complaints and panic symptoms.

Given Ana’s mental health presentation at the time of the interview, her case is more suggestive of a risk trajectory than resilience. However, her symptomatology also needs to be understood as one moment in the middle of an unfinished migration process, just a few months into reunification with her mother in NYC and with the immigration case to determine whether she would be authorized to stay with her mother in the United States permanently still ahead. Moreover, despite functional impairment to include fainting episodes and emergency room
visits, in certain respects Ana had shown remarkable functional strengths and resourcefulness, to include maintaining a close relationship with her mother over a long separation, establishing a supportive friend group, retaining her academic and professional ambitions, leaving behind her abusive situation in El Salvador, and finding her way to the United States. These all provided potential promotive and protective resources for the future.

Despite Ana’s reluctance to seek formal counseling, she was benefitting from a variety of psychosocial interventions at broader ecological levels, including reunification with her mother, provision of a safe home and community environment, and access to education. While not addressing her mental health symptoms directly, these factors were instrumental in providing the conditions, or in COR terms caravan passageway (Hobfoll, 2014), for accumulation of new resources as Ana attempted to move on from her traumatic experiences by building of a new life in the United States.

*Recovery following acute stress experience.* Jorge, a 17-year-old boy from Ecuador, grew up in a supportive family environment and safe but impoverished community. He came to the United States with the intention of earning money to support his family at home while at the same time completing his last year of high school before studying medicine and becoming a doctor. He traveled with an adult cousin in a coyote-led group and had a very traumatic journey. Frequently, he and his travelers were denied access to food and had to rush into the bush to avoid being arrested and deported home by local officials. While in Guatemala he witnessed another person from the group being crushed under their bus and was then threatened by the coyote not to tell anyone else about the incident. Jorge, who was traumatized by what he had seen and many times felt like he did not have the will to continue the journey, was encouraged by his cousin to be strong and carry on. Then, when Jorge arrived in the U.S.-Mexico border town of Reynosa, he
and his cousin were kidnapped and held in squalid conditions by members of the Zetas gang, who contacted his family and threatened to kill him if they did not pay a ransom. While held captive he developed scabies, but eventually he was released when it became apparent his family had no money to respond to the gang’s demands.

Jorge and his cousin crossed the Rio Grande into Texas undetected but were spotted shortly afterwards by a U.S. immigration helicopter. After being pursued for several hours through thickets that left Jorge with ripped clothes and cuts all over his body, Jorge and his cousin gave themselves up. They were separated and his cousin, being over 18 years old, was subsequently deported. While in immigration detention, Jorge was treated for his scabies. At that time he was experiencing an acute trauma reaction focused primarily on the fatal accident he had witnessed, including nightmares about what he had seen and an exaggerated startle response, alongside other symptoms such as difficulty sleeping, lack of appetite, and a desire to isolate.

After Jorge was transferred to an ORR children’s shelter, he felt more settled and his symptoms started to improve. A counselor worked with him every day and by the time he was released to NYC he was sleeping better and slightly less anxious. As he did not have any family in NYC he was sponsored by a family friend who had not known in advance of his arrival and who Jorge had never previously met. During his first few months in NYC he was not yet enrolled in school and reported feeling down and “useless” not doing anything. He was also anxious to start working so that he could repay the debts his family had accrued to pay the coyote to bring him to the United States. His difficulty securing a lawyer to help with his case was another source of stress. However, Jorge tried hard to conceal his feelings, including on his regular video calls to his family back in Ecuador, which often left him feeling lonelier rather than comforted.
Jorge completed his study interview nine month after arriving in NYC and still appeared very emotional recounting his migration experience. On the DISC-IV, he met criteria for past-year diagnoses of PTSD, major depressive disorder, agoraphobia, and separation anxiety disorder, all with severe functional impairment. However, he did not meet past-month criteria for any disorders, and suggested that overall he was feeling better. He attributed these improvements primarily to his religious faith, which had been an important source of coping for him throughout his migration. He also suggested that finally getting enrolled in school had given him a sense of purpose. He was also working under the table to pay off the debt for his trip and support family at home. Jorge’s guardian, however, reported some ongoing concerns about his anxiety and sadness. On the A&A, Jorge recorded only one wish: “To stay in this country so I can help get my parents ahead.” Jorge and his guardian were provided with mental health referrals but at the follow-up telephone interview several months later Jorge reported that he had not sought treatment and no longer needed it. He suggested that he still had some bad days but was now attending school and work. He suggested that, with the help of prayer, he was putting his migration experiences behind him and coping with his anxiety about his impending court case. His guardian remained concerned that Jorge was still very distressed. However, he reported challenges finding time for therapy and a need to prioritize finding a lawyer to represent Jorge in immigration court.

Commentary. Jorge’s migration experience was in some ways a reversal of Ana’s: he benefitted from a stable home environment and sustained access to parental support in the pre-migration period; he was exposed primarily to short-term, acute stressors rather than chronic ones; and his post-migration adjustment was associated with a loss rather than acquisition of
close, parental support. Reflecting these contrasts with Ana’s situation, Jorge also had a very
different clinical presentation and symptom course.

From a resource-based perspective, Jorge’s childhood experience of growing up in a
close-knit family in Ecuador and in a poor but otherwise stable neighborhood appears to have
provided an environment that also facilitated Jorge’s development of important internal coping
resources: a strong attachment to his parents, the ability to modulate emotion and behaviors,
good social and communication skills, a strong sense of agency, and self-motivation. These
promotive and protective resources were, however, counterbalanced against the environmental
stress of poverty, which prompted additional stressors throughout Jorge’s migration process:
denying Jorge and his family regular access to basic necessities such as food; compelling Jorge
to separate from his family so that he could support them from the United States; placing Jorge at
extra risk when his family could not pay the ransom demanded by his Mexican kidnappers; and
pushing him into working in the United States prematurely to pay off his travel debts (thus
potentially jeopardizing his immigration case).

Jorge’s case, like Ana’s, highlights the context- and timing-specific nature of risk and
supportive factors and of manifestations of traumatic stress. Whereas, in the aggregate, Jorge’s
avoidance of pre-migration adversities such as domestic and gang violence was almost certainly
protective, the absence of such adversities likely made the violence he experienced during his
journey all the more impactful. Indeed, his PTSD-type reaction suggests what a shocking affront
these journey experiences were to him, whereas other children with chronic exposure to violence
were potentially rather more desensitized to such stressors. Similarly, while Jorge’s loving
family was a strong supportive factor in the pre-migration period, separation from them was a
stressor in the post-migration period, causing him considerable distress, denying him an
important protective resource during his acculturation in NYC, and likely slowing his recovery from his trauma symptoms. His anxiety and depression diagnoses are suggestive of the sense of isolation, hopelessness, and desperation being left to face these challenges without their support initially provoked in him.

The counseling Jorge received while at the child shelter illustrates how the provision of supports at critical moments, or turning points (Rutter, 2012), in unaccompanied children’s migration can have a long-term impact on resilience processes. Jorge’s shelter experience appears to have provided him with the time, space, and skills to regroup psychologically and ground himself before the challenge of resettling in NYC. In the shelter setting, Jorge’s interpersonal sensitivity and emotional expressiveness—hindrances during his journey—were likely a promotive resource, enabling him quickly to develop a strong, therapeutic relationship with his counselor, to trust her, and to disclose his painful experiences.

Jorge's slow recovery from his journey traumas following his arrival in NYC underscores the notion of resilience as a process that evolves over time based on the availability of resources at multiple layers of unaccompanied children’s social ecology. While Jorge initially lacked the external supports to help him address his acute stress symptoms, he was able to rely on internal resources such as his religion and strong attachment to his family to cope. By the time of the study follow-up interview, he had been able to access resources such as school and employment, which in providing him a community and a sense of utility likely exerted a strong anti-depressant effect. While shocking, his journey stressors existed in isolation and had not precipitated further, long-term resource loss, and thus these trauma symptoms were dissipating over time. As for all the children in the study, Jorge’s looming court case and potential deportation posed an ongoing threat to the life he was building in NYC, and as such it made sense that he and his guardian
were prioritizing finding an affordable lawyer to take his case over seeking counseling to address his remaining symptoms. Given this balance of needs, he may have benefitted particularly from access to collaborative care offering combined legal, social work, and counseling services.

**Resilience trajectory combining multiple risk and protective factors.** Elin, a 10-year-old girl from Honduras, was exposed to multiple stressors throughout her childhood and migration process. However, she was also surrounded by family who provided her with both emotional and material support. Her father separated from her mother when Elin was a baby, leaving her mother to provide for Elin and her older sisters on her own. In order to do so, she traveled undocumented to NYC to find work when Elin was one. Elin’s oldest sister assumed responsibility for her care and enjoyed a close, maternal relationship with her. Elin was also very close to her other family members, in particular her big sister’s children, whom she regarded more like sisters than nieces. She described happy times spent together with them, her grandparents, aunts, uncles, and cousins in Honduras. Elin stated that in addition to her large family, her other favorite thing about Honduras was school, where she particularly enjoyed math and computer class.

Elin was also exposed to a number of stressors in Honduras, including the murder of a relative during a burglary and a heavy gang presence in her neighborhood. In order for her to be able to stay in school, her mother paid for a driver to take her and her sister there every day. Eventually, the family decided that the country was too dangerous for the children to stay and her mother arranged for her and her second sister, aged 14, to be brought to the United States by a coyote. The timing of this decision was also influenced by Elin’s mother being diagnosed with breast cancer, which left her anxious to get her children out of Honduras and to safety in NYC while she still had the resources to do so.
The coyote brought Elin and her sister up through Central America with other children and adults by bus, paying bribes to various officials along the way. Fearful about the dangers of the journey, Elin’s mother contacted her daughters regularly on the trip via the coyote’s cellphone. Elin and her sister were taken into custody by Customs and Border Protection officials in an intentional handoff prearranged by Elin’s mother and their coyote, although Elin and her sister had been told by the coyote that when they walked across the border they would find their mother on the other side. Elin was apparently scared and tearful in the CBP facility where she and her sister were initially detained. They were locked up with other children in a cold room with open bathroom facilities, without mattresses, and with only an aluminum blanket to keep them warm. Elin’s older sister had Elin sleep on her legs to keep her as comfortable as possible. Elin felt calmer in the ORR child shelter to which she and her sister were transferred and she reported being treated well, given new clothes, taking classes, and making friends there. However, she was also apparently anxious to be released and sometimes cried on the phone to her mother. Following her arrival in NYC, she enrolled in school quickly, settled easily, and made friends with other Spanish-speaking students. She had also stayed in contact with some of the children she had met in the child shelter via Facebook. Elin’s mother noted that Elin missed her big sister and that she and the sister who had accompanied her on her journey felt constrained living in her small apartment in the Bronx, where they slept in the living room with a cousin. Her mother reported that with time she was earning Elin’s trust. She also noted that her cancer had gone into remission. When asked during the interview how she felt about being apart from family in Honduras, Elin replied, “Sad, but at the same time happy because I am with my mother.” She was also hopeful that her older sister might be able to join them in the United
States soon. Her mother had not yet managed to find a lawyer to represent Elin and her sister in their immigration cases.

On the DISC-IV, Elin presented with some past-year and past-month mood and anxiety symptoms, but did not meet criteria for any disorders with functional impairment. On the A&A she gave as her three wishes “to be with my whole family,” “to be a teacher,” and “to stay in the United States forever.” At the follow-up phone interview, Elin’s mother reported that she had been concerned that Elin seemed sad and anxious. In particular, she was missing her big sister and nieces. Elin’s mother recounted that she had taken Elin to see a pediatrician about these difficulties but that Elin was not comfortable talking to him because he was male and spoke little Spanish. He referred Elin to a female psychologist and after two or three sessions she seemed happier and the therapist told her she did not need any further treatment. At the time, Elin’s mother did not have health insurance for her children. A friend helped her apply, but by then she had already accumulated a bill of $650 that she reported she could not pay.

Elin’s psychological presentation differed quite starkly from that of her accompanying, 14-year-old sister. On the DISC-IV, Elin’s sister met both past-year and past-month criteria with functional impairment for separation anxiety disorder, major depression, and conduct disorder (all based on her mother’s report, whereas Elin’s sister self-reported few symptoms). Of note, despite growing up in the same family, the two sisters’ pre-migration experiences had differed significantly. Elin’s sister was already five years old when her mother came to the United States. In addition to experiencing her mother’s departure more acutely, she never enjoyed the same, maternal relationship with her older sister as Elin. Eventually, the older sister came to physical blows with her and sent her to live with her grandparents after she claimed that she had been touched inappropriately by the older sister’s husband. Her mother reported that she had started
skipping school and that the family was concerned that she would become pregnant by a boy she had stated dating. Elin’s sister did not mention this during her interview, but did discuss her anxiety, sadness, and guilt about leaving her ailing grandparents behind in Honduras. She mentioned that the adjustment to NYC and living with her family here had been hard. She also commented that it was difficult for her to trust people and talk about her feelings.

Commentary. Like many children in the study, Elin presented with mental health symptoms following a long history of exposure to significant stressors including separation from caregivers, a childhood spent living in a dangerous neighborhood, murders of relatives and other community members, stressful journey and detention experiences, and a challenging acculturation process in NYC. However, and again in keeping with many of the children interviewed, in spite of these challenges and some associated distress Elin had continued to function well in key developmental domains such as school, family, and peer relationships. She had been facilitated in doing so by a cluster of promotive and protective resources that had curtailed the potential resource loss from the stressors she had faced.

For Elin, like many children in the study, maintaining access to a parent figure and school were key factors in sustaining normative developmental processes and facilitating access to additional resources. In particular, the secure, parent-like attachment she developed with her older sister from infancy seems to have helped to protect against the potential impact of early separation from her parents and to have promoted the development of many internal assets associated with good coping and healthy development: her interpersonal trust, emotional flexibility, optimism, social competence, and achievement orientation. Similarly, Elin’s school experiences fostered a cluster of other resources associated with resilience: self-esteem, a sense of structure, close peer relationships, and a supportive community. All these factors likely
contributed to Elin’s overall sense of safety and security, despite the gang violence to which she was exposed in the pre-migration period.

For Elin, some of the most significant supportive factors were not direct psychosocial interventions but factors that fostered access to other resources. For example, her mother had hired a private driver so that she and her sister could continue going to school despite their dangerous neighborhood, so providing a literal passageway through which to access school and its associated resources. At the structural level, U.S. immigration policies authorizing unaccompanied children’s release to undocumented parents provided a similar caravan passageway (Hobfoll, 2014), both reducing children’s risk of being trafficked once they reach the United States and granting them access to a whole range of resources associated with reunification with parents in the community, such as access to normative school, family, and peer relationships. However, the difficulties experienced by Elin’s mother finding affordable legal representation and counseling are reminders of the challenges to resource access faced by many unaccompanied children and their families and the need for greater coordination of services for them.

Elin’s case also provides an example of how individual-level assets interact with factors at different ecological levels to support resilience. Elin’s journey and detention experiences were stressful for her, suddenly placing this 10-year-old girl outside the hands of her loving family for the first time. However, Elin’s strong attachments, internalization of her family’s love, and confidence that she was cared for were likely instrumental in helping her through this ordeal. Her 14-year-old sister’s efforts to look after her on the journey and her mother’s daily calls to the coyote to check in likely reinforced her sense that she was loved and supported. Elin’s apparent secure attachment style also likely helped her maintain a sense of connection with her mother.
despite the fact they had been separated since her infancy, allowing them to develop a trusting relationship quickly following her arrival, and facilitating her adjustment to life in NYC. Her warm, open interpersonal style also allowed her to adapt quickly into her new school and to make new friends easily. Elin’s cognitive flexibility and willingness to share her emotions also helped her to access external supports. She was able to acknowledge both how much she missed her older sister and that she wanted to be in New York with her mother. Her expression of sadness and anxiety was likely evidence of good psychological coping rather than psychopathology. It may have helped her internally process her migration experience while at the same time communicating a need for support to others. For Elin, this led to a brief and apparently positive experience in psychotherapy.

By contrast, Elin’s sister’s more severe clinical presentation and her more inhibited interpersonal style are reminders of the complex and variable ways in which risk and supportive factors interact, and how subtle differences in timing and context may alter risk and resilience trajectories even between children who come from ostensibly similar environments and who share many experiences. Whereas Elin was an infant when her mother left, her sister was already five years old, likely making the separation much more distressing for her and meaning she did not develop the same mother-like relationship with their older sister as Elin. Their eventual estrangement may have contributed to her apparent acting out behavior, and possibly made her vulnerable to negative or even dangerous influences in the community. This strained relationship also appeared to have crossed over into a more challenging process of reunification with their mother than Elin experienced, and more difficulty making new friends in NYC. At a biological level, Elin’s sister’s older age may also have conferred additional risk for psychopathology, especially depression.
Table 15 brings together some of the tentative conclusions on unaccompanied children’s risk and resilience processes drawn from the study findings and reflected in these case vignettes. These conclusions are linked in the table to the associated conceptual literature, although many of the studies cited do not address the mental health needs of unaccompanied children specifically. Further, theory-informed and hypothesis-driven research is needed to investigate these conclusions more robustly.
Table 15. Tentative conclusions drawn from study findings

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<tr>
<th>Psychosocial context</th>
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<tr>
<td>Understanding of unaccompanied children, their rights, and needs requires consideration of their multiple contexts: psychological, legal, familial, social, educational, political, and economic (Derluyn &amp; Broekaert, 2007)</td>
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<tr>
<td>Unaccompanied children’s migration is characterized by processes of risk and resilience involving a dynamic interaction between multiple vulnerability, protective, and promotive factors (Ager et al., 2013)</td>
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<tr>
<td>Unaccompanied children are impacted directly and indirectly by factors at multiple social ecological levels (Betancourt &amp; Khan, 2008; Ungar et al., 2013)</td>
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<tr>
<td>Unaccompanied children’s risk and resilience processes evolve over time based on timing- and context-specific factors (Tol et al., 2013)</td>
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<th>Mental health diagnosis</th>
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<tr>
<td>Reflecting their high levels of exposure to extreme stressors and limited access to supports, unaccompanied children present with overall rates of mental health diagnosis akin to those of child refugees from the world’s other most dangerous regions</td>
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<tr>
<td>Current distress (and disorder-related impairment) does not preclude sustained, effective engagement in personally and culturally meaningful domains and a trajectory towards wellbeing (Barber, 2013; Bonanno &amp; Diminich, 2013)</td>
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<td>Impact of stressors and supportive factors on unaccompanied children’s mental health is mediated by their effect on the availability of resources, with distal, chronic stressors typically more impactful for unaccompanied children than acute, short-term ones (Hobfoll, 2012)</td>
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<tr>
<td>Expressions of distress reflect migration histories (e.g., internalizing vs. externalizing disorders) and patterns of resource loss (e.g., separation anxiety disorder vs. PTSD) (Hobfoll, 2014)</td>
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<td>Mental health screening may be complicated by:</td>
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<td>o Self-concept emphasizing narratives of survivorship over victimization</td>
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<tr>
<td>o Misgivings about impact of mental health status on immigration cases</td>
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<th>Mental health service utilization</th>
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<tr>
<td>Broad range of psychosocial interventions impact unaccompanied children’s mental health and wellbeing, complicating notion of unmet need</td>
</tr>
<tr>
<td>Accessibility as well as availability of resources a key consideration in service use</td>
</tr>
<tr>
<td>Cultural distinctions between nervios and locura may help normalize symptoms and reduce stigma, but also hinder service use (Guarnaccia et al., 2005)</td>
</tr>
<tr>
<td>Given unaccompanied children’s complex and varied route through U.S. immigration system, a combination of school-based, collaborative care, and other interdisciplinary approaches to services required</td>
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Limitations

This was a small, exploratory study representing one step towards developing a more comprehensive understanding of the mental health needs of unaccompanied children. We assessed a convenience sample of unaccompanied children and their families using measures that have not previously been validated with this population. As such there are limitations to the inferences that can be drawn.

The sampling for the study limits the generalizability of the findings with respect to children’s resettlement process, age, and geographic region. Participants were recruited through legal orientation meetings for guardians of children apprehended by U.S. immigration and then resettled to families in the NYC area pending their immigration cases. These children’s experiences may be very different from those of the approximately 15% of children who remain in government-sponsored shelters or foster-care throughout their immigration adjudication process, in whom specific detention-related concerns have been observed (e.g., Bhabha & Schmidt, 2006; Women’s Refugee Commission, 2009).

The age range for our study assessment measures meant our sample was limited to unaccompanied children ages 10 to 18. Their needs likely differ from those of older unaccompanied youth, who may not have family available to help them, frequently have limited access to services such as education and healthcare, and can be especially vulnerable to exploitation and discrimination (Feerick Center & Vera, 2015). To our knowledge, no study has looked specifically at the needs of unaccompanied children under the age of 10, who represent a small percentage of unaccompanied children (Byrne & Miller, 2012). Furthermore, it should be noted that the 10 to 18 age range covered by this sample is already quite broad, spanning several distinct periods with regard to biological, cognitive, emotional, and social development.
Qualitative data suggested that children in the study differed considerably based on age in their experiences and responses to migration (e.g., reasons for migration, journey experiences, guardianship arrangements, and experiences of distress and coping). Although the sample size was too small to discern age-based differences in quantitative analyses, taken together the study findings highlight the importance of taking into account unaccompanied children’s age and developmental stage rather than regarding them as a single, homogenous group.

Findings drawn from this sample of unaccompanied children resettled to the NYC area may not be generalizable to unaccompanied children in other parts of the United States. Unaccompanied children in NYC potentially have access to the city’s large Latino community and institutional initiatives to improve access to services for unaccompanied children (Feerick Center & Vera, 2015). However, many unaccompanied children are resettled to areas of the United States with less established immigrant communities, less provision for their needs (e.g., mental health and legal services), highly restrictive immigration legislation, strict and highly visible immigration enforcement procedures, and more discriminatory attitudes towards immigrants (Roth & Grace, 2015). All these factors may impact unaccompanied children’s process of adjustment and their mental health and wellbeing.

Selection bias based on the convenience nature of the sample also limits the generalizability of findings. Not only was recruitment limited to those children whose families opted to attend voluntary, government-sponsored orientation meetings, the sample was drawn from the subsection of the attendees at these meetings who agreed to be contacted to learn more about the study (about 40% of attendees at the LOPC meetings where the study was presented). Within that group, the final sample consisted of the approximately 20% of children and guardians who agreed to participate in this time-consuming and potentially anxiety provoking
and emotionally demanding study. Given that it was not possible to obtain data on why families did not participate in the study, attempts to characterize this subpopulation of study-participating children are speculative. However, considering the demands of the study, it seems likely that it selected for guardians who were especially warm, attentive, trusting, and resourceful. Some children might lack such care, compromising their access to other resources such as school, medical care, and legal assistance. Relatedly, despite efforts during recruitment to emphasize a broad interest in child’s migration experience, some families may have been primed to participate because of concerns about the child’s mental health or hope that participation would help them to access other resources, such as the many families who asked the study team for legal referrals. Alternatively, some children who were especially traumatized by their migration experiences may have declined to participate because of their high level of distress. Each of these factors potentially shaped our findings.

Reluctance to share certain aspects of their experiences, impression management, and perceived demand characteristics may also have impacted our findings. Efforts were made to put participants at ease, to balance directive questioning from structured instruments with open-ended questions about children’s experiences during the narrative interview, and to give children the opportunity for self-disclosure via their autoethnographies. Nevertheless, some children and guardians may not have felt comfortable sharing traumatic experiences in a one-off interview with a stranger (indeed, some guardians noted that their children had not told them about aspects of their migration). Furthermore, despite reassurances of anonymity and confidentiality, some participants might have self-censored in relation to certain sensitive topics, such as their experience of discrimination and their thoughts about their immigration cases and treatment by the government. There is also a possibility that some participants, honing in on the study’s
mental health focus, overemphasized children’s symptoms. It is also possible that some participants were motivated to participate in the study by the possibility of mental health service referrals—perhaps to include psychological assessments in support of their immigration cases—and that they overstated symptoms to make sure referrals were provided. However, it should be noted that the informed consent for the study stated that any participants interested in mental health referrals would be provided with these. Furthermore, on Likert-type items from the screening measures, most children and guardians rarely placed children’s symptoms at the severe end of the range. In addition, from a cultural standpoint, if participants had been inclined to pathologize children’s experience, it appears that they would have endorsed items such as agitation, incoherence, hallucinations, and rule-breaking associated with locura rather than the anxiety and depression symptoms normalized as nervios in Latino culture. Furthermore, when provided with referrals based on the children and guardians’ reporting of symptoms, many families chose not to seek mental health assistance.

Formal measurement of trauma response in this study was limited to the assessment of PTSD on the DISC-IV and RATS. Measurement of certain symptoms that have been associated with trauma in children at different developmental stages and in non-Western contexts (e.g., enuresis, parasomnias, somatic complaints, convulsions) would have provided a more complete profile of trauma response in our sample. A further limitation of the study is that it did not include any measures of guardian exposure to traumatic stressors and guardian mental health difficulties. Traumatic exposure and psychopathology in parents have been identified as a risk factor for child mental health difficulties in other populations of migrant youth (Fazel et al., 2012), and many guardians in the study described very stressful experiences of their own.
No mental health measures have been validated for use with unaccompanied children in the United States. Although care was taken to select instruments which had been validated for use with similar populations (e.g., the HSCL-37A, RATS, and A&A for Spanish-speaking and other unaccompanied children in Northern Europe, and the DISC-IV for Latino immigrant youth in the United States), this nevertheless presents a caveat to the data obtained using them. Preliminary analyses, although limited by the small sample size, provided some initial evidence for the reliability, construct validity, and criterion validity of these measures. However, the lack of a cross-culturally validated, gold standard measure for mental health diagnosis in migrant youth from Latin America against which other measures can be compared necessarily limits confidence in the data they provide.

Statistical analyses in the study were hindered by the small sample size, which reduced the power to identify associations between different variables analyzed. The small sample size also meant that statistical tests were largely limited to non-parametric tests and simple bivariate analyses that did not allow for identification of confounding effects or tests of mediation and moderation. Given the complexity of risk and resilience pathways suggested by the qualitative analyses in this study, findings drawn from the simple tests of association conducted should be regarded as tentative. The fact that some characteristics were shared by the great majority of children interviewed (e.g., experience of pre-migration violence, mother as guardian) limited the variability of the sample and thus the likelihood of Type II error in tests involving these variables. The two sets of siblings in the sample inevitably shared certain experiences, as well as having the same guardian provide data. While the inclusion of siblings in the sample added richness to the qualitative data, in some statistical analyses this presented a violation of the assumption of independence of observations.
The cross-sectional study design, with all data except the follow-up on mental health service utilization collected at a single time point, limited the capacity to make causal inferences based on associations between different variables. In some instances (e.g., the relationship between pre-migration abuse and current mental health presentation) the clear time sequence allowed for greater confidence in the direction of causality. However, had associations between post-migration stressors (e.g., bullying in school) and current psychiatric symptoms proved significant, the direction of the relationship would have been harder to discern. Given that risk and resilience pathways develop over time (Panter-Brick & Leckman, 2013), longitudinal research is needed to understand these processes more fully.

The study, and in particular the qualitative analyses, helped identify a number of different factors that appear to contribute to risk and resilience pathways in unaccompanied children. However, the ability to understand and test hypotheses relating to these processes empirically was limited by the study’s lack of non-diagnostic measures. Although the Stressful Life Events and Adaptation and Attitude questionnaires provided some broader contextual data, the inclusion of other instruments assessing variables such as functioning across multiple domains, psychological constructs such as self-efficacy and attachment, and access to psychosocial resources might have helped provide a more detailed sense of the interrelated factors informing risk and resilience in the sample.

**Future Directions**

Some of the limitations of the current research reflect its particular goals. Rather than testing hypotheses and providing answers to specific questions, the primary objective was to provide a broad view of unaccompanied children’s situation and data to stimulate future research, interventions, and advocacy with these youth.
Research. Future research should seek to investigate the needs of other groups of unaccompanied children not represented in this study, such as children under 10 and those who have passed the age of 18, children retained in different types of government detention, children living in the community in other parts of the country, children from different parts of the world, and children who have entered the country undetected. Comparisons between findings from this study and previous research (e.g., Feerick Center & Vera, 2015; Women’s Refugee Commission, 2009) suggest both similarities (e.g., separation trauma) and differences (e.g., experience of discrimination and level of community support) in the experience of unaccompanied children based on their demographics and migration contexts. Likewise, it would be helpful to understand how unaccompanied children’s experiences and needs compare to those of other migrant youth in the United States, as Bean and colleagues did in their research with unaccompanied and other migrant children in Northern Europe (e.g., Bean et al., 2007; Derluyn et al., 2008). Identification of what is common and unique to different groups of migrant youth would facilitate better understanding of their experiences and help tailor services to different children’s particular needs.

In the future, studies should also address limitations inherent in research using convenience samples. In their longitudinal research in the Netherlands, Bean and colleagues were able to recruit thousands of children and caregivers into their study, representing a large proportion of all unaccompanied youth in the country. This was in large part as a result of conducting the study under the auspices of the Nidos Foundation, a guardianship organization responsible for the care of all unaccompanied children in the Netherlands. Given the less coordinated approach to unaccompanied children in the United States, this type of design is likely not possible. The closest equivalent might be coordinating research through the
government’s Office of Refugee Resettlement, but this would likely present ethical concerns. A more viable solution in future research might be to better understand selection bias by gaining data on reasons for agreeing or declining to participate from all potential research subjects.

The pattern of results from the DISC-IV (e.g., high rates of separation anxiety but low rates of PTSD) likely reflect a combination of the particularities of unaccompanied children’s experiences, cross-cultural differences in their presentation of distress, and limitations in the measurement of their symptoms using instruments that have not been adapted and validated for use with children from Latin America. Future research should seek to tease apart these differences and understand the factors influencing different manifestations of trauma and other forms of distress in unaccompanied children. Criterion validation of a structured diagnostic interview such as the DISC-IV (e.g., via comparison with results of a culturally sensitive clinical interview) would help verify diagnostic prevalence rates and, by providing a point of comparison, facilitate the development and adaptation of culturally appropriate screening measures.

Our sample was too small to make definitive statements about the psychometric properties of the screeners used in our study, but our initial results suggested that the RATS and externalizing scale of the HSCL-37A may have limited utility in screening for PTSD and behavioral problems in unaccompanied children in the United States. Future validation research should assess the psychometric properties of a wider range of instruments including tests of functioning and positive coping to facilitate understanding of risk and resilience broadly rather than just mental health presentation narrowly. Determination of cutoffs for these measures should involve not only comparison against other psychological measures but also children and caregivers’ impressions of the child’s mental health, wellbeing, and need for help (Bean, 2006;
Bolton et al., 2007). Validation studies of this kind will be greatly facilitated by larger sample sizes.

Future research involving longitudinal designs and larger samples should seek to test specific, theory-driven hypotheses related to children’s risk and resilience processes in order to identify critical moments and areas for intervention with unaccompanied children. For example, results from this study suggest that aspects of Conservation of Resources theory (e.g., the relative impact of traumatic events versus associated resource loss, the clustering of resources in resource caravans [Hobfoll, 2014]) may be highly applicable to these children’s migration experience and of practical significance in assessment of need and resource provision. The results of our study suggest several potential areas for more targeted, theory-driven research, such as factors mediating the relationship between pre-migration abuse and vulnerability to migration stressors, the impact of aversive detention experiences, the protective role of psychosocial interventions provided in child shelters, and the role of child-caregiver attachment and post-migration community resources in supporting resilience processes. Future studies should also seek to measure variables at different systemic analysis—ranging from biomarkers of stress to the mental health impact of government immigration policies—largely ignored in the child migrant literature to date.

There is also a need for more studies incorporating mixed methodological approaches. In this study, qualitative data detailing children’s experiences and perspectives was invaluable in clarifying findings from quantitative analyses, and the autoethnographies in particular helped access children’s attitudes in ways that were less clear from the other study measures. Future studies should prioritize methodologies that place children at the center of the research experience. The participatory action research model used in the focus groups led by
unaccompanied youth for the research by the Feerick Center and Vera Institute (2015) offers a compelling example of such research. A rapid ethnographic assessment approach (e.g., Betancourt et al., 2009), whereby unaccompanied children are asked to describe aspects of their communities rather than their own personal experiences, should also be considered. These qualitative, child-centered approaches may improve accurate reporting of events (by reducing demand characteristics and facilitating authentic communication), help identify and understand protective attitudes in unaccompanied children (e.g., narratives of fortitude and overcoming), and additionally serve as a form of psychosocial intervention for the participating children.

**Psychosocial intervention.** Although unaccompanied children are exposed to myriad stressors during their migration processes and frequently present with mental health symptoms, to conceptualize them as a de facto clinical population obscures the resilience trajectories observed in these children in this and other studies. Definitions of service provision for unaccompanied children should include the broad range of services that contribute to their wellbeing: ranging from school and legal services to community programming and more formal psychological services such as school-based counseling, support groups, and specialized mental health treatment.

Corroborating findings from previous research, our study indicated that families often have considerable difficulty accessing psychosocial services. It suggested both a need for greater availability of services (from legal representation to counseling) and also interventions to help children access existing resources. ORR’s post-release services offer one example of a program designed to facilitate service assess. However, our findings suggest that families would benefit greatly from additional assistance in navigating the complex educational, healthcare, and legal systems they encounter. Many guardians of unaccompanied children have themselves endured
traumatic migration processes, and frequently they are confronting their own legal, social, and economic challenges when they take on the additional role of caring for their recently arrived children. These guardians should be assisted not only in supporting the unaccompanied children entrusted to their care, but also in accessing psychosocial services they may require for themselves. Good parent mental health is an important protective factor against psychopathology in displaced children (Fazel et al., 2012).

One model for service access is providers working with unaccompanied children in one field acting as a conduit to other services (e.g. an immigration lawyer referring a child client to a therapist). NYC, with its commitment to expanding and integrating services to meet unaccompanied children’s needs, would provide an ideal place to model and compare the feasibility of different pathways into care (e.g., via schools, pediatricians, lawyers, and immigration court). For several families in our study, school in particular provided an access point for additional services. Schools’ potential as a gateway to services for unaccompanied child should be leveraged via in-service trainings on the mental health needs of unaccompanied children, the development of in-school programming to support resilience in immigrant youth, and assistance in coordinating referral to other needed services (e.g., attorneys and specialized mental health treatment). Another means of facilitating service access and improving children’s outcomes across psychological, social, and legal domains is through interdisciplinary approaches to care. Their effectiveness should be tested empirically and these data used to disseminate such services around the country.

At present, there are few therapeutic interventions tailored specifically to the needs of unaccompanied children (Collier, 2015; Descilo et al., 2010). Effectiveness trials should be used to test specific therapeutic interventions that have shown efficacy with children with related
challenges (as per Descilo et al., 2010), and approaches adapted as necessary. This will help ensure that unaccompanied children who require focused mental health treatment are receiving appropriate services.

Advocacy. The study drew attention to a number of areas where there is a continued need for advocacy, on the one hand to reduce children’s exposure to certain stressors and on the other hand to bolster particular supports.

The study findings affirmed the importance of facilitating children’s rapid reunification with family. Family reunification served a protective role by reducing children’s exposure to detention-related stressors, ending long separations from loved ones, and providing children with the most supportive setting possible from which to navigate the stressful post-migration period. It also served a promotive role by restoring regular child-parent contact and allowing children access to other developmentally normative experiences such as going to school and enjoying free-time with family and new friends. Family reunification has been a significant area of progress in the government’s treatment of unaccompanied children, with the percentage of children released from detention to the community progressing from approximately 56% to 85% between 2008 and 2014, and over three-quarters of these children being reunified with parents or other close family members (Graham, 2014). However, in response to the child-migrant crisis policies have been proposed in recent years that would reduce children’s release to family in the community (American Immigration Council, 2015). The mental health field has a role to play in asserting the psychological necessity of reuniting children with family whenever possible and as quickly as possible.

The mental health field also has a role to play in highlighting the negative impact of detention on unaccompanied children. Despite many years of advocacy efforts by legal and
children’s rights groups, children are still kept in alarming conditions by the Department of Homeland Security, as corroborated by the harrowing accounts from many children in our study about their time in Customs and Border Protection facilities. By comparison, Office of Refugee Resettlement child shelter facilities appear to have served an important role for some children in grounding them after traumatic migration experiences and helping to equip them and their families for the stressful post-migration period. Work highlighting best practices in this area may help improve the treatment of children across government agencies.

Advocacy is also needed in support of the mental health significance of children’s access to education, healthcare, and legal representation in the post-migration period. For children in our study, school enrolment was a cornerstone of post-migration adjustment, providing them with access to a regular curriculum, but also English-language learning, peers, and referral to other forms of professional support. Although children’s access to education regardless of immigration status is protected federally, unaccompanied and other migrant children face obstacles to school enrolment in many parts of the country (e.g., Roth & Grace, 2015), and for youth over 19 there are currently few opportunities for post-secondary public education (Feerick Center & Vera, 2015). Improving educational access would foster children’s sense of purpose, facilitate their acculturation, and ultimately enable them in becoming the contributing members of society that they aspire to be.

Compared to education, unaccompanied children’s access to other services is severely limited. In order to facilitate access to mental health treatment, our field should advocate for unaccompanied children’s right to government health insurance. Until children in our study had applied for public insurance programs, most could not afford to pay for treatment. However, New York is one of only a handful of states where children without legal status have access to
such programs. Without insurance, their treatment options are restricted to grant-funded programs and pro-bono services. However, these alone cannot address the volume of unaccompanied children requiring assistance.

The mental health field has an additional role to play in the ongoing efforts to secure unaccompanied children’s right to due process of their immigration claims. Mental health professionals can play a practical role in children’s cases by providing expert psychological testimony documenting their exposure to traumatic stressors and the psychological impact of these experiences. They can also assist children in disclosing painful events that they may be reluctant to share with their lawyers but that may be vital to their claims for immigration relief (Baily et al., 2014). More broadly, it is important to document the emotional burden placed on the many unaccompanied children who struggle to find attorneys and, as a result, face a daunting immigration process and uncertainty about their futures without legal assistance. Furthermore, by calling attention to the high rates of exposure to abuse, abandonment, violence, and other protection concerns in unaccompanied children, juxtaposed against the high rates of deportation among children who do not have attorneys to advocate for them on the basis of such concerns, the mental health field can assert the importance of increasing legal representation for these youth.

Advocacy promoting the availability and accessibility of psychosocial resources for unaccompanied children should draw attention to the supports already available to them, the potential for leveraging these to provide a more comprehensive network of services, and the resulting benefits to the entire community. Some resources that played a vital role in study children’s post-migration adjustment, such as loving families and access to the local Latino community, were automatically available to children following their arrival. Other resources,
such as school and church, were accessible within existing infrastructures. Many of the remaining resources, such as mental and physical healthcare, can be provided through coordination and expansion of existing services and their integration into care pathways. These improved services should be made available not only to unaccompanied children and their families but extended to the broader public, as one example of the way in which immigrants add resources—social, cultural, and economic—to their new communities rather than taking them away.

Documenting unaccompanied children’s vulnerability is an inevitable aspect of advocacy on their behalf. However, it may also inadvertently reiterate narratives of victimization that misrepresent unaccompanied children’s migration experiences and present concern for their needs as an optional form of charity. Instead, wherever possible advocacy efforts should be framed in terms of unaccompanied children’s rights to protections and resources that will support them in a trajectory of healthy development. Such a model better captures unaccompanied children’s view of themselves, the psychological, familial, community, cultural, institutional, and structural factors that inform their resilience processes, and the ways in which they contribute to a better society for all.

Table 16 provides a summary of these directions for future research, psychosocial intervention, and advocacy.
Table 16. Summary of future directions for research, psychosocial intervention, and advocacy with unaccompanied children

<table>
<thead>
<tr>
<th>Research</th>
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<tbody>
<tr>
<td>• Research studying larger, more broadly representative groups of unaccompanied children over time, utilizing range of methodologies</td>
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<tr>
<td>• Validation and use of broad range of measures assessing mental health presentation, functioning, and other psychological constructs</td>
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<tr>
<td>• Testing of theory-driven hypotheses related to unaccompanied children’s risk and resilience processes to inform interventions</td>
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<tr>
<th>Psychosocial Intervention</th>
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<tr>
<td>• Expanding definition of psychosocial interventions for unaccompanied children to include not only mental health treatment but also other key resources such as school, community activities, and legal representation</td>
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<tr>
<td>• Facilitating access to existing services (e.g., use of school-based mental health services, enrollment in public health insurance, referral to pro bono legal programs)</td>
</tr>
<tr>
<td>• Developing and disseminating interdisciplinary services and networks of care for unaccompanied children that:</td>
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<tr>
<td>o identify critical moments and areas for intervention</td>
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<tr>
<td>o integrate medical, legal, psychological, and social supports</td>
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<tr>
<td>o leverage resources in mutually reinforcing ways</td>
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<tr>
<th>Advocacy</th>
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<tr>
<td>• Highlighting the psychological implications of:</td>
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<tr>
<td>o facilitating rapid reunification with family in the community</td>
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<tr>
<td>o improving Customs and Border Protection detention conditions and expanding best practices for Office of Refugee Resettlement facilities</td>
</tr>
<tr>
<td>o increasing availability and accessibility of education, physical and mental health care, and legal representation</td>
</tr>
<tr>
<td>o promoting access to developmentally normative experiences</td>
</tr>
<tr>
<td>• Providing expert psychological testimony in support of unaccompanied children’s immigration petitions and counseling during their legal processes</td>
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<tr>
<td>• Emphasizing a resilience perspective and adopting a rights-based (rather than a needs-based) approach to resource provision</td>
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</table>
Conclusion

Until the last few years, improving the situation of unaccompanied immigrant has been a rare area of relative consensus within U.S. immigration politics. Starting 30 years ago, a series of laws and policies reduced harmful detention practices, improved children’s access to resources following their release to the community, and expanded the forms of immigration relief available to them (Baily et al., 2011). This governmental commitment to unaccompanied children was underscored by international legal standards and ethical principles on the rights of children. These demand that children have access to developmentally normative experiences such as living with family and attending school, assert children’s right to protections such as legal representation, and emphasize that decision-making be guided by the best interests of the child. The findings from this study attest to the psychological significance of these policies and the need for continued progress in the treatment of unaccompanied children and the resources made available to them.

However, the huge rise in the number of unaccompanied children fleeing the humanitarian crises in Central America has placed a strain on the resources hitherto put in place for these children, politicized their situation, and tested the U.S. government’s resolve to adhere to international standards for children’s protection. Faced with the challenging and at times competing demands for humanitarian relief and immigration enforcement prompted by the child migrant crisis, the government has been accused of prioritizing the latter (American Immigration Council, 2015; Rosenblum, 2015).

Since the arrival of the children interviewed in this study, in summer 2014 the Obama Administration launched, in its own words, an “aggressive deterrence strategy.” This included a public awareness campaign in Central America informing families that children who attempted
to enter the United States would be sent back, helping Mexico reinforce its southern border, expediting the removal process for unaccompanied children following their arrival, and initiation of in-country processing of asylum applications (American Immigration Council, 2015; Hiskey, Córdova, Orcés, & Malone, 2016). One stated goal of this strategy is to deter unaccompanied children from risking their lives on the dangerous journey to the United States. However, reflecting findings from this study, recent research (Hiskey et al., 2016) has suggested that families from Central America are all too aware of journey dangers and the likelihood of being sent back to the United States and only risk their children’s lives due to the even greater danger of staying in their home countries.

Following the implementation of the U.S. government’s deterrence polices, the number of unaccompanied children apprehended at the U.S.-Mexican border did drop significantly from 68,541 CBP in FY 2014 to 39,970 in FY 2015. However, the number of apprehensions in FY 2016 rose again, to 59,692 (CBP, 2016). This coincided with another upsurge in violence in the Northern Triangle, particularly in El Salvador where the end of a gang truce propelled the country past Honduras to become the nation with the world’s highest intentional homicide rate (Gomez, 2016). These alarming developments serve as a reminder of the fact that the United States indeed borders one of world’s deadliest regions and of the country’s legal and ethical obligations to protect the rights of the children who are overwhelmingly the target of this violence.

In the face of these challenges, the adequacy of the protection measures put in place by the U.S. government since 2014 has been questioned (American Immigration Council, 2015). For example, in-country processing of immigration petitions is only open to the small minority of unaccompanied children’s whose parents have legal status in the United States. Based on this
criterion, not a single child in our study would have been eligible for this program. Furthermore, any children admitted through in-country processing would count against the current limit of 4,000 refugee admissions allotted annually to the entire Latin America and Caribbean region. This contrasts with the estimated tens of thousands of unaccompanied children who are likely eligible for protections under immigration law (UNHCR, 2014), before even considering other immigrant adults and youth. Likewise, the so-called “rocket dockets” that have been created to fast-track children’s removal hearings, with initial hearings within 21 days and sometimes completed via video conferencing, have left many children without legal representation and raised concerns about whether their claims for relief are receiving due judicial process (American Immigration Council, 2015). Given the stark differences in rates of immigration relief among children with and without representation (TRAC, 2014), these seem well founded.

Following the surge, legislative efforts to build on the progress of the last few decades in protecting unaccompanied children’s rights and needs have largely stalled, and countermeasures have been proposed that would walk back some of the protections provided by bills such as TVPRA. In late 2015, Congress did approve $750 million to tackle the organized crime in the Northern Triangle countries that is such a significant push factor for child migration (Gomez, 2016). However, the Border Security, Economic Opportunity, and Immigration Modernization Act, which was approved by the Senate and would expand protections for unaccompanied children (e.g., requiring that they have access to legal representation), has remained stalled in congress since 2013. Furthermore, a series of bills have been proposed that would, among other changes, make children eligible for immediate deportation without appearing before an immigration judge, expand the time limit for unaccompanied children to be transferred from Customs and Border Protection detention to Office of Refugee Resettlement facilities from 72
hours to 30 days, require mandatory detention until children’s initial hearings, and limit the government’s ability to provide legal counsel (American Immigration Council, 2015). The election of Donald Trump to the U.S. presidency on a platform of increased immigration enforcement and restriction may increase the likelihood that these and other proposals curtailing unaccompanied children’s rights to international humanitarian protection, humane treatment in the U.S. immigration system, and due process of their cases will be signed into law.

Given the fraught politics and legal questions surrounding unaccompanied children, their psychosocial context is often neglected (Derluyn & Broekaert, 2008). However, our study indicated the psychological impact of systemic factors at every level of their social ecology. Thus, policies that prohibit unaccompanied children fleeing violence to come to the United States unless their parents are documented, measures to restrict children’s access to legal representation and their right to due process of their immigration claims, legislation to keep children in detention rather than releasing them to their families, and other changes proposed in response to the child migrant crisis would have damaging psychological consequences for tens of thousands of the Americas’ most vulnerable youth. Conversely, measures that open children’s access to legal representation and fair assessment of their immigration claims, allow them to live with their parents while these are being decided, permit them to go to school and enjoy other communities activities, and to receive health and mental health services if they need them can help place them on trajectories of normative development and resilience. Many of these resources already exist, and can be made more accessible with minimal changes to existing infrastructures. Others need to be scaled up. Children’s right to all of them is enshrined in international law.
A focus on psychosocial context also encourages us to see unaccompanied youth as
cchildren with individual stories. This study suggests that hearing those stories is an important
starting point for understanding these children’s migration experiences and their complex risk
and resilience trajectories. They help us understand children’s mixed feelings about leaving their
home countries and coming to the United States, how they can have experienced horrific
adversity and have normal childhood wants and needs, and how they can be highly distressed
and yet functional in many aspects of their lives. The tentative findings from this small
convenience sample of unaccompanied children reunified with family in NYC will benefit from
re-examination in larger, more broadly representative samples. That research should be closely
allied to ongoing advocacy efforts to protect the rights and needs of unaccompanied children and
to promote the availability and accessibility of key psychosocial interventions. One challenge in
these efforts will be to resist simple categorization of unaccompanied children based on their
legal, political, or social contexts, and to retain appreciation for the fact that each child and
family has a unique story and perspective.
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