Making visible the invisible: The short- and long-term impact on the mental health of migrants and asylum seekers

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"I left my country because of problems with the gangs, they were sexually abusing me and now I'm two months pregnant."
–17-year-old Guatemalan girl

"My trip through Mexico was bad because I've walked a lot...before we got to Tonala we were assaulted by a group of criminals and they wanted to rape a girl in our group."
– 17-year-old El Salvadorian boy

"I saw the love of the people [new arrivals to a shelter]. You could still feel their happiness as human beings. In time, [that happiness] turned into pain, just sadness. That enthusiasm of being a human being was no longer there."
–Migrant at a shelter

Children separated from their parents "not only experience trauma now but will likely suffer from this event for the rest of their lives. When children experience strong or prolonged adversity without adequate adult support, they are flooded with stress hormones which can disrupt the development of the brain and other systems" (1).

"A sense of safety is critical to a child's health and well-being. Constant fear and anxiety harm a child's physical growth and development, emotional stability, self-confidence, social skills and ability to learn" (1).

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INTRODUCTION

We are at a watershed moment in the experience of overland migration from Central America and through Mexico to the United States. Changes in policy and practice leading to the purposeful and deliberate separation of children from their parents at the U.S.-Mexico border, together with indefinite detentions, reductions in refugee and immigrant quotas, and overcrowded shelter conditions in border regions have added to heightened levels of the poverty, insecurity, and violence long experienced by migrants in their countries of origin or during their migratory journey. Exposure to crime, violence, and poverty compounded by the grueling conditions crossing Mexico without the resources to aid and protect them, captures the migration experience for tens of thousands. We are witnessing a humanitarian health/mental health crisis of enormous proportion that is impacting children and their parents, families, communities and populations at large individually and collectively in the short- and long-term and, in many cases, with deleterious consequences for life.

One key aspect of this crisis, the mental health impact, although always present, has been neglected and mostly invisible. Yet, as pointed out by Venta (2019) (2), "the true emergency on our Southern border is the mental health of the children and families that migrate from Central America to the United States and find themselves here indefinitely awaiting immigration proceedings." One of the greatest tragedies is that this crisis is fully preventable.

In the migration experience involving mainly the Northern Triangle of Central America (El Salvador, Guatemala and Honduras), Mexico and the United States, we have identified four groups:

1. persons from Mexico migrating to the United States;
2. persons leaving their homes in Central America and other countries, and crossing México with the aim of entering the United States;
3. returning Mexican and Central American origin migrants from the United States; and
4. families left behind by a migrant father, mother, or both parents, leaving their children in care of others. In this paper we focus on the second group, migrants traveling from Honduras, El Salvador, Guatemala and through Mexico.

CONTEXT

Migration is a mixed movement involving groups with different motivations for migrating. One group is motivated to migrate primarily for economic reasons in the hope of improving their quality of life. Another is escaping armed conflicts, violence, and persecution (3). A third major motivation for migration is reunification with family members.

In Central America, the conditions that have pushed hundreds of thousands of people from Honduras, El Salvador, and Guatemala to leave everything behind and brave the dangers of an overland migration are not entirely new. Extraordinary levels of violence, abuse and poverty have been a commonplace in these countries for decades. The following descriptions provide a brief overview by country of conditions up to 2016.

Migrants from Honduras

Different studies agree that Central Americans from Honduras mainly flee from two types of violence: violence committed by organized crime and violence experienced at home. Gangs and other criminal organizations threaten, harass, beat, rape, dismember and kill Honduran children and adolescents with impunity, and threaten to harm their families. Unbridled violence within families, which includes child abuse and incest, as well as gender-related violence, force many children and adolescents to flee for their lives. This helps explain the increased number of girls migrating alone. In an October 2016 report, Amnesty International affirms that 727 of the 5,148 murder victims in Honduras in 2015 were under the age of 19 (4).

The 2016 report from the Comisión Nacional de Derechos Humanos, 20163 titled: *Unaccompanied Central American Children and Adolescents in the Context of International Migration in their Transit through Mexico and with Need of International Protection* (5) based on information from the Inter American Commission on Human Rights, establishes the alarming situation in Honduras with regard to sexual abuse of children in particular. "[It] has increased by 200% [in 2014 and 2015], according to the statistics kept by the authorities

of the Public Prosecutor for Children and organizations dedicated to providing assistance to children victims of such crimes. On average, 35 children or adolescents become victims of sexual violence every month and the most common crimes are rape, "special rape" and lewd and lascivious conduct. Most of these crimes occur in the home environment." The Inter-American Commission country report also pointed out that "... while children and adolescents are particularly vulnerable to recruitment by gangs or suffer from various forms of physical violence, young and teenage girls are additionally particularly vulnerable in this context to sexual and gender violence."

Migrants from El Salvador

In El Salvador, gang violence and organized crime have proliferated and disproportionately victimized children and adolescents. The gangs themselves are migrating to neighboring countries. In its 2008 Special Report on transnational criminal gangs, the CNDH states: "Legislative public policies (...) implemented by police forces . . . in Honduras and El Salvador from 2002 on, led to an increase in the migratory exodus of the "mareros" [gang members] towards Guatemala where they had already found an entry to Mexico . . . Because of the conditions that have allowed them to recruit followers and even imitators, we can now see a greater concentration of gang members in this part of our [Mexico's] southern border" (5). Amnesty International also reported that "levels of gang-related violence and organized crime surged, and homicide rates soared. According to official records, 4,253 homicides were registered in the first eight months of 2015, compared with 3,912 for the whole of 2014. Criminal violence forced many Salvadorians to leave the country, and also led to the internal displacement of thousands of families..." (4).

The CNDH has documented cases in which Salvadorian victims listed persecution by criminal gangs as the basis of their application for refugee status (6). Violence within families in El Salvador, where seven out of every ten children experience physical violence in the home, further impels children to flee (7). As in Honduras, "girls in El Salvador endure frequent sexual abuse, much of it occurring within the home. Additionally, El Salvador has the world's highest rate of femicide/feminicide. More than 25% of these killings are of girls under the age of 19" (6).

Migrants from Guatemala

The situation in Guatemala is similarly grim. The University of Lanús (8), in a 2010 report refers to the increased migration of Guatemalan children due to violence: "In 2010, 49.4% of homicides in Guatemala took place in the five departments [out of 22 departments in the country] with the highest levels of migration (i.e., Guatemala, San Marcos, Huehuetenango, Quetzaltenango and Jutiapa). Guatemalan children, especially girls, experience high levels of domestic violence, including incest. Between 2003 and 2012, domestic violence grew by more than 500%; the largest proportion of its victims were female. Sexual abuse by family members is common, but it often remains hidden, both because children and adolescents are fearful and ashamed to report it, and because they lack confidence that the authorities can protect them. Violence associated with gangs and organized crime has also risen, disproportionally affecting youth. Children and adolescents flee to escape violence in the home or coercion to join violent groups." These Guatemalan children often cross the border into Mexico in the hope of staying in the state of Chiapas to work on coffee plantations or in homes as domestic workers. However, there are no reliable statistics as to the number of migrant children and adolescents of Guatemalan origin who remain to work in the southern region of Mexico.

Migrants Traveling Through Mexico. An increase of violence and social disadvantage on one side, and a harsh migration policy on the other have intensified the burden on migrants traveling through Mexico. Insecurity and human rights violations against migrants from or through Mexico on their way to the United States. The new wave of Central American migration comes with increased violence; stepped up pressure to limit the numbers that reach the northern border has increased risks, as migrants choose the more dangerous Pacific route (e.g., Chiapas, Oaxaca, Michoacán), where violence is higher due to tensions between especially fierce cartels but official patrols are fewer and the chances of arrest are less. This has increased victimization of those crossing through Mexico, with special consequences for the mental health of persons involved (9).

A recent (2018) study by Verdugo and Medina (10) highlights four important challenges México faces in providing protection to national and foreign migrants:

1. the costs of the migration movement, with local authorities lacking the financial resources and the knowledge to address the problem;
2. the adoption of new routes by migrants to avoid arrests, through municipalities with fewer resources, puts them at greater risk of violence with the higher presence of drug traffickers;
3. the evasion from the authorities by migrants and/or being abandoned by human traffickers – *polleros* or coyotes – increases their vulnerability and risk of victimization. Also, getting caught up in illegal activities that extends their time of stay waiting and in hiding; and
4. the reproduction of social problems such as involvement with gangs, prostitution and/or drug trafficking as mechanisms of survival of migrants traveling through Mexico. In particular, migrants coming originally from Central America who declare themselves as Mexicans to avoid deportation to their places of origin.

THE NEW MIGRATION EXPERIENCE

The new migration surge from the region has no doubt been spurred by spikes in the various conditions that push people to leave. One of these is increased poverty. In Honduras the poverty rate is reaching 82%; it is estimated at 77% in Guatemala and 49% in El Salvador (11). In Mexico, 48.8% have an income below the poverty line and 10.6% live in extreme poverty (12). The average poverty and extreme poverty rates for Central America are 37.9% and 13% respectively, in Honduras extreme poverty reaches 19.4% of the population, in El Salvador, 7.6% (13). Another impetus to migrate is natural disasters, some related to climate change. Earthquakes, hurricanes, and droughts, combined with existing poverty, have collapsed the livelihoods of many. The growing violence and extortions (e.g., pay up or die) on people by local gangs have increased the costs of remaining even further (11).

The Americas are home to 13% of the world's population and 37% of all intentional homicides, affecting specially males from 15-29 years of age. Firearms are involved in around three quarters of all homicides often related to organized crime groups and street gangs. The region also occupies the second place in the number of women and girls killed by intimate partners and other family members. El Salvador has the highest rate of homicide per 100,000 inhabitants in Latin America; Honduras, Guatemala and México are among the top ten (14)

A 2017 Doctors Without Borders study reported that, among displaced migrants, crime and violence was the most common motivation to leave their country in search for asylum in a new country (15). This study also found that upon arriving to Mexico, many asylum seekers from Central America become victims of criminal organizations where many are robbed, kidnapped, abused, raped, tortured, and killed. Those who survive these violent acts are often left with long-term trauma that has a lasting impact on their health and wellbeing. Mexican migrants returning from the United States also report higher rates of violence when crossing the Mexican border (16).

Another study cites persecution and other forms of grave or irreparable harm (e.g., armed conflict, serious disturbances of public order, natural disasters or the inability or unwillingness of a State to protect the human rights or its citizens) that not only moves people toward migration, but also leaves them without an option of returning to their country of origin if their asylum request is denied (3,17).

But what makes this new migration experience differ most from migration before 2017 are changes in official policy and the practices of state actors, and which are directly responsible for additional trauma suffered by migrants during the migration journey and once they reach the border and, some would argue, before.

AT THE U.S.-MEXICO BORDER

While for most, their hardships began long before they reach the U.S.-Mexico border (18). Once at the border, migrants are faced with another wave of traumatic experiences. Those seeking to enter at the southern border are subject to long wait times—typically either in detention centers once inside the U.S. border (19), or in Mexico under the "Remain in Mexico" policy—as they await the initial credible fear interviews of their asylum proceedings (20). Family separation and

prolonged detention under unhealthy conditions add to the pain of the experience.

Detention centers. Varying reports from news outlets, firsthand accounts from attorneys and physicians who have visited, and testimonials from migrants who have been released from detention centers detail the "overcrowded and unsanitary conditions" (21) migrants encounter while incarcerated at these detention facilities. The Inspector General's Office of the Department of Homeland Security, "observed serious overcrowding and prolonged detention of unaccompanied alien children (UACs), families, and single adults that require immediate attention" (22). Aside from obvious concerns of unsanitary and inhumane conditions, detention centers for migrants at the border face a multitude of allegations of excessive use of force, sexual assault, and improper use of solitary confinement as punishment, against adults and children (23).

As a result of prolonged incarceration under these conditions, adults and children have been found to display "obvious signs of mental health trauma...such as bedwetting, isolation, regressive behavior and self-injurious behavior" when interviewed by government investigators (22). Yet, even when trauma and physical distress symptoms are evident, migrants are refused basic medical and mental health care.

Family separation. President Trump formerly announced his "zero tolerance" policy in April 2018 – referring all migrants who entered the United States without status for criminal prosecution – which resulted in the separation of thousands of migrant children from their parents (24). It was later discovered that the policy of separating families had been implemented for more than a year prior to the announcement (25) and disclosure of the practice shocked advocates worldwide. Migrant children were placed in the custody of the Department of Health & Human Services Office of Refugee Resettlement, while parents remained in the Department of Homeland Security custody, usually in detention facilities or other federal jails while being processed for immigration proceedings.

Despite a June 20, 2018, executive order signed by President Trump ending family separation (26) and a nationwide preliminary injunction against the policy of separating families and ordering that all children be reunited with their parents within 30 days (27) family separations continue, and it is unclear how many children remain separated from their families as a result of the past and continued implementation of the zero tolerance police. The American Civil Liberties Union, the non-profit civil rights legal advocacy organization taking lead on the family separation litigation, reported that the U.S. government admitted to separating nearly 5,500 children from their families (28) with a median length of detention of 154 days (more than five months).

In its assessment of the implementation of the Trump administration's family separation policy, the U.S. Commission on Civil Rights concluded that "The impact of separating immigrant families and indefinite detention is widespread, long-term, and perhaps irreversible physical, mental and emotional childhood trauma" (29). And while studying the mental health impact of family separation has been difficult, as families are still being reunited and assessed, studies of other immigrant populations indicate that family separation results in adverse effects on mental health and functioning. In studying the forced separation of refugee parents and children, family separation has been described as the "the single greatest source of the refugee's current distress" (30,31)

Impacts of the new migration policies extend to citizen children in the U.S. with immigrant parents who had been detained and/or deported reported, and who report a much higher rate of symptoms of post-traumatic stress disorder (PTSD) than citizen children whose parents either had legal permanent resident status or were undocumented but had no prior contact with immigration enforcement (32). Efforts to address mental health concerns for separated families in detention are thwarted by various challenges and the insufficient provision of resources by the U.S. government (33).

Trauma once inside the United States. In order to remain in the United States, migrants must demonstrate to immigration judges that they are eligible for some form of deportation relief—i.e., asylum, Convention Against Torture, withholding of removal, Special Immigrant Juvenile status for children, or other humanitarian forms of deportation relief. Throughout this process, migrants are forced to retell

their traumatic experiences, which can re-trigger or aggravate trauma symptoms (34,35).

If released into the United States, either on their own recognizance while they await further proceedings or after being granted some form of deportation relief, migrants can become eligible for public benefits and health care resources with their newfound lawful status. In contrast, migrants who escaped or never encountered immigration enforcement upon entering the United States – that is, they entered without status – fear of deportation, exclusion from public benefits and health care systems, and discrimination will act as both renewed and prolonged sources of trauma.

A PRIMER ON EXPERIENCE, TRAUMA, AND MENTAL HEALTH

Traumatic experiences may take many forms. These can be acute, single events: a life-threatening accident, being assaulted or witnessing someone else being injured or killed, or involvement in a fire, flood, or other natural disaster. They can also take more chronic forms, including ongoing physical, sexual, and psychological abuse and maltreatment. Adverse childhood experiences (ACEs) such as emotional, physical, sexual abuse, family violence, parental loss, parental psychiatric or substance use disorders have been recognized as an important category of experience, often chronic, with especially severe implications for risk of adverse mental and physical health and other social determinants of health across the life course. In addition to abuse, childhood adversities include neglect (36), often accompanied by contextual factors such as household financial stress, instability or displacement, food insecurity, and substance abuse by a caregiver or other adult.

How potentially traumatic events (PTEs) and ACEs impact health is complex and varies greatly by age/developmental stage at the time of exposure, nature of the event, chronicity, and other factors (37). ACEs have strong associations with all classes of mental disorders at all life-course stages (38). More specifically, ACEs have a high risk of associated affective mental health disturbances (i.e., depression, anxiety, and panic, with PTSD being the most common), somatic disturbances (particularly sleep and severe obesity) and substance abuse later in life (39).

Age of exposure impacts the risk of developing PTSD. A study of infants and young children exposed to war trauma (40) found children 3-5 years were at higher risk of developing PTSD than children of 1.5-3 years. In these cases, the quality of mother-child interactions affected child responses, with maternal resilience and sensitive maternal caregiving helping to repair disruptions. Among trauma-exposed youth and adolescents, mental health disorders, chiefly PTSD, were diagnosed in 38% of a sample in a study of unaccompanied migrant youth (41).

FROM ADVERSITY TO TRAUMA

Childhood adversities have particular neurodevelopmental consequences (36). Researchers found child neglect and/or sexual abuse to be strongly associated with cognitive deficits from childhood to adulthood, and that all forms of childhood maltreatment associated with mental health symptoms. These can appear as impaired memory of childhood and mood disorders, which in this population have a higher rate of treatment resistance (42).

Exposure to different combinations of trauma is linked to greater degrees of dysfunction. Children and youth exposed to psychological maltreatment, defined as thwarting a child's basic emotional needs including psychological safety and security in the environment, may have worse outcomes than youth who experienced only physical or sexual abuse (43). The damage from psychological maltreatment is abetted by its insidiousness, as it is difficult to define, assess, and determine when an experience has reached the threshold of maltreatment. Vachon and colleagues in contrast, found that different forms of child maltreatment have equivalent psychological and behavioral effects, and notably that these do not vary by sex or race (44). Despite this finding, they recommended that population health and intervention strategies pay greater attention to emotional abuse, as it is less detectable and punishable. Given the characteristics of the new migration experience, this category of childhood trauma is especially relevant to children and youth, particularly in the cases of children separated from their parents.

TRAUMA EXPOSURE AND HEALTH: THE COMORBIDITIES OF TRAUMA

All trauma has consequences. Even where the trauma is acute, limited to a single exposure, and does not result in PTSD, adverse effects are observable in the brain and the bodies of trauma exposed individuals, and risks of developing future disease are increased. Immune functioning and the reproductive, gastrointestinal and musculoskeletal systems are all impacted (42). Psychological impacts are varied, and include associated impaired memory, particularly verbal memory, and depression, anxiety, and PTSD. These are long term conditions and often treatment resistant. Trauma has an observable effect on brain structure, in the form of a smaller hippocampus.

Complex trauma, as in instances of repeated abuse in children, takes a particular toll on health and mental health. In these cases, the hypothesized mechanism between chronic stress and health/mental health in these instances is allostatic load and cortisol abnormalities (45).

TRAUMA PREVALENCE AND PTSD

Trauma is commonplace. A study conducted in the U.S. using nationally representative samples found that 60% of men and 51% of women report at least one lifetime traumatic event (46). Another study (47) using a cross-national data set of 20 countries found a 70% prevalence of lifetime traumatic experience exposure. In the European Study of Epidemiology of Mental Disorders, 63.6% of respondents reported exposure to at least one PTE during their lifetime (48). In the United States, more than 3 in 5 adolescents reported having experienced at least one traumatic stressor; adolescent PTSD prevalence in the U.S. may be as high as 6% (49).

Not all trauma or adverse experiences lead to PTSD. In Norway, where PTE exposure among twins age 19-36 was 26.5%, lifetime prevalence of PTSD was 2.6%. In the U.S, the prevalence of PTSD is 7.8% (48). PTSD is associated with all Axis I and II conditions, especially personality disorder, where the role of childhood trauma is important.

PTSD has numerous health impacts – more than tobacco and alcohol use. A study of Vietnam vets with PTSD found links with arthritis, insulin dependent diabetes, and thyroid disease, up to 30 years after initial trauma exposure, even when accounting for other health behaviors (42).

BURDEN OF PTSD TO THE INDIVIDUAL AND SOCIETY

PTSD is quite disabling and imposes a tremendous long-term burden on the individual and society. Persons who develop this condition are less able to carry out their everyday activities and have six times more risk than paired controls to develop other mental disorders. This increased risk remits when people overcome the symptoms of PTSD (47,50,51,52). In the United States, where traumatic events are more often discrete/acute than chronic, 12% of population averaged three PTSD episodes in their lifetime (52). With the average duration of each PTSD episode at 7 years, this means over two decades of individual suffering from PTSD. Kessler (52) advocates for the classification of another form of PTSD – complex PTSD – a "disorder of extreme stress not otherwise specified," common among those exposed to chronic interpersonal violence at an early age.

The effects of PTSD translate into losses in role functioning and life course opportunities. PTSD has larger effects on work loss – roughly 3.6 days per month – than major depressive disorder. Trauma victims unable to cope with the stresses of higher paid position may work in jobs paying less. The impacts are felt in terms of educational attainment and relationships as well as employment. For the society, in addition to a less capable workforce and lower productivity, the impacts include increased welfare dependency and higher rates of substance abuse.

With intergenerational trauma, as seem among the offspring of survivors of the Holocaust and other atrocities of war, community trust and cohesiveness are also eroded. Individuals and families become isolated, less able to connect with others. This hits particularly hard on disadvantaged communities and

alienated populations, such as refugees and immigrants who struggle with making a life in new and unfamiliar surroundings, and for whom, historically, security and advancement has depended on their capacity for collaborative effort and a sense of belonging (*pertenencia*).

According to Patel et al (53), risk factors for PTSD include:

- Previous mental illness, being a single woman, young and old age, less education, belonging to a minority group and insecurity (54). The experience of violence, before, during and after forced displacement in its different forms: sexual, organized, political and economic, along with difficult conditions of survival, uncertainty, loss of cultural status, language difficulties and differences in culture in New scenarios also increase the risk of getting sick (55,54).
- Economic risk factors include income, food security, employment, income inequality, and financial strain, all present among migrants. Gender is also important, females are more vulnerable to gender-based violence, sexual harassment and food insecurity and have more mental disorders specially depression and anxiety. Males have a greater risk of substance use disorders.
- Ethnic minorities are susceptible migrants, discrimination adds risk for developing disorders including psychosis, depression and anxiety disorders.
- Child maltreatment and gender violence are common, enduring, and substantial contributors to poor mental health that are also exacerbated in the presence of these new threats.
- Culture can protect mental health through shared meaning and identity, while the loss of cultural identity in the context of forced migration is associated with negative mental health outcomes (56,18).

TRAUMA, MIGRATION, AND THE LESSONS OF WAR

Exposure to traumatic events is especially high in situations of political conflict, as individuals and entire communities become the victims of violence or witness atrocities committed against others. Today, migration joins war as a context for vulnerability to extreme trauma. Worldwide, the overall prevalence of migrant's experience violence during their journey was 29% (57). Among unaccompanied child migrants arriving at the U.S.-Mexico Border, the prevalence of exposure to traumatic events has been estimated to be as high as 85% (41,58).

The study of wartime and refugee trauma, much of it on Holocaust survivors, offer insights on the present and future impacts of the kinds of prolonged and extreme trauma on individuals, families, and communities that characterize migration today. Yehuda found adult offspring of holocaust survivors had higher levels of self-reported childhood trauma, particularly emotional abuse and neglect, relative to comparisons, and attributed the different to parental PTSD (59). Emotional abuse was an independent risk factor for PTSD in the child and was highly related to parental PTSD. The risk of PTSD is found to be greater following exposure to a trauma involving assaultive violence, and higher for those exposed to prolonged violence-associated stress (52). Among Bosnian refugees living in the United States, 65% suffered from PTSD; in Palestinian children exposed to war trauma, the rate was 72.8%.

Temores-Alcantara and colleagues, through semi-structured interviews of migrants in shelters in Chiapas, have described a migratory grief among persons from Central America crossing Mexico, which include job loss, distance from the primary network, i.e. family; loss of territorial and cultural roots (55).

MIGRATION, TRAUMA AND MENTAL HEALTH

Leyva-Flores and colleagues (57) studied 12,023 migrants in five shelters (Chiapas, Oaxaca, San Luis Potosí, Coahuila, and Baja California) along the route of a cargo train, the most frequent mode of transportation for overland migrants traveling through Mexico. The researchers documented a high prevalence of migrants suffering from forms of violence (24% physical; 19.5% psychological, including humiliation; and 2% sexual). These types of violence were most evident in females and the transgender population. Mexican migrants are less frequent victims of violence and discrimination as compared to Central American

migrants and those from other countries, of whom 69% had been robbed, 24% beaten and 9.6% kidnapped.

Children of families deported have high rates of stress attributed to the loss of support networks, inability to communicate with friends, relationship problems with their parents, financial problems, and to violence (19). Behavioral problems in migrant children are associated with discrimination and a negative receptive context, involving aggressive behavior, non-adherence to rules, drunkenness and the use of marijuana (60,61). Deported adolescents show higher rates of substance use than their age counterparts in Mexico.

Studies of premigration trauma exposure among Central American migrants arriving to the U.S. border have reported a prevalence of PTSD of 32%, 24% depression and 17% of both disorders with 70% meeting the requirements for asylum (62). Studies conducted among Honduran transmigrant young males in shelters in northern Mexico have also found high levels of migration-related stressors including abuse and a high prevalence of major depressive episodes (MDEs), alcohol dependency and alcohol abuse (63).

Exposure to traumatic events and daily stressors contribute significantly to mental health issues in migrants seeking asylum. According to Doctors Without Borders (17), one-third or 32.5% of a sample of 467 migrants interviewed in five shelters across Mexico, had experienced physical violence by a nonfamily member. This type of traumatic experience is more salient in El Salvador and Honduras, mainly from members of criminal groups. By and large, migrants are exposed to many types of traumatic events in their countries of origin and during their asylum-seeking journeys. In the same 2016 study, almost half (48%) of the 467 migrants reported having been threatened with their lives. For persons from El Salvador, it increased to 62%. A total of 78% reported that this event had a severe impact on their social and professional lives. Moreover, 56% of interviewees from El Salvador and 45% from Honduras had experience a violent death inside the family, 31% knew someone that had been kidnapped and 17% knew of someone that is or was missing. More than 74% had seen a body of someone murdered. Of those interviewed, 57% reported that the decision to leave their country was related to violence.

Sexual abuse was commonly reported among persons receiving medical care from Doctors Without Borders in 2015 and 2016 in Mexico. Of the 4,700 medical consultations provided, approximately 31% of females and 17.2% of males reported having been victims of sexual abuse while crossing; rape was reported by 10.7% and 4.4% respectively (17). Almost half (47%) reported problems in their emotional wellbeing and in their ability to seek help, due to these traumatic events. Some reported high level of physical and emotional pain (shots, kicks and punches, mutilations with machetes during a kidnapping, bone fractures from blows with baseball bats, injuries suffered from being thrown from a running train, etc.) inflicted on them as a means to extort and get information about their families so they could pay ransom, or as a threat to others when orders from the criminal groups are not followed. Some migrants needed medical and psychiatric help, services that were not available in the shelters or in the sites where the abuse took place (17).

Approximately 47% of 1,817 patients treated by Doctors Without Borders reported needing mental health services due to physical violence. In Mexico, 52% had symptoms of anxiety, 33% of depression, 12% post-traumatic stress disorder (PTSD), 5% behavioral problems, 2% psychotic symptoms, and 1% cognitive problems (17).

These results are consistent with what has been reported in the literature of mental health impact of forced displacement, war and armed conflict. According to systematic reviews, the most common disorders are psychosocial stress, depression, PTSD and anxiety (23). Substance use disorders, and to a lesser extent psychosis, have also been linked (16). In children, the most frequent symptoms are emotional in nature, difficulties in sleeping and playing and psychosomatic symptoms (54, 61).

According to Liu and colleagues (2017), kidnapping (11.3% prevalence of PTSD) and sexual abuse (9.8%) – two frequent experiences of migrants – are the risk factors more strongly linked to PTSD (47). Prevalence of PTSD associated with sexual assaults among women reached 20%. A history of exposure to traumatic experiences increases the risk of PTSD. Using national samples of 24 countries as part of the World Mental Health Survey (including Mexico), the researchers

found that this vulnerability was limited to the presence of violence (i.e., physical, rape and other sexual aggressions) in their traumatic experience.

RESILIENCY

The resilience of migrants, as they integrate into U.S. communities and participate in education systems and labor force, is of great importance. Earlier this paper provided context on the reasons that drive migrants to leave their children and families and country to travel thousands of miles not knowing when or if they will ever see them again. In this section, we attempt to highlight both the internal and external forces that enable them to thrive under damaging circumstances.

Pulitzer Prize winner Sonia Nazario's (2014) story of a Honduran 13-year old boy's struggle to find his mother in the U.S. reveals the widespread desperation and frustration that single mothers from Central America living in extreme poverty and without the means to feed and raise their children suffer (64). According to Nazario, parents and children who make this trip are often left with no choice but to make their journey across Mexico and to the U.S. and endure the horrific misery and peril of being raped, beaten, tortured, and even killed. As was stated earlier, migrants from Central America and Mexico are fleeing war, poverty, crime and violence, and persecution.

This tenacity and belief of "I can't give up" or "I can't return to my country defeated" for many individuals means being deported 5, 10, 20 times yet maintaining their resolve to succeed for a better life for their children or reuniting with a parent/family. "I stay on course and focus on the reasons why I came to this country, to [work hard] and do something with my life," said one youth from Honduras. Another youth from El Salvador said, "instead of feeling sorry for myself, the inner turmoil [that I experienced in my journey] helps me build strength." Nazario suggests that by focusing on the strengths, courage, stories of struggle, including flaws of immigrant people, then their vocation and humanity can be illuminated as an asset to this country's future.

The concept of resilience for purposes of this paper refers to an individual's human ability to persevere in the face of adversity and demonstrate a capacity to overcome and self-regulate to deal with past, present, and future traumas and challenges (65). Simply put, an individual's exposure and response to adverse and traumatic experiences depends on the individual himself/herself (e.g., lived/life experiences, motivation, hope), and their interaction with social and environmental context. Figure 1 (adopted and modified from OECD and Aguilar-Gaxiola) (65,66) illustrates the main elements that characterize resilience of individuals with an immigrant background. Adversity refers to the events, conditions, and increased exposure to such events/conditions (e.g., grinding poverty, crime and violence). Adjustment refers to the individuals' ability to self-regulate or manage their emotions and behaviors and adapt to a new social and environmental context that lead to protective/risk factors associated with mental wellness/illness. More exposure to risk factors translates to increased vulnerability to chronic mental illness conditions (negative outcomes). Protective factors that align to an individual's perseverance and ability to manage adversities and increased exposure to desperation and hostile environments are more likely to make necessary adjustments that lead to positive outcomes. Negative outcomes mean a treatment gap combined with an increasing risk of age-related chronic physical and mental conditions (65).

A key building block of resilience that maximizes protective factors and minimize risk factors is sense of belonging (*pertenencia*). Giving that migrants are uprooted and lose what they value the most when they migrate north—family and country (64). When traumas have been overwhelming from their journey and face more debilitating risk factors (multiple secondary adversities) (67) and conflicted environments, it leads to feeling displaced (68) marginalized, and unable to reclaim a sense of belonging or *pertenencia*. On the other hand, when people feel productive and a form of acceptance that does not paralyze their creativity, their hopes, and their human capabilities to contribute and feel a part of community life, their core values and strengths (protective factors) overcome all risks. Simply put, when people with an immigrant background tap into their protective factors, they are more likely to self-manage prior and new traumas and slowly regain what they value most a sense of purpose and belonging, and ultimately family and country (secure base).

Recognizing and accepting immigrants as making a positive contribution to the U.S. economy and society is not only true but the right thing to do (69). While most immigrant people come to the U.S. for economic reasons, it is important to recognize that not only are immigrants the labor force, they also create jobs as small businesses owners (64). Their identity, roles in the labor force, and contributions to the economic, social, and diversity composition enhance the mosaic of U.S. culture.

MENTAL HEALTH PROMOTION, PREVENTION, AND TREATMENT

From an equity perspective, the acceptance of mental health as a fundamental human right draws attention to the needs of specific vulnerable populations who are at an increased risk of having mental health problems, including people affected by violence, conflict, and forced migration.

Care requires new legal definitions and norms:

- Support for initiatives that have called for a broader criterion to the definition of "refugee" so victims of criminal groups can also be considered eligible for international protection and therefore held in account for the granting of asylum or the statute of refugee (17);
- An end to systematic deportation; and
- An Increase in asylum and humanitarian visas and temporal protection for persons running away from violence are needed.

Structural changes are needed to phase the problems described by Verdugo and Medina (2018) the attention to the problem requires a specific budget targeted to meet the challenges that this new movement has brought to Mexico, training of local authorities and community resources, skills development to deal with the problem can make a difference (10). Migrants don't trust the police, the migration authorities nor the military, and thus do not report abuse, only 13.9% of the 29.4% of those affected, reported an event to authorities or social organizations (57).

The control of human trafficking and the aid provided to persons that are in need would diminish exploitation and reduce risks of victimization and finally, the provision of learning and labor facilities would reduce the involvement with gangs, prostitution and drug dealing (See Table 1).

To ensure that a development program is successful, the mental health of those affected need to be taken care of. The early identification and management of acute stress and anxiety can prevent development of more serious problems. Close and repetitive exposure to harsh conditions derive in severe mental disorders that tend to have a long-term effect, thus interventions should start early and maintained on time. The negative outcomes are extensive and include depression and post-traumatic stress; the most frequent and lasting disorders average 5 years and can extend to 20 years in severe cases. Other impacts include anxiety, suicide, psychosis and substance use disorders. The impact has an intergenerational transmission; thus, the protection of children and adolescents is a recommended action.

Not all persons will develop a mental disorder, the WHO prevalence estimates in conflict settings derived from a systematic review and meta-analysis are that the prevalence of depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia would be around 22.1% at any point in time (70).

But most of them will require humanitarian care to solve every day needs and an important proportion psychosocial intervention. WHO has recommended a scaled intervention provided in the first instance by firsts contact persons trained in humanitarian interventions (WHO/UNHCR Humanitarian mhGAP) (71) to support in assessing and management of transient negative psychological responses triggered by conditions of extreme adversity. Complementary actions in this first step are information on human rights and legal status and on the security of the routes and the help resources available; adequate nutrition should be granted specially for the pregnant or breastfeeding mother, and in general one traveling with small children that require their protection. First contact humanitarian care should include prevention of humiliation, and promotion of a sense of belonging among other activities.

In a second phase, intervention should be provided in shelters and in communities (72). The aim of the mhGAP toolkit is to ensure that people with mental health conditions receive high-quality, evidence-based

mental health services that promote human rights, dignity and equity and promote the expansion of mental health services beyond the primary health-care setting, highlighting opportunities that exist in the community, providing guidance to identify needs and match them with activities, and combat stigma and discrimination.

Actions should target developmentally sensitive periods early in the life course. "There is a large known impact of social determinants during childhood and adolescence on mental health but also in the effectiveness of interventions to prevent mental disorders – measures that have proven effective include life skills, parenting interventions, protection from neglect and violence." The challenge is how to do the interventions in a population in transit and in shelters where migrants stay for varied periods of time (48).

Persons with preexistent mental disorders and those with severe stress or acute anxiety severely affected requite health assistance in shelters and referral to services that should be open for all persons in need irrespectively of their nationality or status as beneficiaries of different services.

SPECIAL CARE STRATEGY

There is a need to define interventions and to take them to shelters and the sites where migrants gather, and later when mental disorders are stablished, and hopefully when the migrant population has been integrated, to the health, education and labor environments.

Invest in the capacity of the mental health teams and persons in the community to address the increase in the number of people who will need care.

Actions: We need mental health and human rights Interventions to prevent risks and its impact on mental disorders. The Lancet Commission on Global Mental Health40 has proposed a series of interventions with evidence of positive impact in low resources settings, we have selected and adapted these interventions to the conditions of migrants.

These disorders tend to remain after the experience, especially if it included torture. The impact persists in the long term and is not transitory (54), therefore the interventions must respond to emergencies, but they must also be maintained as part of the community care system.

RECOMMENDATIONS

The two overarching goals of the Border Humanitarian Health Initiative (BHHI) – to reduce health/mental health burden of migration and to protect the human rights and dignity of migrant populations – are fully germane to addressing the grave mental health/ health and trauma-related issues presented in this paper. The previous sections in this paper, Resiliency, Mental Health Promotion and Treatment and Special Care Strategy are meant to address goal 1 (i.e., reduce health burden of migration) and its objectives (i.e., reduce illness/improve public health, address unique mental health needs of the migrant populations, and mitigate the long-term impact of ACEs). The following recommendations aimed at policymakers, civil servants, advocates, academia, and philanthropy modified from the CLASP (73) are meant to address goal 2 (i.e., protect the human rights and dignity of migrant populations) and its objectives (i.e., reduce exploitation of migrants, minimize criminal risk and impact, and establish minimum treatment standards for migrants):

1. Policymakers should ensure that the best interests of migrant children, including U.S. citizen children living in mixed-status families, are held paramount in immigration policy decisions.
2. Multinational, federal, state, and local policymakers, civil servants, and advocates should ensure that immigrant families have access to the programs and services they need to promote their children's healthier development.
3. State and local policymakers, civil servants and advocacy organizations should ensure early detection and intervention childhood programs have the resources they need to better serve children in immigrant families.
4. The philanthropic community should protect, defend, and elevate the wellbeing of children in immigrant families. According to Hispanics in Philanthropy, an organization that has focused its efforts on the "quickly shifting landscape of the migrant exodus, the impact of immigration policy enforcement on both sides of the border region, and evolving funder

responses, "[t]he most critical action a funder can take is to provide immediate general operating funding to give organizations much-needed resources and the flexibility to adapt as the situation evolves. The following list reflects information to date on targeted immediate, medium, and long-term needs. These needs may shift in response to changing policies and conditions on-the-ground."

CONCLUSION

The hardships and trauma that migrants experience in their migratory journey is inextricably associated with short and long-term mental health consequences. While the impacts of trauma are already evident from their country of origin, entering Mexico, most will come face to face with new traumas and prolonged by more crime and violence. And for those who make it to the U.S., the struggles to overcome the damage caused from traumas and the stress of starting from scratch exacerbates their health and mental health status. These experiences by migrant children combined with other types of violence, past traumas, isolation, and oppression increases their vulnerability to crime, risk factors, mental disorders, and, for many, loss of life. We agree with Venta's conclusion that the real emergency at the U.S. southern border "is an emergency of mental health affecting children and families who have been exposed to traumatic violence at staggering rates and arrive (and reside) in our country with pronounced mental and physical health problems" (2).

The recent anti-immigrant actions by the Trump administration has led to detention and deportation policies that have also contributed to the dehumanization and demonization of migrants, especially children escaping unbearable conditions in search for an opportunity for a better life. Two well-documented incidents that made headlines and ended in tragedy should unite us and transform immigration policies and restore compassion and humanity. First, a 2015 incident where a 12-year-old Ecuadorean girl who was being trafficked and eventually died of self-inflicted suffocation while staying at a shelter without adequate protection, care and treatment. The second, the 2019 tragic death of Salvadorian Oscar Alberto Martínez Ramírez and his 2-year-old daughter Valeria, who drowned attempting to cross the Rio Grande when his desperation and frustration with a crowded U.S.-Mexico border shelter. Any failure to acknowledge the ravages of violence done on vulnerable migrants (i.e., children and adolescents) during their arduous journey, exposed to traumas associated with mental illness, denying them of a human right to voice their asylum claim, and separating children from their parents, constitutes, in itself, a violent act with irreparable short-term and long-term consequences to their mental health and well-being. Failure to acknowledge the link between trauma and its lasting impact on mental health in the migrant population ensures that the issue will remain invisible and their stories mute.

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APPENDIX

Figure 1. A graphical description of the elements characterizing resilience of immigrants

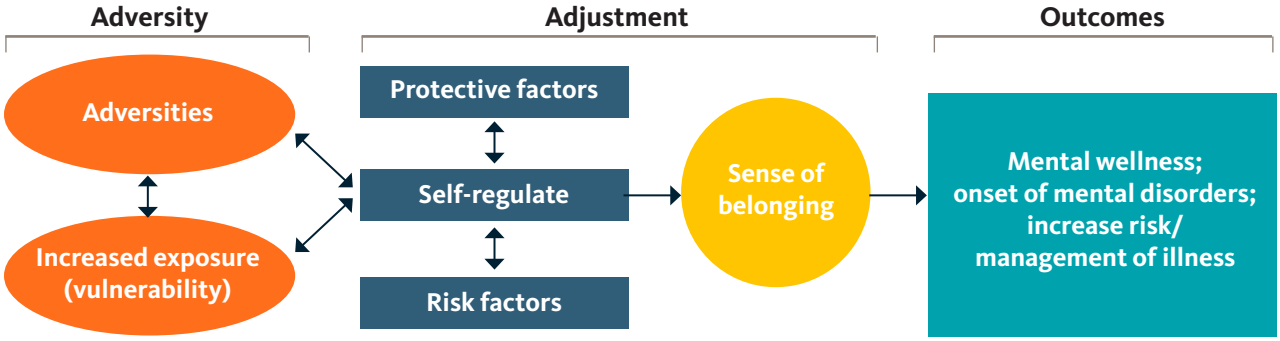

TABLE 1. Proposed actions to address and reduce risks

Poverty	• Provide financial protection to people and families with mental disorders
Hunger	• Ensure adequate nutrition to all children and pregnant women for optimum brain development. Water, food, clothing for all that need. • Reducing prevalence of depression and anxiety through improved food security
Wellbeing	• Provide prevention and care of mental health - alcohol and drug use disorders in community platforms (train human resources) • Implement a suicide prevention strategy • Provide free treatment for severe disorders in local institutions
Learning opportunities in shelters and other community sites	• Provide early child stimulation and cognitive stimulation of older adults • Promote life skills training for children and adolescents and adults including legal skills • Assist population with psychosocial disabilities
Ensure gender rights	• Prevent violence against women, girls and boys, and among sexual minorities
Alternatives for money earning	• Facilitate opportunities to earn money to prevent prostitution and drug distribution
Make human settlements inclusive, safe, resilient, and sustainable	• Create built environments to minimize social determinants of poor mental health and unsafe use of intoxicants, to prevent self-harm and suicides • Prevent incarceration of persons with mental disorders in institutions
Special interventions – crisis – violent massive acts	• First contact, humanitarian mhGAP and mhGAP y tool kit for community interventions