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The Biology of Hope

Fernando Stein

Texas Children's Hospital, FStein@texaschildrens.org

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The Biology of Hope

Children do not immigrate; they flee. I have used this simple phrase during the recent years that I have been thrust into the debate related to the migration of children alone or with families across the southern border of the United States. Most of these human beings come from the *Trifinio*, the tri-country area where the borders of Guatemala, Honduras, and El Salvador touch one another. Murder rates in the area are the second highest in the region, behind only Venezuela¹. The combined murder rate of Latin America is three times higher than the rest of the world. In addition to violence, extreme poverty leading to malnutrition significantly increases the risk of death in children².

In Europe during the Spanish Civil War, there was exportation of children by parents--an ironic phenomenon of families trying to save their young by sending them away. More than 50,000 minors left Spain for countries in Latin America and Europe during the late 1920s and mid-1930s³. Similarly, during the months preceding the Second World War, the *Kindertransport* (German for "children's transport") moved children from Germany, Austria, Czechoslovakia, and Poland into England to save predominantly Jewish children. The numbers are imprecise, but at least 10,000 children were saved this way⁴. These are heart-wrenching decisions that play out with the following calculus in the current context: keep children close and face the risk of their death by bullet or famine, or hand children to a *coyote* (a person who smuggles people illegally into the United States) and send them north in the hopes of a better and safer life.

What is this if not an extreme expression of the most basic of biological instincts-- to save your young? Yes, this is the biology of hope.

The question of the migration of children that society faces in the United States is being framed in an agitated and hyper-politicized partisan rhetoric mixed with imprecise facts. Tales of an *invasion* are articulated and military movements as well as legal impediments have been implemented to deter orderly access to requesting refuge and sanctuary for children and families running away from the violence and extreme poverty of the *Trifinio*. The American Academy of Pediatrics (AAP) has taken a strong and unequivocal position in opposing the treatment of children as criminals and housing them in prison-like environments. I have personally visited some of the facilities where children are detained and I have witnessed the conditions in which they are held. Beginning in

January 2017, executive orders issued by the federal government and discussions in the media regarding immigrants seeking refuge or living in the United States have challenged us to look deep into our own value system.

As pediatricians, the national discussion about immigration policy is not an abstract political issue but a reality in the lives of our patients and their families. I have witnessed the impact of the immigration debate as it has become evident in the every-day pediatric practice for our patients and families. As caregivers and citizens, we are challenged to reevaluate our value system and resolve the competing interests of values, laws, morality, ethics, and politics.

I have had the privilege of joining AAP leaders visiting the southwestern border of the United States, including the detention facilities there and community organizations that help immigrant families and children who have been released after being legally processed. In these places, one truly sees it all. There are moments of compassion and warmth where the best of what society and human beings can offer is present for the scared children and adults. You also can see and touch *the wall* that separates nations and people. Most importantly, there are the families and children who are entering the country looking for refuge. They are fleeing abject poverty, violence, and hunger. Let me describe what we saw.

Capture and processing

Motorized vehicles of various sizes came to the detention center. A tall warehouse building had 25- to 40-foot-high thick and hard chicken wire-like metal separations for each area. Women with children, unaccompanied minors, occasional adult males with children, and rarely an entire family constituted the deliveries that arrived all day and all night. Clothes were removed, standard issued clothing replaced their own, and possessions (including shoes, security blankets, and other simple items such as toys) were confiscated and placed in individual plastic bags. A mountain of these bags formed quickly near the door.

Older adult males were separated from younger adult males and young adult males from male children. This was the same process for women, although young children could stay with their mothers. About 1,000 individuals per day were processed at the Ursula (Texas) Detention Center alone, according to the Customs and Border Protection officials we

spoke to during our visit. The place was clean but cold, and the lights were on 24 hours a day for security reasons. Simple food and drink were provided. The guards were kind and polite but stern. Many were immigrants themselves.

Separation and reunion

There were cries of desperation when brothers and sisters were separated because of age or gender — fear exacerbating existing trauma — but they were usually reunited in less than 48 hours. After being photographed, having basic biometrics performed, and receiving a cursory health check (inspection with no vital signs, unless appearing ill or complaining of illness) and an interview, the detainees were released. There was no capacity to hold them because there would be 1,000 more arrivals the next day. Ankle monitors were placed on all adults. Possessions were returned.

Community to the rescue

The communities of Harlingen, Del Rio, and McAllen are not exactly wealthy, and yet they sent buses to pick up the children and families at the release site to take them to churches and other community facilities.

At Sacred Heart Church Respite Center in McAllen, Texas, volunteers lined up in two rows. As the children and families walked in, they were received with applause to make them feel welcome. They were served a warm, hearty meal and each person was given a set of clean, age-appropriate clothes and personal hygiene items for the journey across the country to their sponsors.

I personally spent time with several beautiful, loving families. They cried as they told me stories that support the concept of *credible fear*: family members killed, boys threatened with death if they did not join drug gangs, and threats of sexual abuse and kidnapping. These families made the decisions to leave their homes, often having to leave some of their loved ones behind.

We are hardwired for compassion. Compassion is the deep feeling that arises when confronted with another's suffering coupled with a strong desire to alleviate that suffering. There are at least two neural pathways--one activated during empathy, having us experience another's pain; and the other activated during compassion, resulting in our sense of reward. Compassionate medical care is purposeful work, work that nourishes the

neural pathways associated with reward. Compassion is innate, and is the antidote for burnout.

I believe that it is not only important to provide compassionate care, but we have a moral duty to help these families and children. It is in our nature, even our biology, to do so.

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