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# Scaffolding Resilience: Child Life Work with Immigrant and Refugee Children in the Hospital Setting

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**Scaffolding Resilience: Child Life Work with Immigrant and  
Refugee Children in the Hospital Setting**

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### **Abstract**

Immigrant and refugee children experience and cope with significant traumatic experiences in their countries of origin, in host countries, and during their immigrant or refugee journey, impacting their development and ability to cope with stress. Child life specialists who encounter immigrant and refugee children and families in the healthcare setting have an ethical and professional duty to advocate for the rights of these vulnerable children and families as well as approach clinical work from a strengths-based, culturally competent, patient and family centered, trauma sensitive perspective. This paper endeavors to guide child life work with immigrant and refugee children in the healthcare setting, discussing the details of current political policy, legislation, and their effects on immigrant and refugee children, investigating precedents set by medical and educational institutions for the support of immigrant and refugee children, and recommending actions to scaffold immigrant and refugee children's resilience from the individual specialist level to the Association for Child Life Professionals policy level based on the application of Bronfenbrenner's ecological systems theory to the role of the child life specialist with immigrant and refugee children.

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## Introduction

Isolation, fear, desperation, frustration, helplessness, endurance, courage, strength, hope - these words define and describe the experience of many immigrant and refugee children and families I have had the privilege of working with in the hospital setting. Often separated from extended family and friend support networks with linguistic and cultural barriers, immigrant and refugee children and families face enormous challenges as they navigate daily existence in their new homes (Shenfeld, 2017). The additional hurdle of hospitalization adds even more stress to these patients and families as they struggle not only to comprehend and navigate a foreign environment and culture in a foreign language, but also must grapple with the traumas and anxieties stemming from their experiences in their countries of origin, fears of miscommunications leading to difficulties with medical treatment, or even possible apprehension and deportation. Immigration documentation status and refugee identity can impact the hospitalization itself (American Academy of Pediatrics, 2013). In some cases, immigrant and refugee status can cause lengthier hospitalizations so that patients can have access to continued treatment and not be deported back to a country without the healthcare infrastructure to support their needs. Healthcare history in countries of origin can also affect hospitalization, as health, living, and treatment disparities can result in inadequate care, preventable disease, and delayed development (Young et al, 2016). Trauma experiences and chronic stress also impact the health of patients and families, both from their experience in their country of origin, their immigration or refugee journey, and their experience living in anti-immigrant and refugee conditions (American Psychological

Association, 2014). The threat of deportation is also traumatizing, in some cases resulting in complex psychological and physical conditions such as *Uppgivenhetssyndrom*, a medical condition of complete and total catatonic-like withdrawal observed in refugee communities in Sweden whose only effective treatment is a residency permit (Aviv, 2017). Hospitals do not exist in vacuums, nor do the patients and families they serve or the individuals who serve them. As child life specialists, we must be aware of and are responsible for interacting with and accounting for the variables and stressors which are associated with the wider social and societal context outside of the hospital setting, especially in regards to their impact on individuals within the healthcare setting and their effects on patient care and hospital policy.

There is a crucial need for developmental and psychosocial support for immigrant and refugee children and families worldwide. It is my hope in limiting the scope of this paper that a more focused inquiry into child life work with hospitalized immigrant and refugee children in the US can identify themes and strategies which may be applied by child life specialists and interdisciplinary medical teams to this critical work with this vulnerable population both within and outside of the healthcare setting in the US and other countries worldwide.

## **Background**

Before entering into a discussion of the immigrant and refugee experience and child life's role therein, we must first establish an understanding of this paper's lexicon. In this work, the word immigrant refers to an individual who has immigrated or traveled to a host country from their country of origin for the purpose of resettlement, someone who has moved from one country to another in order to begin a new life there. The word immigrant has two main qualifiers – documented and undocumented. Documented immigrants are individuals who have resettled in their host country through the processes and policies of the host country's government. Undocumented immigrants are individuals who have entered and/or resettled in their host country by some other means. In some instances, these qualifiers acquire additional labels, such as legal vs. illegal. For the purposes of this paper, only the words documented or undocumented will be used as this author chooses to embrace strength-based vocabulary. In close association with the word immigrant, the word migrant refers to an individual who travels for the purposes of employment. The word migrant may refer to an individual who travels within their country of origin or from their country of origin to a host country, but carries the distinction of temporary relocation. When the intention of an individual who has traveled to a host country for work changes to the intention of traveling to a host country for resettlement, the description of migrant changes to immigrant. The word refugee refers to an individual who has fled their country of origin due to reasons such as war, persecution, or natural or manmade disasters and whose reason for fleeing has been legally recognized by the host country. Refugee status carries legal protection and material assistance, or

asylum, and refugees are usually granted Licensed Permanent Residency (LPR) status after one year of continuous residence in the host country. The word asylum denotes the political and legal protection granted by a host country to a refugee. Those granted asylum are refugees, while those seeking asylum are asylees. These labels radically alter the opportunities open to immigrant and refugee children and families, impacting their access to healthcare, education, employment, and economic and legal resources. When working with this patient population, it is important to understand this terminology in order to understand the unique psychosocial needs, stressors, and adverse health effects impacting children and families as a result of these labels.

Other terminology is also relevant to this paper's discussion of the role of certified child life specialists with immigrant and refugee children. The term Unaccompanied Alien Children (UAC) is a label given by the US government to children under the age of 18 years who have no parent or legal guardian present and are undocumented at the time of their apprehension. This label results in very specific treatment and courses of action that will be discussed later in this paper (Chen et al, 2015). Unaccompanied Refugee Minors (URM) is a version of the UAC designation reserved for children who have gained refugee status, meaning that they can prove that they have fled their country of origin due to reasons such as war, persecution, or natural or manmade disasters and that their reason for fleeing has been legally recognized by the host country, that they have been recognized as victims of human trafficking and earned what is called a T visa, that they have been given Special Immigrant Juvenile Status (SIJS), or that they have witnessed or been harmed by substantial abuse and have agreed



to collaborate with law enforcement and government officials to assist with investigation and prosecution of the crime, the necessary qualifications for a U visa (Administration for Children and Families, 2015). The term Temporary Protected Status (TPS) refers to a designation granted by the US Secretary of Homeland Security to immigrants from specific countries where the US government judges that conditions or circumstances prevent their safe return. This status protects individuals with TPS from deportation and marks them as eligible for employment, travel, and healthcare. TPS, however, is, as its name denotes, a temporary status and the protection does expire. When TPS expires, individuals no longer under this protection lose documented immigration status and are required to return to their country of origin unless those individuals pursued other documented status during their TPS period (National Immigration Law Center, 2016).

Deferred Action for Childhood Arrivals (DACA) is a program from the Obama administration established via executive action that offers temporary relief from deportation and work authorization for undocumented immigrants who immigrated to the US in childhood and meet a set of requirements (National Immigration Law Center, 2017). DACA does not provide a path to citizenship, but DACA status is protective and can be renewed. The Development, Relief, and Education for Alien Minors (DREAM) Act, also a product of the Obama administration, does attempt to provide a path to citizenship, providing conditional residency based on specific qualifications which, after a period of 6 years during which more requirements must be met, the individuals could be granted lawful permanent residency through a three step process (National Immigration Law Center, 2017). Political controversy and discussion surrounding TPS, DACA, and

the DREAM Act may result in stress and uncertainty for individuals with those statuses or aspirations for those statuses and may affect their ability to cope during hospitalization.

For the purposes of this paper, it is additionally important to mention the vocabulary surrounding the removal of undocumented immigrants. The US Immigration and Customs Enforcement (ICE) and US Customs and Border Patrol (CBP) seizes custody of undocumented immigrants and relocates them back to their country of origin through a process known as deportation. According to ICE and CBP policy, certain locations are recognized as “sensitive locations”, meaning that ICE or CBP officers will not pursue undocumented immigrants for the purpose of apprehending and deporting them when those undocumented immigrants are in certain designated places (US Customs and Border Protection, January 18<sup>th</sup>, 2013). These “sensitive locations” are listed as schools, medical treatment centers, places of worship, religious or civil ceremonies, and public demonstrations (US Immigration Customs and Enforcement, January 31, 2018). According to ICE policy, apprehension may take place in so-called “sensitive locations” when “exigent circumstances exist, other law enforcement actions have led officers to a sensitive location, or prior approval is obtained from a designated supervisory official” (US Immigration Customs and Enforcement, January 31, 2018). The wording of this policy has remained the same throughout changes in administrations (US Department of Homeland Security, March 15, 2017). However, ICE apprehension has become an increased threat for undocumented immigrants within “sensitive locations”, as evidenced by the US government’s *Fiscal year 2017 ICE Enforcement and Removal*

*Operations Report* (US Immigration Customs and Enforcement, December 13, 2017). To avoid apprehension and deportation, undocumented immigrants can pursue sanctuary. Many locations, from churches to cities, have declared sanctuary status in an effort to protect undocumented immigrants. Sanctuary status means that the city, church, or organization will limit its cooperation with ICE agents in order to protect undocumented immigrants who are legally considered low-priority insofar as they do not have a criminal record (Le, 2017). Hospitals and schools have declared themselves as sanctuaries in addition to churches and cities (Icahn School of Medicine, January 3, 2017). Child life specialists should be aware of the sanctuary status of the city in which they are working and their hospital's sanctuary status in order to best understand and advocate for the rights of patients and families in their care.

Beyond terminology, it bears merit to discuss who the immigrant and refugee children are that American certified child life specialists may be supporting during their hospitalization. According to data from the UN Refugee Agency, there are approximately 65.6 million forcibly displaced people worldwide, over half of which originate from South Sudan, Afghanistan, and Syria. Of those 65.6 million people, approximately 22.5 million become refugees and approximately 189,300 of them resettle in host countries (UN Refugee Agency, 2017). Approximately 84,995 refugees were resettled in the US in fiscal year 2016 from countries such as the Democratic Republic of Congo, Syria, Burma, Iraq, Somalia, Bhutan, Iran, Afghanistan, and many others (Lopez et al, 2017). The Immigration and Nationality Act (INA) specifies numerical limits for dispensation of lawfully permanent resident status to immigrants based both on per-country limits and

family-based admission categories. Each fiscal year, an allotted number of immigrants per-country are granted documented immigration status with preference given to family reunification. According to a February 2016 Congressional report, the INA establishes a “permeable cap” of legal admissions at 675,000 individuals (Kandel, 2016). The limit is referred to as a “permeable cap” because it includes both immigrants who are sponsored by families, immigrants with employment-based preference, immigrants who have gained a VISA through a lottery system, and immediate relatives of US citizens, refugees, and asylees for whom no limit applies (Kandel, 2016). Estimates from a Pew Research Center 2015 study approximate that 44.7 million individuals living in the US are foreign born, 33.7 million of which are documented (including both naturalized citizens and those with a temporary protected status) and 11.0 million of which are undocumented (Lopez et al, 2017). These documented and undocumented immigrants come from Mexico, China, India, and many other areas of the world. The immigrant and refugee children and families in America, just like all families in America, range widely in age, gender, race, religion, culture, sexuality, nationality, and health status.

The immigrant and refugee patient population with which American certified child life specialists work and about which this paper will discuss is incredibly diverse. Patients and families come from more places, speak more languages, and have more cultural variety and lived experiences than this paper can possibly cover. For this reason, this paper will not focus on specific details pertinent to individual refugee and immigrant patient populations by country of origin, culture, or language. Rather, it will approach child life work with immigrant and refugee children from a developmental theory

perspective, inquiring into child life's role with this patient population from the perspective of Urie Bronfenbrenner's ecological systems theory. Additionally, following a review of the established literature on immigrants and refugees, statements from medical institutions, and policy documents, this paper will propose suggestions for child life work with this patient population, both on an individual patient-specialist level and on a broader policy level, suggesting considerations for hospital policy and standards and actions for the Association of Child Life Professionals.

## Literature Review

There is a wealth of literature speaking to the experience of immigrants and refugees. Much of the existing literature documents the experience of adult immigrants and refugees, or those over the age of 18 years. The literature review of this paper will discuss this literature, drawing upon the experience of immigrant and refugee adults in order to understand the lived experience of immigrant and refugee caregivers and/or adults in the lives of immigrant and refugee children. Of great focus in this literature review is the immigrant and refugee experience within the healthcare setting and the established precedents for immigrant and refugee care, including studies documenting the evidence of adverse health effects of anti-immigrant legislation and the need for consideration of such effects by healthcare providers and politicians. Studies included in this literature review were available on the public domain via online resources or accessible through the Bank Street library. Studies were included which discussed documented or undocumented immigrants and refugees. While the scope of this paper is limited to the US, studies pertaining to countries other than the US were also included for the purpose of reflection and comparison. This literature review sought to inquire into the available literature in order to gather evidence for the role of child life specialists with this patient population.

Many of the articles reviewed for this paper discussed the adverse health effects of anti-immigrant legislation on immigrants and refugees. The Center for Disease Control and Prevention (CDC) has spearheaded inquiry into the effects of adverse childhood experiences (ACEs), documenting the effects of traumatic stress on children through the

collection of longitudinal data (Center for Disease Control and Prevention, 2016). According to these studies, the CDC has uncovered the strong relationship between ACEs and disrupted neurodevelopment, social, emotional, and cognitive issues, risky behaviors, disease, disability, social problems, and early death (CDC, 2016). The work of the CDC is corroborated by the work of Harvard's Center on the Developing Child, showing how the stress of major adversity in early childhood, such as that of immigrants and refugees, can impact brain development, altering brain architecture and conditioning the body's stress response system to be on a continual alert, negatively impacting biological growth and development, attention span, learning abilities, and even leading to heart disease (Center on the Developing Child, 2007). The work of the National Scientific Council on the Developing Child also bears evidence of the adverse effects of stress, illustrating the negative effects of persistent fear and anxiety on children's learning and development (National Scientific Council on the Developing Child, 2010). The lived experience of immigrant and refugee children and families is not the only cause of trauma. As evidenced by many of the articles reviewed for this paper, anti-immigrant legislation and political rhetoric results in traumatic stress, adverse health effects, and can be associated with or considered responsible for social conditions leading to adverse childhood experiences.

As seen in the reviewed literature, anti-immigrant legislation, policies, and political rhetoric causes adverse health effects for the immigrant and refugee population. A 2013 study of the adult American Latino population showed a strong correlation between perceived discrimination and anti-immigrant legislation, bearing implications for

traumatic stress and adverse health effects within the Latino community (Almeida et al, 2016). A systematic literature review of the last decade's worth of articles on immigrants identified a clear association between immigration policies and adverse health outcomes, especially mental health, and the increase in adverse health effects in localities and jurisdictions where policies were not welcoming to immigrants and refugees, particularly among children of undocumented families, sex workers, and members of the LGBT community (Martinez et al, 2015). A study investigating the health consequences of legal stratification, or documented versus undocumented status, from a life-course perspective revealed that undocumented legal status can result in disadvantages, marginalization, and increased exposure to health risks, including ACEs (Torres et al, 2016). In an inquiry into the effects of pro-immigrant legislation, a study investigating the effects of DACA on the Asian Pacific Islander (API) community documented that DACA improves the mental health, access to health care, educational opportunities, and economic stability of DACA recipients within the API community, providing evidence for the positive health effects of pro-immigrant legislation (Sudhinaraset et al, 2017). Additional studies of DACA suggest improved access to healthcare through the protective status provides great mental health benefits to DACA-eligible individuals, not only in their increased abilities to access healthcare, but also through the relief of the fear of deportation (Venataramani et al, 2017). As the adverse health effects of anti-immigrant legislation and policies and the positive effects of pro-immigrant legislation and policies becomes apparent, healthcare professionals have begun to take a stand, calling on politicians to act in the best interest of immigrant and refugee children and families (Kazan, January 27, 2017).



Of particular focus of healthcare professionals is the toxic effect of the treatment of Unaccompanied Alien Children (UAC). According to US governmental policy, when UAC are apprehended, they are automatically charged with violating US customs and immigration laws, detained, and placed in deportation proceedings involving the complex interplay between multiple legal systems (Chen et al, 2015). Apprehended 0-18 year old UAC are fed through CBP processing centers. After 72 hours in holding at CBP centers, UAC are then transferred by ICE to the Department of Health and Human Services' Office of Refugee Resettlement (ORR) custody where they are either repatriated or sent to residential centers (Kandel, May 11th, 2017). According to the 2008 Trafficking Victims Protection Reauthorization Act (TVPRA), UAC originating from contiguous countries, as in Mexico or Canada, must be returned to their country or placed into formal removal proceedings within 48 hours of apprehension (Kandel, May 11<sup>th</sup>, 2016). A UAC from Mexico or Canada is thus not given access to any form of legal proceedings, except if he or she is able to prove to CBP that the UAC is a victim of a severe form of human trafficking, is at risk of human trafficking upon return, has a "credible fear of persecution", and is able to make an independent decision about their return according to CBP officer determination (Luiselli, 2017). Contiguous country repatriation of UAC, or "voluntary return", must occur within business hours to the country of the UAC's nationality or their last habitual residence and a government official or designee must sign for custody of the UAC (Kandel, May 11<sup>th</sup>, 2016). UAC from non-contiguous countries who are not immediately repatriated may be temporarily released to family members or sponsors while they await legal proceedings, but many are held in

detainment facilities where they face adverse conditions as they juggle the enormous pressures and demands of seeking legal relief from deportation in a foreign country where they may or may not speak the language, where they are separated from their family and support systems, and while they cope with the effects of whatever trauma or conditions caused them to seek residency in the US (Chen et al, 2015).

A UAC's treatment and processing by ORR is dictated by multiple factors. According to statements from ORR, a child's history of trafficking or sexual abuse, safety and flight risk concerns, special needs (including mental health and medical concerns), location of family and/or sponsor, siblings, age, gender, criminal history, stage of immigration hearings, place of apprehension, and length of stay in ORR custody can result in differences in their treatment (Administration for Children and Families, 2018). Age of UAC is a particularly determining factor in their placement. During processing, UAC must submit to extensive medical age assessment by ORR medical professionals, consisting of both imaging technology and physical examination, using dental, skeletal, and physical evidence to estimate the age of UAC to corroborate or negate any records UAC have or statements UAC make about their age (Administration for Children and Families, 2018). Children deemed to be under the age of 13, children and adolescents who are part of a sibling group with children deemed to be under the age of 13, adolescents who are pregnant or parenting, and those with special needs are placed in a setting deemed the "least restrictive" (Administration for Children and Families, 2018). The "least restrictive" setting does not always mean release to family or sponsorship. ORR coordinates the release of UAC to family, foster care, or sponsorship, but may also

choose to place UAC within detainment at staff secure facilities or secure facilities. Placement within staff secure facilities, locations where ORR staff offer intensive supervision, or secure facilities, locations associated with correctional facilities, occur when UAC are deemed a risk to themselves or others, at risk to escape, have a delinquent history including any gang involvement, have been considered disruptive by CBP or ORR, or have been previously apprehended and repatriated (Administration for Children and Families, 2018). Detainment facilities do not meet AAP standards for appropriate care and treatment of children (Linton et al, 2017). Awareness of the treatment of UAC and the traumatic effects of that treatment is essential to child life work with this population, providing awareness of the stressors, trauma history, and increased need for coping support a UAC may exhibit if encountered in the hospital setting. Additionally, it is not clear whether an unaccompanied individual under the age of 18 years apprehended by ICE in the healthcare setting would qualify as a UAC. Parents and caregivers are not always able to be present at the bedside. According to a Congressional brief on UAC, federal officials base UAC designation on the presence of a parent or guardian with a child within the hours immediate to their apprehension and may or may not alter such a designation following family reunification (Manuel et al, 2016). The possibility of an undocumented patient who is apprehended by ICE becoming designated as a UAC and being subjected to UAC treatment is a prospect of which child life specialists and members of the interdisciplinary medical team must be aware. Patients' and families' fear of and stressors related to this possibility can also be a factor contributing to patients' and families' abilities to cope with hospitalization.

UAC must also undergo legal proceedings discussing their immigration status. Children have a right to counsel in their legal proceedings, but the US government does not appoint counsel for UAC and many UAC are forced to represent themselves due to a loophole in the language of Section 292 of the INA wherein counsel is required “at no expense to the Government” (Manuel et al, 2016). Some UAC may have access to pro bono and volunteer counsel representation and translator services. However, of the 31,091 cases of UAC completed between July 18, 2014 and June 28, 2016, 11,781 UAC were not represented by any sort of counsel and 88.2% of unrepresented UAC were ordered removed (Kandel, January 18<sup>th</sup>, 2017). Of the UAC granted representation, only 13.4% were ordered removed (Kandel, January 18<sup>th</sup>, 2017). Children are either granted permission to remain in the US and become documented or are removed through “voluntarily return” or deportation to their country of origin (Chen et al, 2015). If UAC are granted permission to remain, their designation changes to that of Unaccompanied Refugee Minor (URM). Both UAC and URM have been found to have significant mental health issues, such as statistically significant rates of PTSD, anxiety, and psychopathology (Huemer, 2009). Rates of mental illness and exposure to traumatic events were even more pronounced among unaccompanied adolescents. In a comprehensive literature review, unaccompanied adolescents were found 36% more likely to have experienced sexual violence than the 7% of their assaulted accompanied peers and 25% more likely to experience the killing of their parents, homelessness, or being kidnapped than the 6% of their accompanied peers who experienced the same trauma across a multitude of studies in many different UAC and URM population groups

(Huemer, 2009). In the words of the president of American Academy of Pediatrics (AAP), Dr. Fernando Stein in the AAP's *Statement on Protecting Immigrant Children*, "children do not immigrate, they flee... they need our compassion and assistance." (Stein, 2017). As non-partisan, pro-children healthcare professionals, individuals in the healthcare community must take a stand on behalf of and in support of immigrant and refugee children and families, both by advocating for their rights and by approaching their care with an awareness of the traumatic events children and families have experienced and may still experience, whether due to their immigration and refugee status or through their detainment (Linton et al, 2017). Child life specialists should be included in the group of individuals called upon in the AAP's statement.

There is evidence for the adverse health effects that stem from or are comorbid with the conditions necessitating or catalyzing immigration. In a comparative study of recent refugees and immigrants as compared to UK-born residents, rates of Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Malaria, Hepatitis, helminth infections and eosinophilia, sexual and reproductive issues, poor prenatal care and maternal health, non-communicable diseases, such as heart disease, and mental health conditions were much higher in the population of refugees and immigrants than the UK-born residents (Finnerty et al, 2017). In a 2013 study comparing individuals seeking healthcare at Refugee Health Services with their matched Australian counterparts, there was a significantly higher incidence of mental illness among the refugee and asylum-seeker participants than in the Australian-born comparative group. Refugees and asylum-seekers were shown to be four times more likely to have PTSD within the last month and twice as

likely as their matched Australian-born counterparts to have it during their lifetime, 92.5% of refugees and asylum-seekers reported having witnessed a traumatic event, and their scores for depression and anxiety were also statistically significant (Shawyer et al, 2017). Despite the evidence of a crucial need for healthcare and mental health support for immigrants and refugees, barriers exist blocking access to care and were a focus of much of the reviewed literature.

While the 1986 Emergency Medical Treatment and Labor Act (EMTLA) requires that any person seeking emergency medical treatment or care receive healthcare (Centers for Medicare & Medicaid Services, 2012), there is evidence of barriers in place for immigrants and refugees seeking treatment in the healthcare setting. In a systematic literature review of the last decade's worth of articles seeking to identify barriers to healthcare for undocumented US immigrants, researchers identified common themes and categories such as healthcare and political policy, insurance and documentation needs, the structure of the health system, and individual-specific barriers such as discrimination, deportation and fear of deportation, communication issues, finances, shame or stigma, and lack of knowledge of the health care system (Hacker et al, 2015). A literature review examining refugees' experiences of general practice in 11 different host countries also highlighted similar barriers, discussing difficulty locating and physically accessing services, language barriers, poor doctor-patient relationships due to stigma and perceived or actual discrimination, and cultural conflicts (Cheng et al, 2015). The evidence of these barriers to healthcare and the intense need for quality healthcare support for immigrants and refugees has prompted the discussion of strategies to increase healthcare access.

Among these strategies, common themes such as increased cultural competency, access to translators, and integrated medical homes (Huston, 2004) are supported by organizations like the World Health Organization (World Health Organization, 2008) and the American Academy of Pediatrics (Linton et al, 2017).

There is also evidence within the literature for the role of the child life specialist with immigrants and refugees. In a study examining the association between hair cortisol concentrations (HCC) and trauma experience in adolescent Syrian refugees in Jordan as compared to their Jordanian adolescent peers during and following an 8 week intervention for stress attunement, changes in HCC levels over and following the 8 week period demonstrated the effects of culturally-competent, strengths-based, psychosocially sensitive coping education. HCC levels were observed to normalize amongst the different groups, providing psychoneuroendocrinological evidence in support of interventions rooted in child life theory (Dajani et al, 2018). The positive effects on mental health of multimodal interventions with immigrants and refugees targeting social and family adversity and structural inequalities through community and school based interventions also provide evidence for child life's role with this population, illustrating the effects of normalization, self-esteem building, peer inclusion, and culturally competent, strength-based, child and family centered care (Reed et al, 2016). Evidence in literature also serves to guide child life's role. A qualitative study of Afghan, Bhutanese-Nepali, Burmese, Iraqi, Chin, Karen, Karenni, and Somali refugee families in Rochester, NY examining the impact of culture and community-specific values on parental identification of developmental delays showed a significant impact on parents' or caregivers'

perception, identification, and practices regarding developmental delay and disability within the refugee communities. Of note, many languages lacked a word for “development” in regards to the mental and physical growth of a child, exposing both cultural and linguistic barriers to conceptual understanding (Kroening et al, 2016). The effects of culture, community-specific values, and language on parenting and parental understanding of development and developmental delay bear immense implications for culturally competent child life work. A literature review examining the refugee, undocumented immigrant, and asylum-seekers’ experience of parenthood illustrated the intense stressors unique to parents of this population, documenting the need for recognition of and support for specific population-centered stressors and communication assistance in order to enhance parents’ resilience and strengths (Merry et al, 2017). Statements from the AAP on psychosocial disaster support (Shonfield et al, 2015) and USAid’s *Psychological First Aid for Refugees and Internally Displaced Persons in Iraq Guide for Field Workers* (USAid Primary Health Care Project, 2014) stress many interventions present in any certified child life specialist’s toolbox: nonjudgmental listening, unconditional support, validation, developmentally appropriate explanations, strengths-based assessment, establishment of routine, and maintaining dignity.

At the root of child life work and the core of interventions discussed in the reviewed literature is the emphasis on building and supporting resiliency. In her work with refugee children in a camp in Dunkirk, France, certified child life specialist and Child Life Disaster Relief Director Caralyn Perlee spoke about the resiliency of refugee children observed through their play, as they reenacted ISIS attacks, perilous journeys on



boats and trucks, raids, and leaving their homes, families, and friends, sharing their stories verbally through an interpreter and through directed and child-centered play modalities (Perlee, 2017). Harvard's Center on the Developing Child defines resilience as "an adaptive response to serious hardship", discussing how crucial the presence of a supportive adult, learning self-efficacy, control, and self-regulation, and grounding stability in faith and cultural traditions can be to fostering a child's resiliency (Center on the Developing Child, 2015). A literature review of resilience in children and youth corroborates the observations of Harvard's Center on the Developing Child, illustrating the influence of supportive adults, self-confidence, and consistency in developing resilience irrespective of the differences amongst populations and time periods studied (Zollowski et al, 2012). A global perspective on the systems analysis of resilience in literature discusses the continual development and evolution of individual's resilience as they adapt to new stressors (Masten, 2014). Child life work with immigrants and refugees in the hospital setting grows out of this resiliency theory, using the language of play in strength-based, culturally-competent, child and family centered interventions to scaffold and support children as they adapt to adversity, overcoming adverse childhood experiences and traumas specific to and impacting their hospitalization, whether due to the effects of illness, injury, or treatment, anti-immigrant policy and legislation, discrimination, or so many of the barriers that exist for this population of patients and families.

## Discussion

The role of child life specialists with the immigrant and refugee child patient population has become all the more critical with the current political and global immigrant and refugee crisis. Drawing on the extensive evidence of the crucial need for psychosocial and developmental support discussed above, this paper will focus on the role of the American certified child life specialist working with immigrant and refugee children undergoing hospitalization in the United States through the application of Urie Bronfenbrenner's ecological systems theory to child life practice.

The call to help all children and families forms the root of the child life vocation. The mission statement of the Association of Child Life Professionals begins, "we, as child life professionals, strive to reduce the negative impact of stressful or traumatic life events and situations that affect the development, health, and well-being of infants, children, youth, and families" (Child Life Council, 2002, p.1). This mission to help children and families experiencing stressful or traumatic events is built on nine principles of professional ethics - beneficence, nonmaleficence, respect for persons, autonomy, justice, veracity, fidelity, competence, and confidentiality. Based on those nine ethical principles, the child life Code of Ethics states that child life specialists must maximize the physical and emotional health and social, cognitive, and developmental abilities of infants, children, youth, and families while minimizing their stress and trauma, recognizing child life specialists' responsibility toward patients, families, and other professionals. This Code of Ethics serves primarily for the benefit of and in protection of infants, children, youth, and families in circumstances where stress or trauma may be

damaging (Klein et al, 2000). In work with immigrants and refugees, the mission statement and code of ethics must continue to define the role of the child life specialist, reminding and guiding child life specialists to work for the best, most ethical treatment of children and families in their care, especially where host country politics, policy, legislation, and life experience may add to the stress and trauma of hospitalization.

Life experience in different cultural and social contexts influences the development of children, impacting their perception of themselves, their perception of their environment, and their experience-based knowledge of how to interact with their environment (Spencer et al, 1997). Urie Bronfenbrenner examined the effects of the social context on the development of children. In his ecological systems theory, Bronfenbrenner discussed the interaction between the child, family, and their environment and the effect of that interaction on the child's development, categorizing the context of a child's lived experience into five interdependent systems (Thompson, 2009). An illustration of Bronfenbrenner's ecological systems theory can be found in Table A in the appendix of this paper. Most proximate to the child, Bronfenbrenner's microsystem consists of the immediate contexts in which the child develops, such as the child's home, school, family, place of worship, or, in the case of a hospitalized child, the healthcare setting. Bronfenbrenner labeled the interacting links between the contexts of the microsystem as the mesosystem, or, for example, the ways in which a child's home and a child's healthcare setting become integrated and affect one another. Bronfenbrenner's exosystem represents the context separate from the child that continues to impact the child's development, such as the workplace of the caregiver. Beyond the

exosystem, the macrosystem represents the social and cultural context in which the child develops, its realities, consistencies, and inconsistencies in belief systems that surround and affect the exosystem, mesosystem, and microsystem of the developing child (Thompson, 2009), such as the sanctuary status of the hospital or state in which the child lives. Most distant from the microsystem, but no less impactful is the chronosystem or the temporal context of the child's development and the impact of the time period on the child's lived experience. While the dynamics of an ecological system and an individual's place within each relationship and context are constantly evolving and changing (Boyd Webb, 2009), the ecological systems of the hospitalized immigrant or refugee child bear constant implications for child life work with this patient population. Awareness of the influence of each system on the development of immigrant and refugee children defines ethically and culturally appropriate child life practice.

The child life role of advocate can become overwhelming when considered and applied to each level of Bronfenbrenner's ecological systems theory. As child life specialists, our clinical experience working with patients and families in the microsystem, mesosystem, or exosystem levels may be the most familiar and thus the most cognitively accessible for consideration. However, the interdependent nature of the microsystem, mesosystem, exosystem, macrosystem, and chronosystem in the development of the child mandates consideration of the role of the child life specialist in each level. This interdependency means that child life advocacy work geared towards chronosystemic positive change can impact the ability of a child and family to cope with hospitalization in the same way as microsystemic patient and family specific child life interventions. In

child life practice, the connections between the ecological systems and their effect on the coping of patients and families can already be seen in the practice of stress potential assessment (Gaynard et al, 1998), in which specialists consider a child and family's previous health care experiences, the child's temperament, coping style, age, and gender, the caregiver's anxiety and distress, family characteristics, socioeconomic status, the ability of the caregiver to be present and involved at the bedside, the acute or chronic nature of the illness, the length of hospitalization, and the invasive nature of treatments in order to best tailor child life care to the unique needs of the patient and family (Koller et al, 2008). Consideration of all levels of Bronfenbrenner's ecological systems theory is already common practice in child life clinical care. While acting in the advocate role of the child life specialist on the chronosystem level may seem like too large a task for any one specialist, the urgency of the needs of immigrant and refugee children and families, the interdependency of the systems, and the ethical responsibility of our profession demand that child life's role be considered and acted upon in each level. The magnitude of the need must serve not to overwhelm, but to compel child life specialists to come together on an organizational basis to advocate for vulnerable patient populations when actions go beyond the scope of any one individual. In the discussion of child life work with hospitalized immigrant and refugee children, this paper will begin with the chronosystem and progress through Bronfenbrenner's ecological systems, inquiring into child life's role in each system as an advocate and developmental and psychosocial support on both an organizational and individual-specialist relationship basis.

### The When of Child Life Work – Child Life in the Chronosystem

The temporal context of hospitalization can result in a myriad of effects for any patient and family. Children and their families hospitalized during the holiday season, for example, cope with very different stressors and have very different hospital experiences than children who are hospitalized at other times of the year by nature of that which is going on around them in their environment, what their expectations are, and what is expected of them. The impact of time period on the hospitalized child and family, or their chronosystem, carries a great deal of weight for the immigrant or refugee child. The reasons for the child's immigration or asylum seeking in their country of origin, the child's documented or undocumented status, the child's family's documented or undocumented status, the political administration's policy in regards to healthcare access and legal status for that child and that family, the hospital's policy in regards to sanctuary, and the child's developmental level and ability to understand the above are all dependent on and affected by time. All these factors also impact the child's ability to cope with hospitalization, increasing or decreasing stress and trauma. In providing care that is responsive to the unique stressors and traumas of patients and families, child life specialists must recognize the implications of the effect of each system, tailoring advocacy efforts to meet the unique systemic needs of each ecological level and reflecting the ethical duty of the specialist to support and advocate for the individual from the microsystem to the chronosystem. Recognition of the temporal aspect of advocacy is especially critical in regards to immigrant and refugee children.

The chronosystem of the immigrant and refugee child is relevant to the role of the certified child life specialist both within and outside of the healthcare setting. In the mission statement and code of ethics, child life specialists are called on to advocate for the rights of children and families and to work to minimize stress and trauma (Child life Council, 2002; Klein et al, 2000). The role and responsibilities of certified child life specialists with immigrant and refugee children and families thus extends globally to wherever children and families experience stress and trauma. In *When Disaster Strikes: A Proposed Model for Child Life Programming in Disaster Relief Settings*, certified child life specialist Caralyn Perlee writes about the application of child life theory and support to disaster relief work, fostering and promoting children's skills to communicate, express emotion, learn, heal, and build trusting relationships through play despite traumatic and stressful circumstances (Perlee, 2011). Preserving children's right to play and access to play materials is an essential role of a child life specialist. The call to advocate for children's and families' rights is woven throughout the ecological systems of a child life specialist, but is dependent upon the chronosystem, following the triage of need on the global and temporal scale. As child life specialists working in the healthcare setting or in the community, general knowledge of the lived experience of children and families worldwide is crucial to informing competent care. By becoming knowledgeable about the factors in a child or family's chronosystem, child life specialists can better support patients and families in their care on all systemic levels.

Due to the overarching nature of chronosystemic work, global and temporally centered child life advocacy work may best be visualized through its impact on the

microsystemic level. In classical representations of Bronfenbrenner's ecological systems theory, the interdependent systems appear as concentric circles, as depicted in Table A in this paper's Appendix of Tables and Figures. While this classical representation serves to illustrate the nesting of the ecological spheres of influence on a child's development, such an illustration can be limiting, directing individuals towards a rigid understanding driven by the separation of each system into systemic-specific spheres which, though they are interdependent and influence one another, nonetheless appear to interact in the concentric setting progressing from those systems closest to the child to those farthest from the child. In actuality, the ecological systems interact with one another and with the development of the child not in a progressive, concentric nature, but rather simultaneously, each impacting the development of the child continuously and at the same time. For this reason, this paper will not discuss the ecological systems in the classical order, transitioning from the chronosystem to the microsystem to best illustrate the role of the child life specialist with immigrant and refugee children in the hospital setting.

#### Patient and Family Centered Care - Child Life in the Microsystem

The most intimate level of Bronfenbrenner's ecological systems theory, the microsystem is the level in which the most interaction occurs between the child life specialist and the immigrant or refugee child. Consisting of factors integral to the hospitalized child's identity, the microsystem contains the contexts in which the child develops, impacting the developmental and psychosocial needs and stressors of the



immigrant or refugee child and presenting factors child life specialists must consider when providing care and constructing interventions. An individual's perception of and experience of stress and the resources an individual draws upon to cope with stress vary widely intrapersonally and interpersonally (Boyd Webb, 2009). The microsystem of the immigrant or refugee child represents the level upon which a child both experiences stress and finds resources to respond to stress, as seen in the stress potential assessment (Gaynard et al, 1998). The microsystem can also be viewed as the root of resiliency within the ecological system. It is within this system that children are impacted by the presence of a supportive adult, that they interact with their environment directly and learn self-efficacy, control, and self-regulation, and that they experience their faith and cultural traditions, crucial components to developing a child's resiliency (Center on the Developing Child, 2015). It is within the microsystem that the child intimately experiences stress and must adapt to stressors, the definition of resilience (Masten, 2014). Interventions for hospitalized immigrant or refugee children must be geared towards the microsystemic level of support, scaffolding resiliency on the most intimate level and working outwards from the microsystem to the chronosystem to create change and provide support for this patient population. Child life advocacy work, even work on the chronosystemic level, is thus microsystemically based, rooted in individual patient and family centered care, building resilience through culturally competent, developmentally appropriate interventions which lay the groundwork for chronosystemic and macrosystemic change on the temporal, global, national, societal, and cultural levels.

Each seemingly small act in patient care within the healthcare environment has the capability of influencing change in the world at large.

### Culture, Trauma, and Competency - Child Life in the Macrosystem

The macrosystem, or social and cultural context, also affects the hospitalized patient and family, especially immigrants and refugees. As mentioned in the literature review of this paper, anti-immigrant legislation and policy can result in traumatic stress, adverse health effects, and social conditions leading to adverse childhood experiences. The local, state, and national policies and political rhetoric of host countries may have a strong impact on immigrant and refugee children, impacting their ability to cope with hospitalization. Additionally, the social and cultural context of their country of origin, any conflicts between the social and cultural customs in their country of origin and their host country or between their country of origin and the cultural and social context of the hospital setting can adversely affect immigrant and refugee children's ability to cope with hospitalization. The impact of an immigrant or refugee child's identity on their social and cultural context can also impact their hospitalization. As mentioned above, a child's identity as UAC can result in treatment that may be highly traumatic for the child, impacting their ability to cope with medical exams and treatments in the hospital setting. Child life specialists must be knowledgeable about the possible effects of immigrant and refugee children's social and cultural context, meeting them where they are in their journey as a patient and as an immigrant or refugee child and providing care that is both culturally competent and trauma sensitive.

Child life specialists' role as supporter and advocate for children and families is also relevant on the macrosystem level. Moving from the global and temporal context to the social and cultural context on the US national scale, child life specialists have the ethical responsibility to maximize the physical and emotional health and social, cognitive, and developmental abilities of children and families and to minimize their stress and trauma (Klein et al, 2000). While the Association of Child Life Professionals (ACLP) is not a political body and it plays no role in the legislative, judicial, or executive functions of the US government, the ACLP is the governing or leading body of certified child life specialists and seeks to advance the profession and promote its standards on both a national and international level. As a body of certified child life specialists, the ACLP is similarly called upon to act as a supporter and advocate for all children and families, speaking up and acting to support children and families in concordance with the same code of ethics as individual certified child life specialists. On the macrosystem level, the ACLP must follow the precedent set by other governing bodies that support children and families within and outside of the healthcare setting, such as the AAP, standing in support of and producing policy statements in support of immigrant and refugee children and families.

#### The Implications of Caregiver Identity - Child Life in the Exosystem

The exosystem, or the context independent of the child that nonetheless affects the child, also plays a role in hospitalization. On a basic level, the identity of the caregivers of immigrant and refugee children affects their ability to be present at the

bedside and provide support to the hospitalized child. The presence or absence of a caregiver at the bedside may result from issues stemming from socioeconomic status, familial and employment responsibilities, physical and geographic location, issues with transportation, knowledge of and access to the healthcare environment, and fears regarding a caregiver's own apprehension due to undocumented status, unfamiliarity with and misunderstandings of the healthcare environment, or perceived or actual discrimination (Hacker et al, 2015; Cheng et al, 2015). The identity of immigrant and refugee children's caregivers impacts children's hospitalization beyond presence and support. Issues with language barriers and cultural conflicts may increase caregiver anxiety and decrease both the caregiver's and child's ability to cope. In an evidence-based practice statement on child life assessment of variables associated with a child's coping ability, the ACLP highlights a caregiver's anxiety as predictive of a child's emotional distress during hospitalization, during invasive procedures, and following discharge, stating that parental anxiety strongly correlates with their child's adverse response (Koller, 2008). Furthermore, the study concluded that children of lower socioeconomic status were more fearful, children with mothers who were less educated felt less in control, and children whose parents were present during hospitalization and understood information regarding hospitalization and post-discharge behavior exhibited less negative behavior following discharge (Koller, 2008), suggesting implications for the effects of caregiver identity on the hospitalization of immigrant and refugee children. Child life specialists' understanding of the impact of indirect ecological context, or the

exosystem, on a child's ability to cope is essential for child life support of immigrant and refugee children.

Child life specialists are called upon to support both the patient and the family. With the immigrant and refugee patient population, child life specialists' role and responsibilities in familial support can be a vital component of indirect patient support. Providing support for siblings and extended child family members of hospitalized immigrant and refugee children and helping to identify stressors individual to a caregiver or family's ability to navigate not just the healthcare environment, but also the environment in which the healthcare setting is located, such as the city, state, or country falls within child life scope of practice. The AAP has compiled resources relevant to exosystemic child life work of which child life specialists should be aware, such a recommendations for referrals to legal resources and an *Immigrant Child Health Toolkit* for which links are available in the resources section of this paper (AAP, 2018).

### Connecting and Coping - Child Life in the Mesosystem

The connections, or mesosystem, between the healthcare environment, the community, and the immigrant or refugee child and family are complex and result in a varied impact on the hospitalized child. The healthcare environment itself results in unique psychosocial stressors for immigrant and refugee children. The ACLP's evidence-based practice statement on factors relevant to a child's coping ability mentions a child's temperament, coping style, age, gender, acute vs. chronic illness, exposure to invasive procedures, and experience with previous hospitalization as predictive in

children's ability to cope with hospitalization (Koller, 2008). In regards to immigrant and refugee children, a child's primary language and ability to understand the spoken and written language of the hospital setting, the child's understanding of their hospitalization and the hospital environment, the circumstances that resulted in their hospitalization, previous medical treatment and examination in the host country, the presence of a caregiver, and the caregiver's ability to cope with and understand the child's hospitalization are equally if not more impactful. Additionally, as discussed in the literature review, immigrants and refugees are statistically more likely to have experienced traumatic events either as victims or witnesses, to have adverse childhood experiences, or to be suffering from PTSD (Huemer et al, 2008; Shawyer et al, 2017; Dajani et al, 2018; Luiselli, 2017). Child life specialists' knowledge of psychosocial stressors unique to immigrant and refugee children's experience in the healthcare environment as a result of the intersectionality of their identity and the complex connections between aspects of their lived experience is essential to child life support of this patient population.

The role of child life specialists as supporters and advocates for immigrant and refugee children extends into the mesosystem, as child life specialists incorporate their knowledge of psychosocial stressors and the intersectionalities of immigrant and refugee child identities into healthcare setting specific advocacy. Patient and family centered, culturally competent care defines ethical child life practice. With immigrant and refugee children and families, such ethical practice includes advocating for the use of translating services in any and all patient and family interactions when necessary to preserve and

facilitate clear communication, respectfully educating members of the interdisciplinary medical team about the unique psychosocial stressors specific to the immigrant or refugee child and family experience in respect to current politics and immigrant or refugee identity, and supporting culturally competent practice and respect of cultural and faith-based differences and needs in the hospital setting. These workplace interventions may also extend into the policy level, in advocating for sanctuary and in creating a protocol for interacting with ICE agents in the healthcare setting.

### Microsystemic Child Life Interventions

As stated in the beginning of this paper, immigrant and refugee children and families are highly diverse, ranging widely in identity in regards to their country of origin, immigrant or refugee experience, documentation status, languages spoken, culture, faith, sexuality, or socioeconomic status. The psychosocial and developmental needs of this patient population are equally diverse and call upon the full range of support from both the child life specialist and the interdisciplinary medical team. Child life interventions for hospitalized immigrant and refugee children cannot be standardized and must be tailored to meet the specific needs and goals of each patient and family. However, given the shared stressors across immigrant and refugee identities, there are child life interventions that can be beneficial for this patient population on both the individual microsystem level and on the policy level. The interventions proposed in this paper may not necessarily benefit all immigrant or refugee children or their families or

may need alteration in order to best support a patient and family. These interventions are thus proposed with regard to the discretionary practice of the certified child life specialist.

Play is widely regarded as the language of children. It is through play that children experience and learn about their surroundings as well as through play that they communicate and express their emotions (Thompson et al, 1981). In the healthcare setting, child life specialists use play to assess developmental levels and understanding, to prepare children and adolescents for procedures and correct misconceptions about procedures and treatments, to educate children and adolescents about diagnoses, to provide outlets for emotional expression and satisfaction, and to normalize the hospital setting and a child's place therein (Gaynard et al, 1998). In this context, play is typically categorized into two types – directed play and non-directed, child-centered play. This paper will propose child life interventions in both categories of play. The interventions proposed are by no means meant to be limiting. There are more ways to use play to support immigrant and refugee children than any paper could discuss. Rather, these proposed interventions are meant as a starting point for child life specialists, not only scaffolding resilience within immigrant and refugee children, but also scaffolding resilience-based practice for child life specialists in the healthcare environment.

Directed play is play with a purpose that is led by someone other than the child. Directed play is often used therapeutically to give a child the opportunity to interact with and attain mastery over a traumatic experience or event within the safety of a supportive, therapeutic relationship (Webb, 2015). This form of play is commonly used by child life specialists in a type of directed play called medical play, in which the child life specialist



uses play with medical tools, toys, and dolls or figurines to communicate with the child about a medical topic, such as to prepare the child for a procedure or discuss a diagnosis. A large component of directed play is the ability for the child life specialist to establish a supportive, therapeutic relationship with the child and to be able to communicate with the child both through the medium of play and through strength-based, developmentally appropriate dialogue. In child life work with immigrant and refugee children, communicating with the child in a language the child speaks fluently during both directed and non-directed, child centered play is essential, whether the specialist is fluent in that language or whether translating services are used. Supporting fluent communication will not only facilitate the formation of a supportive, therapeutic relationship between the specialist and the child, but also normalize the child's linguistic needs, validate the child's identity as a speaker of that language, and demonstrate to the child that the specialist is a person with whom they can communicate.

By definition, directed play has both a leader and a purpose, someone who is guiding the players, such as the child life specialist, and a point to which they are being guided which is founded in an intention, such as a plan of care or treatment goal. In the clinical environment, child life specialists construct interventions with this intentional form of play in order to restore mastery to children over trauma. With immigrant and refugee children, directed play may be very similar to directed play done with any child in the hospital setting, such as the medical play mentioned above, meant to restore control over experiences specific to the medical environment, such as in needle play with cloth dolls. Directed play with immigrant and refugee children may also be more specific to the

immigrant and refugee experience with the goal of giving the child the opportunity to express anxieties and traumas related to their journey to the host country, their experience in their country of origin, or their experience since arriving in the host country. Art-based interventions, such as the building of dioramas, illustration and writing of storybooks, or meaning-making items can augment the storytelling process, validating the child's experience as well as restoring their control over it. The process of telling their immigration story may have associated traumas of its own, especially in the cases of UAC or URM where the telling and retelling of their story is integral to their legal proceedings (Luiselli, 2017). Giving hospitalized immigrant and refugee children the chance to reclaim the telling of their story in a medium that is their own, such as through play, restores agency and control over their story to the child or adolescent. In support of pediatric cancer treatment, the creation of necklaces or long strands of beads with associated meaning to memorialize treatment and milestones, such as the Beads of Courage initiative, is common practice. Working with immigrant and refugee children to create similar talismans can have intense therapeutic value, offering the child or adolescent the chance to process their trauma and build their resilience in a safe environment with the guidance and support of a compassionate, knowledgeable adult figure. Journaling or illustrating their story can also assist in the reclamation process.

Non-directed, child-centered play is, as its name denotes, play which the child directs. This form of play is different from directed play in that it is founded in the belief that children know where they need to go in order to process their experiences and that therapists or specialists should follow the child's lead (Landreth, 2012). Both the directed

and non-directed, child-centered forms of play have merit in the hospital setting and both can grow out of treatment plans and goals. Offering the immigrant or refugee child the tools to reenact their experience in the presence of an adult who is able to understand them, communicate with them, and support them during and following the play is essential to child-centered play (Webb, 2015). In the hospital setting, providing immigrant and refugee children with access to sand and water play that incorporates figurines or dolls and loose medical and non-medical parts, such as gauze, tongue depressors, bottle caps, and rubber bands, can facilitate the child's processing of their immigrant or refugee and hospital experiences. In processing their experiences, whether through directed or non-directed play, the hospitalized immigrant or refugee child can attain mastery over them through interaction with the child life specialist. The child life specialist's strength-based, developmentally appropriate narration throughout the play-based intervention can not only validate and assert the child's control, but also lay the groundwork for the child's self-regulation and self-efficacy, scaffolding the child's resilience.

In directed and non-directed, child centered play with immigrant and refugee children, child life specialists must be mindful of their own biases and reactions as well as their scope of practice. Providing nonjudgmental, unconditional support of children as they process their trauma story is vital to the therapeutic process. In play, immigrant and refugee children may process traumatic events that are difficult hear, watch, and support, such as exploitation, assault, or rape (Webb, 2015), ISIS attacks and raids (Perlee, 2017), perilous journeys in boats or atop trains like *La Bestia* (Luiselli, 2017), or ICE or CBP

apprehension and ORR processing and detainment. 80% of women and girls who cross Mexico to get to the US border are raped, a traumatic experience that is so common amongst immigrating women and girls that many begin contraceptive precautions as part of preparation for their immigration journey (Luiselli, 2017). In addition to the trauma of rape, abductions, kidnappings, and murder of immigrants crossing the border from Mexico to the US are common and it is estimated that approximately 120,000 immigrants disappeared crossing the border between 2006 and 2015 (Luiselli, 2017). Knowing how to continue to maintain a warm, caring presence and support a child or adolescent as they process intensely traumatic events through play by monitoring one's own body language, verbal expressions, and mental bias as well as acknowledging when a child or adolescent may require support that falls outside the scope of child life practice, such as psychotherapy or legal aid, is an important component of work with this patient population.

#### Hospitalization, Immigration, and Refugee Status through the Developmental Lens

The developmental level of the immigrant or refugee child greatly impacts their ability to comprehend both their hospitalization and their immigration journey or status. Infants, babies aged 0-1, will have no concept of hospitalization or immigration. In Erikson's Trust vs. Mistrust stage of psychosocial development and Piaget's sensorimotor stage of cognitive development, infants seek to form attachments and feel safe, exploring their environment through the use of their senses, learning cause and effect, and object constancy (Rollins, 2005). Infants' experience of hospitalization and

immigration is through sensory stimulation, presence or separation from a caregiver, and through their experience of their physical needs, such as pain, hunger, thirst, or comfort. Child life interventions for immigrant and refugee infants should grow out of this developmental foundation, focusing on the infants' needs for appropriate sensory stimulation, maintenance of a predictable routine, response to the infants' cues, and incorporation of the caregiver, maximizing their involvement and supporting the formation of attachment.

Toddlers, children aged 1-3 years, may view hospitalization or immigration as a punishment or as a result of their own actions. In Erikson's Autonomy vs. Shame and Doubt stage of psychosocial development and transitioning from Piaget's sensorimotor to preoperational stage of cognitive development, toddlers seek to gain agency over their environment and enforce their will, making sense of their environment through sensory-driven exploration and incorporation of knowledge into a highly egocentric worldview, prone to magical thinking (Rollins, 2005). Toddlers' experience of hospitalization and immigration is, like the infant, through sensory stimulation, but, given their stage of psychosocial and cognitive development, toddlers understand and experience sensory stimulation in the application of their agency, interpreting the sensory-based information as a product of their own actions through egocentric magical thought. Toddlers may be prone to fears of bodily injuries and pain, frightening fantasies, or they may react negatively to separation from caregivers, and the loss of routines, rituals, and familiar environments (Rollins, 2005). Child life interventions for immigrant and refugee toddlers should also be focused on maximizing the involvement of the

caregiver, looking to restore normalcy through the establishment of routines, rituals, and the incorporation of comfort items. Using play, child life specialists can help toddlers to regain control over their environment and overcome the trauma of hospitalization and immigration by enforcing their will and restoring the ability to explore.

Preschoolers, children aged 3-6 years, may also view hospitalization or immigration as a punishment or as a result of their own actions. In Erikson's Initiative vs. Guilt stage of psychosocial development and Piaget's preoperational stage of cognitive development, preschoolers strive to enforce their will and feel accomplished, gaining independence and building their understanding of their environment and their place therein through the purposeful exploration and manipulation of their world (Rollins, 2005). Preschoolers are also prone to magical thinking and, while they use language and understand basic logic, their reasoning is not limited to logical deductions, resulting in self-blame and fears similar to those of toddlers, such as bodily mutilation and loss of control. Child life interventions for immigrant and refugee preschoolers should build upon the involvement of the caregiver as a comforting, familiar presence, incorporating routines, rituals, and comfort items to restore normalcy and providing the preschooler with developmentally appropriate choice in activities with opportunities for gratification, offering the preschooler the chance to feel in control and accomplished.

School-aged children, children aged 6-12 years, have an increased ability to comprehend meaning in a series of actions and may understand hospitalization as a result of illness or injury and immigration as a result of the need to flee traumatic circumstances in the country of origin or to seek safety or to reunite with family members in the host

country. In Erikson's Industry vs. Inferiority stage of psychosocial development and Piaget's concrete operational stage of cognitive development, school aged children seek to feel successful and competent in activities valued by their peers and trusted adults, understanding their environment in an increasingly logical way that is based on their learned experience and concept of the order of sequences and constancy, building justification for their experiences and their understanding of the experiences of others on this logical base rather than the magical thinking of younger children (Rollins, 2005). School aged children fear many of the same things as their younger peers, such as separation from caregivers and familiar environments, loss of control and mastery, and bodily mutilation or injury, but with their increased logical thinking processes, school aged children also have a concept of and fear of illness, disability, and death. Child life interventions with immigrant and refugee school-aged children should incorporate the aforementioned themes of caregiver involvement and familiarity, encouraging choice through experiences that offer developmentally appropriate gratification, education and mastery of new information and skills, and promote the school age child's development of self-esteem through skill building, group activities, peer support, and self-expression.

Adolescents, individuals aged 12-18 years, have an ability to comprehend the meaning behind actions similar to an adult's comprehension. In Erikson's Identity vs. Role Confusion stage of psychosocial development and Piaget's formal operations stage of cognitive development, adolescents seek to make sense of their place in their world, thinking systematically about concrete and abstract concepts using both deductive and abstract reasoning and considering both immediate and hypothetical ramifications of

actions in present and future-oriented thought as they define themselves in association with their attributes, strengths, and relationships in an egocentric, emotion and risk-driven mentality (Rollins, 2005). Adolescents' increased ability to understand both hospitalization and immigration may result in fear of dependence on and control by adults, separation from friends, family, and familiar environments, fear of bodily injury and pain, loss of identity, concerns about body image and sexuality, and concerns about how hospitalization or issues related to immigration, such as documented status, may affect how they are viewed and how they perceive they are viewed by their peers.

Adolescence is the period of time most children of undocumented immigrants learn about their undocumented status (Sudhinaraset et al, 2017). UAC over the age of 13 years are also treated much differently when processed by ORR (Administration for Children and Families, 2018) and are more likely to experience rape and gang violence (Luiselli, 2017). Child life interventions with immigrant and refugee adolescents should focus on supporting adolescents' control of themselves and their environment, enforcing their right to privacy, respecting their independence and self-care abilities, and encouraging and facilitating self-expression, involvement with peers, access to developmentally appropriate information, and opportunities to explore their identity in conjunction with processing their immigrant or refugee experience.

#### Multisystemic Interventions – Immigrants, Refugees, and Child Life Policy

Child life specialist interventions with this patient population extend beyond direct patient care to the policy level. As clinicians and advocates, child life specialists



have the ethical duty to protect the rights of their patients and families. As mentioned in the beginning of this paper, medical treatment centers are listed as “sensitive locations” within ICE operations policy (US Department of Homeland Security, October 4<sup>th</sup>, 2011). Whether or not the hospital in which a child life specialist or other member of the interdisciplinary medical team is practicing has declared itself to be a sanctuary, all hospitals and healthcare settings qualify as “sensitive locations”, meaning that ICE should not be apprehending anyone unless when “exigent circumstances exist, other law enforcement actions have led officers to a sensitive location, or prior approval is obtained from a designated supervisory official” (US Immigration Customs and Enforcement, January 31, 2018). If ICE arrives at a hospital or healthcare setting, they can legally only enter a public area and must be invited or allowed into private areas, such as exam or treatment rooms, unless they have a warrant to do so (National Immigration Law Center, 2017). While in the public places of a healthcare setting, ICE has legal access to anything in “plain view”, including what they see or hear, but cannot pursue information in private areas without a warrant. Healthcare providers, including child life specialists, and their patients are protected by the Health Insurance Portability and Accountability Act (HIPAA) and both have no legal obligation to provide information, including documentation status if known, and may refuse to provide information to law enforcement unless law enforcement has a warrant specifically asking for such information (National Immigration Law Center, 2017). ICE warrants must be valid, judicial documents, signed by a judge or magistrate, and must be stating the exact address of the medical facility and the time during which it is to be searched. It is not legally

justifiable for ICE to use their authority beyond the scope of their warrant and it is within healthcare provider's rights to refuse a warrantless search of their facility, except where ICE claims "probable cause" (National Immigration Law Center, 2017). As advocates for patients' and families' rights and clinicians with rights in the healthcare setting, establishing a protocol for interactions with ICE is a responsibility of child life specialists and all members of the interdisciplinary medical team and should be an established, practiced, and well known part of workplace policy, regardless of the sanctuary status of the hospital or healthcare setting. Additionally, placement of signs designating private and public areas can help to secure the safety of undocumented patients and families, providing clear, legally binding designations of locations where ICE can be present with or without a warrant.

A precedent for policies in protection of immigrant and refugee children and their families, such as a reaction plan for ICE visitation, exists in many settings, both within and outside of the healthcare setting. In a letter to state-funded early childhood centers and superintendents, Connecticut governor Dannel Malloy, acting commissioner of the Connecticut Office of Early Childhood Linda Goodman, and Connecticut Commissioner of Education Dianna R. Wentzell confirmed their support for immigrant and refugee children, highlighted the steps mentioned above in response to ICE visitation, and cited the Family Education Rights and Privacy Act (FERPA) (Malloy et al, February 28, 2017). Medical schools like the Icahn School of Medicine at Mount Sinai in New York have also enacted similar policies, speaking out in protection of their patients and students by declaring sanctuary and financial aid and support for those affected by

DACA (Icahn School of Medicine at Mount Sinai, 2018; Icahn School of Medicine at Mount Sinai, January 3, 2017). While the legal efficacy of sanctuary is actively being debated on the federal level (Clarke et al, 2017; Quigley et al, 2017; Toomey et al, 2017) and the implications of state funding for sanctuary states is actively being discussed (Haberman, 2017), the American Medical Association has suggested that hospitals should declare themselves to be sanctuaries, moving one step beyond the “sensitive location” designation to offer patients and families further protection (Dooling, 2017). This movement towards sanctuary is further founded in statements from the AAP, documenting the crucial need for support for this patient population (AAP, 2018). Without a doubt, support for the varied needs of immigrant and refugee children and families must extend from an integrated interdisciplinary collaboration, combining policy and clinical work to protect the rights of patient and families and support their healing and development.

## Conclusion

There is a fundamental need for psychosocial and developmental support for immigrant and refugee children in America today. As certified child life specialists, the primary documents of our vocation call upon us to act as advocates for and supporters of culturally competent, developmentally appropriate care for all children and families both inside and outside of the healthcare setting. As mandated reporters who are bipartisan, child and family advocates, child life specialists have the responsibility to stand up for the rights of immigrant and refugee children and families, following the established precedent of the American Academy of Pediatrics (AAP) and of state and local educational and medical institutions. Based on child developmental theory, ethics, human rights, and evidence in literature, the Association of Child Life Professionals (ACLP) must advocate for the dignity and respectful treatment of all immigrant and refugee children and families regardless of nationality, religion, culture, faith, sexuality, gender, language preference, or criminal background, including their right to legal representation, humane living conditions, and access to healthcare and language-appropriate education (Linton et al, 2017). Our knowledge of the effect of trauma on child development and child health and our ethical responsibility as child life specialists mandates that the ACLP demand elimination of exposure to the traumas of detention, family separation, and processing, drawing on statements by the AAP (Linton et al, 2017). This ethically driven child life advocacy influences all levels of child life care, from national and international ACLP level policy to individual patient care plans.

In her essay discussing her work as a legal translator for UAC in immigration proceedings, Valeria Luiselli quotes the Immigrant's Prayer or *Oracion de la Migrante*, a prayer shared among immigrants aboard *La Bestia*. Also known as *el tren de la muerte* or the death train due to the high rate of mortality of those who attempt to ride it, *La Bestia* travels the length of Mexico and serves as a conduit for immigrating children and adults from Central America on their way to the Mexican-American border. This excerpt of the Immigrant's Prayer or *Oracion de la Migrante* encapsulates the immigrant and refugee experience: "*Partir es morir un poco/ Llegar nunca es llegar*" "To leave is to die a little/ To arrive is never to arrive" (Luiselli, 2017, p 98). As child life specialists, we are called to minimize stress and trauma and to maximize development and healing. With this vulnerable patient population, whose life experiences are full of stress and trauma inside and outside of their experiences in the healthcare setting, who "die a little" and "never arrive", and whose very identity affects their ability to access care and support, we are called as child life specialists, we are called as advocates, and we are called as humans to welcome immigrant and refugee children and families with culturally competent, child and family centered, developmentally appropriate, compassionate care. With validation, nonjudgmental support, and empathy, we are called to welcome each immigrant and refugee and to scaffold the resilience present in each child and family as they build their new homes in their new country. By working together on all systemic levels, we have the resources and knowledge to create real and lasting positive change for immigrant and refugee children and families in America and abroad.

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**Appendix of Tables and Figures**

Table A. Classical Illustration of Bronfenbrenner's Ecological Systems Model

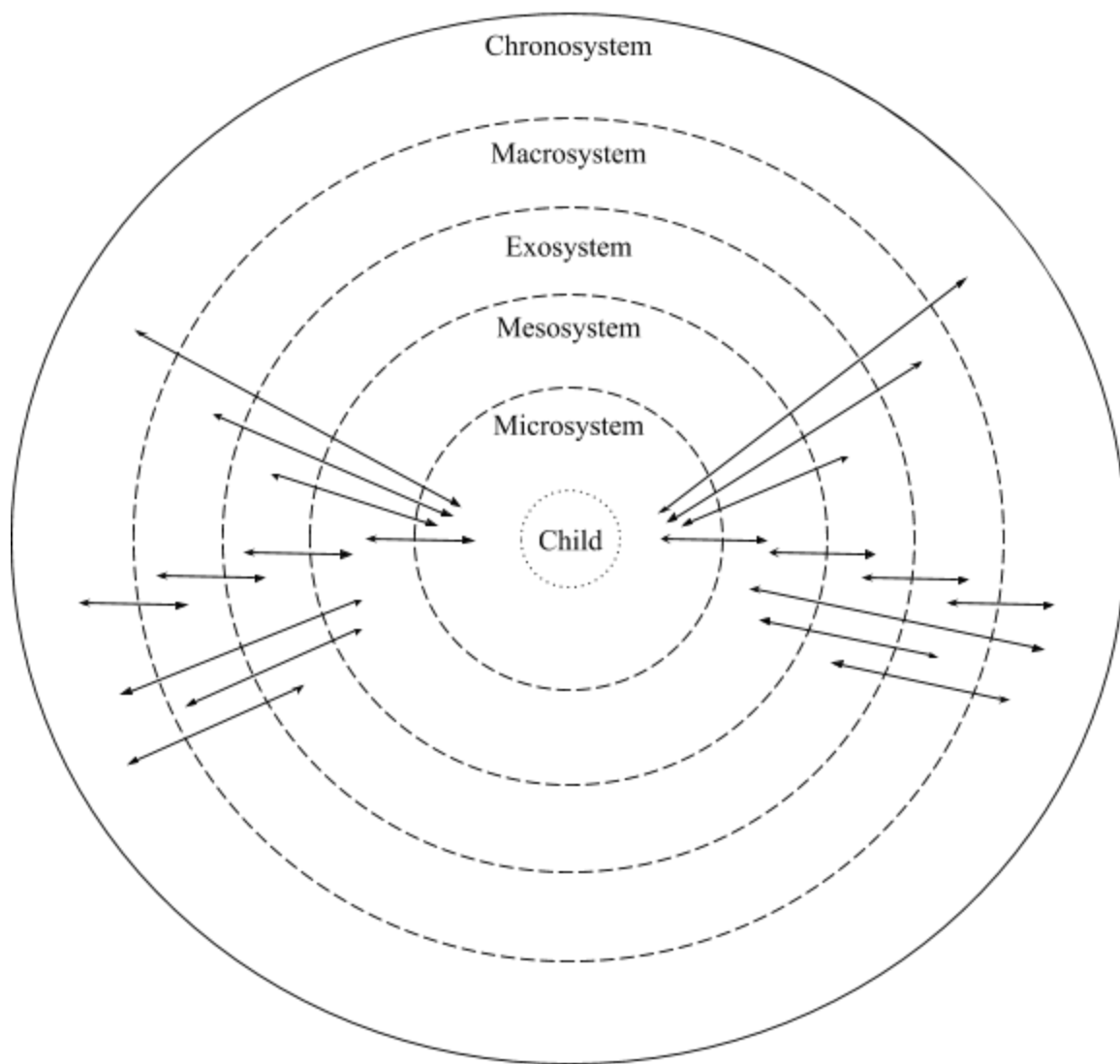


Table B. Child Life Interventions and Hospitalized Immigrant or Refugee Child Factors Delineated According to Ecological Systems

<i>Ecological Systems</i>	<i>Hospitalized Immigrant or Refugee Child Factors</i>	<i>Child Life Interventions</i>
<p>Microsystem</p>	<ul style="list-style-type: none"> <li>- Child’s identity, including but not limited to temperament, age, gender, preferred coping style, developmental level</li> <li>- Child’s acute vs. chronic illness</li> <li>- Child’s primary language and ability to understand the spoken and written language of the hospital</li> <li>- Reason for hospitalization</li> <li>- Understanding of reason for hospitalization and treatment</li> <li>- Child and family’s support system and established coping mechanisms</li> </ul>	<ul style="list-style-type: none"> <li>- Individual patient-level interventions, such as directed and non-directed child-centered play sessions</li> <li>- Advocating for translator usage if necessary</li> <li>- Patient-specific advocacy measures, such as ensuring that patients and their caregivers both feel and are safe and respected within the health care setting</li> <li>- Connecting patients and their families with community resources</li> </ul>
<p>Mesosystem</p>	<ul style="list-style-type: none"> <li>- Child and family’s trauma history in regards to immigrant or refugee journey and reception in host country</li> <li>- History of past medical procedures</li> <li>- Exposure to hospital-based trauma (such as invasive procedures)</li> <li>- Ability to navigate the hospital environment</li> <li>- Ability to navigate the host country</li> </ul>	<ul style="list-style-type: none"> <li>- Healthcare setting specific advocacy, such as hospital sanctuary status or ICE raid protocols</li> <li>- Patient and family centered, culturally competent care</li> <li>- Advocating for translator usage and working to make access simple</li> <li>- Respectful education of coworkers on the unique stressors for</li> </ul>

	<ul style="list-style-type: none"> <li>- Presence of a caregiver and that caregiver's coping capacity</li> </ul>	<p>immigrant and refugee children and families, both in regards to hospitalization and in regards to the political climate</p>
Exosystem	<ul style="list-style-type: none"> <li>- Caregiver identity, including but not limited to documented or undocumented status, socioeconomic status, race, country of origin, anxiety, and ability to be at the bedside and feel safe in the hospital setting</li> <li>- Language barrier</li> <li>- Cultural conflict between culture of child/family and hospital environment</li> </ul>	<ul style="list-style-type: none"> <li>- Child life familial support, including work with siblings and extended family members</li> <li>- Response to familial stressors stemming from ability or inability to navigate both hospital environment and host country</li> <li>- Working in the healthcare environment and in the community to create and endorse supportive resources for immigrants and refugees</li> </ul>
Macrosystem	<ul style="list-style-type: none"> <li>- Anti-immigrant legislation and policy measures</li> <li>- Political rhetoric</li> <li>- Social and cultural context in the country of origin</li> <li>- Social and cultural context in the host country</li> <li>- Conflicts in cultural and social customs between host and origin countries</li> <li>- Identity-based policies, such as the treatment of UAC</li> </ul>	<ul style="list-style-type: none"> <li>- Advocating for the minimization of stress and trauma for children on the national scale</li> <li>- Releasing literature and producing policies which support immigrant and refugee families in the hospital setting and the nation on the ACLP level</li> </ul>

<p>Chronosystem</p>	<ul style="list-style-type: none"> <li>- Reason for leaving country of origin</li> <li>- Documented or undocumented status</li> <li>- Access to healthcare</li> <li>- Government administration, policy themes, and attitudes towards immigrants and refugees</li> <li>- Discrimination on a cultural level</li> <li>- Hospital Sanctuary status</li> <li>- Developmental level</li> <li>- Ability or inability to comprehend factors related to immigration, refugee status, or hospitalization</li> </ul>	<ul style="list-style-type: none"> <li>- Global and local disaster relief efforts</li> <li>- Advocating for the minimization of stress and trauma for children on the global scale</li> <li>- Preserving the rights of children and families</li> <li>- Maintaining an ongoing quest for an understanding of and assessment of crises affecting children and families worldwide</li> </ul>
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