ImmHELP
Immigrant Health Equity and Legal Partnerships

Understanding the Impacts of Childhood and Complex Trauma Among Individuals Seeking Asylum and Other Humanitarian Relief in the United States

A CONSENSUS REPORT

November 2024

Introduction

The current report summarizes the range of effects that childhood trauma and complex trauma can have over the course of the lifespan and the implications that the diverse manifestations of traumatic stress can have for individuals seeking asylum and other humanitarian relief* in the U.S. immigration system.

An efficient and just immigration system accounts for the complex impacts of trauma exposure in adjudication processes and outcomes, and trauma-responsive practices in immigration systems can reduce distress for all parties involved, including adjudicators themselves.

Background

The wide-reaching developmental, relational, cognitive, behavioral, psychological, and social impacts of trauma can affect an individual's vulnerability to future adversity, as well as the content of their testimony about the past (e.g., due to memory lapses) and presentation and behavior during legal proceedings (e.g., limited emotional expression, lack of tearfulness). These factors may shape how an asylum seeker's testimony is perceived, as well as their risk of harm if returned to their country of origin. Therefore, it is important that those making legal and judicial decisions regarding asylum-seeking individuals with childhood and/or complex trauma have a foundational knowledge of common trajectories of traumatic stress, which can vary depending on frequency, type, and timing of trauma exposure, as well as subsequent access to safe environments and mental health care.

Rationale

An asylum-seeking individual's trauma history may include traumatic events experienced in their country of origin, during migration, and after arrival in the United States. Additionally, those seeking asylum and other humanitarian relief generally experience limited rights and protections, which in turn complicates access to stable health care, education, and employment during the immigration and adjudication process. Many new arrivals with pending immigration cases are unable to access behavioral health services to treat past traumas, and due to this lack of treatment and/or additional trauma exposure during their years in the United States with vulnerable legal status, traumatic stress symptoms may worsen or become more disabling.

Asylum-seeking individuals, both those who arrived in the United States as minors and as adults, may be called on to testify about traumatic experiences from many years ago, including those from childhood. In such cases, an individual may be discussing or

* Throughout this report, we refer primarily to individuals seeking asylum; however, this terminology is intended to broadly encompass humanitarian relief, including but not limited to withholding of removal and protection under the Convention Against Torture. The information in this report applies across immigration proceedings when the individual seeking protection has experienced childhood or complex trauma.

processing those events for the first time, while actively experiencing the physical and emotional dysregulation associated with traumatic stress. Their risks and fears of physical and psychological harm (e.g., corresponding with return to their home country) can be influenced by a broad range of exposure to adversity, threat, and victimization in childhood and/or throughout the migration process. This report thus aims to help adjudicators better understand asylum-seeking individuals' development, health status, behavior, and needs through a trauma-responsive lens, in order to contextualize and inform their immigration case.

Authors' Qualifications

This consensus report was written by members of Immigrant Health Equity and Legal Partnerships (ImmHELP) who have expertise in human development, traumatic stress, and trauma-responsive interviewing and assessment. Members of this writing group include faculty, staff, and students at the University of California, San Francisco, Stanford University, and Palo Alto University who are licensed mental health workers, clinical trainees, researchers, and policy experts in mental health, education, and immigration. We are qualified to submit this report on the impacts of childhood and complex trauma among individuals seeking asylum and other humanitarian relief in the United States. This report was informed by a review of the empirical evidence on the effects of complex trauma over the course of development, as well as our collective clinical experience serving immigrant children, youth, adults, and families. Additionally, this report was reviewed by other physician and psychologist members of ImmHELP who were not members of the writing group; they concurred with the content of this report and support its submission as a consensus report.

Key Terms

- **Potentially traumatic events** are experiences that seriously threaten a person's safety or life. Examples include neglect (particularly in children and dependent adults); separation from caregivers; physical or sexual assault; domestic or community violence; identity-based discrimination; sudden loss of a loved one; serious accidents, injuries, or health conditions; natural or man-made disasters; or armed conflict or war.[1] These events may be experienced directly or indirectly (e.g., hearing about them). Because there is individual variation in how threatening events are perceived, we describe them as "potentially traumatic" throughout this report.[2]

- **Threat-based trauma exposure** refers to instances where a person directly experiences violence or is in a constant state of fearing harm. This can involve a

[1] American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

[2] Kilpatrick, D. G. (2020). Defining potentially traumatic events: Research findings and controversies. In J. G. Beck & D. M. Sloan (Eds.), *The Oxford Handbook of Traumatic Stress Disorders* (2nd ed.), pp. 15-44. https://doi.org/10.1093/oxfordhb/9780190088224.001.0001

single event, such as witnessing a bombing, or repeated occurrences, such as being chronically abused by a caregiver. **Deprivation-based trauma exposure** refers to experiences in which a person lacks necessary developmental stimulation, such as neglect, inadequate nutrition, lack of caregiver attunement, or insufficient opportunities for learning. Like threat-based exposure, deprivation can entail a single severe incident or repeated experiences.[3,4]

Notably, different types of trauma exposure frequently co-occur (see footnote 3), meaning that an individual is likely to experience both threat- and deprivation-based trauma exposure, and research often collapses both categories into the broader category of 'child maltreatment,' making it difficult to examine the unique contributions of each type of exposure. The prevalence of co-occurring threat- and deprivation-based trauma exposure is particularly relevant for asylum seekers, given the high number of overall trauma exposures reported in the literature with this population. The neurodevelopmental changes associated with each type of exposure that are described below should thus not be assumed to be mutually exclusive; they likely intersect in unique and complex ways within subgroups and individuals.

- **Traumatic stress symptoms** include a range of developmental, emotional, behavioral, cognitive, and social symptoms that can emerge in the days, weeks, and months after a potentially traumatic event. These can include:
    - Re-experiencing the event (e.g., vivid flashbacks, intrusive memories, nightmares, intense psychological distress, feelings of panic);
    - Avoiding reminders of the event (e.g., articles of clothing, places, thoughts);
    - Changes in mood and cognitions (e.g., persistent negative mood, difficulty feeling happiness, feeling responsible for the trauma, memory problems);
    - Changes in arousal and reactivity (e.g., hypervigilance, jumpiness, difficulty concentrating, sleep problems); and
    - Dissociative experiences (e.g., feeling significantly detached from reality and/or one's body).

  Many people experience these symptoms for some period of time following trauma exposure, even if they never meet the full diagnostic criteria for posttraumatic stress disorder (PTSD), defined further below.[5] Even without a PTSD diagnosis,

[3] McLaughlin, K. A., Weissman, D., & Bitrán, D. (2019). Childhood adversity and neural development: A systematic review. *Annual Review of Developmental Psychology, 1*(1), 277–312. https://doi.org/10.1146%2Fannurev-devpsych-121318-084950

[4] Miller, A.B., Sheridan, M.A., Hanson, J.L., McLaughlin, K.A., Bates, J.E., Lansford, J.E., Pettit, G.S., & Dodge, K.A. (2018). Dimensions of deprivation and threat, psychopathology, and potential mediators: A multi-year longitudinal analysis. *Journal of Abnormal Psychology, 127*, 160–170. https://doi.org/10.1037/abn0000331

[5] Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* https://store.samhsa.gov/sites/default/files/sma14-4884.pdf

traumatic stress symptoms can significantly impact daily functioning, making it difficult to maintain relationships, attend school, or keep a job.[6] When an individual is just below the threshold for a PTSD diagnosis, which means that their symptoms are characteristic of PTSD or a similar disorder but do not quite meet full criteria, they may receive a diagnosis of "other specified" or "unspecified" trauma- and stressor-related disorder. Although these diagnoses may not be as familiar as PTSD to the general public, they still represent a significant level of distress or functional impairment in major life activities (see footnote 1). These diagnoses are often used in the context of forensic evaluations of asylum seekers, as assessors have limited time to build trust and rapport, access information from family members or other data sources, or capture fluctuating symptoms over multiple assessment sessions; these factors may preclude a more specific diagnosis.

- **Posttraumatic stress disorder (PTSD)** can develop following exposure to a potentially traumatic event. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition–Text Revision (DSM 5-TR), the primary diagnostic classification system used for mental health conditions in the United States, PTSD is defined by exposure to actual or threatened death, serious injury, or sexual violence, along with symptoms in four areas: re-experiencing, avoidance, changes in mood and cognitions, and changes in arousal and reactivity (see footnote 1). Only a small percentage of individuals with trauma exposure meet full criteria for this diagnosis.[7] Much larger proportions of individuals who have experienced trauma develop depression and anxiety disorders.[8,9,10]

- **Complex trauma** refers to prolonged or repeated exposure to potentially traumatic events, often in childhood, as well as the constellation of traumatic stress symptoms that tends to accompany sustained exposure to threat and harm.[11] Complex trauma symptoms often differ from traumatic stress symptoms seen in individuals who

---

[6] Kletter, H., Weems, C.F., & Carrion, V.G. (2009). Guilt and posttraumatic stress symptoms in child victims of interpersonal violence. *Clinical Child Psychology and Psychiatry, 14*(1), 71–83. https://doi.org/10.1177/1359104508100137

[7] Schein, J., Houle, C., Urganus, A., Cloutier, M., Patterson-Lomba, O., Wang, Y., ... & Davis, L. L. (2021). Prevalence of post-traumatic stress disorder in the United States: a systematic literature review. *Current Medical Research and Opinion*, *37*(12), 2151–2161. https://doi.org/10.1080/03007995.2021.1978417

[8] Elmore, A. L., & Crouch, E. (2020). The association of adverse childhood experiences with anxiety and depression for children and youth, 8 to 17 years of age. *Academic Pediatrics*, *20*(5), 600–608. https://doi.org/10.1016/j.acap.2020.02.012

[9] Gardner, M. J., Thomas, H. J., & Erskine, H. E. (2019). The association between five forms of child maltreatment and depressive and anxiety disorders: A systematic review and meta-analysis. *Child Abuse & Neglect*, *96*, 104082. https://doi.org/10.1016/j.chiabu.2019.104082

[10] Vibhakar, V., Allen, L. R., Gee, B., & Meiser-Stedman, R. (2019). A systematic review and meta-analysis on the prevalence of depression in children and adolescents after exposure to trauma. *Journal of Affective Disorders*, *255*, 77–89. https://doi.org/10.1016/j.jad.2019.05.005

[11] Kliethermes, M., Schacht, M., & Drewry, K. (2014). Complex trauma. *Child and Adolescent Psychiatric Clinics, 23*(2), 339–361. https://doi.org/10.1016/j.chc.2013.12.009

have experienced a single potentially traumatic event. Individuals with complex trauma are more likely to demonstrate more severe emotional dysregulation, intense and persistent negative beliefs about self, problems in interpersonal relationships, challenges building or sustaining relationships, and difficulty feeling closeness.[12] Complex PTSD (CPTSD), characterized by a combination of 'typical' PTSD symptoms and the symptoms described above, is recognized as a distinct diagnosis in the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11). However, this diagnosis is not yet included in the DSM-5-TR and thus is not yet widely utilized in U.S. health care systems.

Exposure to Trauma among Asylum Seekers

Asylum seekers are an incredibly heterogeneous population—diverse in country of origin, race/ethnicity, language, culture, religion, reasons for migration, migration and resettlement journeys, and personal and cultural strengths.[13] Intersecting with this diversity, many who seek refuge in the United States share the experience of trauma exposure, including exposure to adverse and life-threatening events before, during, and after migration, and often at much higher rates than the general population of the United States.[14,15,16,17,18] Even a single potentially traumatic experience can be deeply impactful over the course of the lifespan, and asylum seekers often endure multiple traumatic events.

Pre-Migration Trauma

Some of the most common experiences of pre-migration trauma include witnessing or being victimized by community violence, being physically or sexually abused or assaulted, being separated from one's caregiver or child, and learning about or witnessing the severe

---

[12] Maercker, A., Cloitre, M., Bachem, R., Schlumpf, Y. R., Khoury, B., Hitchcock, C., Bohus, M. (2022). Complex post-traumatic stress disorder. *Lancet, 400*(10345), 60-72. https://doi.org/10.1016/s0140-6736(22)00821-2

[13] Ward, N., & Batalova, J. (2023). *Refugees and asylees in the United States*. Migration Policy Institute. https://www.migrationpolicy.org/article/refugees-and-asylees-united-states

[14] Blackmore, R., Gray, K. M., Boyle, J. A., Fazel, M., Ranasinha, S., Fitzgerald, G., ... & Gibson-Helm, M. (2020). Systematic review and meta-analysis: The prevalence of mental illness in child and adolescent refugees and asylum seekers. *Journal of the American Academy of Child & Adolescent Psychiatry*, *59*(6), 705–714. https://doi.org/10.1016/j.jaac.2019.11.011

[15] Cardoso, J. B. (2018). Running to stand still: Trauma symptoms, coping strategies, and substance use behaviors in unaccompanied migrant youth. *Children and Youth Services Review, 92*, 143–152. http://doi.org/10.1016/j.childyouth.2018.04.018

[16] de Silva, U., Glover, N., & Katona, C. (2021). Prevalence of complex post-traumatic stress disorder in refugees and asylum seekers: systematic review. *BJPsych Open*, *7*(6), e194. https://doi.org/10.1192/bjo.2021.1013

[17] Ghandour, R. M., Sherman, L. J., Vladutiu, C. J., Ali, M. M., Lynch, S. E., Bitsko, R. H., & Blumberg, S. J. (2019). Prevalence and treatment of depression, anxiety, and conduct problems in US children. *The Journal of Pediatrics, 206*, 256–267. https://doi.org/10.1016/j.jpeds.2018.09.021

[18] Sidamon-Eristoff, A. E., Cohodes, E. M., Gee, D. G., & Peña, C. J. (2022). Trauma exposure and mental health outcomes among Central American and Mexican children held in immigration detention at the United States–Mexico border. *Developmental Psychobiology, 64*(1), e22227. https://doi.org/10.1002/dev.22227

injury, illness, or death of a loved one (see footnotes 15, 18).[19] In one study of primarily Central American immigrant youth who had recently been released from federal immigration custody, 97% of the sample had experienced at least one potentially traumatic event before migrating, and the average number of pre-migration traumas was 4 (see footnote 18). Other studies have found even higher rates of pre-migration trauma among unaccompanied Mexican and Central American immigrant youth (e.g., an average of 8 potentially traumatic events; see footnote 15). These adversities and traumas may be the drivers of migration for an asylum seeker, or they may constitute contextual background experiences that operate in conjunction with the specific risks or threats that lead individuals to seek asylum or humanitarian relief.

Peri- and Post-Migration Trauma

Immigrants also risk many unsafe conditions along their journeys, such as extortion by coyotes and cartels, kidnapping, robbery, sexual assault, and serious illness or injury.[20,21,22] A recent longitudinal, cross-country study found that asylum-seeking youth traveling alone through multiple countries are likely to face sustained trauma exposure throughout their journey.[23] Separation of children, siblings, caregivers, and other family members at the border, as well as conditions in federal immigration custody and being forced to recount past traumatic experiences multiple times throughout the immigration and adjudication

[19] Baily, C. D. R. (2017). *Investigating the mental health needs of unaccompanied immigrant children in removal proceedings: A mixed methods study*. [Doctoral dissertation, Columbia University]. Columbia Academic Commons. https://doi.org/10.7916/D8TM7GSF

[20] Cleary, S. D., Snead, R., Dietz-Chavez, D., Rivera, I., & Edberg, M. C. (2018). Immigrant trauma and mental health outcomes among Latino youth. *Journal of Immigrant and Minority Health*, *20*, 1053–1059. https://doi.org/10.1007/s10903-017-0673-6

[21] NeMoyer, A., Rodriguez, T., & Alvarez, K. (2019). Psychological practice with unaccompanied immigrant minors: Clinical and legal considerations. *Translational Issues in Psychological Science*, *5*(1), 4–16. https://doi.org/10.1037/tps0000175

[22] Perreira, K. M., & Ornelas, I. (2013). Painful passages: Traumatic experiences and post-traumatic stress among immigrant Latino adolescents and their primary caregivers. *The International Migration Review, 47*(4), 976–1005. http://doi.org/10.1111/imre.12050

[23] Pfeiffer, E., Behrendt, M., Adeyinka, S., Devlieger, I., Rota, M., Uzureau, O., ... & Derluyn, I. (2022). Traumatic events, daily stressors and posttraumatic stress in unaccompanied young refugees during their flight: a longitudinal cross-country study. *Child and Adolescent Psychiatry and Mental Health*, *16*(26), 1–12. https://doi.org/10.1186/s13034-022-00461-2

process, may further traumatize newly arriving asylum seekers.[24,25,26,27,28,29,30,31,32] Children and adolescents are especially likely to experience trauma as a result of experiences in federal custody, as their developmental and health needs are often neglected in these settings.[33,34,35]

Once in the United States, asylum seekers experience additional unique stressors that can exacerbate traumatic stress and adjustment difficulties. Compared to citizens and immigrants with longer tenure in the United States, recently-arrived asylum seekers often face decreased access to social and health care services, due to geographic, educational, and economic instability and associated challenges meeting basic needs; insufficient language access and navigation support to utilize social systems; and ineligibility (or

[24] Chilliak, S., Musacchio, S., Montreuil, T., & Williams, S. (2024). Interviewing asylum-seeking children: A scoping review of research to inform best practices. *Trauma, Violence, & Abuse*, 15248380241260014. https://doi.org/10.1177/15248380241260014

[25] Desai, N., Adamson, M., Cohen, L., & Pirrotta, E. (2021). *A new way forward: What Congress must do to protect the dignity, health and safety of children in immigration custody.* National Center for Youth Law. https://youthlaw.org/publication/a-new-way-forward/

[26] Executive Office for Immigration Review. (2023). *Director's memorandum: Children's cases in immigration court* [DM 24-01]. https://www.justice.gov/d9/2023-12/dm-24-01_1.pdf

[27] Lu, Y., He, Q., & Brooks-Gunn, J. (2020). Diverse experiences of immigrant children: How do separation and reunification shape their development? *Child Development, 91*(1), e146–e163. https://doi.org/10.1111/cdev.13171

[28] MacLean, S. A., Agyeman, P. O., Walther, J., Singer, E. K., Baranowski, K. A., & Katz, C. L. (2019). Mental health of children held at a United States immigration detention center. *Social Science & Medicine, 230*, 303–308. https://doi.org/10.1016/j.socscimed.2019.04.013

[29] MacLean, S. A., Agyeman, P. O., Walther, J., Singer, E. K., Baranowski, K. A., & Katz, C. L. (2020). Characterization of the mental health of immigrant children separated from their mothers at the U.S.–Mexico border. *Psychiatry Research, 286,* 112555. https://doi.org/10.1016/j.psychres.2019.112555

[30] Matlow, R. B., Shapiro, A., & Wang, N. E. (2023). Pediatric Perspectives and Tools for Attorneys Representing Immigrant Children: Conducting Trauma-Informed Interviews of Children from Mexico and Central America. *Laws*, *12*(1), 7–26. https://doi.org/10.3390/laws12010007

[31] Pesonen, A.-K., Räikkönen, K., Feldt, K., Heinonen, K., Osmond, C., Phillips, D.I.W., Barker, D.J.P., Eriksson, J.G., & Kajantie, E. (2010). Childhood separation experience predicts HPA axis hormonal responses in late adulthood: A natural experiment of World War II. *Psychoneuroendocrinology, 35*(5), 758–767. https://doi.org/10.1016/j.psyneuen.2009.10.017

[32] Young Center for Immigrant Children's Rights. (2020). *Reimagining Children's Immigration Proceedings: A Roadmap for an Entirely New System Centered Around Children*. Young Center for Immigrant Children's Rights. https://www.theyoungcenter.org/reimagining-childrens-immigration-proceedings

[33] Meek, S., Edyburn, K., & Smith, C. (2021). *Federal policy and state licensing standards for the operation of residential facilities housing unaccompanied migrant children.* The Children's Equity Project. https://childandfamilysuccess.asu.edu/sites/default/files/2021-04/CEP-ORR-report-041721.pdf

[34] U.S. Department of Health and Human Services, Office of Inspector General. (2019). *Care provider facilities described challenges addressing mental health needs of children in HHS custody* (OEI-09-18-00431). https://oig.hhs.gov/oei/reports/oei-09-18-00431.asp

[35] U.S. Department of Health and Human Services, Office of Inspector General. (2020). *The Office of Refugee Resettlement's incident reporting system is not effectively capturing data to assist its efforts to ensure the safety of minors in HHS custody* (OEI-09-18-00430). https://oig.hhs.gov/oei/reports/oei-09-18-00430.pdf

inadequate information about eligibility) for certain public benefits.[36,37,38] Acculturative stress and experiences of discrimination, social isolation, and fear of deportation due to insecure legal status in the United States are also widely reported and contribute to adverse stress-related health effects among asylum seekers and immigrants.[39,40,41,42] Further, the cumulative health impact of these stressors may be worsened by anti-immigrant rhetoric and policies.[43,44,45]

These experiences of pre-, peri-, and post-migration trauma have lasting impacts. Recent meta-analyses indicate that refugee and asylum-seeking individuals have much higher prevalence rates of PTSD (28 to 31%; see footnote 14)[46,47] and CPTSD (16 to 38%; see footnote 16) than the general population (lifetime prevalence rate of PTSD around 3 to 8%; see footnote 7). Asylum seekers also exhibit high rates of other mental health needs and disorders, especially depression, anxiety, and substance use concerns (see footnotes 14, 15, 17, 18, 19, 22, 46).

---

[36] Ángeles, S. L. (2021). Exploring high school newcomer youths' futures: Academic and career aspirations. *Journal of Urban Learning, Teaching, and Research, 16*(1), 3–22.

[37] Barofsky, J., Vargas, A., Rodriguez, D., & Barrows, A. (2020). Spreading fear: The announcement of the public charge rule reduced enrollment in child safety-net programs. Health Affairs, 39(10), 1752–1761. https://doi.org/10.1377/hlthaff.2020.00763

[38] Kaiser Family Foundation. (2023). Health coverage and care of immigrants. https://www.kff.org/racialequity-and-health-policy/fact-sheet/health-coverageand-care-of-immigrants/

[39] Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46*(1), 5–34. https://doi.org/10.1080/026999497378467

[40] Patel, S. G., Tabb, K. M., Strambler, M. J., & Eltareb, F. (2015). Newcomer immigrant adolescents and ambiguous discrimination: The role of cognitive appraisal. *Journal of Adolescent Research, 30*(1), 7–30. https://doi.org/10.1177/0743558414546717

[41] Sirin, S. R., Sin, E. J., Clingain, C., & Choi, E. (2020). The antiimmigrant sentiment and its impact on immigrant families. In W. K. Halford & F. van de Vijver (Eds.), *Cross-cultural family research and practice* (pp. 415–436). Elsevier Academic Press. https://doi.org/10.1016/B978-012-815493-9.00014-4

[42] Vazquez, V., Rojas, P., Cano, M. Á., De La Rosa, M., Romano, E., & Sánchez, M. (2022). Depressive symptoms among recent Latinx immigrants in South Florida: The role of premigration trauma and stress, postimmigration stress, and gender. *Journal of Traumatic Stress, 35*(2), 533–545. https://doi.org/10.1002/jts.22768

[43] Hatzenbuehler, M. L., Prins, S. J., Flake, M., Philbin, M., Frazer, M. S., Hagen, D., & Hirsch, J. (2017). Immigration policies and mental health morbidity among Latinos: A state-level analysis. *Social Science & Medicine, 174*, 169–178. https://doi.org/10.1016/j.socscimed.2016.11.040

[44] Philbin, M. M., Flake, M., Hatzenbuehler, M. L., & Hirsch, J. S. (2018). State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States. *Social Science & Medicine*, *199*, 29–38. https://doi.org/10.1016/j.socscimed.2017.04.007

[45] Torres, S. A., Santiago, C. D., Walts, K. K., & Richards, M. H. (2018). Immigration policy, practices, and procedures: The impact on the mental health of Mexican and Central American youth and families. *American Psychologist*, *73*(7), 843–854. https://doi.org/10.1037/amp0000184

[46] Henkelmann, J. R., de Best, S., Deckers, C., Jensen, K., Shahab, M., Elzinga, B., & Molendijk, M. (2020). Anxiety, depression and post-traumatic stress disorder in refugees resettling in high-income countries: Systematic review and meta-analysis. *BJPsych Open*, *6*(4), e68. https://doi.org/10.1192/bjo.2020.54

[47] Patanè, M., Ghane, S., Karyotaki, E., Cuijpers, P., Schoonmade, L., Tarsitani, L., & Sijbrandij, M. (2022). Prevalence of mental disorders in refugees and asylum seekers: a systematic review and meta-analysis. *Global Mental Health*, *9*, 250–263. https://doi.org/10.1017/gmh.2022.29

Mechanisms of Traumatic Stress

PTSD and CPTSD are not inevitable in the wake of trauma exposure. The human body is built to respond and adapt to stress—a process known as allostasis. When the brain recognizes threatening stimuli, a stress response is triggered, releasing a cascade of hormones that enable a range of physiological and behavioral functions to respond to the stressor.[48] Under normal conditions, this is a healthy and efficient process. However, prolonged or ongoing adversity can take a toll on the body, resulting in over-activity of the stress response system and over-exposure to stress hormones. The altered reactivity patterns and flood of stress hormones cause wear and tear on many of the body's systems (e.g., metabolic, immune, cardiovascular); this is referred to as high allostatic load (see footnote 48). Increased allostatic load reflects the cumulative effects of stress on the body, which can, in turn, contribute to increased risk of developing mental health disorders, such as depression, anxiety, and PTSD, as well as increased impulsivity, risk-taking behaviors, and substance use (see footnote 48). In terms of physical health, a high allostatic load has been linked to higher rates of infection and common illnesses, hypertension, cardiovascular disease, type 2 diabetes, and even cancer.[49]

Researchers continue to explore the specific mechanisms by which trauma gets "under the skin" and results in heterogeneity in developmental, health, emotional, behavioral, and social outcomes. Allostatic load is a helpful biomarker of physical dysregulation as related to cumulative stress, *and* the subprocesses and other complex pathways by which the body's systems are altered in the course of childhood and complex trauma exposure (e.g., social information processing, emotional processing, accelerated biological aging) are the focus of ongoing study.[50,51] Although our nuanced understanding of the life course of trauma is still being refined, the current evidence base is clear: traumatic stress has diverse trajectories shaped by a host of individual, environmental, and epigenetic factors, as well as frequency, type, and timing of trauma exposure.

Variability Based on the Frequency of Potentially Traumatic Events

A recent study of Central American and Mexican asylum-seeking children who had migrated to the United States with their families found that the number of potentially traumatic events children had experienced before migration was the greatest predictor of PTSD symptom severity at the time of their arrival in the U.S. (see footnote 18). Research

---

[48] McEwen, B. S. (1998). Stress, adaptation, and disease: Allostasis and allostatic load. *Annals of the New York Academy of Sciences*, *840*(1), 33–44. https://doi.org/10.1111/j.1749-6632.1998.tb09546.x

[49] Guidi, J., Lucente, M., Sonino, N., & Fava, G. A. (2021). Allostatic load and its impact on health: A systematic review. *Psychotherapy and Psychosomatics*, *90*(1), 11–27. https://doi.org/10.1159/000510696

[50] Doan, S. N. (2021). Allostatic load: Developmental and conceptual considerations in a multi-system physiological indicator of chronic stress exposure. *Developmental Psychobiology, 63*(5), 825–836. https://doi.org/10.1002/dev.22107

[51] McLaughlin, K. A., Colich, N. L., Rodman, A. M., & Weissman, D. G. (2020). Mechanisms linking childhood trauma exposure and psychopathology: A transdiagnostic model of risk and resilience. *BMC Medicine, 18*, 1–11. https://doi.org/10.1186/s12916-020-01561-6

has consistently found that the *frequency* of exposure to potentially traumatic events has a profound impact on the development and maintenance of traumatic stress symptoms. Compared to individuals who have experienced a single or few traumas, those who experience multiple potentially traumatic events, particularly during childhood, are more likely to develop PTSD, other psychiatric disorders, and more severe psychological symptoms.[52,53,54,55,56,57] Individuals who experience persistent victimization *throughout childhood* tend to have the most severe internalizing, externalizing, and traumatic stress symptoms (relative to those who experience multiple potentially traumatic events during a discrete period in childhood).[58]

There is substantial and growing evidence that stress sensitization helps explain these outcomes. Repeated adversity and trauma early in life can sensitize individuals to stress, increasing the salience of later stressors and contributing to amplified stress responses and physiological and emotional dysregulation (see footnote 56). The mechanism of stress sensitization appears, in part, to involve reductions in the volume of the amygdala and hippocampus that occur following childhood adversity. The amygdala is a region of the brain responsible for identifying threats and processing emotions, and the hippocampus is implicated in memory, learning, and regulating the hypothalamic-pituitary-adrenal (HPA) axis, which controls the body's stress response. Reductions in the volume of these areas is associated with greater physiological reactivity to stressors.[59] Additionally, recent

---

[52] Breslau, N., Chilcoat, H. D., Kessler, R. C., & Davis, G. C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: Results from the Detroit Area Survey of Trauma. *The American Journal of Psychiatry*, *156*(6), 902–907. https://doi.org/10.1176/ajp.156.6.902

[53] Breslau, N., Peterson, E. L., & Schultz, L. R. (2008). A second look at prior trauma and the posttraumatic stress disorder effects of subsequent trauma: A prospective epidemiological study. *Archives of General Psychiatry*, *65*(4), 431–437. https://doi.org/10.1001/archpsyc.65.4.431

[54] Cougle, J. R., Resnick, H., & Kilpatrick, D. G. (2009). Does prior exposure to interpersonal violence increase risk of PTSD following subsequent exposure? *Behaviour Research and Therapy*, *47*(12), 1012–1017. https://doi.org/10.1016/j.brat.2009.07.014

[55] Gonzalez, A., Monzon, N., Solis, D., Jaycox, L., & Langley, A. K. (2016). Trauma exposure in elementary school children: Description of screening procedures, level of exposure, and posttraumatic stress symptoms. *School Mental Health*, *8*(1), 77–88. https://doi.org/10.1007/s12310-015-9167-7

[56] McLaughlin, K. A., Conron, K. J., Koenen, K. C., & Gilman, S. E. (2010). Childhood adversity, adult stressful life events, and risk of past-year psychiatric disorder: a test of the stress sensitization hypothesis in a population-based sample of adults. Psychological Medicine, 40(10), 1647–1658. http://doi.org/10.1017/S0033291709992121

[57] Park, J., Jun, J. Y., Lee, Y. J., Kim, S., Lee, S.-H., Yoo, S. Y., & Kim, S. J. (2015). The association between alexithymia and posttraumatic stress symptoms following multiple exposures to traumatic events in North Korean refugees. *Journal of Psychosomatic Research*, *78*(1), 77–81. https://doi.org/10.1016/j.jpsychores.2014.09.007

[58] Dierkhising, C. B., Ford, J. D., Branson, C., Grasso, D. J., & Lee, R. (2019). Developmental timing of polyvictimization: Continuity, change, and association with adverse outcomes in adolescence. *Child Abuse & Neglect, 87*, 40–50. https://doi.org/10.1016/j.chiabu.2018.07.022

[59] Yang, R. J., Mozhui, K., Karlsson, R.-M., Cameron, H. A., Williams, R. W., & Holmes, A. (2008). Variation in mouse basolateral amygdala volume is associated with differences in stress reactivity and fear learning. *Neuropsychopharmacology, 33*(11), 2595–2604. https://doi.org/10.1038/sj.npp.1301665

longitudinal research[60] suggests that reductions in the volume of the amygdala and hippocampus after childhood trauma may mediate the relationship between the trauma exposure and depression symptoms for youth who have additional adverse life experiences. That is, trauma exposure significantly predicts reductions in the volume of these brain regions, and the reduced volume in these regions, in turn, predicts greater depression symptoms—*specifically among youth who have experienced multiple potentially traumatic events.* Given that asylum-seeking individuals often experience high rates of childhood adversity and other pre- and peri-migration traumas, many have likely experienced the effects of stress sensitization, which may help clarify the high rates of PTSD and other mental health problems among this population.

Exposure to multiple potentially traumatic events is also linked to other psychosocial and behavioral outcomes relevant to asylum seekers. In comparison to individuals who have experienced fewer potentially traumatic events, those with high rates of trauma exposure are at greater risk for increased emotional distress, substance use, and suicidal behaviors.[61,62] Additionally, having already had exposure to multiple potentially traumatic events increases one's risk of further victimization.[63,64] This increased risk appears to be a complex phenomenon that may be related to many factors and patterns of post-traumatic adaptation, including loss of self-esteem and sense of mastery, avoidance or dissociation symptoms, health-risking behaviors, and changes to coping strategies (see footnotes 62, 63, 64).[65]

Variability based on the Types of Potentially Traumatic Events

The dimensional model of adversity and psychopathology, a well-established framework in trauma science, distinguishes between the impact of childhood trauma exposures constituting 'threat' (e.g., physical assault, sexual abuse, witnessing domestic or community

---

[60] Weissman, D. G., Lambert, H. K., Rodman, A. M., Peverill, M., Sheridan, M. A., & McLaughlin, K. A. (2020). Reduced hippocampal and amygdala volume as a mechanism underlying stress sensitization to depression following childhood trauma. *Depression and Anxiety, 37*(9), 916–925. https://doi.org/10.1002/da.23062

[61] Adams, Z. W., Moreland, A., Cohen, J. R., Lee, R. C., Hanson, R. F., Danielson, C. K., … & Briggs, E. C. (2016). Polyvictimization: Latent profiles and mental health outcomes in a clinical sample of adolescents. *Psychology of Violence, 6*(1), 145–155. https://doi.org/10.1037/a0039713

[62] Turner, H. A., Shattuck, A., Finkelhor, D., & Hamby, S. (2017). Effects of poly-victimization on adolescent social support, self-concept, and psychological distress. *Journal of Interpersonal Violence, 32*(5), 755–780. https://doi.org/10.1177/0886260515586376

[63] Duckworth, M. P., Iezzi, T., Radenhausen, M., & Galarce, K. A. (2021). Impact of childhood maltreatment and polyvictimization on adult revictimization. In *Handbook of Interpersonal Violence and Abuse Across the Lifespan: A Project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)* (pp. 4255-4274). Springer International Publishing.

[64] Musicaro, R. M., Spinazzola, J., Arvidson, J., Swaroop, S. R., Goldblatt Grace, L., Yarrow, A., Suvak, M. K., & Ford, J. D. (2019). The complexity of adaptation to childhood polyvictimization in youth and young Adults: Recommendations for multidisciplinary responders. *Trauma, Violence & Abuse*, *20*(1), 81–98. https://doi.org/10.1177/1524838017692365

[65] Herzog, S., D'Andrea, W., DePierro, J., & Khedari, V. (2018). When stress becomes the new normal: Alterations in attention and autonomic reactivity in repeated traumatization. *Journal of Trauma & Dissociation*, *19*(3), 362–381. https://doi.org/10.1080/15299732.2018.1441356

violence) and those constituting 'deprivation' (e.g., neglect, poverty, food insecurity, institutionalization; see footnote 3). Many neuroimaging studies have found distinct neural phenotypes between children with threat-based trauma exposure and those with deprivation-based trauma exposure.

Threat-based trauma exposure via physical violence is one of the most common forms of pre-migration trauma reported by asylum seekers (see footnotes 15, 18, 19). Studies find that children exposed to threat and violence have reductions in hippocampal and amygdala volume, as discussed in the previous section. When presented with threatening cues, threat-exposed children also demonstrate heightened activation of the amygdala and anterior insula, which make up part of the brain's salience network that identifies and filters stimuli. These structural and functional brain changes are not consistently observed in children exposed to deprivation (see footnote 3).

In contrast, children with exposure to deprivation are observed to have reductions in the volume and thickness of areas of the brain implicated in goal-oriented, cognitively demanding tasks and cognitive control. Children with deprivation exposure are also observed to have reduced activation in the regions of the brain involved in cognitively regulating emotional responses, compared to threat-exposed children, who demonstrate heightened activation of these regions (see footnote 3). Other studies have also found that childhood deprivation exposure has more potent effects than threat exposure on executive functioning skills, particularly inhibitory control and working memory.[66] Stays in immigration detention and Office of Refugee Resettlement facilities constitute a form of deprivation-based trauma exposure, which is associated with high rates of mental health problems, particularly for children and individuals held for prolonged durations (see footnotes 25, 28, 29, 33, 34).[67,68] Given the potential long-term consequences of deprivation-based exposure on executive functioning, stays in these settings may also pose risks for individuals' cognitive and daily living skills.

Variability based on the Types *and* Timing of Potentially Traumatic Events

Another layer of complexity in the associations between childhood trauma exposure and subsequent neurodevelopmental, emotional, and behavioral outcomes are interactions between the type *and* developmental timing of trauma exposure. For instance, a recent global meta-analysis of 81 magnetic resonance imaging (MRI) studies found age-related

[66] Johnson, D., Policelli, J., Li, M., Dharamsi, A., Hu, Q., Sheridan, M. A., … & Wade, M. (2021). Associations of early-life threat and deprivation with executive functioning in childhood and adolescence: A systematic review and meta-analysis. *JAMA Pediatrics, 175*(11), e212511. https://doi.org/10.1001/jamapediatrics.2021.2511

[67] Mares, S., & Jureidini, J. (2004). Psychiatric assessment of children and families in immigration detention – clinical, administrative and ethical issues. *Australian and New Zealand Journal of Public Health, 28*(6), 520–526. https://doi.org/10.1111/j.1467-842x.2004.tb00041.x

[68] Steel, Z., Momartin, S., Bateman, C., Hafshejani, A., Silove, D. M., Everson, N., Roy, K., Dudley, M., Newman, L., Blick, B., & Mares, S. (2004). Psychiatric status of asylum seeker families held for a protracted period in a remote detention centre in Australia. *Australian and New Zealand Journal of Public Health, 28*(6), 527–536. https://doi.org/10.1111/j.1467-842x.2004.tb00042.x

differences in associations between early interpersonal trauma (e.g., child abuse) or socioeconomic deprivation (e.g., poverty) and the volume of specific brain regions.[69] These results lend support to the stress acceleration hypothesis, which posits that children who experience trauma that threatens the child–caregiver relationship (e.g., abuse, neglect, child–caregiver separation) are more likely to exhibit accelerated development of the brain regions involved in emotional processing.[70] Premature development results in premature termination of neuroplasticity of these regions.[71] This seemingly adaptive response to inconsistent, limited, or absent caregiver protection and co-regulation may confer an increased ability to independently navigate potential danger and self-regulate at a much younger age in the short term (see footnote 70). However, the tradeoff for early maturation may be decreased brain plasticity at an early age, which may contribute to problems with emotional regulation over the course of development and increased vulnerability to fear-related mental health problems like anxiety and traumatic stress in adulthood (see footnotes 70, 71).

The stress acceleration hypothesis holds great relevance for asylum seekers, who often experience various disruptions to child–caregiver relationships, such as domestic violence or family separation. Research indeed finds that asylum-seeking unaccompanied youth exhibit higher rates of distress, substance use problems, and mental health disorders than youth who migrate with caregivers (see footnotes 15, 27). Relatedly, asylum-seeking children and caregivers who have been separated during the immigration process exhibit severe physical and emotional dysregulation and traumatic stress symptoms in the aftermath of separation (see footnotes 18, 28, 29).[72] These empirical findings align with the stress acceleration hypothesis that caregiver presence can buffer the effects of traumatic stress—highlighting the importance of family unity throughout immigration and asylum processes for moderating the most severe effects of complex trauma.[73]

---

[69] Vannucci, A., Fields, A., Hansen, E., Katz, A., Kerwin, J., Tachida, A., … & Tottenham, N. (2023). Interpersonal early adversity demonstrates dissimilarity from early socioeconomic disadvantage in the course of human brain development: A meta-analysis. *Neuroscience & Biobehavioral Reviews*, *150*, 105210. https://doi.org/10.1016/j.neubiorev.2023.105210

[70] Callaghan, B. L., & Tottenham, N. (2016a). The stress acceleration hypothesis: Effects of early-life adversity on emotion circuits and behavior. *Current Opinion in Behavioral Sciences, 7*, 76–81. https://doi.org/10.1016/j.cobeha.2015.11.018

[71] Callaghan, B. L., & Tottenham, N. (2016b). The neuro-environmental loop of plasticity: A cross-species analysis of parental effects on emotion circuitry development following typical and adverse caregiving. *Neuropsychopharmacology, 41*(1), 163–176. http://doi.org/10.1038/npp.2015.204

[72] Habbach, H., Hampton, K., & Mishori, R. (2020). *You will never see your child again*. Physicians for Human Rights. https://phr.org/our-work/resources/you-will-never-see-your-child-again-the-persistent-psychological-effects-of-family-separation/

[73] Cohodes, E. M., Kribakaran, S., Odriozola, P., Bakirci, S., McCauley, S., Hodges, H. R., … & Gee, D. G. (2021). Migration-related trauma and mental health among migrant children emigrating from Mexico and Central America to the United States: Effects on developmental neurobiology and implications for policy. *Developmental Psychobiology, 63*(6), e22158. https://doi.org/10.1002/dev.22158

Another example of the interaction between type and timing of trauma exposure includes recent research that finds threat-based trauma exposure in childhood among youth assigned female at birth (AFAB) is associated with earlier menarche. Early pubertal maturation, in turn, predicts adolescent-onset distress, fear, and externalizing disorders. In contrast, this pattern is not found among AFAB youth with deprivation-based trauma exposure in childhood (see footnote 51).[74] Notably, AFAB asylum-seekers frequently report experiences of physical and sexual violence before, during, and after migration[75]—highlighting the potential for accelerated pubertal development and increased risk for adolescent-onset mental health problems among this population, which poses an increased risk for longer-term health impacts into adulthood (see footnotes 51, 74). Similar to the stress acceleration hypothesis, this research also suggests that accelerated biological processes are a key mechanism linking trauma exposure to mental health outcomes (see footnotes 51, 70).

The Cascading Effects of Complex Trauma

The complex trauma-related neurodevelopmental changes described above manifest in a range of health, emotional, behavioral, and social outcomes, which vary based on individual vulnerabilities, developmental stage, and socioecological contexts. PTSD and CPTSD are not the only outcomes of complex trauma. In fact, as is evident from the prevalence rates of these disorders, a minority of individuals who have experienced potentially traumatic events develop traumatic stress symptoms that meet the threshold for a diagnosis (see footnotes 7, 14, 16, 47). However, many more struggle with serious and challenging trauma symptoms that are just below the diagnostic threshold or that have other manifestations, such as depression and anxiety—and these individuals can still face substantial impairment in their functioning and quality of life (see footnote 5). Individuals may also experience ebbs and flows in the severity of their traumatic stress over the course of time.

In preschool-aged children, symptoms of traumatic stress may include eating or sleeping problems, significant distress over separation from caregivers, excessive crying, regression in acquired developmental skills (e.g., toilet training, speech), and social withdrawal. In school-age children, trauma exposure may lead to nightmares, difficulties concentrating, expressing concerns about their or loved ones' safety, aggression toward peers, school avoidance, and reenacting their trauma in play or daily routines. In adolescents, trauma symptoms and reactions commonly include depression, anxiety, social withdrawal,

---

[74] Colich, N. L., Platt, J. M., Keyes, K. M., Sumner, J. A., Allen, N. B., & McLaughlin, K. A. (2020). Earlier age at menarche as a transdiagnostic mechanism linking childhood trauma with multiple forms of psychopathology in adolescent girls. *Psychological Medicine*, *50*(7), 1090–1098. https://doi.org/10.1017/S0033291719000953

[75] Ramage, K., Stirling-Cameron, E., Ramos, N. E., Martinez SanRoman, I., Bojorquez, I., Spata, A., … & Goldenberg, S. M. (2023). "When you leave your country, this is what you're in for": Experiences of structural, legal, and gender-based violence among asylum-seeking women at the Mexico-US border. *BMC Public Health*, *23*(1), 1699. https://doi.org/10.1186/s12889-023-16538-2

expressions of fear and guilt, aggressive behavior, school truancy, risk-taking behaviors (e.g., with substance use and sexual activity).[76,77,78] At any given developmental stage, the experience of a traumatic event can catalyze a developmental regression (i.e., loss of a previously acquired developmental skill). Among children who do ultimately develop PTSD, the disorder tends to persist over time and become more disabling if left untreated.[79]

Given the developmental and cumulative nature of skill building, when one experiences challenges and deficits in regulating emotions and behavior, creating and maintaining relationships, navigating self-care, and engaging in problem-solving and long-term planning in childhood and adolescence, these skill challenges and related symptoms of traumatic stress can extend into young adulthood (see footnotes 76, 77, 78). Often, this can present long-term consequences for and functional impairment in social and romantic relationships, independent living, parenting, and school/work in adulthood.

Complex Traumatic Stress & Immigration Proceedings

Complex trauma over the course of the lifespan, particularly when untreated, can have significant implications for asylum seekers' legal cases. Understanding these effects of trauma on asylum seekers' narratives, as well as how language and culture shape memory and chronology, is important for interpreting the credibility of their behavior and the content of their testimony during immigration proceedings. A trauma-responsive approach in immigration proceedings limits retraumatization and vicarious traumatization, reduces distress for all parties involved, and enables more efficient processes and just outcomes. The following sections describe common emotional and behavioral manifestations of complex traumatic stress and their potential implications for immigration proceedings.

Affect Dysregulation

Adverse changes in affect and difficulty with affect regulation are common symptoms of complex traumatic stress. When discussing past traumas and experiencing many trauma-related reminders, as in the case of immigration proceedings, it is valid and common for an individual to present with severe anxiety or sadness (e.g., sobbing, shaking), explosive anger (e.g., yelling, becoming physically dysregulated), detached numbness (e.g., blunted or flattened affect, lack of tearfulness), or resourced calm (e.g., speaking clearly, no visibly

---

[76] Cruz, D., Lichten, M., Berg, K., & George, P. (2022). Developmental trauma: Conceptual framework, associated risks and comorbidities, and evaluation and treatment. *Frontiers in Psychiatry, 13*, 800687. https://doi.org/10.3389/fpsyt.2022.800687

[77] National Child Traumatic Stress Network [NCTSN]. (2010). *Age-Related Reactions to a Traumatic Event.* https://www.nctsn.org/sites/default/files/resources/age_related_reactions_to_traumatic_events.pdf

[78] Substance Abuse and Mental Health Services Administration [SAMHSA]. (2024). *Recognizing and Treating Child Traumatic Stress.* https://www.samhsa.gov/child-trauma/recognizing-and-treating-child-traumatic-stress

[79] Hiller, R. M., Meiser-Stedman, R., Fearon, P., Lobo, S., McKinnon, A., Fraser, A., & Halligan, S. L. (2016). Research review: Changes in the prevalence and symptom severity of child post-traumatic stress disorder in the year following trauma–A meta-analytic study. *Journal of Child Psychology and Psychiatry, 57*(8), 884–898. https://doi.org/10.1111/jcpp.12566

evident dysregulation). Individuals' presentations may also change within the course of an interview or testimony. This is all within the scope of a complex trauma response.

Avoidance

Avoidance of trauma-related reminders is a hallmark symptom of traumatic stress, as exposure to such reminders (including memories, thoughts, and feelings related to the trauma) elicits intense physical and emotional dysregulation. In asylum cases, this may manifest as potential non-disclosure, such as not revealing certain incidents or not sharing detailed information about a specific event. Another manifestation of avoidance is through somatization, or the expression of psychological symptoms through physical symptoms. This may result in repeated illnesses and physical pain, which may affect an asylum seeker's attendance at and engagement with immigration proceedings.

Memory Problems and Dissociation

Memory deficits about key aspects of traumatic experiences are included in the diagnostic criteria for PTSD, but trauma impacts an individual's memory regardless of whether they develop PTSD. The effects of trauma on episodic and autobiographical memory (i.e., memory of one's own life events) are typically due to dissociative amnesia and include fragmentation, gaps, and distortion (see footnote 1). These memory disruptions may be even greater when an individual is recalling events in the distant past (e.g., childhood trauma). It appears that trauma memories are often state-dependent, meaning that they are encoded while an individual is in a particular state (e.g., mood, environment) and later retrieved most easily when in that same state.[80] Conversely, this may show up as difficulty recalling memories when the individual is not in the same state during their immigration proceedings. This may look like forgetfulness, mixing up chronology when narrating a sequence of events, leaving out details, and providing somewhat different accounts of events in a declaration and testimony in court.

Relatedly, dissociation is a common complex trauma response that makes it difficult to stay present and focused under stress (see footnote 64). Dissociation involves unintentional detachment from the present, resulting in feelings of disconnection from one's body or thoughts and affecting normal processes of memory encoding. Dissociation can be an ongoing symptom or one that arises in the presence of trauma reminders, such as when an individual is called upon to recount past trauma.

Difficulties with Executive Functioning

As described previously, individuals who experience certain types of complex trauma are more likely to have difficulty with executive functions, such as self-monitoring, inhibition, and working memory. These deficits may make it harder for asylum seekers to engage in

[80] Jaffe, A. E., Blayney, J. A., Bedard-Gilligan, M., & Kaysen, D. (2019). Are trauma memories state-dependent? Intrusive memories following alcohol-involved sexual assault. *European Journal of Psychotraumatology*, *10*(1), 1634939. https://doi.org/10.1080/20008198.2019.1634939

impulse control, decision-making, and processing and retaining new information. These factors may affect the appearance of an individual's consistency and credibility in asylum proceedings.

Negative Beliefs about Self, Others, and the World

Individuals' sense of self, others, and the world is often profoundly transformed by repeated and ongoing trauma exposure. Increased negative beliefs about self, others, and the world are characteristic of PTSD and amplified in CPTSD (see footnote 12). A fragmented self-concept, low self-esteem, significant shame, self-blame for the traumatic experiences, and/or a sense of hopelessness may contribute to difficulties with an asylum seeker's self-advocacy or appear like low interest or motivation in court, which in turn may cast doubt on their credibility. Such negative beliefs about one's own guilt and/or beliefs about a lack of safety among others or in the world generally may also manifest in timid, insecure, fearful, or avoidant body language during proceedings (e.g., lack of eye contact, fidgeting), which may be misperceived as disinterest or rudeness.[81]

Behavior Changes or Challenges

As described previously, the neurobiological changes associated with childhood and complex trauma exposure are, in turn, associated with a range of affective and behavioral changes. For example, negative mood, difficulty concentrating, decreased interest in activities, and a sense of isolation—all characteristic symptoms of PTSD and CPTSD—may contribute to behavioral difficulties. Often, these behavior challenges affect major life activities, such as building social support, getting enrolled in and consistently attending school, seeking and maintaining employment, obtaining mental health treatment, making healthy decisions about relationships and safety, and even participating in required tasks for one's own legal case. Although adjudicators may look for relationship-building, motivation, focus, and problem-solving as behavioral indicators of stability and self-care, the compounding effects of complex traumatic stress may contribute to slow or limited progress in these behaviors. Behavioral impacts of complex trauma may be particularly exacerbated when an individual faces ongoing trauma exposure (e.g., separation from their child, continued threats from individuals in their home country, uncertain legal status in the U.S.) or retraumatization (e.g., being made to repeatedly recount past traumatic experiences during the asylum process).

Complex trauma exposure is also related to changes in the regions of the brain involved in goal-oriented behavior and reward processing; therefore, difficulties with behavioral and impulse control are other common behavioral symptoms. This may manifest as self-injury, suicidal ideation and behavior, risk-taking, aggressive behavior, and overreliance on

[81] Rogers, H., Fox, S., & Herlihy, J. (2015). The importance of looking credible: the impact of the behavioural sequelae of post-traumatic stress disorder on the credibility of asylum seekers. *Psychology, Crime & Law, 21*, 139–155. https://doi.org/10.1080/1068316X.2014.951643

avoidance- or escape-based coping strategies (e.g., substance use). These behaviors also expose individuals to additional risk for potential retraumatization.

Retraumatization

There is a high rate of polyvictimization and retraumatization among individuals who have at least one prior potentially traumatic experience.[82] Asylum seekers who have previously experienced trauma as children or young adults also appear to have a high probability of retraumatization (see footnotes 15, 18, 23). The high potential for being retraumatized during immigration or adjudication processes means that individuals may begin to exhibit new or worsening symptoms at any point.

Sociocultural Factors Affecting Asylum Seekers during Immigration Proceedings

Beyond an individual's unique manifestations of complex traumatic stress, there are other sociocultural factors that can affect asylum seekers' behavior and testimony content during immigration proceedings.

Limited Access to and Utilization of Health Care

Asylum seekers have low rates of access to and utilization of mental health care, due to stigma associated with mental health services, ineligibility for public health insurance in most states, increased salience of somatic (rather than emotional or behavioral) symptoms, inequitable language access in health care settings, and other provider- and institutional-related barriers (see footnotes 36, 37, 38). This means that many asylum seekers, especially those with strong avoidant symptoms, are unlikely to receive prompt mental health treatment to address their complex traumatic stress.[83] Without such support, asylum seekers may have relatively few strategies to manage their symptoms, and/or their usual strategies may not be sufficient when facing stressful circumstances, including asylum interviews or court proceedings (see footnote 24). Lack of trauma treatment also means that many asylum seekers have never narrated (let alone integrated and healed) potentially traumatic aspects of their history prior to doing so for a declaration or court testimony. This may result in significant dysregulation, which may in turn shape perceptions of the individual and their narrative.

Cultural Scripts

Culture refers to the shared beliefs, values, customs, and practices of a particular group, and cultural scripts are explicit or implicit frameworks of behavior and interpretation that are influenced by cultural norms. Cultural scripts shape how individuals within a given

---

[82] Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2009). Lifetime assessment of poly-victimization in a national sample of children and youth. *Child Abuse & Neglect*, *33*(7), 403–411. https://doi.org/10.1016/j.chiabu.2008.09.012

[83] Due, C., Green, E., & Ziersch, A. (2020). Psychological trauma and access to primary healthcare for people from refugee and asylum-seeker backgrounds: A mixed methods systematic review. *International Journal of Mental Health Systems*, *14*, 1–18. https://doi.org/10.1186/s13033-020-00404-4

culture perceive and respond to various experiences, including trauma.[84,85,86] For example, cultural scripts may differ in the perception of locus of control (e.g., whether events that happen to an individual are perceived as within or beyond their control). Cultural scripts may also convey what is acceptable in terms of emotional expression and coping: some may encourage open expression of grief, while others promote emotional restraint. These differences in cultural scripts, together with individual differences in temperament and interpretation, contribute to heterogeneity in trauma narratives, emotional expression, behaviors, and coping strategies—underscoring the importance of cultural competence in understanding asylum seekers' appearance and behavior during immigration proceedings.[87,88] U.S. immigration legal systems also have their own cultural scripts (e.g., expectations that past events are narrated in a linear manner), which may differ from those of asylum-seeking individuals and contribute to misunderstandings (see footnote 86).

Summary and Conclusions

The effects of childhood and complex trauma over the course of the lifespan are diverse and hold significant implications for the behavior and testimony of asylum-seeking individuals in U.S. immigration proceedings. An asylum-seeking individual's trauma history may include events experienced in their country of origin, during migration, and after arrival in the United States. Research suggests that asylum seekers are generally exposed to trauma at much higher rates than the general population of the United States. Many experiences during the immigration and adjudication process may also further traumatize asylum seekers—for instance, separation from children, caregivers, or other family members, immigration detention, required retelling of past traumas several times, and uncertain legal status in the United States. Asylum seekers also often have limited access to mental health care, which means that they may not have processed past traumas or be familiar with emotional regulation strategies before being called on to recount them during immigration proceedings.

Complex traumatic stress has a range of manifestations and trajectories over the lifespan, depending on various individual, environmental, and epigenetic factors, as well as frequency, type, and timing of trauma exposure, which can carve different developmental pathways. Given this heterogeneity in inputs and outcomes, it is not possible to predict *exactly* how potentially traumatic experiences will affect an individual. However, the

---

[84] Engelbrecht, A., & Jobson, L. (2016). Exploring trauma associated appraisals in trauma survivors from collectivistic cultures. *SpringerPlus, 5*(1565), 1–11. https://doi.org/10.1186/s40064-016-3043-2

[85] Kälin, W. (1986). Troubled communication: Cross-cultural misunderstandings in the asylum- hearing. *The International Migration Review, 20*(2), 230–241. https://doi.org/10.2307/2546033

[86] Shuman, A., & Bohmer, C.E. (2004). Representing trauma: Political asylum narrative. *Journal of American Folklore, 117*, 394–414. https://doi.org/10.2307/4137717

[87] Bishop, S. C. (2021). Intercultural communication, the influence of trauma, and the pursuit of asylum in the United States. *Journal of Ethnic and Cultural Studies*, *8*(2), 187–208. http://doi.org/10.29333/ejecs/667

[88] Chentsova-Dutton, Y.E., & Maercker, A. (2019). Cultural scripts of traumatic stress: Outline, illustrations, and research opportunities. *Frontiers in Psychology, 10*, 2528. https://doi.org/10.3389/fpsyg.2019.02528

common constellation of symptoms that tends to accompany sustained exposure to threat and harm is known. This includes: re-experiencing the trauma through vivid flashbacks, intrusive thoughts, or nightmares; severe physical and/or emotional dysregulation; avoidance of trauma-related reminders such as memories, locations, or specific people; negative mood; memory problems; difficulty with concentration; hypervigilance; risk-taking behaviors; sleep problems; dissociation; intense guilt or shame; low self-worth; problems building or sustaining relationships; and challenges with problem-solving and long-term planning. Clinically, these symptoms most often constitute diagnoses of anxiety disorders, depressive disorders, and posttraumatic stress disorder—all of which are generally observed at much higher prevalence among asylum-seeking populations relative to the general population. Regardless of diagnosis, these symptoms can be significant and contribute to functional impairment in social and romantic relationships, parenting, school, work, and independent living.

The effects of childhood and complex trauma can also substantially influence asylum seekers' experiences in immigration proceedings. In particular, avoidance, memory problems, executive functioning challenges, negative beliefs about oneself and the world, emotional dysregulation, and behavior challenges may affect asylum seekers' presentations and testimony, and the information in this report informs how adjudicators should interpret and understand these factors. The research presented throughout also more broadly highlights the importance of considering childhood trauma exposure when making humanitarian relief determinations. The circumscribed experience of threat, danger, or harm that may be the focus of a given asylum claim is often contextualized by a broader history of adversity and trauma exposure, which has a cumulative impact on individual functioning and perceived safety. That is, consideration of the specific elements of the particular situation that an individual is fleeing may not be sufficient when complex trauma is present. Stress responses in the wake of more recent traumas are likely compounded by the effects of past traumas, which impacts an individual's cognitive threat processing, exacerbates emotional dysregulation, and generally diminishes day-to-day functioning. Thus, the risks of danger or harm, including psychological harm (e.g., deterioration of psychological condition, more disabling symptoms), following denial of a request for relief are shaped not only by the presenting incident or threat, but also by the complete history of complex trauma and threat exposure.

In sum, individuals seeking asylum and other humanitarian relief are a group at high risk for experiencing mental health concerns associated with a posttraumatic stress response. While there is no single mental health profile of an asylum seeker (or any other person who has experienced complex traumatic stress), the current science is consistent on the impacts of complex trauma on various facets of mental health and overall functioning. Understanding the effects of complex trauma on asylum seekers thus has significant implications for immigration court proceedings.

Authorship

Suggested citation:
Edyburn, K. L., Jimenez-Salazar, M., Khalil, M., Hussain, F. Z., Rader, C., Mancini, J., & Garg, M. (2024). *Understanding the Impacts of Childhood and Complex Trauma among Individuals Seeking Asylum and Other Humanitarian Relief in the United States: A Consensus Report.* Immigrant Health Equity and Legal Partnerships, University of California, San Francisco, & Stanford University. https://immhelp.org/wp-content/uploads/2024/11/ImmHELP_Impacts-of-Trauma_Consensus-Report_11.2024.pdf

Kelly L. Edyburn, Ph.D. (they/elle) is an Assistant Professor of Clinical Psychiatry and Behavioral Sciences at the University of California, San Francisco and a bilingual licensed clinical psychologist on the behavioral health team at Youth UpRising/Castlemont Health Center, a UCSF Benioff Children's Hospital Oakland school-based clinic in Oakland, California, where they provide individual and family therapy for newcomer immigrant and LGBTQIA+ youth and their families. Dr. Edyburn earned their Ph.D. in Counseling, Clinical, and School Psychology from the University of California, Santa Barbara, and their research and clinical work center on (1) culturally and linguistically responsive school and community mental health services for newcomer immigrant youth, LGBTQIA+ youth, and youth with developmental trauma, (2) youth-led care and innovation in behavioral health, and (3) capacity-building and policy change to address social determinants of health and promote equity in child and adolescent mental health. Dr. Edyburn also provides training for health care professionals, educators, and legal service providers to improve developmentally appropriate, trauma-responsive care for asylum-seeking children in federal custody and immigration proceedings.

Maria Jimenez-Salazar (she/her/ella) is a Postdoctoral Psychology Fellow in the Multicultural Clinical Training Program at the University of California, San Francisco, where she is training in the implementation of evidence-based practices with immigrant youth and families. Maria earned her PhD in Clinical Psychology from Fordham University, where she pursued major areas of study in child and adolescent psychology and forensic psychology. She focused her dissertation on identifying risk and protective factors of mental health in the migration process of unaccompanied immigrant children from Central America. Maria has provided didactic trainings on working with immigrant youth and families, presented research papers and symposia addressing issues of trauma among justice-involved populations, and co-authored publications on immigrant mental health. Maria is a first-generation Ecuadorean immigrant. She looks to meld her lived experience of childhood migration, clinical training in child and adolescent psychology, and research on trauma among justice-involved youth to expand the reach of strengths-based, culturally responsive practices in newcomers' contexts of reception.

Maryam Khalil, B.S.H (she/her) is a pre-medical student, Fulbright Schuman Scholar, and recent Stanford graduate who is immensely passionate about global health and serving

vulnerable populations. She is a member of the Stanford Human Rights in Trauma Mental Health Program and wrote her thesis about the impact of international refugee law deviations on Libyan healthcare with the Center for International Security and Cooperation at Stanford University. Her clinical and research experiences focus on improving health access for migrants, refugees, incarcerated individuals, and the houseless community.

Fatima Z. Hussain, B.S. (she/her) is a Clinical Psychology Ph.D. student at Palo Alto University focused on improving cultural awareness in social systems and outcomes for marginalized communities through clinical work, research, and policy. Fatima is currently a member of the Multicultural Suicide Research Center at Palo Alto University and the Stanford Human Rights in Trauma Mental Health Program.

Carolina Rader, B.S. (she/her) is a second-year Ph.D. Student in Clinical Psychology at Palo Alto University. She earned her B.S. in Psychology and Political Science from Santa Clara University, where she worked as a student researcher in Dr. Thomas Plante's Clinical and Health Lab. Currently, she is a member of the Human Rights in Trauma Mental Health Program at Stanford University and the Clinical Crises and Emergencies Research Lab at Palo Alto University. She is passionate about promoting culturally informed assessments and translating psychological science into public policy.

Julia Mancini, M.S. (she/her) is a fourth-year Clinical Psychology PsyD student at the Palo Alto University–Stanford PsyD Consortium. Her clinical work involves providing therapeutic services to marginalized youth and their families who have experienced traumatic stress, especially migrants from Latin America. She also has expertise in knowledge translation, particularly utilizing social justice principles and community-engaged research to close knowledge gaps between academia and marginalized groups' lived experiences and promote systemic change.

Manasi Garg (she/her) is an undergraduate at Stanford University studying Symbolic Systems on the Neuroscience track. She is interested in pursuing a career in clinical psychology, focused on the mental health of marginalized and neurodiverse populations. She is involved in research on the psychological and behavioral impacts of phone use at The Change Lab and is a member of the Stanford Human Rights in Trauma Mental Health Program. She is also a certified Domestic Violence Advocate and passionate about the intersections of gender, race, psychological violence, and trauma recovery.

ImmHELP

Immigrant Health Equity
and Legal Partnerships