I Don't Want to Die: The Case of a Migrant Child

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"*No quiero morir!*" As I entered the Emergency Department (ED), I immediately heard this message screamed repeatedly in Spanish: "I don't want to die!" As the child psychiatry fellow on call, I received the consult: "Juan Morales is an eight-year-old Central American boy, separated from his mother at the Mexican border a few days ago and sent to a local foster agency, who has now sent him here for fits of acute distress, paranoia, and attempts to run away."

His episodes of inconsolable crying had increased in duration to hours at a time. He had repeatedly tried to flee. He had flung himself on the sidewalk, refusing to get up. He had talked to a door addressing it as his uncle and called an umbrella his aunt. He said that other children holding pencils had machetes.

"*No quiero morir! No quiero morir!*" The boy's pleas were pierced by rhythmic wails. "*Mami!*" We knew the mother's name. The agency estimated it would take at least a week and a half to learn her detention site. Then they would need to coordinate with U.S. Immigration and Customs Enforcement (ICE) to gain the ability to speak with her.

On interview, Juan did not answer any questions even by native Spanish speakers. No matter what we said, he repeated his screams. We offered cookies and juice, but he did not even turn to look. He stood, pumping his sneakered feet in an agitated bounce. He trembled. His face was tense, brows drawn together and mouth agape and—like the Greek mask of tragedy—fixed and inconsolable. He clung to a seated police officer who had escorted him to the ED. Rather than leaving soon upon arrival as usual, the officer stayed for hours trying to comfort the boy. When the officer eventually left, Juan protested, "*Policia! Policia! No quiero morir!*" Soon, Juan similarly clung to the woman providing him one-to-one observation.

His counselor from the agency pleaded for admission. "He's psychotic! We can't manage him!" The agency had started a process of seeking to place the child in a more secure facility to address his elopement risk but did not know how long the placement process would take. With similar children, the process had taken anywhere from three days to several weeks.

My supervising attending said that since April 2018, multiple migrant children were brought in distress to our ED. One presented with flashbacks of prior domestic violence. Another in acute distress believed her parents were or would be killed. We evaluated these migrant children weeks before our mayor even knew they were in the city.

"So," I asked, "what should we do with this kid?"

Should we release him and risk him getting hurt running away to let him serve as a martyr, a spectacle to stain the social conscience? Or should we offer the best crude approximation of a safe home that a psychiatric unit could provide? When we confront social systems that make us sick, must we choose between complicity with the mental illness and complicity with the social ill? How to proceed?

Let us first assess the problem. Public officials separated this family under the color of the law. It inflicted severe trauma to this likely already traumatized child. The government is morally obligated to eliminate family separation and institute safe guards to forbid this practice from ever resuming.

We must build effective collaborations to care for these children and advocate for speedy family re-unification and justice for these young trauma victims. Four main ways we can help are through treatment, research, forensic evaluations, and advocacy.

Treatment

- Assessment should begin with determining whether the child's basic needs are met, like the needs for family re-unification, legal representation for immigration proceedings, housing, and food security, among other things.
- Children should be evaluated by pediatricians for possible medical consequences of common refugee experiences like injury, malnutrition, and sexual abuse.
- As child psychiatrists, our comprehensive psychiatric evaluations should include assessing how much the child can now depend on an emotionally available attachment figure.
- In addition to minding AACAP's Practice Parameters, we should develop culturally tailored evaluation and treatment methods in collaboration with people from the same countries and ethnic groups as our patients. We could recruit immigrants who have social service experience like teachers and train them to collaborate with us as bicultural workers. A bicultural worker serves not only as a language interpreter but also collaborates with the clinical team in developing and delivering culturally tailored assessment and treatment.

Research

- Researchers should also develop validated psychological instruments for the assessment of migrant children in Spanish and in the indigenous languages of Central America.
- Research should investigate best practices in caring for these migrant children.

Forensic Evaluations

- We can help children fleeing from persecution by conducting forensic evaluations for asylum affidavits.
- We can do these evaluations through organizations like Physicians for Human Rights and human rights clinics based at medical schools. These organizations offer training on conducting psychological evaluations for asylum affidavits.
- Human rights clinics based at medical schools provide trainees who assist with writing the affidavit. Collaborating with trainees lessens the time burden of this work and offers opportunities to teach and to recruit into child psychiatry.

Advocacy

- As individuals and through organizations like AACAP, we can educate the public and advocate for specific public policies.
- We can continue to educate the public on the traumatic effects of family separation to help build widespread support for humane policies for migrant children.
- We can advocate for faster family re-unification, sound immigration policy, and justice for those victimized while in detention, as well as financial and administrative support to ensure that these children's needs are met.

All such efforts will doubtlessly meet numerous obstacles. We should develop forums where we give each other practical and emotional support in facing these obstacles.

Every day as child psychiatrists, we develop partnerships in caring and advocating for children. It is our practice to meet the challenge of these dual roles. ■

Disclaimer: Since we were unable to obtain parental consent, names are fictional, and alterations were made to identifying characteristics in order to protect patient identity.

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