# Relating with migrants: ethnopsychiatry and psychotherapy

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**Summary.** After an historical review of cultural anthropology, transcultural psychiatry and ethno psychiatry, we will examine the literature on intervention with migrants within mental health system. In the first part, we will consider the therapeutic relationship with Arab-Muslim patients and look at specific issues such as gender differences, individualism, sociality, stigma, religion. The second part will be focused on cultural mediation, migration and family intervention and post-traumatic stress disorder and, finally, the experience of being a foreign therapist. Conclusions will discuss the importance of culture, individuality and universality of human suffering, when treating a foreign patient.

*Key words:* migration, psychotherapy, ethnopsychology, cultural competence, ethnopsychiatry, health and culture.

**Riassunto** *(La relazione con i migranti: etnopsichiatria e psicoterapia).* Dopo avere dato dei cenni storici di antropologia culturale, psichiatria transculturale ed etnopsichiatria si passa ad esaminare la letteratura che descrive gli interventi nel campo della salute mentale effettuati con i migranti. Nella prima parte si prendono in considerazione dei suggerimenti tecnici quando si ha a che fare con pazienti arabi musulmani e si analizzano questioni come differenza genere, individualismo/collettività, stigma, religione. Nella seconda parte si descrivono altre questioni: mediazione culturale, migrazione e intervento rispetto alla famiglia, Disturbo Post Traumatico da Stress per finire ad analizzare il caso in cui ad essere straniero è il terapeuta. Nella conclusione si riflette sull'importanza di tenere in considerazione, oltre alla variabile cultura, anche la peculiarità di ogni singolo paziente e l'universalità della sofferenza umana.

*Parole chiave:* migrazione, psicoterapia, etnopsicologia, competenza culturale, etnopsichiatria, salute e cultura.

## INTRODUCTION

Migratory processes have brought together different cultures. In countries like Canada, USA, UK, and France, where there is already the third-generation of immigrants, many authors consider culture as a key variable when relating to a foreign patient. Native culture is needed for a better understanding of how customs, beliefs, religion, values, genders and also attitudes towards mental health service affect individual personality and the way psychological and physical distress is expressed. Mental health professionals need to consider all of these factors in order not to misinterpret what the patient says or does. In addition, they should be aware of all processes that migration implies not only at the individual level, but also in relation to familiar and social contexts: indeed, the complexity of premises and consequences requires sociological and psychoanalytical views on migration [1].

This article wants to primarily be a review on psychiatry, psychotherapy and migration. For such cause we won't bring our clinical experience but we will make reference to the most meaningful scientific articles published on the matter. We will primarily focus the attention on the psychodynamic perspective and this decision is motivated by two major factors: first, because it articulates the narrative dimension of the migrant's internal experience and, second, because we sustain that some theoretical and clinical postulations and phenomena on which the psychoanalytical practice founds him are a universal common to the human condition.

## HISTORICAL BACKGROUND: CULTURAL ANTHROPOLOGY

The birth of cultural anthropology may be traced back to the publication of Edward Burnett Tylor's *Primitive culture*, in 1871 [2]. In this work he refers to "culture" as a set of beliefs, abilities and customs that man necessarily acquires since he belongs to society.

Nowadays, cultural anthropology is mostly interested in investigating the relationship among different cultures co-living within metropolitan contexts and, more specifically, it takes into account concepts like "acculturation" (*i.e.* cultural transformation of society as a result of the interaction between two different cultures), "inculturation" (*i.e.* transmission

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of culture from one generation to the next) and "assimilation" (*i.e.* when a minority group gives up its culture in order to accept the dominant culture).

There are different cultural anthropology tendencies and schools:

1. Malinowski [3], a functionalist, is regarded as the leading figure of the British school. In his conception, "culture" is not reducible to external factors such as biology, geography or climate: different cultures can coexist in the same climatic area and one culture can develop in different climatic areas;
2. in the American school, instead, the "cultural functionalist relativism" prevails. The leading figure is Franz Boas [4] who deems "culture" as the capacity to use reason rather than biological inheritance. In addition, he distinguishes "culture", peculiar to man, from "society" which is a notion common to all animals;
3. the so-called French school stresses the historical and sociological perspectives. Durkheim employs the concept of "collective consciousness" to indicate the synthesis of individual consciousnesses and the original "morality" of the group. In his anthropological contribution, he takes into account the question of social structure [5], the formation of religious ideas and the development of moral ideas [6]. Durkheim's nephew, Mauss, studies magic and primitive populations [7-9]. Claude Levi-Strauss [10] paves the way to structuralism and applies the concept of structure to social organizations. Furthermore he examines myths [11-14];
4. in the Belgian school Arnold Van Gennep is certainly one of the most representative figures: he has devoted himself to ethnographic studies on several European ethnic groups [15];
5. also Ferdinand de Saussure can be regarded as a leading figure with his structural analysis of language [16];
6. in Germany, it is worth mentioning Wundt and his works *People Psychology* and Ratzel's *Ethnology* [17];
7. in Russia, V. J. Propp studied in depth linguistics issues [17] and folktales; his major contribution, in fact, has been the structural analysis of fairytales [18];
8. in the Roman school, Ernesto De Martino is one of the leading figures in the field of history of religion with his research on origins of cults and religious myths.

## HISTORICAL BACKGROUND: TRANSCULTURAL PSYCHIATRY IN ITALY

The relationship between migration and mental disorders had been studied in Italy before the 1970's. In the field of Transcultural Psychiatry, and despite the differences between their methodological approaches, Benedetti [18], De Martino [19] and Frighi [20] addressed numerous issues, some of which are still of great interest and importance: the effects of cultural values on psychiatric epidemiology, the damages on mental health caused by cultural changes, the main clinical frameworks amongst different cultures, the comparison between western psychiatric therapeutic methods and indigenous methods.

The 1970's and 1980's witness the publication of many contributions by different thinkers such as Ernesto De Martino [20], Terranova and Cecchini [21]. Several conferences were organized and researchers from all over Italy were given the opportunity to meet and discuss their ideas. Among them we want to mention: Luigi Frighi, Matteo Vitetta, Colucci d'Amato, Francesco Remotti, Filippo Barbano, Michele Risso, Bruno Callieri, Salvatore Inglese, Antonio Iairia, Giuseppe Beneduce and Piero Coppo.

In 1982, in Turin, the SIPT (Italian Society of Transcultural Psychiatry) was established and Rovera was appointed President. Issues like therapeutic relationship, cultural identifications and projections, acculturation, cultural transition, disculturation and cultural relativism were examined in relation to the concepts of norm and deviance.

Between the 1990's and the end of the century, new initiatives within the field of Cultural Psychiatry flourished: university courses, conferences, seminars and an increasing number researchers interested in the subject. All of these activities led to Italy's participation in the WACP First World Congress in China, in 2006.

In more recent times, it is worth mentioning the specific Master degree in "Migration, Culture and Psychopathology" offered at the Università Cattolica del Sacro Cuore in Rome (director: Pietro Bria; scientific-academic coordinator: Emanuele Caroppo).

## HISTORICAL BACKGROUND: ETHNO-PSYCHIATRY

Beneduce [22] provides an extensive account of the development of ethno-psychiatry. To begin with, the birth of transcultural psychiatry dates back to the publication of Kraepelin's analyses of his studies on *dementia praecox* [23], after his journey to Giava; generally speaking, transcultural psychiatry deals with the comparative study of treatment and illness procedures in different cultures. The term "ethnopsychiatry" appears for the first time in Carothers's work [24] within the field of colonial psychiatry.

With regard to colonialism, Franz Fanon denounces how violence and humiliation were inflicted on colonized populations to emphasize western and white people's supremacy [25, 26]. Western medicine, diagnostic classification and treatment methods were imposed with no respect for traditional practices of treatment; Fanon notices how the true doctor-patient relationship was totally lacking and how the patient was often very scared by white doctors and hospitals. Fanon's conclusion is that there

is real need for an understanding of the historical, cultural and social contexts when dealing with clinical issues [27].

Ethno-psychiatry, thank to George Devereux, becomes an autonomous subject where anthropology, psychiatry, psychoanalysis and history of religion meet [28]. The concept of "culture" becomes therefore crucial [29] although, according to Devereux, it cannot account for every individual behaviour. Furthermore, the author stresses how observation is influenced by the observer's subjectivity and how ethnocentrism is relevant when dealing with someone coming from a different cultural background [30].

Devereux also studied shamanism in depth. According to his view, through the observation of shamanism, the investigation of the "ethnic unconscious", as well as beliefs, therapeutic methodologies and treatment efficiency, is made possible [29].

Finally, Beneduce [22] outlines some Italian forerunners of ethno psychiatry:

- E. De Martino, religion historian, who studied myth, folk medicine, possession, shamanism and mourning [31-33];
- A. Di Nola, De Martino's student, who has examined the meaning of religious ceremonies in Central Italy, traditional medicine, folk feasts and magic [34-37];
- Michele Risso, who worked on Italian migrants in Switzerland [38].

## OVERVIEW OF ISSUES RELATED TO PSYCHOTHERAPEUTIC INTERVENTIONS WITH MUSLIM-ARABS

Grinberg, in his studies on migration from a psychoanalytic standpoint [39], pointed out how departure always implies separation: any separation leads to a crisis, since there is a rupture with the past and with the homeland. Nevertheless, instead of considering it as a single trauma, it is preferable to speak of a whole of factors which, in the long run, can affect physical and mental health. The dramatic change migrants experience brings a disorganization that each person will deal with at different times, according to her personal resources. In general, a bond with the good internal object enables the Ego to tolerate and process the experienced changes.

The choice of leaving might be supported or obstructed by family, and the decision can also be passively suffered (that being the case of children). Sorrow for leaving one's family can be so deep that it will outcome into a projective defence mechanism in which the individual will feel persecuted by her own suffering and will experience her family as hostile and refusing.

Upon arrival, manic defences can take place in order not to experience loss and abandoning: the individual idealizes the host country and perfectly adjusts to the new social and working life; "postponed depression" is what Grinberg calls the exhaustion of manic defences and the arise of depressive feelings. Sometimes, persecutory or confusional anguish takes place and can develop, in most severe cases, into psychotic breakdowns. Individual suffering, once it has been acknowledged and not denied, can lead to progressive assimilation of the new culture. The individual who manages to adjust regains her projectuality and will keep on idealizing the image of the home country.

Finally, the author takes into account the return moment. When the person goes back home, after a long time spent elsewhere, she is likely to find a reality which is very different from what she expected: friends, relatives, houses, society, all have changed over time and new conflicts can arise between who stayed and who left.

According to the sociologist Zanfrini [40], the return to one's own home can be shocking for many reasons: everyday life in the home country is easily idealized when living far away from it; migrants can engage in aggressive and arrogant attitudes - given their experiences abroad; women may not find a job and opportunities for their emancipation; families need to reorganize themselves in order to welcome the returning family member.

### *Gender differences*

Within the therapist-patient context, gender differences may play a crucial role especially when they are relevant to either of the two cultures.

In Arabic communities man is considered to be the strongest, and a woman's duty is that of getting married and looking after children, rather than pursing any professional career: within this perspective, divorce is viewed as a stigma. A divorced woman would therefore lose her children and could re-marry to a widower or become a married man's second wife. There is a specific male hierarchy: a man is the head of the family and is under his father's authority; his father needs to respect the clan leader who is lower than the head of the tribe. Compared to the young, the elderly respect Arabic society more, and their respect is seen as a sign of wisdom and experience. The therapist should not minimize the patient's parents' authority or attempt to change family hierarchical rules. As far as gender differences are concerned, the therapist dealing with a female Muslim should be aware that a straight gaze means sexual availability and that when women glance down it is not necessarily because they are shy or insecure; in fact, it would be useful to explain to them how this behaviour might be misunderstood by western people. Similarly, the encounter between a female therapist and a male patient might be difficult as her authority will not be recognized [41].

### *Society based on individualism/collectivism*

Islamic beliefs and practices deeply affect Arabian lifestyle. The Koran teaches the value of pity, humility and compassion towards human beings, and underlines the importance of patience, loyalty, integrity and control of impulses and desires. The in-

dividual able to take care of others will be loved and rewarded by God: clearly the welfare of all members is vital to the community. This factor should be taken into account if the clinician belongs to a type of society where individualism, self-achievement, independence, psychological emancipation from parents and personal identity are regarded as the most important goals. In such a society, social roles are internalized by the individual and sense of guilt comes from the inside; but in the Arabic societies guilt is attributed from outside, from those members of society who exert control over everyone else. The individual is therefore destined to remain isolated. For this reason, when treating a patient coming from this cultural background, it is recommended to ask other family members to participate in therapeutic sessions. The presence of another member of the family does not have to be considered a sign of dependence but as the normal tendency of the Arabic family: all members will expect to be questioned by the therapist and will make an effort to solve the problem [41].

Dwairy suggests practicing what he calls "analysis of culture", a method that can be very useful when the patient comes from a culture in which collectivity is more important than individuality [42]. In such a society, a person knows that needs, desires, instincts, values and judgments are collective and not individual: the person needs to turn down her own wishes (or express them when she is alone). A likely consequence is the occurrence of conflict between family (or social) values and repressed individual needs and desires; therefore, rather than dealing with the repressed contents, the therapist should help the client to find alternative values, less strict but still within her own system of beliefs, and closer to her personal needs. This is consistent with Beck's approach that holds that oppressive thoughts should be replaced by more functional ones. The therapist should keep in mind that in a society where repression comes from the outside it is much more important to develop competences and skills rather than defence mechanisms. Happiness, indeed, is related to social acceptance [44].

### *Stigma*

Another aspect to be taken into account is the stigmatizing role attributed to the psychiatrist or psychologist. Women, in particular, may feel their marriage plans put at risk because of the therapeutic relationship. Psychiatrist and psychologists can be viewed with mistrust from Arabic patients especially when their religious values are ignored instead of being respected as source of comfort and relief. Since distress is usually expressed with physical symptoms, patients expect to receive prescriptions for medication without any need of talking about personal problems; physical symptoms are more easily accepted and depression is often described as an oppressive feeling to the chest or as an abdominal pain [45]. For instance, depressive, manic and hypomanic patients seem to lack mood-related symptoms, and when they are asked whether they feel sad or euphoric they answer "no" or "I don't know". The same can be said for cognitive symptoms related to guilt and lack of self-esteem [41].

Often, the communication style used to describe symptoms appears impersonal and rather formal because it is quite difficult to talk to someone unfamiliar about personal problems and also because patients are afraid they could damage their family's honour: the inexperienced professional might assume she is facing resistance [41].

Dwairy [42] suggests "metaphor therapy" for Arabic patients as it can give access to unconscious contents without necessarily having to bring them up to consciousness. This method is particularly functional for those patients who are not able to face repressed contents and show low levels of individualization and problem solving skills. The basic tenet of the metaphor therapy is that problems should be represented by means of metaphors (Arabs have a highly metaphorical language taken from the Koran) and solutions should be searched in symbolic terms which can then be applied to real life. Dwairy [42] illustrates an example and a possible interpretation: an Arabic patient, who represses her anger towards her parents, feels like a dam, surrounded by an arid landscape, and forced to contain the increasing water pressure: the risk she feels is that of an explosion and the ensuing destruction of the surroundings. When the therapist asks to think of a solution by using this image the patient answers that holes in the dam would help water to flow slowly out and the land would benefit from the water and become green and flourishing. Through the same metaphor, the patient learns that her conscious anger towards her parents could help her to improve, rather than damage, her relationship with them. Acquired consciousness would later help the patient to progressively modify her behaviour towards her parents and find a good compromise.

### *Religion*

Religious aspects are essential to the everyday life of Muslims. There are five main principles of which the therapist should be aware: the first is that Islam believes in one God and in Mohammed, his Prophet; the second is that a Muslim needs to say 5 prayers every day after ablutions meant to purify the body. Knowledge of these two precepts is of great use: as an example, mental health professionals can encourage the person to take care of herself since the body is God's gift and should not be abused. In general, meditation and prayer are very supportive when experiencing difficulties and they can be used in therapy: if a patient asks to pray in front of the therapist, such request should be fulfilled. The lack of desire for praying can be seen as a symptom of distress and can come along with a deep sense of guilt [46, 47].

The third principle of Islam is fasting during Ramadan. This precept can be found in other religious practices and may not be understood or it may be discouraged by a non-practicing or non-believing clinician. For a Muslim, instead, it is of extreme importance for many reasons: to purify soul and body, to gain self control and not to forget the poorest who suffer hunger every day. The fourth principle says a Muslim needs to help people in need through charity; the fifth orders a journey to Mecca once in a lifetime.

According to Carter and Rachidi [46, 47] two current approaches can help to reconcile western and eastern principles:

1. Rogers' approach includes different concepts which are consistent with Muslim belief systems: authenticity, honesty, positive and unconditioned consideration, acceptance, empathy, understanding, active listening. Furthermore it implies that who turns to a therapist is looking for self-realization, personal fulfilment, increased responsibility and establishment of adequate social relationships;
2. cognitive therapy takes into account emotions and values of each individual in order to identify constructive actions leading to personal happiness. Cognitive approach's goals are both that of identifying dysfunctional thoughts and that of teaching patients not to be catastrophic: patients need to learn how to be objective without risking to commiserate others or themselves. Right decisions and productive actions are made possible by the practice of rational thoughts. Generally, it is recommended to present the therapist as an authority able to show what is to be done in order to solve the problem: that is exactly what happens with traditional healers. The Arab community often shows an external *locus of control* which means that responsibility for what happens is external: this applies especially to those who believe in jinn, sorcery and the evil eye [41]. The therapist should respect the importance given to traditional healers and to supernatural entities in general.

## CULTURAL MEDIATION

Dealing with a patient who comes from a totally different cultural context and who cannot speak the host country language requires help from a cultural mediator. A cultural mediator can assist both for translation and de-codification of cultural issues related to the experienced distress. Beneduce [22] suggests some rules which should be followed for a successful linguistic-cultural mediation: the therapist should reject the typical dual relationship and pay attention to the transference and counter transference reactions elicited by the presence of the mediator in the setting; the therapist should also tolerate her frustration when not able to understand what is happening between the patient and the mediator; the mediator should try to identify personal conflicts brought up in the therapeutic session and should be helped by the therapist in order to dominate transference-counter transference processes. In general, a profound respect between mediator and psychotherapist is necessary: respect is at the base of cooperation, which enables treatment itself.

Nathan [48] has created an ethno-psychoanalytic instrument which implies the use of different professionals (doctors, psychiatrists, psychologists) each with a different cultural background: the patient is welcome to bring anyone into the group (*i.e.* relatives, friends or neighbours) and they all try to build a new shared background. Salvatore Inglese explains that the purpose is to "create a group container where the patient can establish herself "as if" she were within her original cultural framework (…). The container's function is crucial because migration inevitably entails the dissolution of the patient's cultural frameworks (…). Nathan's most recent intention is (…) to show that the distinction between "wild" and "scientific" thought is an ideological mystification performed in order to impose the will of the strongest" [48, p. 16-17]. Any problem a patient brings to the group is analysed from several point of views and interpreted in several different ways until a reformulation of what has been said and a proposal of effective intervention is made available.

## MIGRATION, SOCIETY, FAMILY AND FAMILY THERAPY

Following Zanfrini [40], migratory processes can be explained according to different sociological frameworks. According to "network theory" migration can be defined as a set of social relationships influencing one person's decisions. The choice of a country is normally affected by the fact that some friends have already migrated to that country and will presumably provide the new migrant with different sorts of support: help with housing and employment, bureaucratic procedures, adjustment to the different culture. This theory explains why migratory flows to a country continue despite the scarcity of job opportunities. In addition, the thought of a relative working abroad causes a feeling of "comparative deprivation" and awareness of one's own poverty. This factor brings other individuals to migrate and spread a "migration culture".

Migration, however, has social costs for the ones who leave and for the ones who stay. As a matter of fact, an upsetting of family balances occurs. Moreover, we need to acknowledge an important change: it was typically a man who migrated to support financially his family, while women were called "white widows"; the new trend is that of a female migration and a subsequent redefinition of relationships: wives are often the main financial sources and they gain power compared to their husbands – who therefore lose their traditional role. Sometimes wom-

en who migrate are divorced or widows and in this case too they provide for the support and education of their children.

Children, granted to grandmothers or aunts ("migration orphans"), can experience consequences on their psychological and emotional well-being due to the absence of their mothers. Zanfrini [40] says this cannot be considered a general rule, though. Sometimes the distancing of one parent means an improvement of the child's condition, especially when there is some conflict in the parental couple; also, it is important not to forget that children can hope for a better future compared to what their compatriots can expect.

Social support is crucial: a "culture of migration" would function as a justification and mothers would not be blamed for leaving their children at home. On the contrary, they would be supported since their effort is viewed as a generous sacrifice. Without any social-cultural justification, sense of guilt would increase distress in the mothers, and children would be victims of stigmatization by their own community.

Given these premises, during a family therapy it is important to focus on the changes that society, family and individuals go through. Symptoms that onset or get worse with migration, such as depression, anxiety, psychosomatic illnesses, addictions and behavioural problems, can all be experienced by any family member in any place and at any time: at the time of departure from home or later during the trip, at a crucial time (physical illness, divorce or grief) or when they go back home. The family therapist stresses the complex interactions between the different actors and their context [49].

Falicov [49] highlights some significant implications that the migratory process has on a relational level, particularly when family members live in different places. Separations from and reunions with one's own family cause tension, especially between mothers and children; needless to say, sometimes host countries' policies make reunions difficult to realize. Women, quite often turn to mental health units because they experience depressive feelings caused by separation from their children. In this case, it is suggested to the mother not only to keep in contact with children but with the temporary caregiver too and to increase contacts through phone calls, internet, or even sending toys, clothes and pictures.

Another aspect that should not be underestimated is that the contact with the new culture leads to a conflict between tradition and modernity: in the couple, the woman becomes more aware of her rights and claims an equal position with the husband. As a consequence of these negotiations between the two, a fracture can occur. Even reunions with children can be traumatic because they may be like an encounter between strangers: a typical example is that of a rebel adolescent and a mother who, while abroad, has made a new life and had new children. In these cases, the therapist tries to help the family by asking them to bring letters, photographs and pictures which can remind them of events prior to and following migration. This helps not only to recall their story, but also to give significance to migration by inspiring mutual empathy between those who left and who remained at home. When the whole family moves abroad, conflicts between parents and children might be frequent: these conflicts correspond to those between tradition and modernity. Parents are likely to be too strict and rigid with their children, and the therapist needs to enhance mutual understanding by motivating parents to adjust to the host culture [49].

The process of "acculturation" can be problematic at the time of migration but we should not forget that also going back to the home country involves "re-acculturation" and re-adjustment to home rules: in a very short time the migrant is asked to forget her previous life style [50]. Acculturation depends on more than a few factors: education level, occupation, use of media, political involvement, social relationships, etc.

In conclusion, the therapist's task is to help families to acknowledge cultural and intergenerational conflicts, and to adjust their belief system by keeping some cultural values and assimilating new ones.

## POST TRAUMATIC STRESS DISORDER AND MIGRATION

From what has been discussed so far, it is evident that migrants have to go through several struggles or "micro traumas" which require good adaptation skills. Along with a list of "vulnerability" factors [51, 52] *(Table 1)*, also protection factors can be outlined [52]: social support, social integration, preservation of cultural identity and traditional cultural practices (rituals, language and traditional activities).

Migration can be highly traumatic. This is the case of escapes, as it happens for refugees. It is well known how atrocious journeys are to Europe and how frequently migrants die during those journeys.

**Table 1** | *Mental health vulnerability factors in migrants*

| |
|---|
| Age (migrating from adolescence on can influence the occurrence of mental disorders) |
| Separation from places, people or "dear" objects |
| Loss of roles and their identification |
| Stress or traumas prior to migration that derive from social or political situation |
| Significant aspects of the migratory process (*e.g.*, difficulties encountered during the journey to Italy) |
| Low possibilities of finding support within the home community and poor social network |
| Negative attitudes of native population and perceived discrimination |
| Difficulties with understanding and speaking host country language |
| Cultural shock caused by the inadequacy of interpretative codes (proportional to the distance between native culture and host culture) and acculturation-induced stress. |
| Poor socio-economic conditions in the host country |

Such experiences in which life itself is jeopardized can lead to develop post traumatic stress disorder (according to DSM IV-TR criteria) [53].

Morrison *et al.* [54, 55] outlined a parallelism between negative and positive schizophrenia symptoms and PTSD: flashbacks, images, intrusive thoughts, hyper alertness and possible paranoia are very similar to schizophrenic positive symptoms, while emotional withdrawal, emotional flattening and de-realization are common to schizophrenic negative symptoms. The authors suggest that psychosis and PTSD represent responses to traumatic situations. In both cases, avoidant behaviours or dysfunctional control strategies, as well as autobiographical memory distortions are activated. Ellason e Ross [56] suggest the presence of a subcategory of trauma that can provoke psychotic disorders.

Nowadays quite a few techniques are used to treat PTSD [57]. Hypnosis is often accompanied by pharmacological, cognitive-behavioural or psychodynamic treatments [58]: this technique aims at the creation of false memories [57]. Group therapy is used for patients who had a traumatic experience within a group: patients narrate their stories to the group and feel supported without being judged. Papadopoulos [59] believes group therapy with refugees is better than other methods for two major reasons: because it helps to come out from the condition of withdrawal that follows a trauma, and because the group helps to establish good affective relationships with real people in a real context. Cognitive-behavioural therapies help to work on anxiety symptoms within a safe therapeutic context [60]. Its major techniques are: "exposure therapy" (progressive exposure to anxiety-inducing stimulus), systematic desensitization (relying on counter-conditioning principle and based on the association of positive stimuli and muscular relaxation with an anxiety-inducing stimulus), stress inoculation therapy (the patient learns new coping strategies); cognitive therapy is not based on exposure and the treatment consists of modifying irrational or dysfunctional thoughts. EMDR *(eyes movement desensitization reprocessing)* is quite a recent technique which relies on the assumption that some information has been stored into memory in a dysfunctional way as a consequence of the trauma. Even the most recent theories on memory [61] suggest that pathology is caused by memories of experiences that have not been successfully processed. The technique of EMDR follows a fixed schedule and it is divided in different phases [62]: the patient needs to focus on the most meaningful aspects of the trauma while associating, at the same time, eye movements and other bilateral stimulation. EMDR is set up on neuroscientific findings: this practice would activate new neural pathways that would allow the re-processing of traumatic memories. Through the EMDR technique it is possible to work on the most distressing images associated with the trauma, and also on emotions and emotional distress arising when remembering the event.

Analytical psychotherapy for PTSD seems to be difficult because the patient is afraid to experience traumatic memories again within the transference relationship [57]. Severe traumas like war, imprisonment or tortures, lead to an interruption of the normal psychological development and alter the person in her whole. The feeling of alienation experienced in such situation is made worse by the condition of being an exile: the patient, who has fled to a foreign country after a trauma, has to deal with the loss of her own culture and relationships, and needs to face material difficulties. As Ghislaine Boulanger says [63], the therapeutic setting becomes very important: long term imprisonment or torture experiences are characterized by unpredictability and, as it has been observed, daily habits and activities are important in such situations. For these patients the therapeutic setting guarantees stability and security: the setting becomes an important therapeutic factor in itself [64], a basic element that could be referred to Winnicott's concept of holding. Hence, Boulanger [63] holds that narration of traumas allows symbolization: through the narration, the patient becomes an active witness of her own events and emotions.

Unfortunately, the way to "rebuild" one person's capacity of trust is very long and difficult and not always successful. Even the analyst needs to handle many difficulties especially at a counter transference level; the transference- counter transference relationship is very delicate as it could trigger a torturer-victim relationship with which the patient might not be able to cope.

## A SPECIFIC INTERPRETATION OF PTSD

Marwan Dwairy [44] presents interesting comments on the case of Palestinian children during the Israeli occupation [65]. These children are constantly subject to stress and traumas (among which, such frightening events like night time incursions of Israeli soldiers into their homes). It has been said that the constant experience of warfare has made them somehow addicted to violence. In his studies, Dwairy examines PTSD from a collective point of view: it is the whole society, in fact, that undergoes the strain induced by occupation and daily violence. According to Dwairy [44] some criteria can describe a collective response to post-traumatic stress, although he believes that they should be viewed as a healthy reaction rather than as a disorder. As an example, just before the *intifada*, slumber and avoidance had been the collective response to the presence of Israeli soldiers.

## THE MIGRANT PSYCHOANALYST

We are quite used to think of migrants as people who ask for help, as patients. It would be interesting, instead, to change perspective and see what happens when the therapist is a migrant. Akhtar [66] has investigated the subject and described two specific cas-

es: when the patient is a local and when the patient shares the analyst's same background.

In general, implicit cultural meanings always effect therapy: therefore, when the psychoanalyst is a foreigner misunderstandings are likely to happen. According to Akhtar, a basic rule should be that of taking a neutral attitude, equidistant from both cultures.

When the patient is local the analyst should wonder why the patient has chosen a foreign professional: one possible interpretation is that there could be an unconscious desire to find the lost object of childhood (*e.g.*, perhaps an Afro-American nursemaid who suddenly left?). The patient might also want to protect herself from her own shame or fear of failure and might have chosen a foreign analyst because it is common sense that foreign analysts are less competent.

When there is cultural diversity, and even more when there are visible somatic differences, many projections and stereotypes could influence free associations. So, while it is necessary to control the way diversity affects free associations, it is important not to neglect the patient's personal meanings.

The foreign analyst does not lead the interview in her native language and may not understand metaphors, double meaning expressions, allusions, puns. When this happens the patient can be interrupted to ask further explanations: what is important to understand is whether this interruption can be negative and, at any rate, it should not occur too often.

The analyst may want to make a comment using her own native language; in that case, some questions would be pondered:

- What happened during the talk that induced her to switch languages?
- Would it be of use to translate what has been already said in another language?
- Would it be preferable to translate straight away?
- Can the patient be traumatized by the analyst's speaking in her own language? Could that make the relationship more spontaneous instead?

Another issue that needs to be considered is that there could be a reversal of roles from a linguistic point of view. A disparity of roles in the therapeutic relationship is generally accepted and the analyst is the one who leads the talk: when the therapist is a foreigner, though, the patient might be more competent at the linguistic level. To a patient characterized by narcissistic vulnerability the poorer linguistic competence of the analyst may be seen as "weakness" and would therefore be an obstacle to the narcissistic identification with the idealized therapist [67].

When the therapist and the patient are both foreigners and speak the same language the risks might be a collusion about nostalgic issues and the impossibility to investigate prohibited subjects; also the switch of aggressiveness from internal to external, might be eased through a mechanism of projection.

It is important to avoid cultural rationalization of intra-psychic conflicts. Akhtar [66] reports the case of a Jewish woman, daughter of a holocaust survivor, who called to set an appointment. She said that she was a fervid Zionist and asked whether the analyst was Arabic because she would not give her money to a terrorist. Akhtar comments that an ethnic rationalization may hide the patient's sado-masochist attitude.

Another element that should be taken into account is the acculturation gap between the therapist and the patient. Although from the same country, they might hold different beliefs and there might be differences concerning Ego and Super-Ego. The most likely case is that of the "westernized" therapist: the therapist is likely to have been living in the host country for many years and to be more adjusted to the new culture. The cultural gap is also linguistic: the therapist could realize he has lost command of the native language while the patient has a more complex vocabulary; the therapist might then feel ashamed or envious.

At other times, instead, the therapist serves as a "bridge" between the past and the future. The therapist has gone from her primary objects and early experiences to her new identity, and this is exactly what the patient asks for [67]: the therapist becomes the symbol of what the patient would like to be. Similarly, the possibility of speaking the same native language can be very practical because the language spoken in the host country can easily symbolize super-egoic features with the subsequent risk of repressing some contents [68]. The native language, instead, allows easier access to childhood memories, free associations, emotions and unsolved conflicts [69]. Nevertheless, since the foreign language could represent paternal super-egoic features, the use of one's native language in the therapeutic talk can imply collusion. In other words, the will to keep the foreign language out of the therapeutic relationship would signify the wish or a pre-oedipal condition.

Finally, it is important to understand whether the rejection of the foreign language corresponds to the rejection of the entire new culture. Akhtar [66] points out that, although it is useful to understand the peculiarities of the patient-therapist relationship, the universality of human beings should not be forgotten.

## CONCLUSIONS

The premise of this paper is that the increasing number of migrants[1] requires a careful reflection on therapeutic techniques.

We started from a review of some studies on Arab communities and found them useful for mental health professionals working with migrants: it seems clear to us that a therapist should always try to suspend her personal beliefs and philosophy could serve the purpose [71]. Ancora [72] speaks of a "journey" the therapist makes in new worlds, a journey made possible by the combination of daily professional practice and a wish for exploration. The therapist should be able to "decompose" and then later "recompose" herself, to

[1] *As reported in Dossier Caritas [70] Istat has pointed out an increase of half a million units.*

"leave" and "return" to herself, in a sequence which is meant to build a shared "platform" for the treatment.

Western treatment techniques have been imposed on colonized populations, and some authors, such as Bourdieu [73], have spoken of a "symbolic violence". Colonizers, indeed, imposed behavioural rules, religious beliefs, educational and health systems, and even worse forms of coercion like the enrolment in the colonial army or forced labour. "Ceremonies, traditions, bodies of these people had been already judged as inferior […] certain that it was the European man's duty to free these people from barbarity, ignorance and poverty" [22, p. 33]. Porot [74], a colonial psychiatrist, defined North Africans as "primitive", "ignorant" and "credulous". Even Fanon pointed out the impossibility for a foreign practitioner to work in a colonial environment where whites and hospitals are feared by the local population [26].

Nowadays, we try to be aware of our prejudices and ethnocentrism in order not to influence our relationship with the migrant. Bhui *et al.* [74] speak of the possibility of acquiring *cultural competence* which would enable professionals to better understand the concept of illness within a specific cultural context. Furthermore, it is crucial to be genuinely interested in knowing different cultures, developing an empathic attitude as well as the awareness of the expectations and prejudices peculiar to patients and health professionals.

After so much emphasis on culture it would be useful to warn professionals about the possibility of being fascinated by exoticism with the risk of missing the real purpose: the encounter between two people.

S. Inglese (in *Principi di Etnopsicoanalisi* by T. Nathan, p. 18 [48]) argues that "cultural material is the container and not the content of discourse; the final purpose is the identification of the idiosyncratic level (individual psychic conflict) lying beneath cultural construction. (...) The professional is also exposed to the risk of viewing the patient as a mere informant of her culture (counter transference fascination) and becomes insecure about her right to intervene according to her approach.

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