The art of medicine
Borderlands

Cristina comes into the tiny clinic in the migrant shelter in Tapachula, Mexico, where I am doing psychological consultations. She is a young woman. She sits down and starts crying, speaking in rushed sentences between sobs. "I am very scared of being found…that's why we are here. They want to kill us, me and my mother. They found us at home. They told my mum they will cut off her head and they will kill me by dropping me in a river…I have nightmares every night, I cannot sleep. I am terrified all the time…And the lady says we must leave in 5 days because we have been here 5 days already and they only allow you 10 days." By now she is gulping air and chest-breathing rapidly in a way that foretells a panic attack. I beg her to stop for a minute and breathe slowly, while I look for the shelter manager, and her mother, Dolores, to try and understand the whole situation. The manager confirms the eviction notice: "We have a new policy. This shelter is only for sick migrants without papers, and they have their papers, so they can only stay 10 days."

Cristina starts sobbing again. Dolores takes her hand and explains. She is divorced and lived in Guatemala with her daughter and her married son. She worked hard as a cleaner and managed to feed her family. She recalls "the gangs saw I earned something and was without a husband. One day they came to my house and said if I did not give them money they would kill me. I was terrified, but neighbours called the police, who rescued us." But it was too dangerous to go home. A year ago the whole family fled to Mexico. Cristina and Dolores obtained residency, rented a place to live, and Dolores found work as a cleaner. However, the gangs found them. "We called the police who brought us to this shelter for safety, but they said there was nothing else they could do. I don't know what to do. We cannot live here. The gangs are present in the other shelters. I know we should leave, I have relatives in northern Mexico, but we have nothing, how should we get there?", Dolores says. "And I don't want to leave my brother. I have never been separated from him!", Cristina sobs. He cannot leave because his papers are being processed.

Panos

We spend an hour doing some stress relaxation and breathing, just to help Cristina calm down. Then we talk through what options they have. One possibility is for Cristina and her mother to travel freely and immediately by joining the Via Crucis de Refugiados, a group of Central American migrants who are travelling the length of Mexico to raise awareness of the violence, human rights violations, and the legal challenges they encounter in Central America and while in transit through Mexico and upon arrival in the USA.

Lawyers and international observers accompany the march. There is transport, food, and shelter along the way and a chance to connect with others who can give advice and assistance. It's not free of risk, but nor is being homeless in Tapachula. I emphasise it is their decision, all I can do is help them think through the advantages and disadvantages of different courses of action. The next morning Cristina and Dolores join the marchers. Her brother is there, like us, to see them off. As she gives me a hug, Cristina tells me that she is crying inside but she knows they should leave. We cannot accompany them because I am teaching migrant mental health the next week. "We'll see you in Tijuana in a month", I promise.

I think Dolores and Cristina have made the right decision, but is it appropriate that as a doctor I support her choice to join a political action that might further expose her to violence? Throughout my medical career I have struggled with defining the borderlines of the medical domain.

When I began my specialist training in the UK, psychiatry was a fuzzy specialty where biological causation was still not properly understood, biological treatments did not always work, and one had to take account of developmental history, family relationships, cultural beliefs, and social context. That was exactly why I found it so interesting. But even within psychiatry the borderlines were unclear. Mid-training I sought leave to do a PhD, a cross-cultural ethnographic study of peace and human rights activists and their motivations for political engagement. The medical postgraduate dean warned me gloomily: "You will have great difficulty re-establishing a medical career."

Paradoxically, it was war that brought the contradictory fragments of my life together. In 1992 I was married to a Slovene philosopher and writing up my thesis in Llubljana when I was asked to help address the psychosocial needs of young Bosnian refugees living in a camp outside town. Therapeutic work of any kind with teenage boys and girls who had been ethnically cleansed from their home towns and now saw their friends and relatives bombed and besieged, demanded political literacy and an honesty and transparency about my own subjectivities. The boys in the group would not talk to me until I told them what I thought of my own government's policy of non-intervention. "I am ashamed of it", I replied, "that's why I am here with you". The boys were constantly in trouble with the camp authorities. Teaching them non-violent negotiating skills to prevent their eviction from their club room was just as important for their self-esteem as group therapy.

But the Bosnian war also taught me that relief workers can unwittingly be used as political instruments that can do harm. As the war intensified, I moved to Sarajevo to teach mental health to social workers. "If your government would lift the siege of our city, 80% of our psychological problems will disappear at once", one of them told me. I realised that Alan Destexhe, the Secretary-General of Médecins Sans Frontières at that time, was right when he argued that peacekeepers and relief workers were: "being made the alibi for the lack of political action, and that we would find ourselves in the dock with the accused…a companion to the territorial conquest and ethnic cleansing, even to a certain extent making them possible". I went home and joined the campaign for military intervention to end that conflict.

Supporting military intervention in the Balkans did not mean I wanted western governments to drop cluster bombs in Afghanistan after 9/11. I did not see how that could help the Afghan people. I was glad when a donor wanting to invest in children's mental health in Afghanistan asked me to do a mental health assessment there in 2002. It was not difficult to discover the burden of depression and anxiety, psychosomatic problems, and suicide attempts among young girls. The reports I read and the health professionals, patients, and families I interviewed all concurred that the high rates of psychopathology in young women were connected to family arrangements, forced and unhappy marriages, and domestic violence. Unfortunately, most solutions offered by health workers for these problems were pharmacological. In my report I argued that "psychological distress in young girls may be a cultural adaptation to stressful living conditions. When a professional health worker defines it as 'mental illness' the legitimacy thus conferred by this definition might actually contribute to young women's disempowerment, by justifying further seclusion and confinement, and ultimately further stress". I argued that clinic-based interventions serving just a few patients were not the best way to address the social and structural problems that so profoundly affected young girls' lives. "These mental health problems may be better addressed through a wide variety of community and education initiatives, including schooling and safe employment possibilities for girls outside the home, literacy, physical recreation for both genders, negotiation and conflict resolution training." But the donor's primary interest was a clinical service and we did not get the money.

More than a decade later, the profound connections between psychological and social wellbeing and the degree to which they underpin good mental health are better accepted and understood. The *IASC (Inter-Agency Standing Committee) Guidelines for Mental Health and Psychosocial Support in Emergency Settings* were published in 2007 after a global consultation process. These guidelines are clear that mental health professionals have a role in advocating for basic needs—food, water, shelter and security—and ensuring they are delivered "in a way that promotes mental health and psychosocial well-being". Additionally, rebuilding social connections is as important as more specialised clinical interventions for individuals. The guidelines also lay out core principles. These include a commitment to equity, non-discrimination, and the human rights of all affected persons, and to "do no harm". This requires, among other things, cultural competence, and "developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches".

Easier said than done. Remaining in the medical domain, providing individual psychological or biological treatments, is less complicated than helping your patients think through the consequences of engaging in political action. But a month later I am sitting in a cafe in Tijuana. Dolores sits behind a cloth covered table in the upstairs room next to three other marchers, Cristina sits beside her. Dolores is telling the assembled international media her story, and demanding better treatment for all Central American refugees with moving articulacy. The tearful troubled mother and daughter of a month ago have been replaced by striking and powerful activists who have travelled 4000 km and appear to have befriended the entire march. They hope to live with relatives in a nearby town. They want to start afresh.

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Lynne Jones is the author of *Outside the Asylum: a Memoir of War, Disaster and Humanitarian Psychiatry* published by Orion and Weidenfeld & Nicolson in June, 2017. All patient information in this essay has been changed to protect patient confidentiality. I thank Peter Ventevogel and Chris Wellbelove for their comments on earlier drafts of this essay.

Further reading

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