The International Journal of Migration and Mental Health

Globalization in Japanese Psychiatric and Mental Health Fields: Considering Globalism through Three Clinical Cases.

The Lüscher Color Test for psychological evaluation of asylum seekers: brown color foresees integration and difficulty in autonomy.

A Study about the denial of Ulysses Syndrome in a sample of homeless immigrants.

Identity's experiences as a Mental Health Factors in migrants communities.

Consistency among evaluators in the detection of risk factors to the mental health of immigrants: Ulysses scale.

A Refugee Children and the cultural shock in diaspora di Lavinia Bianchi e Mario Pesce

Treating mental health disorders related to migration and torture: the experience of MEDU Psyché open clinic in Rome

From Psychosocial and Communitarian Perspective

THE ATHENA NETWORK

Network of psychological and psychosocial support for immigrants living in extreme situations. A global response to global problems

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The Athena Network is defined by 4 characteristics:

1. The Athena Network seeks to provide psychological and psychosocial support to immigrants in the areas of health and specifically in mental health.
2. The Network seeks to help those immigrants who experience extreme situations. The migratory process in today's world, for millions of people, is a process that brings with it a level of stress of such intensity that they exceed the human capacity of adaptation.
3. The Network aims to serve as a space for the exchange of information and experiences concerning activities and researches that aim to protect and improve the mental health of these immigrants.
4. The Athena Network is a non-profit entity and registration is free.

The name Athena evokes the figure of the Greek goddess who protected Ulysses in his long voyage, helping him overcome adversity and danger along the way. Athena is the goddess of knowledge and humanism, which are fundamental values of society.

The Network is made up of a group of health, mental health and psycho social professionals. We have made a personal commitment to the often difficult and sometimes tragic fate of millions of immigrants in the 21st Century. We believe that global problems demands a global response

The Network is an initiative of various institutions with a long history of experience in the work of immigrant mental health, which include the Ulysses Syndrome Programme of the University of Barcelona, the Health Initiative of the Americas of the School of Public Health at the University of California at Berkeley and the Minkowska Center linked to Paris V University.

The Athena Network was launched at the World Psychiatry Association Conference, "Migration, Mental Health and Multiculturalism" in the 21st Century, in Barcelona, October 30th to November 1st, 2010.

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editorial

The idea of editing a magazine that addresses the issue of migration and mental health is a project that has not just come about today, but has been a goal of many professionals who work in this area, as well as leaders of immigrant associations for several years now. The idea of editing this magazine has arisen from the need to have a means of expression for the research and experiences that are being developed and put into practice in this field.

The International Journal of Migration and Mental Health from Psychosocial and Communitarian Perspective is coming to the public with the desire to bring knowledge, ideas and experiences about the current state of mental health of immigrants in the world today. A world in which problems rapidly accumulate for people who emigrate

In addition, the journal aims to fill a gap, since the scientific journals in this area rarely take into account the psychosocial and community perspective, focusing predominately on a psychiatric or cultural perspective.

The articles for the journal have followed a strict review process, as is the case for magazines of high scientific quality.

The journal is not only for academics and professionals in the field of mental health and migration, but also for immigrant associations, NGOs working in this area and all those interested in being up to date in a such an important reality in the world today, that of the mental health of immigrants.

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summary

PRESENTATION OF THE FIRST ISSUE OF THE INTERNATIONAL

JOURNAL OF MIGRATION AND MENTAL HEALTH FROM PSYCHOSOCIAL AND COMMUNITARIAN PERSPECTIVE

We have great pleasure in presenting the first issue of The International Journal of Migration and Mental Health from Psychosocial and Communitarian Perspective.

The articles appearing in this issue are based largely on the papers presented at the Fifth Congress of the Athena Network held at the Urbaniana University in Rome in October 2016, although others are also included.

The first article is **"Globalization in Japanese Psychiatric and Mental Health Fields. Considering Globalism through Three Clinical Cases"** from Yu Abe and Aya Yuasa, Psychiatrist from Department of Psychology of Mejiigakuin University in Tokyo. In this article the authors entail that We analyzed and considered globalism in Japanese psychiatric and mental health services. Although this topic has been deeply studied and considered in many European and North American countries, multiculturalism within the context of the mental health field is still minor in Japan.

The lack of attention and growth in this field within Japan can be, in part, attributed to the minimal percent of the population within Japan who are not Japanese (2%). The state of multiculturalism in Japan can be additionally attributed to how, historically, the Japanese government is not accepting of immigrants. We analyzed the data of Latin American patients with Japanese descent who visited a multicultural, psychiatric clinic located in Tokyo. Based on the data, the patients in this group were divided into three categories: 1) patients with mental disorders who are first-generation immigrants; 2) patients who are second-generation immigrants exhibiting problems with self-identity and cultural identity; and 3) patients who are children of the second-generation immigrants who have yet to establish self-identity. We indicated three clinical cases and suggested the importance of improvement with respect to multicultural, psychiatric, and mental health services, the "globalization" of the field in Japan.

The second text is "**The Lüscher Color Test for psychological evaluation of asylum seekers: brown color foresees integration and difficulty in autonomy" from** Dr. Bonadies Simonetta, psychologist, SPRAR, and Dr. Alberto Polito, psychologist, SPRAR. This study shows the results of a search for the effectiveness of Lüscher Color Test for the psychological evaluation of asylum seekers, with particular attention to integration and autonomy.

The study aims to determine whether the positioning of brown in a statistically less frequent position in the series is predictive of psychological distress. The research was conducted on a sample of 100 asylum seekers, included in the SPRAR projects in the Calabria area. A short version of the Lüscher Test was given to the study cohort, with a report specifically designed on the SPRAR criteria, in order to evaluate integration and autonomy. The result shows that the position of the brown might predict difficulty in integration and autonomy of asylum seekers. The results demonstrate the effectiveness of the Lüscher test for assessing the psychological discomfort of asylum seekers (in particular as regards autonomy and integration).

The thrid article is **"A study about the denial of ulysses syndrome in a sample of homeless immigrants"** from *Carmen González Ferreras,* Pfra. Facultad de CC. de la Educación. Campus Universitario, Puerto Real (Cádiz, Spain) In this article is studied that the most cruel situation of social exclusion is the homeless situation. If you are an immigrant your story is even more critical. You are excluded from the excluded. The problems faced by homeless immigrants in Spain has not been investigated deeply enough.

The purpose of this paper is to detect if Ulysses syndrome occurs in a small group of 5 **i**mmigrants, barely surviving in Cadiz streets (Spain). They have been evaluated through *The Seven Griefs of Migration Interview (Achotegui 2010)*. The results suggest they don't show enough griefs and symptoms to fall under the Ulysses Syndrome diagnosis.

The forth article is **"Iidentity's experiences as a mental health factors in migrants communities"** from Simona Chiapparo, researcher, Associazione Ariete Onlus research department manager, from Barbara Piscitelli, psychologist, trainee at Associazione Ariete Onlus, Vera Sodano, psychologist, Centro Studi Ksenia, and Benedetta Orlando, trainee psychologist, Associazione Ariete Onlus, Alessandro Ingaria, researcher, president of Geronimo Carbonò.

This paper describes first results coming from multidisciplinary research on identity and multiculturalism, which is developed within the socio-cultural perspective of The Charter of Naples / Urbanitas, Solidarity & Sustainable Humanitas Charter, designed in order to explore urban route of strategic and operational programs focusing on implementation of host systems and cohabitation, supporting migrants, refugees and asylum seekers. Such research is realized in collaboration with Geronimo Carbonò and Centro Studi Ksenia, during psychosocial projects supported by Naples Municipality's Decentralized Cooperation Department.

In according to the so-called paradigm of "*cultural and identitary métis*" by Françoise Sironi and the decolonizing theories by Frantz Fanon, the present study aims to investigate the identity's experiences of young migrants and second generation foreign citizens, currently living in urban areas of Naples. The research is based on multidisciplinary methodology based on assessment with psychological scales (Toronto Alexithymia Scale and Body Uneasiness Test) and projective psychological test (Thematic Apperception Test), organized during multimedia story telling workshops. The first results allow to analyze the migrants' perception of urban spaces and their imaginary stories about own ethnic-cultural origins, as crucial elements for the migrants' mental health. Indeed, the research is also focused on the genesis of "fundamentalism identity" factors.

The fith article is **"Consistency among evaluators in the detection of risk factors to the mental health of immigrants: Ulysses scale"** From Joseba Achotegui and Antonio Solanas Professors of Barcelona University, Yara Fajardo collaborator of SAPPIR, Marta Espinosa and Iván Bonilla from University of Barcelona and [3], Dori Espesof rom IAS de Girona y SAPPIR de Barcelona

The article describes the Ulysses scale, which makes it possible to structure and measure the complex clinical and psychosocial information on stress and migratory grief. This is of great interest for health, welfare and research work. This scale can be used in the different professional sectors that care for immigrants, not only for health services, but also for social and educational services.

The characteristics of the scale and the study on inter-observer reliability are presented in the article. The results ensure the reliability of information between evaluators is sufficiently high. This article has two parts. The first part presents a scale of evaluation for risk factors to the mental health of immigrants. Part two studies and demonstrates the reliability of the scale described.

The sixth text is **"A Refugee Children and the cultural shock in diaspora"** from Lavinia Bianchi and Mario Pesce, from Theoretical and Applied Social Research. Department of Education Science Roma, and Mario Pesce Dott. Mario Pesce, Antropologo, Ph.D. in Social Work Roma 3 University of Science of Education Faculty, Rome. This article entails The migration flux, in our era, can be considered as a "social total fact".

The women and men in diaspora have very different kinds of needs, instances and problems.The cultural shock in host country begins a social event that the social science must analize and study.This paper, with a narrative methodology of post-colonial epistemological approach, intends to give voice to the influence of 'culture shock' of a Refugee Child, who considered himself victim of a jinn (voodoo) and how through their own cultural traits, such discomfort is obvious, develops and emerges until in successful treatment of Italian experts.

The seventh article is "**Treating mental health disorders related to migration and torture: the experience of MEDU Psyché open clinic in Rome"** from Chiara Schepisi, MD, Alberto Barbieri, MD, medical coordinator, Other members of the clinical team, Vincenzo Russo, psychologist and cognitive-behavioral psychotherapist and Federica Visco Comandini, psychologist, Francesca Di Rienzo, psychologist and psychosocial volunteer reating mental health disorders related to migration and torture: the experience of MEDU Psyché open clinic in Rome

This article has been demonstrated that a large fraction of forced migrants has experienced torture or other cruel, inhuman and degrading treatments (CIDTs), a condition that may result in the development of traumatic-spectrum disorders or other psychiatric conditions. The goal of MEDU Psyché is to provide psychological and medical support to migrants who have developed traumatic disorders in response to torture and CIDTs. MEDU has applied an integrated therapeutic project based on psychosocial support and cognitive psychotherapy

The results are that About 37% of MEDU patients had experienced torture, while 42% report other potentially traumatic events. Severe insomnia, mood deflection and traumatic memories are the main reasons to seek psychological support. As conclusions the authors consider that torture and CIDTs are frequent among migrants seeking help for psychological suffering. Consistently, symptoms suggestive of a posttraumatic disorder are common among forced migrant

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Globalization in Japanese Psychiatric and Mental Health Fields: Considering Globalism through Three Clinical Cases

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Keywords:

psychiatry, mental health, Japan, globalization, multicultural, immigrant

Abstract

We analyzed and considered globalism in Japanese psychiatric and mental health services. Although this topic has been deeply studied and considered in many European and North American countries, multiculturalism within the context of the mental health field is still minor in Japan. The lack of attention and growth in this field within Japan can be, in part, attributed to the minimal percent of the population within Japan who are not Japanese (2%). The state of multicul-turalism in Japan can be additionally attributed to how, historically, the Japanese government is not accepting of immigrants. We analyzed the data of Latin American patients with Japanese descent who visited a multicultural, psychiatric clinic located in Tokyo. Based on the data, the patients in this group were divided into three categories: 1) patients with mental disorders who are first-generation immigrants; 2) patients who are second-generation immigrants exhibiting problems with self-identity and cultural identity; and 3) patients who are children of the second-generation immigrants who have yet to establish self-identity. We indicated three clinical cases and suggested the importance of improvement with respect to multicultural, psychiatric, and mental health services, the "globalization" of the field in Japan.

Globalization in Japanese Psychiatric and Mental Health Fields: Considering Globalism through Three Clinical Cases

Introduction

The concept of Globalism, or Globalization, first appeared in Webster's dictionary in the year 1961. Ever since the addition of this term in the lexicon, many scholars have tried to create a countless number of definitions for it. Al-Rodhan & Stoudmann [1)] stated Globalization is "a process that encompasses the causes, course, and consequences of transnational and transcultural integration of human and non-human activities (Al-Rodhan & Stoudmann, 2006, 2)."

The concept of Globalism makes itself available to be understood in a way that is multifaceted. Iyotani[2)] pointed out Globalization could mean a global issue such as environmental problems, which one country cannot resolve. He also considered the downside of globalism in so far as technology has exceeded the human-controllable limit, and it could give us unpredictable results.

We considered the Globalism in the field of Psychiatry--its merits and downsides. Because psychiatry also is "human activity," it must encompass the causes, courses, and consequences of transnational and transcultural integration of human and non-human activities. Following Al-Rodhan & Stoudmann, we adopted the definition of the Globalism in the field of Psychiatry, "a process that encompasses the causes, course, and consequences of transnational and transcultural integration of psychiatric activities," for the following article.

Globalization in the field of Psychiatry

When we focused on globalization in psychiatry, we naturally targeted people who cannot/could not globalize themselves. We analyzed the data of Japanese-descended Latin American patients who visited a multicultural psychiatric clinic located in Tokyo, and categorized them in the following three groups:

1) mental disorders of the first-generation immigrants

2) the second generation-immigrants with both self-identity and cultural identity problems, and 3) children of the second-generation (third-generation) immigrants who have yet to establish self-identity.

In the following sections, the categories will be elaborated upon further, in addition there will be an example patient from each category to more clearly exemplify the category/group.

Category 1: first-generation immigrants with mental disorders

The patient within who are first-generation immigrants that came to Japan after they developed their self-identities. However, the fluctuation of their cultural identities can influence their self-identities.

Case A: 49 years old, Male, second-generation Japanese-descended, South American

The patient grew up in Japanese-descended family with a lot of family conflicts and discord between his parents. His parents spoke Japanese, and the remainder of the family mainly used their, non-Japanese, mother tongue. The patient worked as an electrician after graduating from junior high school. The patient's ability to communicate and interact successfully with females was quite poor, as partially reflected in his status as unmarried. He came to Japan when he was 42 years old, longing to visit his parents' country. Approximately 2-3 years following the patient's arrival in Japan, he showed symptoms of dizziness. He received treatment in otolaryngology, yet his condition was not cured. While seeing relative success in his work in a factory, outside of this, the patient struggled a great deal in adapting to Japanese culture.

The patient reported suffering from nightmares; some of the narratives of those nightmares were to be stabbed by a knife, or to be attacked by a snake, resulting in the inability to achieve quality sleep. Patient additionally reported sustained, intense headache. Patient shared recollections of arguments between his parents that he had heard and seen as a child. Patient furthermore recalled his experience as a victim of child abuse/sexual abuse. When the patient was a student in junior high school, an adult man forced him to engage in sexual activities. Apparently, one of the patient's relatives was involved in this experience, providing instruction to the perpetrator or the abuse. During the recollection of these events, the patient became extremely unstable and uneasy, due to the intense trauma of this experience and the intensity with which the vivid memories returned to him. He had no one to talk to regarding these traumas because of the language barrier. From the time his treatment began with an initial out-patient visit, the patient aggressively talked about his traumatic experiences that happened in his childhood and adolescence.

As he came to our clinical consultation a few more times, he expressed his feelings about his father, stating: “My father was too dreadful to talk to. I don't want to go back to my country. I feel so painful when I recall his memory.” In his 6th or 7th session, he reported that the number of his nightmares and recollections of his bad experiences decreased. We guessed that his gender identity was not well-developed because of the fear of his father and trauma from sexual abuse. After more months still, he stated, “It is not easy to solve relationship problems. I think it is natural for me to have such nightmares. I feel better now. I think I can handle my life by myself. All things happened in the past.” He also stated, “I switched my visa status. I think I will stay in Japan for rest of my life because my country is too dangerous.” His case was terminated.

He spoke weakly in his sessions. He seemed anxious in deciding whether to remain in Japan where his father was born. He did not consider going back to his country where he experienced his traumatic episode. He felt there was nowhere he could live safely and relaxed. In his last session, he came to the conclusion to remain in Japan on his own.

Although the patient did not seek treatment until after spending 7 years in Japan, the time spent in the country did not do much toward his adaptation and potential assimilation in the country and culture of his father. He had a cultural identity crisis, as well as self-identity crisis. In the early occurrences of nightmares, the dreams were in his mother tongue. As sessions went on, the language of the nightmares transitioned to Japanese, and the recollections of his past traumas began to decrease. At last, he decided to stay in Japan. We deduced, from the cumulation of these occurrences, that he was overcoming his conflicts with his father, was cultivating his self-identity, and was developing a cultural identity by associating with Japanese culture,

symbolizing the healthier connection with his father he never had, but could have in a way because his father was partially Japanese.

A conclusion we came to as a result of this case is that there are some cases in which patients do not effectively transition to Japan after coming to Japan. There are also some cases in which patients felt self-identity problems because of cultural maladjustment. The symptoms in such cases tended to be hallucinatory delusions and depression. This patient's case was typical insofar as it was a case of globalism crossing borders, where in Patient experienced a mismatch. People, such as the patient, were engaged in economic and social globalization more frequently and more deeply than the rate at which globalized psychology could diagnose and treat people who experienced problems as a result of globalization, generally.

This case type relatively happens often. The French call cases such as these, *Bouffée délirante* (acute confusion). The practical treatments at out-patient psychiatric clinics for these cases vary. Anti-psychotic medications work for a psychotic type, and usually ameliorate symptoms in 3-4 days. We consider that mental health professionals with social and cultural understanding and view for both cultures are necessary; however, it is not well established yet.

Category 2: Second-generation immigrants with both self-identity and cultural identity problems

When we establish our identities with respect to borders, these may be called national identities or diaspora identities. However, it is not necessarily well-established within second-generation immigrants. As the Patient from Case B shows us, there is an impact of cultural identity influenced by self-identity problems after the patient has established self-identity, relatively. The case below told us self-identity problems lead to the patient having transient confusion.

Case B: 24 years old, Female, Japanese-descended, South American mother

The patient was born in a country in South America, was raised within an affluent household that included multiple servants. She was the first child of three sisters. She came to Japan when she was 10 years old. After coming to Japan, she lived with 4 family members, but left her home when she was 17 years old because of a strained relationship with her mother. She lived with her acquaintances and/or an aunt, and worked in a nightclub. Simultaneous to these occurrences, she was forced into prostitution, and became a victim of fraud. This period in her adolescence was merciless. When she was 20 years old, she decided to go back to her home and start over. When she was 22 years old, she was hired as an interpreter and lived in a dormitory.

She spoke her mother tongue in her office, while she spoke Japanese acting in Japanese way when she spoke to Japanese people. It made her very nervous. After three months passed, she started having nausea, and worrying about her surroundings. She suffered from panic attacks and social anxiety, having no idea how to act in public. She ran out of the office, and came back to her parents. She felt that her boss abandoned her. She suddenly recalled painful episodes in her adolescence. She attacked herself claiming that she could not function well, felt no value to living, suffered from sudden crying fits, and was overly conscious of death and mortality.

In a session she stated, “I made much harmony in order to be Japanese. That made me careful with other people. Ever since three months ago, I began worrying about others' casual behaviors. Two months ago, my grandmother passed away. I have not been able to show my real face up to now. I have lived killing myself up to now. I am so tired of adjusting myself to others anymore. I feel there is a huge gap between inner side and outer side of me. I think the 'Japanese way' is so stupid.” She stated that she left her heart in her country. She did not want to act like Japanese people.

This case showed us the conflict and gap between inner side and outer side within the self. From 17 to 22 years old, the gap did not actualize in the way of connecting to culture. At the age of 22, she became an interpreter, becoming more conscious about language and cultural difference between two countries. Gradually, she felt split between the two countries. She became panicked because she could not find a clear answer to the question, “Who am I?” Coincidentally, she came to our out-patient psychiatry treatments.

Her childhood was spent in her country. She used her mother tongue at home, and used Japanese at school after coming to Japan. The relationship with her parents was of poor quality. She developed a negative self-identity in this environment, evidenced with such occurrences as running away from home, prostitution, various forms of abuse, poverty, and fraud. She always needed to accept helplessness. She always needed to be dependent on her aunt and acquaintances, in order to compensate helplessness with dependency to others.

At the age of 22, she was co-dependant financially and psychologically to her boss, who was not Japanese. As the relationship with the boss became bad, her negative self-identity was exposed, and her cultural identity as a Japanese was flawed. She became aware of the rootlessness of her life in questioning who and what she was.

Diaspora identity is the development of one's own social and cultural identity that transcends borders and ethnicities. The idea consisted of deconstructing nationality based upon the traditional principle of exclusion. However, this case unfortunately did not reach the state.

How could psychiatry help this type of people? In French psychiatry, the group with bilingual staff provides strong support. It is not easy to apply this method into Japanese psychiatry because of the deficiency of bilingual professionals; however, it is one of the ideal supports psychiatry could provide to this type of people.

Category 3: Children of second-generation immigrants who have yet to establish self-identity

Persons who fall into this category usually speak their mother tongues at home, learn Japanese at schools, and speak Japanese to their friends. In other words, they learn their mother tongues primarily by means of conversation, and learn Japanese primarily by means of institutionalized education. This situation tends to make for incomplete bilingualism and incomplete acquisition of the mother tongues. There is a distinct possibility that this type of child does not develop a self and a cultural identity very well during the period of adolescences. Below is a typical case of such a child.

Case C: 11 years old, Male, South American, the third-generation Japanese-descended

This patient was both born in Japan and raised in Japan. Patient spoke Spanish to his parents, and Japanese to his brother. He had no difficulty speaking Japanese. At the end of 3rd grade in elementary school, his teacher stated that he was a restless and careless child, and could not catch up in his class. He scored 69 IQ on an intelligence test in a child medical center. He began studying in a special support class from his 4th grade year forward. His father doubted the need for the special support class, and asked us to examine his developmental level.

We considered his medical history and grades at the school, and conducted WISC-IV by a bilingual psychologist. After our assessment, we conducted another text and the patient scored an IQ of 90. The change in his score is obviously not because his intelligence suddenly increased since the end of the 3rd grade until the middle of the 6th grade. It is reasonable to understand that the he could not reflect his intelligence acquired in daily Spanish conversation at home onto the IQ test conducted in Japanese. Generally speaking, in the case the conversational language at home and the studied language at schools differ, such as his case, we need to be careful when conducting standardized tests because the results are possibly lower scores on tests conducted in either language (Figure 1).

It is very difficult to assess and treat such children in Japan. According to Siefen et al., [3] only 1/8th of psychiatric clinics can treat immigrant children, so shows the research data of 100 psychiatrists in German clinics. They also pointed the difficulty and cost for patients to prove interpreters in multicultural clinics in Germany. The research also indicated the reason for not accepting immigrant children, such as difficulty making their parents understand about diseases, language barriers, and the deficiency of clinical experience with multicultural children. It indicated how difficult for clinicians to overcome the language and cultural barriers.

Historically, Germany accepted many Turkish and Yugoslavian immigrants as *Gastarbeiters* (guest part-time workers), and has brought in two million Syrian refugees. The acceptance and treatment of psychiatric problems of immigrant children are tough in such multicultural, open country. Thus, child psychiatry must be a great challenge in any or every country, if a country such as Germany, with such openness and supportive infrastructure, and a large, diverse population of immigrant children to treat.

On the other hand, the field of immigrant psychiatry in France attempts supports for immigrant children and their families by multilingual teams. The teams support culture and language, based upon the idea that “immigration is redeveloping one's identity in few years, which usually developed slowly through few generations.”

The Consideration and Prospective View for Mental Globalization in the field of Psychiatry

Problems of first generation immigrants include the development process of mental globalism, which proceeds along social globalism. It involves the confusion that happens when inherent thoughts, feelings and behaviors along native cultures meet other

social, behavioral and cultural manners; however, they overcame it.

A problems of second-generation immigrant adolescents involve the process to develop both self and cultural identities. Identity for the second-generation immigrant adolescent means a social process wherein the result is belonging to two cultural groups. If globalism creates cultural difference based on integration and equalization, and the difference creates the possibility of integration and equalization, the process of developing identity increases the possibility to belong multiple cultural groups.

It depends on individual quality and environment if patients can repeatedly reacquire cultural difference in their cultural and social mental processes--in other words, in the process of developing identity. Acquiring diasporic identity by going back and forth between two cultures is not easy for many of us. However, as globalism progresses, the diasporic way could be a standard in the future.

For these first and second-generation immigrant mental problems, what psychiatry can provide? Nathan[4] recommends us to use any possible treatments not only limiting to modern psychiatric treatments, but also including alternative treatments, such as shamanism. Sanshu et al.[5] recommends us to provide treatments in patients' communities using their mother tongues. It also means increasing the cultural competencies in all members of patients' medical team.

So, what is possible in the globalism of Japanese psychiatry? The community approach does not work because minority communities are not well established in Japan. In this situation, the likely choice is using bilingual staffs in the medical teams or utilizing medical interpreters. Regarding the Tokyo Olympics and Paralympics in 2020, the Ministry of Health, Labor and Welfare has begun to train medical interpreters, as one of their environment improvement projects for accepting foreign patients from December 2014 onward. Remote medical interpreters using the Internet also have been developed. The are still difficulties with this service, such as confidentiality problems and/or boundaries between medical staffs and patients; however, we expect more and more out-patient psychiatry to use interpreters.

For the second-generation immigrant adolescent problem, we would like to emphasize the importance of psychological assessment and the team approach involving educational settings. It means education for bilingual clinical psychologists is necessary. The Japanese conception of globalism tends to focus on overcoming borders outside of Japan, and not focus on the current situation of foreign people inside of Japan. For globalism in Japanese psychiatry, we indicate the importance of the support system for children with various backgrounds in Japan, as well as for returnees.

Conclusion

Globalism surely has both merits and demerits for psychiatry for foreign people in Japan. Educating and increasing bilingual professionals and medical interpreters are necessities to this process if we understand globalism as a process to cross over borders. Globalism should contribute to all foreign people staying in Japan; however, it only pays close attention to the mental supports for “visiting foreigners,” such as Technical internship students, international students, tourists, but not for “living foreigners” already in Japan.

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The Lüscher Color Test for psychological evaluation of asylum seekers: brown color foresees integration and difficulty in autonomy

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Keywords:

Migrants, integration, Lüscher Color Test.

Abstract

Objective:

This study shows the results of a search for the effectiveness of Lüscher Color Test for the psychological evaluation of asylum seekers, with particular attention to integration and autonomy.

The study aims to determine whether the positioning of brown in a statistically less frequent position in the series is predictive of psychological distress.

Methods and Results:

The research was conducted on a sample of 100 asylum seekers, included in the SPRAR projects in the Calabria area. A short version of the Lüscher Test was given to the study cohort, with a report specifically designed on the SPRAR criteria, in order to evaluate integration and autonomy. The result shows that the position of the brown might predict difficulty in integration and autonomy of asylum seekers.

Conclusions:

The results demonstrate the effectiveness of the Lüscher test for assessing the psychological discomfort of asylum seekers (in particular as regards autonomy and integration).

Obiettivo:

La presente ricerca si propone la validazione del test dei colori di Lüscher per l'analisi del livello di integrazione e di autonomia dei migranti, con particolare riferimento ai richiedenti asilo politico e rifugiati ospiti presso gli SPRAR (Sistema di Protezione per Richiedenti Asilo e Rifugiati). In particolare si vuole indagare l'esistenza o meno di una correlazione fra la posizione della carta marrone nella serie prescelta dal soggetto e il suo livello di integrazione e di autonomia.

Si ipotizza, infatti, che la scelta della carta marrone in posizione diversa da quella statisticamente più frequente, sia negativamente correlata al livello di integrazione e di autonomia.

Metodo e risultati:

Il campione era composto da 100 individui di sesso maschile ospiti presso diversi progetti SPRAR della Calabria, di età compresa tra i 18 e i 38 anni.

I soggetti, in base al posizionamento della carta marrone, sono stati suddivisi in due categorie: quelli che hanno scelto la carta marrone nelle posizioni statisticamente meno frequenti (posizione 1,2,3,4,8) e quelli che hanno l'hanno scelto nelle posizioni

statisticamente più frequenti (posizione 5,6,7).

Si è rilevato che la presenza del marrone in posizioni statisticamente meno frequenti è negativamente correlata (p<.01) al livello generale di integrazione e autonomia. La presenza del marrone in posizioni statisticamente meno frequenti è invece negativamente correlato (p<.01) a tutti gli items della scheda di osservazione del livello di integrazione e autonomia.

Conclusioni:

In linea con quanto presente in letteratura sull'uso del Test di Lüscher, in particolare con gli studi compiuti sulle popolazioni rifugiate a seguito della Seconda Guerra Mondiale, i risultati della ricerca hanno messo in luce come il posizionamento della carta marrone nelle posizioni statisticamente meno frequenti (posizione 1-2-3-4-8 della serie) sia correlato a livelli di integrazione e autonomia bassi o medio bassi, indipendentemente dalla lunghezza del periodo di permanenza del soggetto nello SPRAR di appartenenza.

Di contro, la scelta della carta marrone nelle posizioni statisticamente più frequenti (posizione 5-6-7 della serie) appare correlata a livelli di integrazione e autonomia medio alti e alti.

Parole chiave:

Migranti, integrazione, autonomia, Test dei colori di Lüscher.

Introduction

This work aims to be a useful guide for psychologists and psychotherapists working in the context of first and second reception for refugees, asylum seekers and humanitarian protection holders (RARU) as they often have to work in a completely new context, without validated tools and a suitable bibliography.

The increase in migratory flows towards Europe as a result of wars, political persecution, endemic poverty and search of better living conditions, has forced Western countries to face a problem that now has planetary dimensions. In fact, international migration, although not a recent phenomenon, is becoming the protagonist of today's global scenery.

For over twenty years, Italy has dealt with this phenomenon, and after a first appearance in the early 1990s (mostly in the South), today it's also facing an increase of applications for international protection.

UNHCR 2016 annual report speaks of 65.3 million forced world migrants by the end of 2015(1), with an increase of 9.7% compared to 2014, one of the highest ever recorded in a single year. More than 180,000 migrants arrived in Italy in 2016 and about 123,600 are housed in SPRAR(2) (Protection System for Asylum Seekers and Refugees).

A great scientific literature (Cantor-Graee E., Selten J.P., 2005 162:12-24) confirmed how much migratory experience is closely related to psychophysical health. In fact, if on one side the migration can represent an individual evolution and helps to expand the opportunities of choice and action, on the other hand it exposes the migrant to multiple stress and risk factors.

The departure from families and from the social context, the loss of support systems, the existence of linguistic and cultural barriers, the socio-economic conditions in which this type of population often lives, the traumas that may have occurred before and during the travel, the stress and suffering due to the exile in a strange land and often the discriminatory conduct in the destination countries, make migrant population fragile and full of special needs that may increase vulnerability among these people and facilitate a shift towards mental health issues (Aragona M., Pucci D., Mazzetti M., Maisano B., Geraci S., 2013 N2:169-175).

A series of scientific findings, conducted by Doctors Without Borders between 2015 and 2016, shows an increased risk and a higher incidence of mental disorders among immigrants, specifically higher rates of psychosis, depression, PTSD, mood disorders, anxiety disorders and an increased tendency to somatisation. These are attributable to individual factors, socio-environmental stress factors and exposure to trauma and adversity accumulated over time (Fazel M., Wheeler J., Danesh J, 2005 365: 1309-1314).

In many cases, there is no active screening available to assess the need for mental health support among the residents of the centers. The community health services often lack the expertise and resources needed to recognize signs of distress among this group. Cultural mediators with psychologist and psychotherapist, or other people who could help to establish contact and to reduce cultural distances in order to promote a specific and appropriate therapeutic intervention, are rarely present.

The greatest challenge for the first and second reception centers is to develop integration pathways that will provide autonomy in spite of linguistic, social and cultural barriers. The quick and easy delivery

(1) UNCHR, Global Trends, Forced Displacement 2015.
(2) Ministry of the Interior, www.libertaciviliimmigrazione.dlci.interno.gov.it

of Lüscher Color Test, invented in 1949 by Max Lüscher, makes it extremely useful in the migration context where it is crucial to break down language barriers. It is also able to offer useful indications on the subject's physiological conditions, defining source of tension, compensation mechanisms and expectations (Lüscher M., Scott I., 1969).

Material and method

The purpose of this study is to carry out the validity of the Lüscher color test for the analysis of the migrant integration and autonomy, especially as regards asylum seekers and refugees hosted by the SPRAR (Protection System for Asylum Seekers And Refugees). In particular we want to investigate the existence or the absence of a correlation between the position of the brown color in the selected series and the level of integration and autonomy of the subject who made the choice.

Starting from the data from previous Lüscher test (Lüscher M., Scott I., 1969), which shows that the most statistically-ranked position for brown color in the series is between the fifth and the seventh position, it was intended to check whether it exists a correlation between the position of brown color in the series chosen by the migrants and their level of integration and autonomy. It is assumed, in fact, that the choice of brown color in a different position from that statistically most frequent, that is, in the first four or last position, is negatively correlated with the level of integration and autonomy.

The position of the brown color in the series represents the bodily senses. Studies revealed that displaced persons as a result of the Second World War were more likely to put brown color in a statistically less frequent positions, due to the sense of insecurity experienced and the distance from their "roots" (Lüscher M., Scott I., 1969).

The research sample consisted of 100 males (44% between 18 and 24 years, 38% between 25 and 32 years and 18% between 33 and 38 years) living in the SPRAR centers of the provinces of Cosenza and Reggio Calabria for a period ranging from 3 to 24 months.

39% of participants came from countries of West Africa (Nigeria, Cameroon, Gambia, Senegal, Ivory Coast and Mali), 31% from Bangladesh and Pakistan, and 30% from East Africa (Eritrea, Somalia and Sudan) and Middle East (Egypt, Palestine, Afghanistan, Iran and Iraq).

26% of the selected subjects were Christians and 74% Muslims.

Regarding the civil status, 57% were single, 32% were married men who had left their wife in the country of origin, and 11% were couples migrated with their partner.

Two tools have been used:

-Lüscher Color Test - Reduced Version: Designed by Max Lüscher in 1946, a projective test of great flexibility and reliability that, through easy administration, allows to highlight the unconscious dynamics that are the basis of psychological, adaptive, behavioral and psychosomatic problems. The test in its short form is composed of eight cards of different colors: dark blue, green blue, red orange, bright yellow, purple, brown, black and gray. Regarding the brown color Lüscher says that "*the dispossessed and rootless, having no hearth of their own before which they can relax and be at ease, and with little prospect of security and physical contentment ahead of them, are often found to place brown color right at the beginning of the row. This was particularly the case amongst those who became displaced persons as a result of World War II... so brown also indicates the importance placed on roots: on hearth, home and the company of one's own kind, on gregarious and familial security. Where brown is placed in 8th position, this need for relaxed ease is rejected altogether. Here physical comfort and sensory satisfaction are interpreted as weaknesses to be overcome" (Balzarini G., 1976).*

-Integration and autonomy obser-vation form: an ad hoc tool for assessing the level of integration and autonomy. It consists of 17 items with answer on 4 points Likert scale. Test scores are divided into four categories:

1. Low level of autonomy and integration: scores from 0 to 12;
2. Low-middle level of autonomy and integration: scores from 13 to 25;
3. Middle-high level of autonomy and integration: scores from 26 to 38;
4. High level of autonomy and integration: scores from 39 to 51.

The Lüscher Test, reduced version, was fully completed by all participants individually. The administration was preceded by a short oral explanation in order to clarify the purpose of the research, thanks to the help of a cultural mediator.

The participants also filled out an opening form with some personal details (age, nationality, civil status, religion, SPRAR of belonging and period of stay) while ensuring anonymity.

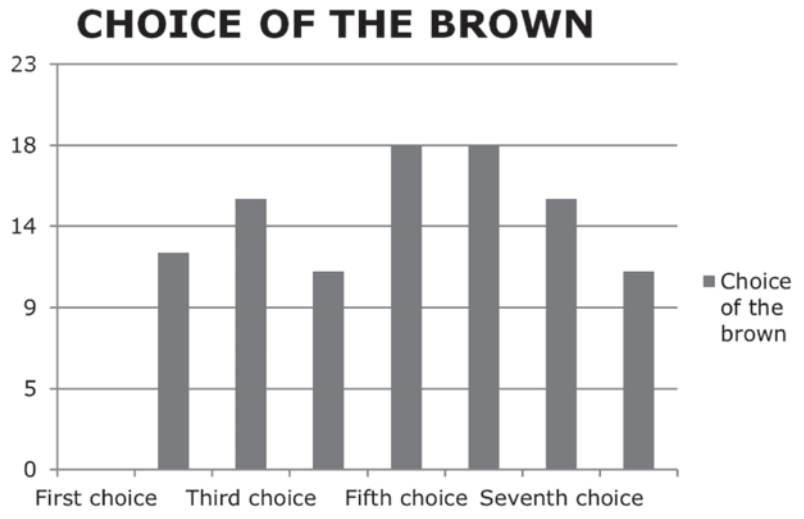
The integration and autonomy observation form was instead filled by the hosting centers operators.

Results

As shown in Table 1, the brown was never selected in the first position, 12% placed it in the second position, 15% in the third and 11% in the fourth. Another 11% placed the brown in the last position, while 51% of the subjects placed the brown in positions that are statistically the most common in the Lüscher test (from the fifth to the seventh position).

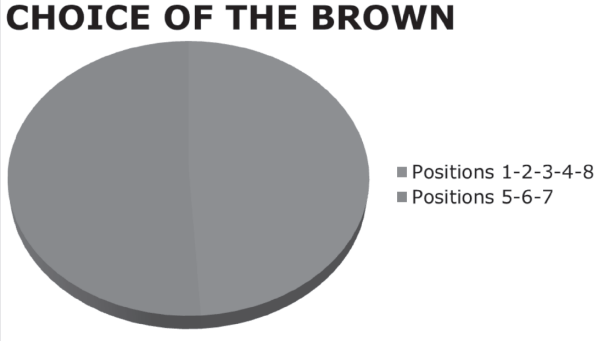
Table 1 Brown Position

		Frequency	Percentage	Valid Percentage	Cumulative Percentage
Valid	2	12	12,0	12,0	12,0
	3	15	15,0	15,0	27,0
	4	11	11,0	11,0	38,0
	5	18	18,0	18,0	56,0
	6	18	18,0	18,0	74,0
	7	15	15,0	15,0	89,0
	8	11	11,0	11,0	100,0
	total	100	100,0	100,0	



The subjects, according to the positioning of the brown, were divided into two categories: those who have chosen the brown in the statistically less frequent positions (positions 1,2,3,4,8), and subjects who have placed the brown in the statistically most frequent positions (positions 5,6,7).

49% of respondents placed brown in the statistically less frequent positions, the remaining 51% in the most statistically-ranked positions.



Regarding the hypothesis of the research and therefore the presence or not of a negative correlation between the position of brown in the selected series and the level of integration and autonomy of the subject who made the choice, it has been found (see Table 2):

-brown presence in statistically less frequent positions is negatively correlated ($p < .01$) to the general level of integration and autonomy

-brown presence in statistically less frequent positions is negatively correlated ($p < .01$) to all items of the Integration and autonomy observation form, except for items 16 and 17, related to the civic sense of the subject.

Table 2
Correlations

		Brown Position	Total Integration
Brown Position	Pearson correlation	1	-,813(**)
	Sig. (2-code)		0
	N	100	100
Total Integration	Pearson correlation	-,813(**)	1
	Sig. (2-code)	0	
	N	100	100
Integration Item1	Pearson correlation	-,631(**)	,803(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 2	Pearson correlation	-,678(**)	,791(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 3	Pearson correlation	-,684(**)	,844(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 4	Pearson correlation	-,566(**)	,771(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 5	Pearson correlation	-,660(**)	,755(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 6	Pearson correlation	-,661(**)	,798(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 7	Pearson correlation	-,569(**)	,702(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 8	Pearson correlation	-,613(**)	,783(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 9	Pearson correlation	-,533(**)	,611(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 10	Pearson correlation	-,659(**)	,773(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 11	Pearson correlation	-,626(**)	,804(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 12	Pearson correlation	-,655(**)	,783(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 13	Pearson correlation	-,697(**)	,827(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 14	Pearson correlation	-,667(**)	,771(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 15	Pearson correlation	-,593(**)	,760(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 16	Pearson correlation	-,471(**)	,602(**)
	Sig. (2-code)	0	0
	N	100	100
Integration Item 17	Pearson correlation	-,357(**)	,531(**)
	Sig. (2-code)	0	0
	N	100	100

Table 2
Correlation brown position/integration and autonomy level** The correlation is significant at level 0.01 (2-code).
* The correlation is significant at level 0.05 (2-code).

Discussions

According to the literature about the Lüscher test, especially to the research undertaken on the refugee populations as a result of World War II, the search results have revealed how the placement of brown in statistically less frequent positions (positions 1-2-3-4-8) is related to low or medium-low integration and autonomy levels, regardless of the length of the subject's stay in the SPRAR.

The choice of brown in the statistically most frequent positions (positions 5-6-7) is related to medium-high and high integration and autonomy levels.

Therefore, the position of the brown card in the series could help us understand if there are difficulties for asylum seekers to integrate and to be independent.

More in general, Luscher's test seems to be a great tool to evaluate the psychological situation of asylum seekers. In fact, it is a quick non verbal instrument (it takes around 5 to 8 minutes) which could give us important information about significant aspects of asylum seekers personalities as well as on the presence of psycological and physiological stressors. As it was highlighted by several researches (Balzarini, 1976), Luscher's test could point put the presence of stress factors way before the consequences become apparent.

In wider perspective, Luscher's test seems to be a useful test in the definition of the Individualized Integration Project (important element in the path of integration and independence of the SPRAR), highlighting early on problems to work on with the beneficiaries.

It is essential to further develop research, increasing the sample number, the nationalities represented and involving asylum seekers of both sexes. It is also essential to involve people of the first reception centers, which are increasingly present in the Italian context.

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A STUDY ABOUT THE DENIAL OF ULYSSES SYNDROME IN A SAMPLE OF HOMELESS IMMIGRANTS

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THE DENIAL OF ULYSSES SYNDROME IN A SAMPLE OF HOMELESS IMMIGRANTS

Abstract

The most cruel situation of social exclusion is the homeless situation. If you are an immigrant your story is even more critical. You are excluded from the excluded. The problems faced by homeless immigrants in Spain has not been investigated deeply enough.

The purpose of this paper is to detect if Ulysses syndrome occurs in a small group of 5 immigrants, barely surviving in Cadiz streets (Spain). They have been evaluated through *The Seven Griefs of Migration Interview (Achotegui 2010)*. The results suggest they don't show enough griefs and symptoms to fall under the Ulysses Syndrome diagnosis.

Introduction

International Migration has raised significantly in the last decades (from 154 million in 1990 to 232 million in 2013), becoming more complex and diverse (UN, 2015). For instance, since the 1980s, the number of both single or married women traveling alone to work outside their own countries has increased by almost a half of all international migrants (UNDP, 2009).

When a migrant embarks on a new life in another country without a family or a friendship network as a help on taking the first steps, with no knowledge of the new language, with no legal documents, enduring social rejection, having neither a regular job nor decent housing or just not having one or the other, etc. this person experiences a great tragedy. This is a twofold tragedy. On one hand, they must cut off ties to their homeland and on the other, they must deal with the many problems of their new life.

Probably there is no other circumstance, including the loss of a loved one, involving as many painful changes as migration does (Achotegui, 2009). *The 7 Griefs of Migration Interview* tries on one hand to determine the seven griefs or losses that the immigrant faces when he arrives at the host country (family and friends, language, culture, land and landscapes, social status, contact with the source group and physical safety). On the other hand, it investigates the symptoms that may appear due to the intense stressors he is facing (Achotegui, 2009, 2010, 2012).

In Spain, there is a growing pocket of social exclusion formed by immigrants who live literally on the street, who have become solitary and unstructured with a bleak future. (Sanchez Morales, 2012) Not having a roof to shelter produces a great insecurity and uprooting that causes a personal and social break down to the individual (Navarro Lashayas, 2013, 2014a, 2014b).

What It means to be Homeless

Few human realities are as unknown

and ignored as the misery of those who lack even a place to shelter from outdoor. Homelessness is not just those ill-looking people carrying all their belongings through the streets, they are also evicted or unemployed, prostituted women, immigrants with or without *papers*, drug addicts or mentally ill without a family, etc. Neither age, nor educational level, nor their past or their future expectations need to be the same... What they all have in common is not having a place to stay temporarily or permanently, not having a home (Cabrera, Rubio & Blasco, 2008).

Perhaps the most internationally accepted definition regarding what it is to be considered a homeless person (HP) (home meaning a place of reference, protection and linkage that goes beyond mere accommodation) is the one proposed by the European Federation of National Associations Working with the Homeless (FEANTSA): *that person who is unable to access and maintain adequate personal accommodation on his or her own or with the help of Social Services, as well as those persons living in institutions (hospitals, prisons, etc.) but without personal accommodation to go to when they are released and people living in subhuman accommodation or in a situation of manifest overcrowding* (Avramov, 1995: 4)

Therefore, the causes of *homelessness* are mainly due to economic and social factors, while those individual factors would remain in the background (Cabrera, Rubio & Blasco, 2008). It is well expressed in the following words: *it is not enough to be drunk or crazy, to become homeless; One also needs to be poor enough or alone enough to have to experience drunkenness or madness in the open* (Cabrera, 1998: 145).

The FEANTSA (2007), has proposed a homelessness type called ETHOS (acronym for European Typology on Homelessness) which includes the residential exclusion heterogeneity. This would be people: roofless, homeless, dwelling in insecure housing and in inadequate housing. Table 1 shows that it goes from the most severe forms - the homeless who do not have a physical place to reside and to have privacy, and without any legal entitlement to claim the use of a space - to *less extreme* situations such as those living in shanty towns. In this conceptual framework the *homelessness* would have two meanings: The *restricted* one that would make reference to the homeless and without housing; and, a *larger broader* one that would cover all types of exclusion (Cabrera, Rubio & Blasco, 2008).

ETHOS –
European Typology of Homelessness and housing exclusión

Roofless	
1	People living rough in the streets or public spaces.
2	People in emergency accommodation: night shelters.
Houseless	
3	People in accommodation for the homeless: homeless hostel. Temporary accommodation. Transitional supported accommodation.
4	People in Women's Shelter.
5	People in accommodation for immigrants: temporary accommodation/recep-tion centres. Migrant workers accommodation.
6	People due to be released from institution: penal institutions. Medical institutions. Children's institutions / homes.
7	People receiving longer-term support (due to homelessness): residential care for older homeless people. Supported accommodation for formerly homeless people.

Insecure housing	
8	People living in insecure accommodation: temporarily with family/friends. No legal (sub)tenancy. Illegal occupation of land.
9	People living under threat of eviction: legal orders enforced (rented). Re-possession orders (owned).
10	People living under threat of violence: police recorded incidents.
Inadequate Housing	
11	People living in temporary / non-conventional structures: mobile homes. Non-conventional building. Temporary structure.
12	People living in unfit housing: Occupied dwellings unfit for habitation
13	People living in extreme over crowding: highest national norm of overcrowding

From FEANTSA (2007: 1)

Knowing the number of HP in Spain is an almost impossible task at present time given the few existing investigations and the difficulty of applying the results in a general way. What is more, evidencing the amount of HP in a restricted sense (they can *only* be thousands of people) and doing it in the broad sense (they could be close to several millions of individuals), is an altogether different task.

The last INH survey of HP (2012), where it was taken into account only those living on the street or who have no housing (*restricted homelessness*) and who have attended centres of assisted accom-modation or catering (e.g., Breakfasts, meals, snacks...) or both, is 22,938. However, the real figure is higher since this survey leaves out those not going to hostels or dining rooms. In addition there is another difficulty: the effects of the 2012 crisis rebound had not yet been felt at the time of the survey. Due to these series of limitations, the figures can't be extrapolated to the entire homeless population (Government of Spain, 2015).

In spite of these great inconveniences and since the Instituto Nacional de Estadística (Statistics National Institute) survey is the largest conducted to date, returning to it with more specific data, it would mean that of 22,938 individuals 6,362 would be roofless people (27.7%) 3,419 of them living on the street and 2,943 of the latest sleeping in fortune lodgings (eg, portals, indoor bank ATMs...). The rest of the sample, ie 16,576, would be in the homeless category (e.g., temporary shelter) (72.3%).

Other data provided is the majority of males versus females (80.3% *vs.* 19.7%) and a majority of those under 45 (57.7%). Therefore, the characteristic profile of HP in Spain is that of a young male. With respect to the place of origin, there is no significant difference between Spanish and foreigners (54.2% vs. 45.8%). The largest group of homeless migrants is African (56.6%), followed by European (22.3%) and American (15.2%).

Homelessness and immigration

Estimating the number of homeless immigrants in Spain is an arduous task given the *no papers* situation in which many of them live, which makes them not legally recognized persons. Despite this, the United Nations estimates that approximately 10% of registered immigrants in Spain have become HP (*homeless in the broad sense*), about 573.000. Most of this population is comprised by young or middle-aged men (although there is an increasing number of women) unaccompanied minors, seniors and in retirement age (Sánchez Morales, 2012).

For an immigrant person having a place to live is not only a basic necessity as it is for any individual, but it is also mandatory for his registration, health card obtainment, social grants application, family reuniting, etc. And although housing alone does not guarantee integration it is the first step to achieve it (Navarro-Lashayas, 2013) and eventually becoming full rights people.

As it could not be otherwise homeless immigrants have the same needs as anyone living in a situation of extreme social exclusion, namely housing and maintenance plus social and occupational integration. But to them is added the special needs from its own immigrant condition. And that immigrant status

puts them at a greater social disadvantage, being excluded from the excluded, as they are denied access to certain social resources (Sánchez Morales & Tezanos, 2004).

Homelessness and mental health

Not living in a suitable private environment with walls that protect the individual from the outside (from insults, robberies, assaults, rapes, etc.) and where a life project can be carried out is the extreme of social exclusion that an individual can endure (as said before). It also inflicts harmful consequences on physical and mental health. These living conditions cause illnesses or chronify the already existing and cut down 20 years their estimated life expectancy versus the general population (Caritas, 2013).

HP have long been invisible to society but also to mental health researchers. The homeless phenomena include social and personal factors such as the psychological ones (Muñoz, 2010). Every international study indicates a prevalence of mental disorders in HPS compared to general population. The prevalence of having a serious mental illness (including major depression, schizophrenia and bipolar disorder) is present at least in 25-30% of those living on the street or in shelters (only staying the night in them and on the street at day time). Although it appears that rates are higher in the United States than in Europe this seems to be due to the difficulties of going to the psychiatric NHS in that country (Rees, 2009).

Fazel, Khosla, Doll & Geddes (2008), made almost thirty researches in a sample of about 5.700 HP. This meta-analysis, although showing results of enormous diversity is still notorious: psychotic disorders would present a minimum of 2.8% and a maximum of 42.3% and major depression would be between 0% and almost 41%. The output obtained regarding alcohol dependence ranged from 8.5% to 58%, while dependence on other substances would be between 4.7% and 54.2%.

Then more specifically in Spain, Muñoz, Pérez & Panadero (2004), in a review of one most relevant research on mental health HP and stressful life events, ended with the following conclusions: a most remarkable fact is the abuse and dependence on alcohol and other psychoactive substances disorder, affecting almost 50%, while about 35% suffer other types of disorders.

Navarro-Lasahayas (2013, 2014a, 2014b) who investigated homeless migrants, points out that some of the consequences of presenting both conditions would be: feeling failed on the migration project, feeling socially unworthy, having sadness and dehumanization feelings, changes in personal identity, lack of control over one's own life, as well as having a temporary perspective of live, a perspective just to the immediate and anomie.

METHOD

Participants

The subjects participating in the investigation are five male migrants from different nationalities who have lived in the street for a long time and who are fluent in Spanish. With exception of the Hungarian one- who was abandoned at birth - everyone else has a family in their countries. Then, a semblance of each of them was made.

One 48-year-old German who has been in Spain for 22 years. He lost his last job 5 years ago and he has been a HP in Cadiz since then. He wants to know nothing about his family, relatives and friends in his country.

One 28-year-old Hungarian, raised in an orphanage and a boarding school which he has fond memories of. He has spent 6 of those years in different Spanish city's streets (last 3 in Cadiz).

One 53 year old Italian citizen who disowns his family (especially his mother). He has been in Spain for 20 years (3 in Cadiz) and does not want to know anything about any person or issue related to Italy.

One 47-year-old Nigerian who is the only one in this sample with a wife and three children (living in Granada on welfare) and a broad family and relatives groupe in his country (parents and 16 siblings). He begs in Malaga and Cadiz and goes to Granada when he is able to. He's been living in Spain for 15 years 8 of those in the streets.

One 43-year-old Romanian, with a mother and two daughters in Romania who he loves very much and keeps occasional phone contact with. He has lived in several countries, including Israel, has been in Spain for 8 years 6 of those in the street (4 in Cadiz).

Procedure

The entire sample has been given *The 7 Migratory Griefs Interview* (Achotegui, 2010), been those filled in their usual sleeping places. So they have not been disrupted their daily chores like asking for money or food at different places in the city.

We want to specify that the researcher belongs to a volunteer organization that

attends to them on a weekly schedule run along the year. Having this regular contact with everyone it is estimated that this special relationship facilitated the attainment of the interviews.

Results

Few results have been obtained since some issues have seem very difficult for them to answer and others questions could not been answered because they did not remember much data of their life.

I. The 7 Migratory Griefs Interview Results

With a large amount of questions listed in the Interview, only the most outstanding data for each of the 7 griefs are in the lay out below.

a) *Grief with family and friends*

German: He does not get along with his family, he would not e even *visit* them. He misses one of his friends a bit, but that is all (*I'm better off here than in Germany*). He doesn't have any friends in Spain.

Hungarian: He was an abandoned newborn baby. He does miss his friends from Hungary (he does not have any friends here).

Nigerian: His wife and his three children live in Granada. He begs for money in the streets of Cadiz and Malaga. He says he misses his Nigerian family and friends. He considers that he has some friends in Spain.

Italian: Complete rejection of his Italian family and friends (he does not have friends in Spain either). He points out that as a young man, he had many altercations in his hometown.

Romanian: He really misses his mother and his two daughters (who live together). He hates his only brother and also his former wife, who abandoned him and their daughters and left with her lover. He would like to meet his Romanian friends again, although he barely keeps in touch with them. However, it would be easy for him to resume friendship if he were to go back, since they live close to his mother's home.

b) Grief with the language

German: He points out it was a bit difficult for him to learn Spanish (which he speaks fluently)

Hungarian: It was not hard for him to learn Spanish (he speaks it fluently) and he say I just *speak the language spoken in the place where I a.*

Nigerian: He also had little trouble learning Spanish. He managed to do so in a short time and he speaks it fluently.

Italian: He did not have difficulty learning Spanish and he speaks it fluently. Not speaking his mother tongue is not a problem for him.

Romanian: He did not have difficulty learning Spanish and he speaks it fluently. Not speaking his mother tongue is not a problem for him.

c) *Grief with culture (habits, religion, leisure...)*

German: The weather is different. He prefers Spain.

Hungarian: He only misses Hungarian food and music, although he definitely prefers Spain.

Nigerian: He misses Nigeria very much.

Italian: He does not miss his homeland at all.

Romanian: He prefers the Spainish one over the Romanian one, which he does not miss.

d) *Grief with the land (landscapes, colours, scents, brightness, humidity, temperatu-re...)*

German: He reneges on his homeland and everything related to it.

Hungarian: He points out *he is from everywhere*.

Nigerian: He misses Nigerian food, music and dance

Italian: He does not miss his homeland at all.

Romanian: He answers with a resounding *no*.

e) *Grief with status (work, economic status, household, papers, health service...)*

German: *I came here mostly to have fun, but life isn't as fun when you live on the streets*.

Hungarian: He has not fulfilled yet his migration project. He does not want to go back to his country.

Nigerian: He has not fulfilled it either. He points out he wants to go back just to see his family, however that would be scary because Nigeria is very dangerous

Italian: *Absolutely unfulfilled migration project.*

Romanian: *Unfulfilled migration project*. He does want to return to his country.

f) *Grief group of belonging* griev (*where they feel they belong to): Quechuan, Peruvian...)*

German: *I'm from Cadiz.*

Hungarian: *I'm from everywhere.*

Nigerian: He misses his homeland: *There's nothing alike... women, the beaches, the green in the countryside –they are all better than in Spain... Even though I'm Nigerian*, *I'm also Spanish.Both.* Had he previously known he would be living on the streets, he would not have come to Spain.

Italian: *I'm from Cadiz... I'm not Italian.*

Romanian: *I feel I am from everywhere: I'm Romanian, Spanish and Israeli.*

g) *Grief with physical risks (occupational accidents, lack of heating...)*

German: He is scared something might happen to him while he sleeps

Hungarian: He is not scared: *why would I?*

Nigerian: He is not scared

Italian: He is not scared

Romanian: He is not scared of living on the streets.

II. The Ulysses Syndrome symptom

Table 2 shows the Ulysses Syndrome symptom record. The symbol "-" stands for a negative answer. The not answer is represented by "NA".

Given the characteristics of the sample, *the cold, heat and dizziness* symptoms are not taken into account since in a living on the street situation suffering from every kind of weather is the common thing and not a true manifestation of psychological distress. In addition, none indicate suffering from dizziness therefore, the response of this item appears as a negative one in the whole sample.

The Ulysses Syndrome symptom record

	German	Hungarian	Nigerian	Italian	Romanian
Discomfort	-	-	-	-	-
Inappetence	Yes	-	Yes	-	-
Insomnia	Yes	-	-	-	Yes
Anxietv	-	-	-	-	Yes
Recurrent Thoughts	-	-	-	Yes	Yes
Irritability	Yes	-	-	-	Yes
Fears.Phobias.Obsessions	-	-	-	-	-
Sadness	Yes	-	-	Yes	Yes
Crivinq	-	-	-	-	-
Expression.Psychomotri-city Problems	-	-	-	-	-
Guilt	-	-	-	-	Yes
Apathy	Yes	Yes	-	-	Yes
Thoughts of Death	Yes	Yes	-	-	Yes
Autolysys	-	-	-	-	-
Headaches	-	-	-	-	-
Fatigue	-	Yes	Yes	-	-
Phvsical Pain	-	-	-	-	-
Cold. Heat. Dizziness	-	-	-	-	-
Confusion	-	-	-	-	-
Deliriums	-	-	-	-	-
Hallucinations	-	-	-	-	-
Alcohol, Drugs	Yes	Yes	-	Yes	Yes
Sexual Problems	-	NA	-	-	NA
Magic.Witchcraft Beliefs	-	-	-	-	-

DISCUSSION

As noted above, a significant number of issues have not been well recorded either because proved to be too complicated for the individuals to answer to or because of their difficulties to remember past events. Since the results are scarce, this research is limited and is mainly of an approximate type.

The results of each of the griefs point out the immigrants from German and Italy being very outright in wanting to know nothing about the family, indeed, showing a strong rejection about it. While the Hungarian one grown up without a family, therefore not miss it. And yet, the Nigerian and Romanian citizens longing for a closer contact with their families and willing to return to their countries. Likewise, the latest are the only ones who indicate that they have friends in their countries and would be happy to resume the relationship with them. Therefore, the data indicate that *grieving for family and friends* is not contemplated by German, Hungarian and Italian individuals but throw a positive answer in the Nigerian and Romanian individuals.

They are fluent in Spanish, which helps them to sort out everyday life issues a bit better (go to the doctor, ask for help, talk to the neighbors of the area...). And although some of them communicate now and then in their native language with some country fellows, none of them misses the use of it in their daily life. So none is suffering *the language grief*.

The Nigeria subject is the only one showing *both griefs, culture and land*. But all of them present the following *status*: none has fulfilled the life project on mind on their arrival to Spain. These people who at the time went for a *great change* to better his life see now how not only this is not happening but yet feel that it could get even worse (e. g., get less money to survive); these circumstances inflict them much stress and further destabilize their lives. But in spite of these facts, all point out that they feel *at home* in this country (even the Nigerian and Romanian who are the ones who most yearn for their land). Therefore, none shows *the belonging to the group grief*.

Finally about *The Ulysses Syndrome 7 Griefs* and regarding their living situation only the German one says to be scared when sleeping in the street (*grieving on physical security*).

Relating the 7 griefs values to the symptoms we could obtain the following *profiles*:

The one with the greatest number of symptoms is Romanian: up to nine and with some of them being very intense, such as recurrent thoughts and insomnia. This great unrest could be due to his desire to return to his country where his two daughters and his mother are waiting for him.

In the other hand, the Nigerian citizen, who also misses his land, is the one that exhibits fewer symptoms presenting however the bigger number of griefs (family and friends, culture, homeland and status). Perhaps having his wife and children living quite close to him and being able to stay with them from time to time is a protective factor for not presenting a large symptomatology.

In the German are found up to seven symptoms and is the only one that indicates fear for its physical security. This is perhaps due to the many altercations he has been involved in and the fear of something happening to him during his sleep when he can not defend itself.

The Hungarian immigrant who seemingly is very optimistic and social has however suicidal thoughts and, although he has not been explicit about this circumstance, perhaps the facts of being an abandoned newborn (never adopted by anyone) hence never developed a true security feeling, coupled with the HP situation in adulthood are the reasons for his thoughts about taking his own life.

The one registering a minor symptomatology and number of griefs, just status, is the Italian one, a very introverted person and with virtually no relationship with any street fellow.

Once seen the relationships of griefs and Ulysses Syndrome symptoms, it is estimated that there is not enough evidence to provide a diagnosis in any of them. This fact was not expected at the starting of research, but given the characteristics of the sample: very deteriorated people by extreme exclusion, who have lost a stable social relationship (family, work, love, friendship...) structure, which further vulnerability increasing. Consuming alcohol or other drugs, lacking control over their own life, filled with hopelessness, disappointment and sadness, etc... They are so chronicled, that the only surviving way in the concrete *jungle* is by denying family and friends, homeland, home culture, etc. And, as a mean of defense also deny almost every grief and numerous symptoms of The Ulysses Syndrome.

Given the situation lived during long time by homeless immigrants, they are *excluded from the excluded* (the so-called *the invisible ones* because of the scarce attention and care that citizens and institutions provide them), it would be very important to know which kind of fortitude they have, what are their adaptation capabilities to survive in most extreme conditions, what are the psychological skills that unfold before the adversities of their everyday life to avoid madness, etc. There are very few studies investigating these points since most of them have been directed to analyze the negative biopsychosocial aspects but not the positive ones. And, since the trend is on positive psychology now would be the right moment - although any time would be good - to investigate these important and interesting angles to address possible interventions to improve their living conditions.

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IDENTITY'S EXPERIENCES AS A MENTAL HEALTH FACTORS IN MIGRANTS COMMUNITIES

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KEY WORDS:

Identity, cultural miscegenation, Charter of Naples, urban spaces, migrants communities.

English Abstract:

This paper describes first results coming from multidisciplinary research on identity and multicul-turalism, which is developed within the socio-cultural perspective of The Charter of Naples / Urbanitas, Solidarity & Sustainable Humanitas Charter, designed in order to explore urban route of strategic and operational programs focusing on implementation of host systems and cohabitation, supporting migrants, refugees and asylum seekers. Such research is realized in collaboration with Geronimo Carbonò and Centro Studi Ksenia, during psychosocial projects supported by Naples Municipality's Decentralized Coope-ration Department. In according to the so-called paradigm of "cultural and identitary métis" by Françoise Sironi and the decolonizing theories by Frantz Fanon, the present study aims to investigate the identity's experiences of young migrants and second generation foreign citizens, currently living in urban areas of Naples. The research is based on multidisciplinary methodology based on assessment with psychological scales (Toronto Alexithymia Scale and Body Uneasiness Test) and projective psychological test (Thematic Apperception Test), organized during multimedia story telling workshops. The first results allow to analyze the migrants' perception of urban spaces and their imaginary stories about own ethnic-cultural origins, as crucial elements for the migrants' mental health. Indeed, the research is also focused on the genesis of "fundamentalism identity" factors.

Italian Abstract:

Il presente articolo descrive i primi risultati di una ricerca multidsciplinare su identità e multiculturalismo, sviluppata nella prospettiva socio-culturale de La Carta di Napoli /Urbanitas, Sustainable Solidarity & Humanitas Charter, mirante alla definizione di un “percorso urbano di indirizzi strategici e piani operativi, volti all'implementazione territoriale dei sistemi di accoglienza e coabitazione, a sostegno dei migranti,rifugiati e richiedenti asilo”. La ricerca è realizzata in collaborazione con Geronimo Carbonò e Centro Studi Ksenia, all'interno dei progetti psico-sociali “*I saved the world today*” e

The picture was photographed by Benedetta Orlando near S. Domenico Maggiore square, Naples

"*Ci vuole un fiore*" svolti con il supporto dell'Assessorato alla Cooperazione Decentrata del Comune di Napoli. Partendo dal cosiddetto paradigma del "*meticciato identitario e culturale*" coniato da Françoise Sironi e dalle "decolonizing theories" di Frantz Fanon, il presente studio mira ad esplorare le esperienze identitarie di giovani migranti e cittadini stranieri extracomunitari di seconda generazione che, attualmente, risiedono nelle aree urbane di Napoli. La ricerca è strutturata secondo una metodologia multidisciplinare che prevede una fase di assessment, condotta con scale psicologiche ((Toronto Alexithymia Scale and Body Uneasiness Test) e un test psicologico proiettivo (Thematic Apperception Test), somministrati a latere di laboratori di multimedia story telling. I primi risultati della ricerca consentono di indagare la percezione degli spazi urbani e la modalità di raccontare storie sulle proprie origini etnico-culturali, come elementi cruciali per la salute mentale dei migranti e delle seconde generazioni. Inoltre, la ricerca si è anche focalizzata sulla genesi dei fattori del "fonda-mentalismo identitario"

Aims and Theoretical bases.(1)

Migrations represent a process that has always been associated with human existence, as Richard Sennett writes in the book "The Foreigner. Two Essays on Exile". Indeed in the actual age, the migrations issue is also charaterized by emblematic biopolitical meanings that are intimately intertwined with capitalist realism that limits the bodies movements' freedom. Still, according to Kelly M. Greenhill, author of "Weapons of Mass Migration", many migrations are an expression of projects aimed at using cross-border movements to obtain political, military and / or economic concessions.

(1) The translate of citations is intended by the authors of the article.

Therefore, in order to understand this complex scenario, we need for a multidisciplinary reflection on the migrants subjects' identitary statutes, trapped in reception conditions directives or asylum policies - which are body control devices, according to Agamben - and psycho-pathologies, like post-traumatic stress syndrome or radicalization proces.

In this perspective, our research project "Cities and Migrations_FuturL@bs"(2)- from which this paper derives - focused on identity dynamics, urban spaces and migrations, within the theoretical framework of Françoise Sironi, founder of *geopolitics clinical psychology*, an integrated and interdisciplinary approach to human sciences, in which the key words are fluidity and multiplicity of theories, methodologies and therapeutic pathways.

The basis of this approach is the ethnopsychiatry as developed by Tobie Nathan and by clinicians of the Centre Georges Devereaux and it is dedicated, through the method of action research, to the study of the experiences of acculturation – migration or hybridization outcome – or of the experiences of deculturation – outcome of conflicts with a strong ethnical and religious component. Both can bring to specific psycho-pathologies such as psychopolitical traumas, psycosocial inhibitions, depressions, cultural identity disorders. Other studied cases may also refer to individual and collective consequences of man's malad-justment to technological progress,which can reveal themselves in stress-related disorders, traumatic organization personality, depression and psychosomatic illnesses.

Therefore, to be able todefine and provide for an adequate treatment, the geopolitics

(2) This reasearch study started within psychosocial projects ("I saved the world today" and "Ci vuole un fiore") realized with the support of Assessorato alla Cooperazione Decentrata, Comune di Napoli.

Therefore, to be able todefine and provide for an adequate treatment, the geopolitics clinical psychology is based on several factors: an intrapsychic factor linked to one's personal life; a geopolitical factor related to the influence of past and present collective history and a contextual one linked to the dominant theories of present time.

As Sironi says, these aspects comparated to a specific weight in the definition of a *restoration of the political dimension* in the therapeutic process are too often underestimated. This is possible through an understanding of the weight that political events have on individual and family; through the recognition of the body'srole in the collective history; through the recovery of the typical patient's cultural world logic in order to bring out its uniqueness; by normalizing the symptoms presented by the patients and, finally, through a critical analysis of the impact of previous psychotherapies (Sironi, 2004).

The route taken by Sironi has led to consider in particular way the construction of identity processes, therefore, Sironi talks of *identity and cultural miscegenation*.

Talking about identity is how to open the mythical Pandora: this concept calls into question psychology, philosophy, anthropology, sociology, legal disciplines and history. History, nowadays, is increasingly being characterized more and more by the arise of new social phenomena: unmarried couples, adoptions by homosexual one, single parents and new migration flows that are not only economic. It turns out the need to explore more carefully the consequent identity paradigms in order to also adapt them to clinical practice. These new identity paradigms, in fact, can be characterized by a so-called experience of meeting-clash between the cultural identity of origin and the host country one, meeting-clash that Sironi puts at the centre of her theory of identity and cultural miscegenation.

According to the author (Sironi, 2011), the construction of half-cast's identity is divided into three phases:

-A first phase of identification with one of two cultural poles, which turns out to be the most rewarding for the subject, while the other pole is cleaved and projected onto another subject;.

- A second phase of identification with the other cultural pole, the one previously devalued;

- A third step of reunification of the parts. The different parts of the self are not lost but exist in a state of mutual fluidity, a state that exceeds both the adhesion to the norm, and the narcissistic pretension of originality.

In the first two steps of the course, the adhesion to a cultural pole rather than another as a result has the desire to be part of groups characterized by very strong values, renouncing at the moment to have its own identity. This aspect shows the important adaptability possessed by these subjects. They are empathetic enough to be able to experience links and membership in social groups with very heterogeneous characteristics, traditions and values between them.

Therefore, in these early steps is extremely difficult to make a choice: rather than implement an exclusive type of thought, based on “or/or”, it imposes a thought based on the “and/and”, for which *a thing and its opposite can co-exist with each other* (Ibid).

The final step instead is realized in the overcoming of this collage of identity: the subject, recognizing the multiplicity, can reach a new unitary identity status through the opening at the multiplicity. If, however, this step fails and the different parts of the self are split off and projected, there may be behavioral disorders, whose symptomatology is characterized by violence, aggressiveness and mood lability. The lack of boundaries, the mixing of the different parts of self, lead to a confusion, a language fluidity that occurs both in written and in oral expression. This pattern is completed by shame, self-hatred, depression, and, sometimes, depersonalization, neglect and schizoid symptoms. As worrying as it can seems,although all elements can lead in that direction, this is not to identify with a frankly psychotic framework. Sironi makes clear this aspect: if the previous pattern seems to fit the psychotic area is because we are faced with an identity problem that has its roots in the most ancient layers of the subject's personality, whose psychology and psychopathology should consider elements that go beyond the clinical and that embrace cultural, political, religious and social determinants etc, especially in relation to the fact that, as Sironi says, *every psychological diagnosis is also political because it is the reflection of a certain society point of view, at a given time, of what cannot be considered the norm and what instead issocial, sexual and cultural deviance* (Sironi, 2010: 162).

In this regard, a very interesting analysis is the one provided by Frantz Fanon.Analyzing the context of the Algerian War and its aftermath, Fanon points out that, after 1954, we have tried to attract the attention of French psychiatrists on the inconsistency of trying *«to heal» a colonized properly, which means to*

make him fully consistent with a social colonial environment. Since it is a systematized denial of the other, the phrenetic decision to deny to the other every attribute of humanity, colonialism forces the dominated people to continually ask the question: «Who I really am?» (Fanon, 2007: 175).

ltural dimension of the subject, but also by the body scheme, both levels being influenced by a seIn this regard, Roberto Beneduce, analyzing Antoine Porot's the contribution to the colonial psychiatry, underlines that, the inconsistency mentioned above, turns into *impossibility to take care* in front of a lack of knowledge of the world of the Other whom is also denied his own humanity (Beneduce, 2007: 61)The dichotomy between the colonized and the colonizer emphasized by Fanon allows us to reflect on the role of the opposite pole of the comparison, the Other. Beneduce makes us note it must be understood not as generalized other, such as that described by Lacan, but as a particular Other, which reflects the dichotomy above in Black vs White. *«[...] there is no doubt that the real White's Other is and remains Black. And mutually. Only, for White, the Other is perceived on the body image's level as an absolute not-I, that is to say the unidentifiable, the non-assimilable. For Black, we have shown, historical and economic realities must be considered as fundamental»* (Fanon, in Beneduce, 2007: 326).

It is perhaps for this reason that Fanon points out that the first thing the colonized learn is not to exceed the limits, those limits that do not exist in his dreams: they are action dreams, muscular, aggressive dreams. However, it is not just a body dimension: it is the whole set of values, traditions, myths to be considered as *an absolute evil* when compared with the world of the colonizer, *given that colonial rule, because of the total and simplifying, has so quickly and dramati-callydisrupt the cultural life of the submissive people. The negation of national reality, the new legal relations introduced by the occupying power, the expulsion towards the periphery of indigenous peoples and their habits by the colonial society, the expropriation, servitude systematized of men and women, make this cultural erasure possible.* (Fanon, 2007:164)

The process od decolonization, therefore, being always both collective and individual, political and psychiatric needs a formal recognition of the historicity of a cultural situation that will rival the construction of the self and of the subject's body image (Beneduce, 2013). As it can be seen, the areas always intersect between each other: cultural, political, social, economic, psychological and anthropological.

Comparing what has been said in the identity building process, it is clear that a fundamental role is not done exclusively by the psychic and cut of historical events of subjection, violence, war and domination.These are intended to normalize a supposed state of inferiority of the colonized which *himself does not recognize any instance. It is dominated, but not domesticated. It is made less, but not convinced of his inferiority* (Fanon, 2007: 17). Such double logic is expressed in the dual reaction of the colonized: if on one hand, in fact, the masses tend to maintain intact their wealth of traditions and values, on the other intellectuals press in favor of accession to the cultural model of the occupant even wanting want to replace it also in the occupation of physical space.The latter is configured as additional layer through which is expressed the ambivalence of the relationship between colonizer and colonized and which inevitably affects the process of identity construction. In fact, in this regard Fanon points out the differences that exist between those employed by the colonized urban spaces-... *is a crime hotspot, populated by disreputable men. [...] A city of nigger, of lurid arabs* –and those occupied by the colonizer –*... it is a city well-fed, lazy, his belly is permanently full of good things. The settler's town is a town of white people, of foreigners* (Fanon, 2007:6).

More recent studies (Mannarini, 2004) have led to the development of the concept of *place identity* described as a cognitive structure that contributes to the overall categorization of the self and social identity formation, in other words it is postulated the possibility, by subjects, to perceive a specific component of itself that is anchored to the relationship with the physical environment.Among the functions carried out by it, of particular interest is the one defined as recognition, thanks to which it would be possible to distinguish between what is known and what is unknown, thus ensuring an environmental-space stability useful to the time constraint that is the basis of the feeling personal identity. Hence *the hypothesis that forced mobility, relocations unwanted, coerced migrations pose a potential threat to identity, with devastating effects in terms psychological and social adjustment due to the rupture of the original attachment bonds* (Mannarini, 2004: 83).Equally relevant is the concept that it is directly derived from that of place identity, namely that of urban identity whose importance and merits lies in the fact that *the symbolic character related to the urban*

context are internalized from the early stages of life, so that the intake of an identity linked to it, or its attribution to other takes place in the mostly unaware form (Ibid: 85).

All the characteristics and qualifications attributed to urban space (in its totality as well as in its various parts) are then, by extension, attributed to its inhabitants and this confirms the view expressed by Fanon about the differences between urban spaces occupied by the colonized and those occupied by settlers described earlier.

The thought of Fanon turns out to be very timely in light of what Ian Chambers says: in a time like the present, meeting with the Other, as mentioned in the beginning, no matter how simple, immediate and continuous, especially after the new migratory flows, implies an uncertainty on the level of identity *between the depth of the roots and the bridge towards an elsewhere, perhaps a better place* (Chambers, 2008: 33).

If it is true that the experience of migration by its very nature involves a crossover, the overcoming of a boundary line which, in turn, affects the cons-truction and processing of new mental constructs (Martelli, 1993: 30) is also true that as Jacoviello and Sbriccioli say, the concept of the border as a separation, exclusion, shows more and more often its inconsistency, whereas the internal restructuring of the system creolisation – that is those phenomena triggered individually from acting in a constantly changing national network – it tends to neutralize these exclusive spaces and to enlarge the new geopolitical space (Jacoviello, Sbriccioli, 2012).

Therefore, the borders should no longer be considered as the closing lines, dams, but as places, both physical and mental, that through the exchange and cultural transformation will create new identities (ibid).

Citizenship Worktable / Naples Charter

"City hall of Naples, enhances the role of Naples European and Mediterranean city, promotes cooperation and trading among people according to historic local tradition, the culture and the image of open mind city" (Comune di Napoli , 1991).

According to this mission, the City Hall projects many activities to support cultural exchanges, good practices and human rights, against discriminatory nationalism. The Citizenship Worktable(3) has the same final aim and is managed by Cooperation Service Legality and Peace Department/CEICC-Europe Direct in Naples.

The committee is composed by social and local organizations that estabilished the Charter of Naples – promoted by Ariete Onlus - which includes asylum applicants and immigrants reception and integration due to urban itinerary with strategic intentions. Guideline purposes of Charter of Naples are urbanitas and sustainable solidarity as the following:

1. Solidarity section concerns many activities inside schools to sensitize families about asylum applicants and immigrates difficulties. These educational meetings should take place during institutional days, for example Migrant Global Rights Day, encouraging networks between citizens, immigrants, international organizations, school and institutions.

2. Sustainability section tracks life condition of immigrants as accommodations and health due to local associations without manage-ment role.

3. Urbanitas section has the mission to promote an harmonic multiethnic accommodation. According the individual skills of each immigrant, it plans citizenship activities in order to facilitate integration. It arranges ludic meetings with involving families in order to share daily life conditions.

As described in Charter of Naples, difficulty of community life grows up by the citizen disinformation and self segregation of immigrants.

For that reason, the final purpose is to promote overcoming the immigration-related stereotypes, through first of all human respect, and then acknowledge shared environment and places, stimulating integrated and unified life style.

The concept of home being extened through public space. It is a mixture between "here and elsewhere which takes place through relationships into the public space" (Brivio , 2013:40).

As been stressed before, the space, which is outstanding for the subject, has an important role to increase identity (Mannarini , 2004).

Following those guide line, Citizenship Worktable implements measures of social transformation and *Intercultural- citizenship*, thinking about new concept of us that takes place into urban space (Mantovani , 2010).

The consciousness about the permeability of cultural borders and work to improve cultural exchange are part of *intercultural*

prospective (Mantovani, 2010), bringing back the concept of frontier as a crossing and not as barrage (Jacovello, Sbriccoli, 2012).

Objectives and methodology

The present research – developed within City and Migrazioni_FuturL@bs project- was based on a cycle of interactive workshops, where people from different cultures, sharing their experiences and their stories passed, have created opportunities to meet, debate and discuss on a number of issues. They were asked to compete on the personal perceptions of shared urban spaces and one's own body within the same space, by comparing them with the original space: place of origin. This research was conducted in collaboration with Centro Studi Ksenia, Geronimo Carbonò Association, Macchia di Colore Association, Lo Scudo Onlus Association and the Order of Architects of Naples.

The study aims to investigate the role that urban space takes in the construction of identity process of young immigrants and second-generation foreigners citizens, in order to subsequently draw up urban routes and empowerment strategies for the improvement of the reception system, support and integration of migrants, refugees and asylum seekers; and to optimize coexistence with the local community. Participants in the research are seven non-EU foreign citizens, five men and two women, from Burkina Faso, Senegal, Ivory Coast, Poland and Belarus, aged between 26 and 46 years (M = 35), living in Italy for a minimum of 6 years to a maximum of 25 years; and two foreigners unaccompanied minors, male, from North Africa.

It was used a qualitative methodology, based on an inductive and exploratory approach, through which the researcher's attention was directed at the specific case study, deepened with an ideographic position (Denzin, Lincoln, 2000 in Lucidi, Alivernini, Pedon, 2008)

The instruments used, in line with the qualitative approach, are:

-**TAS- 20: Toronto Alexithymia Scale**, designed by the research team of Toronto, led by Graeme Taylor (Carretti, La Barbera, 2005) and validated in Italy by Bressi et al. (Bressi, Taylor, Parker et al., 1996). This scale aims at studying the alexithymia construct, with which we refer to a deficit in the cognitive process and emotional regulation. This causes a difficulty to identify, describe and differentiate emotions, a prevalence for operational thinking and a reduction of imaginative processes and a cognitive style oriented to outside reality (Todarello, Pace, 2000).The TAS-20 is a self-report questionnaire, based on a Likert 5-point scale, consisting of 20 items, divided into three dimensions that define the construct:

1. Difficulty identifying feelings (Factor 1)

2. Difficulty in communicating feelings to others (factor 2)

3. Thought externally oriented (factor 3)

-**BUT: Body Uneasiness Test**, designed and built in Italy by Cuzzolaro and his students (Cuzzolaro, Vetrone, Marano, Battacchi, 1999 in Carta, Zappa, Garghentini e Caslini 2008), in 1999, to assess disorders related to body image. The concept of body identity, was born in neurology and, in the last two centuries, has been thoroughly revised from psychology and psychiatry. The first body identity conceptualization, attributed to Shilder, consists not only of the mental representation resulting from the perception that the subject has of himself, but also of personal investments and socio-cultural meanings; aspects that define the image of the body as "a totalitarian structure that brings together the attitudes, experiences, feelings, ways of thinking of the body" (Shilder, 1973).

The self-evaluation test is composed of 71 items with multiple choice on a Likert scale from 0 to 5, and is divided into two parts:

1. BUT a: made up of 34 clinical items, divided into five subscales, which provide an overall score of gravity. These are:

WP: Weight Phobia, morbid fear of weight gain

BIC: Body Image Concerns, excessive concern about physical appearance

A: Avoidance, avoidance behaviors related to body image

CSM: Compulsive Self Monitoring, compulsive control of physical appearance

D: Depersonalization, depersonalization, feelings of detachment and alienation with respect to his own body

2. BUT b: composed of 37 items that list parts and functions of the body; This second part of the test was not used in this research.

- **TAT: Thematic Apperception Test,** created and revisited by Murray (Murray, 1943 in Lis, 1993), consists of 31 pictures, photographs, reproductions, paintings, illustrations. Of these some are applicable to all subjects, both males and females of any age; others can only be used for males (M, male) or females (F, female), others only for adults or adolescents (under 14 years of age). Overall, the separate battery for each type of subject (male/female, young/adult) includes 20 images. The test was originally created as an expression of the needs of the Murray's theory; it is a dialectical theory of personality that considers as determinants of human behavior psychobiological and environmental factors; the central constructs are those of need and pressure. According to the above theory, in the interpretation of the TAT, the initial task is to identify that character, defined as a hero, on which the subject, presumably, has projected needs, motives, believing and emotions.

Results and conclusions

The first qualitative phase of our study has produced results which must be represented in relation to two working groups.

In the foreign youth group emerged a difficulty at verbalizing their feelings and emotions and a narcissistic investment on body image. The social context is described clearly with its own strengths and flaws; the youngest of this group are looking for more places of gathering and sharing, meeting with Others not only like himself but also different. All the members of this group seem to agree in identifying an ancient square in the historic center of Naples as a place symbol of this exploration, in which it can be found Macchia di Colore Association. Specifically, this association, is the meeting location of the participants. This area, although sometimes is scene of many violent clashes and incidents of discrimination, is also recognized on one hand by all as the place where to meet with other migrants with whom to share their past histories and, on the other hand, with the local community, with which confront, integrate and know each other; practicing Sironi's theory as has previously been exposed: the foreigner, after identifying himself first with a cultural center and then with its opposite, now seeks an integration between them, a reunification between parts of the self, starting from the identification of sites that allow the recognition, respect and coexistence of both these parties, to achieve a new identity that will unite likewise past, present and future.

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In the group of unaccompanied foreign minors (living at Center managed by Lo Scudo Onlus Association), there has been the tendency to provide functional autobiographical representations to the needs of the Italian reception procedure; in this case, it could be argued that the unaccompanied minor, not yet has had the opportunity to undertake an identity integration process, given that they are outside their country of origin but not yet included in the new social cultural and economic context; they are hosted in Welcome facilities that, by their very nature, can not represent permanent life solution.

At the unaccompanied minor, as well as to foreigners, it should be given the opportunity to know the place in which will go, to grant, also at the institutional level, the opportunity to become an active and responsible citizen in the place around himself, starting from the places which identifies as functional to the construction of identity, places of encounter, discussion and mutual understanding between themselves and the local population.

In this direction our research will be developed with the aim of investigating identity dynamics and places of coexistence, with special attention for radicalization's risk factors. Risk that is often based on what Fethi Benslama defines the identity crisis of the subject, suspended between the fear of seeing the own community's dissolution and the instinct to produce destruction of new belonging communities. So our research will propose to trace creative experiential and clinical spaces that could stimulate individual metamorphosis' abilities to help migrant people - and all of us - to create new opportunities for common life.

APPENDICE

BUT

Per ognuna delle seguenti domande, scegliere una sola risposta,
segnando una X sulla casella corrispondente.

MAI	RARAMENTE	QUALCHE VOLTA	SPESSO	MOLTO SPESSO	SEMPRE

1. Trascorro molto tempo davanti allo specchio
2. Non mi fido del mio aspetto: temo che cambi all'improvviso
3. Mi piacciono gli abiti che nascondono le forme del mio corpo
4. Passo molto tempo pensando a certi difetti della mia immagine fisica
5. Quando mi spoglio evito di guardarmi
6. Penso che la mia vita cambierebbe profondamente se potessi correggere alcuni miei difetti estetici
7. Mangiare in presenza di altri mi provoca ansia
8. Il pensiero di alcuni difetti del mio corpo mi tormenta tanto da impedirmi di stare con gli altri
9. Ho il terrore di ingrassare
10. Faccio lunghi confronti fra il mio aspetto e quello degli altri
11. Se comincio a guardarmi mi è difficile smettere
12. Farei qualsiasi cosa per modificare certe parti del mio corpo
13. Resto in casa ed evito di farmi vedere dagli altri
14. Mi vergogno dei bisogni fisici del mio corpo
15. Mi sento derisa/o per il mio aspetto
16. Il pensiero di alcuni difetti del mio corpo mi tormenta tanto da impedirmi di studiare o di lavorare
17. Cerco nello specchio un'immagine di me che mi soddisfi e continuo a scrutarmi finché sono sicura/o di averla trovata
18. Mi sento più grassa/o di quello che dicono gli altri
19. Evito gli specchi
20. Ho l'impressione che la mia immagine cambi continuamente
21. Vorrei avere un corpo secco e duro
22. Sono insoddisfatta/o del mio aspetto
23. Il mio aspetto fisico è deludente rispetto alla mia immagine ideale
24. Vorrei sottopormi a qualche intervento di chirurgia estetica
25. L'idea di vivere con l'aspetto che ho mi è insopportabile
26. Mi guardo allo specchio e provo un senso di inquietudine e di estraneità
27. Temo che il mio corpo cambi contro la mia volontà in modiche non mi piacciono
28. Mi sento scollata/o dal mio corpo
29. Ho la sensazione che il mio corpo non mi appartenga
30. Il pensiero di alcuni difetti del mio corpo mi tormenta tanto da impedirmi di avere relazioni con l'altro sesso
31. Mi osservo in quello che faccio e mi chiedo come appaio agli altri
32. Vorrei decidere io che aspetto avere
33. Mi sento diversa/o da come mi vedono gli altri
34. Mi vergogno del mio corpo

TAS – 20

Per ognuna delle seguenti domande, scegliere una sola risposta,
segnando una X sulla casella corrispondente

Non sono per niente d'accordo	Non sono molto d'accordo	Non sono né d'accordo né in disaccordo	Sono d'accordo in parte	Sono completamente d'accordo

1. Sono spesso confuso circa le emozioni che provo
2. Mi è difficile trovare le parole giuste per esprimere i miei sentimenti
3. Provo delle sensazioni fisiche che neanche i medici capiscono
4. Riesco facilmente a descrivere i miei sentimenti
5. Preferisco approfondire i miei problemi piuttosto che descriverli semplicemente
6. Quando sono sconvolto non so se sono triste, spaventato o arrabbiato
7. Sono spesso disorientato dalle sensazioni che provo nel mio corpo
8. Preferisco lasciare che le cose seguano il loro corso piuttosto che capire perché sono andate in quel modo
9. Provo dei sentimenti che non riesco proprio ad identificare
10. È essenziale conoscere le proprie emozioni
11. Mi è difficile descrivere ciò che provo per gli altri
12. Gli altri mi chiedono di parlare di più dei miei sentimenti
13. Non capisco cosa stia accadendo dentro di me
14. Spesso non so perché mi arrabbio
15. Con le persone preferisco parlare delle cose di tutti i giorni piuttosto che delle loro emozioni
16. Preferisco vedere spettacoli leggeri, piuttosto che spettacoli a sfondo psicologico
17. Mi è difficile rivelare i sentimenti più profondi anche ad amici più intimi
18. Riesco a sentirmi vicino ad una persona, anche se ci capita di stare in silenzio
19. Trovo che l'esame dei miei sentimenti mi serva a risolvere i miei problemi personali
20. Cercare significati nascosti in un film o commedie distoglie dal piacere dello spettacolo

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Consistency among evaluators in the detection of risk factors to the mental health of immigrants: Ulysses scale.

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Ulysses scale, migratory grief, mental health

Summary

The article describes the Ulysses scale, which makes it possible to structure and measure the complex clinical and psychosocial information on stress and migratory grief. This is of great interest for health, welfare and research work. This scale can be used in the different professional sectors that care for immigrants, not only for health services, but also for social and educational services. The characteristics of the scale and the study on inter-observer reliability are presented in the article. The results ensure the reliability of information between evaluators is sufficiently high.

This article has two parts. The first part presents a scale of evaluation for risk factors to the mental health of immigrants. Part two studies and demonstrates the reliability of the scale described.

PART I.

DESCRIPTION OF THE SCALE FOR EVALUATION OF RISK FACTORS TO MENTAL HEALTH IN MIGRATION (ULISES SCALE)

1. CONTEXT OF THE SCALE JUSTIFICATION, OBJECTIVES, GENERAL CHARACTERISTICS OF THE ULYSSES SCALE

This scale was designed as an instrument that makes it possible to structure complex clinical and psychosocial information related to stress and migratory mourning, such that it can be ordered in a way that contributes to social service/work and research. The scale can be used by the different sectors that attend to immigrants, not only in health services, but also in others such as social services, education services etc. We present this scale as a part of a collective of larger instruments.

1.1. JUSTIFICATION OF SCALE

The tale or narrative the immigrant brings us possess an extraordinary phenomenological and anthropological value, therefore, in terms of psychosocial work it is important to try to structure and make operative the information we possess in a way that makes it comparable with that obtained by other professionals.

The need for the scale arises primarily in response to the new migration of those in extreme situations in the 21st century. Migration in these extreme conditions has become an important, even determinant, element in biography of the subject due to the psychological tension it provokes, to the point that it constitutes a relevant risk factor for mental health problems.

While migration related stress and mourning is of interest in all migrations, it is even more in the context of migration in extreme circumstances such as those we are seeing in recent times. Emigrating is becoming for millions of people a process that possesses levels of stress so intense that they surpass the capacity for adaptation of human beings. As such, the name "Ulysses Scale" makes reference to the adversities and dangers experienced in solitude by contemporary immigrants that conjure up images of the Greek hero. The scale is a result of the research conducted on the Ulysses Syndrome (Achotegui 2002), although as will be seen later, it is useful for all types of work on mental health issues in migration.

Another factor that has been relevant to putting the scale to use is the growing demand for instruments to evaluate migratory stress and mourning and more specifically, the Ulysses Syndrome.

1.2. OBJECTIVES OF THE SCALE

The objectives of the scale are:

I. To provide the criteria for the evaluation of risk factors for mental health in migration that permits the establishment of comparisons of the risk situations of immigrants that receive attention from social and welfare services.

II. Provide, once the evaluation has been carried out, common and objective criteria concerning:

a. How to distribute welfare/ social service resources (usually scarce) in an equitable way and avoid the risk of interventions based on intuition or a hunch etc.

b. Define the areas in which risk factors exist and which require an intervention in order to permit less focus on certain areas and applying optimally welfare or social service resources to real problems of the immigrant.

In our experience we believe that the intervention is not always adequately focused, with the waste of resources that this implies (and the diminishing of resources for the intervention in the really necessary aspects). We consider that it is just as important to know where an intervention is appropriate as it is to know where it is not appropriate because no (mental health) problem exists, in such a way that resources can be optimized and a psychosocial intervention will not be undertaken (it is not necessary to become involved in how each one lives one's life or in this case one's process of migration.

1.3. CHARACTERISTICS OF THE SCALE

I. The scale functions essentially as a screening tool for evaluating the psychosocial situation of immigrants. It is not intended to be "a psychoanalysis" of the person evaluated, nor find his/her DNA. The objectives are much more modest: they are concerned with a first evaluation that differentiates the intensity of risk factors of the immigrant from a mental health perspective, with the intention, as we have signaled, of a more well structured social service intervention.

II. The scale measures risk factors. The premise is similar to that of an insurance company: the scale assesses the risk of problems (in this case in order to better help those most in need of help, not to charge more). But the fact that a risk factor exists is not to say that he who is more at risk is who will necessarily fall ill. There are people with a high level of risk who do not have problems. For example, shifting this approach to the risk supposed by smoking, we would signal that the well-known Spanish politician Santiago Carrillo has smoked 3 packs per day for years and has been in good health for 90 years despite this being an enormous risk factor. And unfortunately people who lead healthy lives can be fall ill to cancer. Therefore, a risk factor is not the same as a cause. We can say that the scale functions as a type of "smoke detector", that can sometimes be too sensitive, but which serves a preventative and highly valuable function.

III. The scale is etic, that is to say that it evaluates the facts from a conceptual framework that is external to the interpretation that immigrants make of their own situations. (The concept "etic" comes from K. L. Pike, 1967). This conceptual framework is based on the psychoanalytical theory of mourning, social psychiatry and evolutionary psychology, not on the self-perception of how the subject evaluations the facts. These perceptions of the subject are taken up in the section annex of "Observations" to the scale, as a subjective aspect. For example it could be that a mother manifests that she is very little affected by being forcibly separated from her young children or that another expresses that she is highly affected when she does not see her children daily even when they live close by. The scale considers that in the first case the stressor is extreme and in the second it is not. Or that an immigrant who sleeps in the street

says that he is not affected by this situation: the scale considers this a situation of risk and as such it is evaluated as an extreme stressor.

In this way the scale is based on a theoretical model, it is not an inventory of things, or of dates, it is not a laundry list that sums up infinite data related to migration.

For this reason, in contrast with the scale of Homes and Rahe (1966), the scale is not self applied, that is to say that the scale is based on the evaluation made by the professional concerning the facts derived from the immigrant and based on the approach described here.

The evaluation that a person makes concerning the importance of life situations is very relevant (and this is included in the section on subjective observations) but it does not always coincide with the subject's behavior: as illustrated in the classical example; when television viewers are asked what they like to watch, most say documentaries, even though the proportion these programs represent is less than 3% at most.

IV. The scale we show applied to migration here could be utilized in other situations of chronic stress such as "mobbing" or "bullying" etc... adapting the approach in relation to the type of stressors and mourning that is experienced in each situation. We have developed this scale applied to migration in relation to the 7 sorrows related to migration, but we consider it could be interesting to develop it in relation to other situations of stress, such as those we will explain later on. In relation to other scales that evaluate "life events", it can be said that this scale evaluates "migrant events" specifically.

It is also important to point out the fact that a subject can be evaluated from different perspectives (is obvious). This scale evaluates through a prism which is the concrete viewpoint of the influence of migration, especially migration in extreme situations as a risk factor for mental health problems of the subject. Obviously other prisms exist concerning the study of reality, such as the gender perspective (such as feminism), and the perspective of age etc.

V. It is important to point out that the scale is an element, a part of the exploration and that what counts in the end is the professional's global evaluation of the immigrant, in which he/she must link all of the available information as a whole.

VI. The scale can be utilized to evaluate the migratory phenomenon no only in relation to those who emigrate, but also to those who stay behind in the country of origin. That is to say, the scale covers the whole area of migration psychology. In the case of application in countries of origin before emigration, the scale permits evaluation of the vulnerability of the subject in relation to migratory stress and mourning in order to provide the criteria to measure the level of risk to the migrant's mental health, such that the migrant may be conscious of such risks when making the decision to emigrate.

VII. Finally, this scale was presented by Joseba Achotegui in April of 2007 in the Kamakura Congress (Japan) of the Transcultural Psychiatry section of the World Psychiatry Association. The version presented here, version 2008.3.0 is an updated version. In this version I would like to highlight the importance of the advice of Dr. Anna Tuset, a colleague at my department at the University

1. ELEMENTS OF THE SCALE

This part of the text explores the components or elements of the Ulysses Scale, which, as we will see, are based on the concepts elaborated in previous chapters.
The Ulysses Scale is made up of 3 primary components:

I. The situations from which stress and mourning are derived during the migratory process.

II. Evaluation of the intensity of each of the sorrows associated with migration.

III. Evaluation of the factors, in particular vulnerability and stressors, that may modulate each of the migratory sorrows

Developing the elements shown in figure 1 we can see that each of the three parts groups together the following aspects:

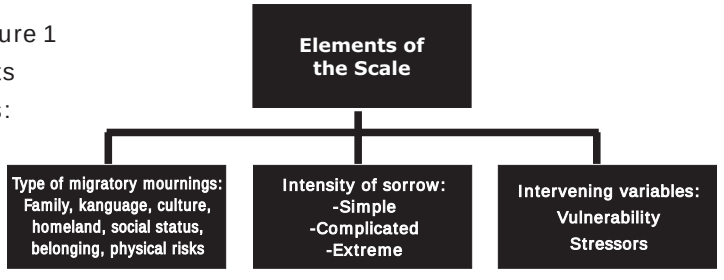

Figure 1. Development of the elements that make up the scale

1.1. DELIMITATION OF THE TYPES OF MOURNINGS THAT OCCUR IN MIGRATION. MIGRATORY MOURNING IS MULTIPLE: THE SEVEN MOURNINGS OF MIGRATION

Migratory mourning is multiple in nature. It is possible that no other situation in the life of a person, including the loss of a loved one, supposes as many changes as migration. Everything in one's surroundings changes, and even more so the further one is, physically and culturally, from his or her place of origin.

As was pointed out in a prior text (Achotegui 1999), migratory mourning can be classified roughly in 7 areas of sorrow:

I. Loss of Family and Loved Ones. The loss of access to family and loved ones is the aspect of migration that perhaps comes to mind most immediately when we think of migratory mourning: farewells, chat rooms etc.

   These separations are important for humans because they affect our sense of attachment, which is an instinct, according to Bowlby (1986), an author who brings together psychoanalytic and cognitive aspects of [psychology]. However, as has been mentioned before, we would point out the different levels of intensity of this mourning, for example, the mourning felt by a young person embarking on his or her own for the first time is altogether different from that of a parent who must leave his or her children behind.

   In all grieving it can be considered that there are two components, sorrow for what has been left behind, in this case, the distance and separation from loved ones, and other part that has to do with the stress and effort associated with adapting to what is yet to come, in this case, the search for new social ties and networks.

II. Language. Learning the language of a host country yields pleasure and satisfaction but also requires effort. The situation is even more difficult when a migrant is afflicted with a disorder such as dyslexia, or illiteracy, or when a migrant is of an advanced age or finds him or herself in a situation where contact with the locals through their language is impossible or where there is absence of courses or other resources for making such contact. Migratory sorrow related to language includes not only the loss of contact with one's native language but also with the effort required in learning and/or adapting to the new language or languages of the host country.

III. Culture. Understood in ample terms, includes the values, customs, and a general sense of the meaning of life etc. Language is tied to culture, but the two are not the same, just as a Spaniard and a Cuban speak the same language but we consider that they belong to two, quite distinct, cultures. In the same way that we assume that the sorrow of the loss of language can be overcome, we consider that any migrant has the capacity to establish contact with the new culture of the host country if he or she does not have prior circumstances or disorders which impede contact with the new culture. The migrant must work through, on one hand, the sorrow for the loss (or lessening) of contact with his or her culture of origin and on the other, the effort necessary in order to gain contact with and adapt to the new culture of the host country.

IV. Homeland. Light, colors, smells, landscape, temperature and so forth are relevant to one's emotional wellbeing and have an impact on those who migrate to places that are darker or colder. These changes can create problems with adaptation, which is well known in the field of anthropology, that human beings originated in Africa in temperate climates. Psychological studies on happiness signal that controlling for numerous variables, people who live in warm places are generally happier. Migrants must work through, on one hand, the sorrow associated with leaving one's homeland behind, and on the other, the stress associated with adapting to a new climate, to new smells, colors, and landscape.

V. Social status. This has to do with documentation papers, the right to work, housing and access to opportunities. In general, the motivations behind migration may include the desire to improve social standing, though there are personal motivations for migration as well. The sorrow for loss of one's social status must be understood to include non-economic factors, such as cultural rights and freedom of movement.

   In general, migrants often lose social status when they migrate, “you go to the end of the line”, as a young migrant from Morocco explains. The problem is that migration in the XXI century supposes that, for many people, there is not even a line into which they can place themselves. If during the next few years after migration, one's situation does not

improve; a migrant becomes demoralized and enters in crisis, feeling that all the effort was not worth it. A migrant has invested the best years of his or her life, perhaps gone into debt, etc. The migrant must also work through the sorrow associated with the loss of the social status left behind, for example, it is frequent that one's housing situation was better before migrating, or en the case of many teachers and well educated professionals who leave their countries of origin and find they must work in the host country in low-wage service jobs etc…feeling frustrated by this new situation, and even more so when they realize there is no way out.

VI. Group Belonging. This refers to all that is related to prejudice, xenophobia, racism etc. People tend to identify with a group, and during migration this identification is modified when one enters into interaction with other groups. Anthropological studies signal that all humans harbor certain prejudices towards other groups. This tendency can be explained by evolutionary psychology that shows how human beings have lived a great part of our history in small groups, familial clans, in constant competition with other, similar groups of humans for generally limited resources. Survival outside of the group was impossible. History has left us with the sense that we must belong to a group and a tendency towards prejudice towards others (as well as a tendency to crack jokes about our neighbors). The problem arises when these attitudes manifest themselves in xenophobic or racist conduct. The existence of prejudice has been intensely studied in social psychology, signaling that it serves the function of simplifying one's analysis of social life, which is characterized by great complexity.

The migrant must work through the sorrow associated with the loss (or lessening) of a sense of belonging that was associated with a group in the country of origin and at the same time, confront the stress associated with forming a new group with which to form social ties.

VII. Physical risks. Physical risks refer to the risks individuals face when they leave their habitual environment behind and migrate, facing numerous and often hostile changes. Like attachment, physical safety is a psychological necessity. Migrants assume the risk of work related accidents when their working conditions are substandard or dangerous, domestic accidents due to living in crowded conditions (especially in the case of minors), fear of being expelled (there is a brigade dedicated to expulsions in the police force), ill treatment, sexual abuse, risks associated with the migratory journey (for example, in rafts), the risk of contracting disease-both because of lack of defenses or due to unsanitary conditions, lack of protection against the cold, and malnutrition etc.

The migrant must work through the sorrow associated with the lessening or loss of physical security enjoyed in his/her country of origin (although this is not always the case, some migrants leave specifically because of the risks in the home country), and at the same time, face the stress associated with new physical risks they encounter when they migrate.

The Seven mournings of Migration:

1. Family and loved ones, especially in the case of forced separation from small children,
2. Language
3. Culture (customs, values…)
4. Homeland (landscapes, colors, light, smells, temperature…)
5. Social status (access to opportunities, papers, work, housing, health….)
6. Group belonging (prejudice, xenophobia, racism….)
7. Physical risks (on the journey, accidents persecution, defenselessness….)

Figure 1 . Types of Migration Related Sorrow (Achotegui 1999)

1.1. MEASUREMENT OF THE INTENSITY OF MIGRATION-RELATED STRESS AND MOURNING: SIMPLE, COMPLICATED AND EXTREME

Not all migration-related mourning is of the same intensity (Achotegui 2002). Therefore, it is important to differentiate between:

- Simple mourning: this is the mourning associated with favorable conditions and which can be worked through in an appropriate way by the migrant. It should be mentioned that even simple mourning has different possible ranges, in the same way that optimal arterial tension is 12-7 but 13-8 is also considered normal, although not quite as good. Simple mourning is a natural part of migration and everyone who migrates experiences it; for example, changes in language and culture. We thus consider that simple mourning can be said to exist "by default", that is to say that the mourning experienced as a result of the migration process is, at minimum, simple in nature.
- Complicated mourning: denoted by the existence of serious difficulties on the part of the migrant in working through migratory sorrow, though it is possible to do so.
- Extreme mourning: the difficulties associated with working through this sorrow are so great that it is not possible to successfully overcome them. Nevertheless, everything could be worse given that being separated from one's children, being scared etc. is extreme....but on top of that one could be sick, detained....all of this enters into the extreme category.

Simple Complicated Extreme

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It can be observed that a continuum of intensity exists such that different types of situations can be classified in three categories: three subtypes along this continuum (simple-complicated-extreme).

The version we present does not include indicators of the elaboration of the types of migratory mourning rather we present indicators of vulnerability and stressors in relation to these types of mourning.

In a later version we will present the indicators of the types of mourning we are working on.

1.1. FACTOR THAT MODULATE THE MOURNING PROCESS IN MIGRATION

We have made reference to the types of mourning and their intensity, but the grieving process is modulated by two factors that we consider relevant:

I. Vulnerability. In the absence of knowledge of the subject in question it is not possible to establish a valuation of the risks to mental health posed by migration. No two people are the same. It is basic therefore to establish criteria to delimit all that which could contribute to a subject having difficulties in migration.

II. Stressors. It is important to analyze in the evaluated subject those difficulties that he/she has experienced during the migratory process, starting with the premise that greater difficulties suppose greater risk.

2.3.1. Vulnerability

Vulnerability related to migration can be understood as the group of limitations, handicaps etc. that a subject bears when he/she migrates and that constitute a risk factor for his/her mental health. Vulnerability would be, en relation to working through the mourning of migration, the "baggage" of limitations with which one leaves his/her house, closes the door and migrates.

We consider that this vulnerability should be evaluated independently for each of the seven sorrows. This is to say that we do not evaluate vulnerability in general, rather the specific vulnerability for each sorrow independently.

As we will show in more detail in the section on indicators of vulnerability, this is based on physical, psychological, age related and personal/ historical limitations. For example, the vulnerability related to the sorrow associated with language values the difficulties this immigrant has at the time of migration to be competent in the language of the host country, for example, whether he/she is deaf or dyslexic.

In the same way as the intensity of mourning, it is evaluated along a continuum. We would therefore consider there to be three levels of intensity of vulnerability.

Simple: small limitations of the subject (no one is perfect), that are compatible with working through the sorrow associated with migration: example, the subject has a bit of myopia, or is a bit shy.

Complicated: there are relevant limitations in the subject but with effort he/she can work through migratory sorrow: for

example, he or she is diabetic, has a dependent personality, or a depressive illness, or is over age 65.

Extreme: there are great limitations that impede working through migratory sorrow: psychosis, relevant handicaps etc.

Vulnerability

Simple Complicated Extreme
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As shown in the last figure a dimension is evaluated, that is to say that there is space in which different situations may fall along the continuum of vulnerability, simple, complicated and extreme.

It is such that being paralyzed is extreme vulnerability, to which psychosis can be added and both continue to be in the extreme category.

The evaluation of vulnerability can be made using 3 criteria:

1. Physical vulnerability: those physical limitations possessed by the immigrant before emigrating and which can be considered to make more difficult working through migratory sorrow: illnesses such as diabetes, heart attacks etc., handicaps such as paralysis, or being deaf...
2. Psychic vulnerability: those psychic limitations possessed by the immigrant before emigrating that can be considered to make it more difficult to work through migratory sorrow: depression, psychosis, dementia etc.
3. Difficulties of one's personal history: having suffered mistreatment, sexual abuse, the death of parents, being a minor etc.
4. Being over age 65

2.3.2. Stressors

Stressors include the external difficulties experienced by an immigrant during the six months prior to our exploration and that we consider to be a risk factor in respect to mental health. These are the obstacles, the discrimination, and lack of access to opportunities; adversities etc. faced by the immigrant which are external to him/her and which affect his/her process of migratory grieving. It is important to point out that stressors are not the stress or the mourning as such; these are psychological processes of the subject, while stressors are factors external to the subject.

In the same way that we commented on vulnerability, we consider that stressors have to be evaluated independently for each of the 7 areas of migratory mourning. Stressors are not evaluated in general, rather the specific stressors for each sorrow independently. In any case, general vulnerability is considered after looking at each area. For each stressor the intensity, frequency and duration must be valued.

Types of stressors

- Simple: some difficulties that do not impede the working through of migratory mourning. In every migration, obstacles must be confronted. Nothing is given to the immigrant, who will have to work hard, finding him/herself faced with a new language, new foods, climate, mentality... but as long as he/she does not face added external obstacles in addition to those that are natural, he/she can adapt. We consider these simple stressors
- Complicated: relevant difficulties which, with effort, can be overcome. These are obstacles that are special, beyond the habitual. For example, in the case of language, that it is difficult for the immigrant to gain access to learning courses, or that he/she has little contact with autochthonous individuals.
- Extreme: There are great limitations that impede the working through of migratory sorrow: the impossibility of working legally, having to live in hiding etc.

STRESSORS

Simple Complicated Extreme
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As we observe here, this graph presents a continuum of growing difficulties and even stressors that are considered extreme can be aggravated and continue being categorized as extreme: such that being without work or housing are stressors that are extreme, but additionally, one can suffer racist attacks or live in hiding and we still consider these stressors extreme. (As in the popular refrain: “everything can get worse”).

Seventy-five percent of depressions are related with significant stressors as signaled by Brown (1978).

In the evaluation of stressors the following is taken into account:

-Stressors in the personal area: for example, family problems that make success of the migration difficult,

-Stressors in the environmental and social areas: for example, laws that discriminate against immigrants,

-Other stressors

1. GRAPHIC DEPTICTION OF THE SCALE VULNERABILITY – STRESSORS APPLIED TO MIGRATION

Mourning	Vulnerability		Stressors	
Family	Simple		Simple	
	Complicated		Complicated	
	Estreme		Estreme	
Language	Simple		Simple	
	Complicated		Complicated	
	Estreme		Estreme	
Culture	Simple		Simple	
	Complicated		Complicated	
	Estreme		Estreme	
Homeland	Simple		Simple	
	Complicated		Complicated	
	Estreme		Estreme	
Social Status	Simple		Simple	
	Complicated		Complicated	
	Estreme		Estreme	
Belonging	Simple		Simple	
	Complicated		Complicated	
	Estreme		Estreme	
Physical Risck	Simple		Simple	
	Complicated		Complicated	
	Estreme		Estreme	

Observations	
Protective factors	
Cultural Factors	
Aggravatinf Factors	
Subjective Factors	

Adapted form "Exclusión y Salud mental" (Compilador J. Achotegui). Chapter 11. Escalas de Evaluación del estrés crónico y la exclusion. Escala Vulnerabilidad-Estresores aplicada a la migración. May 2008. Bcn.

Figure 2. Graphic of the Scale

PART II.

RELIABILITY STUDY OF THE SCALE FOR EVALUATION OF RISK FACTORS TO MENTAL HEALTH IN MIGRATION (ULISES SCALE)

Regarding the Ulysses scale, there are different aspects that have not been previously studied, such as the existing reliability between the judgements of different evaluators. Thus, the main objective of this study is to perform a statistical analysis to determine the degree of consistency between two independent judges, as well as analysing whether or not there is a relationship between vulnerability and stressors, based on a sample from the following different health centres:

- Hospital de Sant Pere Claver,
- Hospital del Mar de Barcelona (Hospital of the Sea of Barcelona)
- Cap de Drassanes

4. Method

101 people participated in the study, of which 60 were men and 41 were women from different centres and were studied in the Hospital de Sant Pere Claver. One criterion for inclusion was that the participants had at least 6 months in the host country, in this case Spain. Participants were finally selected because they were considered to be the ones that best reflected the reality of migration currently.

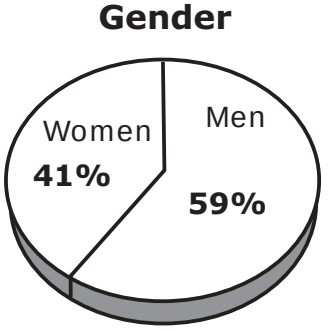


Figure 3. Gender in the sample

In relation to the ages of the participants, we can see that they are predominately less than 30 years of age, followed by those in the 30-45 year age bracket.

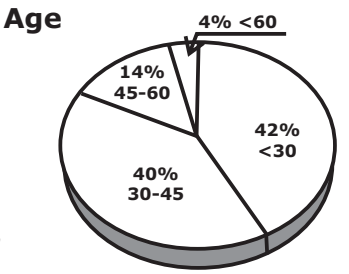
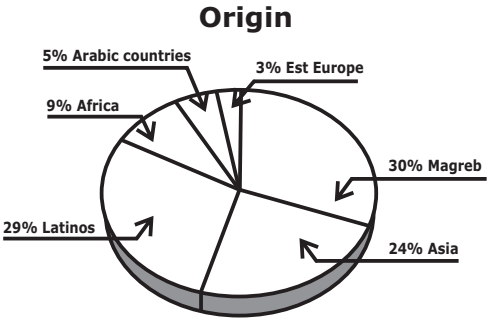


Figure 4. Age of the sample



The totality of the participants that make up the sample are immigrants from all over the world, predominantly Latin America and Asia.

Graphic 5.
Origin of immigrants of the sample

Finally, in relation to the time of stay in Catalonia we can see that those that stay between 5 and 10 years are by far in the majority.

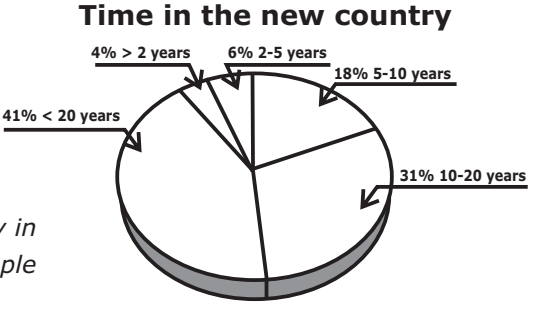


Figure 6. Length of stay in the host country of sample

Instruments

We used the Ulises scale (J. Achotegui 2010), which is not based on binary (i.e., yes or no) or quantitative answers, but requires graduated information, in other words ordinal answers. These answers should be assessed by professionals to be able to carry out an evaluation. It is a matter of making a qualitative assessment of the reality of the immigrant. More specifically, the objectives of the scale are, on the one hand, to provide the criteria for assessing risk factors to mental health due to migration in order to compare the situational risk of users attended to by health care services; And on the other hand, to facilitate, based on the evaluation carried out, consensual and objectifiable criteria on how to distribute healthcare resources in an equitable way and to define the areas in which risk factors exist and in which interventions must be made.

The scale essentially has a screening function (i.e. rapid exploration) to assess the psychosocial situation of immigrants. Therefore, it is a question of detecting, in the first evaluation, the possible existence, and where appropriate, the intensity of the risk factors to the immigrant from the perspective of mental health

The Ulysses scale includes a section of observations, since a scale, like any scientific instrument, is limited and cannot evaluate all the elements that are experienced in migration, the most important aspects that are not evaluated in the scale are recorded as comments in an annex which is located at the end of the scale evaluation sheet. This section is subdivided into the following factors: protective factors, cultural factors, aggravating factors, subjective factors and other factors. The assessment that the person makes about the importance of the situations they experience is very relevant and for this reason is included in this section.

5. Procedure

The scale was administered to participants at the Sant Pere Claver Hospital. Those responsible for administering the scale to the participants were a psychiatrist and a psychologist, chosen for their wide experience and knowledge of mental health of immigrants and in the use of this scale therefore being able to apply the instrument correctly minimizing potential biases as a consequence of variations in the measurement conditions.

The researchers applied the scale after clinical evaluation of the immigrants analysing

the data concerning the seven mournings of migration

The procedure followed was divided into two parts. The first part consisted of the collection of information about the participants through an anamnesis, which is necessary for the subsequent application of the scale. The second part, in which the administration of the Ulysses scale was carried out, was dedicated to the collection of information from the perspective of the seven mournings, evaluating the vulnerability and stressors of each mourning together with the corresponding intensity (ie, simple, complicated and extreme).

6. Statistical analysis

Regarding statistical analysis, the consistency between the two evaluators concerning the risks to participants using the Ulysses scale was calculated using the Cohen κ coefficient, using the statistical package SPSS version 21.

7. Results

As can be seen in Table 1, the values obtained for the Cohen ê, in the case of vulnerability, are high since they all provide consistency between observers equal to 1, except in the case of the *Family*, which is slightly lower, but very close to 1. The results allow us to conclude that in the case of vulnerability the consistency between judges is practically at a maximum, with levels of statistical significance lower than 0.001.

	Coeficiente Kappa	Valor p
Family	0,955	< 0,001
Language	1,000	< 0,001
Culture	1,000	< 0,001
Earth	1,000	< 0,001
Social Estatus	1,000	< 0,001
Belonging	1,000	< 0,001
Physical Risks	0,974	< 0,001

Table 1. The table gives the values corresponding to the Cohen ê to quantify the magnitude of agreement between judges regarding vulnerability indicators.

In the event of stressors, it can be seen in Table 2 that all scales have obtained obtained high values between observers. In most cases, the value of Cohen ê is equal to 1, except for the Family and Risks scales, where their values are slightly lower, but are still very high. These results allow us to conclude that, in the event of stressors, we also obtain a remarkable level of agreement between judges, with levels of statistical significance lower than 0.001.

	Coeficiente Kappa	Valor *p*
Family	0,984	< 0,001
Language	1,000	< 0,001
Culture	1,000	< 0,001
Earth	1,000	< 0,001
Social Estatus	1,000	< 0,001
Belonging	1,000	< 0,001
Phisical Risks	1,000	< 0,001

Table 2. The values corresponding to the Cohen ê are given in the table to quantify the magnitude of agreement between judges with reference to stressor indicators.

Based on the analysis of the consistency between both judges made regarding vulnerability and stressors, a remarkable agreement between the evaluations provided by both judges across all participants was seen. Based on these high levels of consistency, it was possible to add the evaluations of both judges and, thus, jointly determine the degree of agreement between vulnerabilities and stressors of the same type. In addition, the concordance between the scores assigned across different mournings was also obtained.

	Estressors						
Vulnerabililty	1	2	3	4	5	6	7
1. Family	0,048	0,026	0,011	0	?0,101	0	?0,008
2. Language		0,980***	0	0	0	0	0
3. Culture			0,970***	0	0	0	0
4. Earth				1,000***	0	0	0
5. S.Estatus					0,004	?0,012	?0,035
6. Belonging						0,970***	0
7. Risks							0,210**

***p < .001, **p < .01, *p < .05

Table 3 shows the results corresponding to the values of the Cohen ê coefficient, showing that the results are different if vulnerabilities and stressors of the same type are analyzed. On the one hand, results with high values for the ê coefficient were obtained in the following statistical analyzes: Land (ê = 1, p <0.001), Language (ê = 0.98, p <0.001), , 97, p <0.001) and Culture (ê = 0.97, p <0.001). On the other hand, Risks (ê = 0.21, p <0.01) have also resulted in a statistically significant value, but with an acceptable concordance intensity, according to the criteria proposed by Landis and Koch (1977). Finally, according to the same criteria, a very low concordance intensity was obtained for the Family (ê = 0.048) and Status (0.004) scales even though they do not show statistical significance.

5. Conclusions

As for the main objective of the present study, the results allow us to conclude that the agreement between both judges is very high when assessing the degree to which each of the mournings (i.e., family, language, culture, land, status) is present in immigrants, whether in terms of vulnerabilities or stressors. Therefore, the obtained results support the notion that the Ulysses scale is reliable across evaluators. Undoubtedly, the remarkable level of agreement among the evaluators is explained by the fact that the Ulysses scale is a graduated or ordinal measure consisting of three degrees (i.e., simple, complicated, or extreme).

Once it was verified that the reliability between both evaluators was very high and to be able to combine the results, we analysed the level of agreement between vulnerability and stressors for each of the seven mournings. Apart from Family and Status, there is consistency, which is especially relevant in Language, Culture, Land and Belonging, for the rest of the mournings when analysing jointly vulnerabilities and stressors. It was expected that there would be a correspondence between vulnerabilities and stressors, with higher or lower intensity, as was mostly found in the present study, because if weaknesses are detected in certain mournings, it is expected to identify stress factors related to and experienced by immigrants in the last six months. As for the absence of consistency with Family, it could be explained by the non-existence of a direct interaction that increases the vulnerability. It is more difficult to explain why no concordance was found for Status, since undoubtedly the immigrants are in an environment where uncertainties about their legal status, stable residence, etc. are present and should show a level of consistency of vulnerabilities and stressors.

Regarding the cross-analysis of vulnerabilities and stressors, the results correspond with what was expected. That is to say, if the vulnerability of an immigrant is found in certain mournings, a consistency is not expected with the scores that are assigned to them with reference to the stressors that are not related to those mournings.

There are limitations to the results found in the present study. Firstly, consistency in evaluation should be verified through the inclusion of a greater number of judges, since obviously the results presented in this study can be explained by very specific facts, as both evaluators were extremely familiar with the Ulysses scale. Secondly, the same study should be carried out in other countries, where, perhaps, there is not such a great culture shock between the countries of origin and the host countries of migrants. In other words, the Ulysses scale may only facilitate agreement between evaluators when the differences are significant, but the agreement in the evaluation is not so evident if less obvious details should be differentiated.

Finally, there are some possible investigations that have come to light that can be carried out on this subject in the future as a result of this study. Firstly, in the absence of limitations, a study involving a greater number of judges would be of interest in order to replicate, if necessary, the results of the present study. Secondly, a study on the reliability and validity of the Ulysses scale would provide evidence on the adequacy of the measures obtained through the scale. Finally, from a more substantive point of view, it would be advisable to know the profiles of the emigrants who participate to a greater degree, if you prefer, with less focus on the different mournings that are measured by means of the Ulysses scale.

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A Refugee Children and the cultural shock in diaspora

di

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Abstract

The migration flux, in our era, can be considered as a "social total fact". The women and men in diaspora have very different kinds of needs, instances and problems.

The cultural shock in host country begins a social event that the social science must analize and study.

This paper, with a narrative metho-dology of post-colonial epistemological approach, intends to give voice to the influence of 'culture shock' of a Refugee Child, who considered himself victim of a jinn (voodoo)

And how through their own cultural traits, such discomfort is obvious, develops and emerges until in successful treatment of Italian experts.

Lo shock culturale nella diaspora; il caso di un minore straniero rifugiato

La migrazione diventa, oggi, campo di studio e di analisi della società moderna. Migrazione, intesa come vera e propria diaspora, rappresenta un “fatto sociale totale” e diviene campo di scontro nelle istituzioni politiche e nella società. Nel paese di approdo si notano comportamenti di resistenza al trauma cumulativo (Khan, 1963) e, dal punto di vista psichico e corporale, modalità di alterazione dell'evento traumatico superando la ragione del trauma con atti culturali.

Il paper, con una metodologia narrativa di approccio epistemologico post-coloniale, intende dar voce alle suggestioni di shock culturale di un minore straniero rifugiato, che considerava se stesso vittima di un *jinn (voodoo)* e di come, attraverso i propri tratti culturali, tale disagio si palesi, sviluppi, emerga fino alla comprensione e risoluzione operata dagli esperti di cura in Italia.

Gli obiettivi del lavoro, sono rintracciabili nelle seguenti istanze: far emergere le ragioni culturali e sociali del trauma; mettere in evidenza la v*ariabile religiosa e variabile culturale* (Fanon F, 1952) nella relazione di cura; riconoscere le pratiche di resistenza messe in atto dai migranti e assumere un paradigma dell'umanizzazione.

(1) Are attributable to Lavinia Bianchi paragraphs: *The migrant is his body. Microtrauma of the borders, The story of Frantz; a young Gambian in Molise.*

(2) Are attributable to Mario Pesce paragraphs: *Introduction and methodological notes: Inside cultures, inside witchcraft, Frantz Fanon's theory: an epistemology choice, Colonial and post-colonial. From the white sugar to brown sugar, From the totalising institution to the institution of establishing post-colonial dialogue, Conclusion.*

Il corpo "è il primo e il più naturale strumento dell'uomo" (Mauss M, 1935) e, soprattutto, luogo antropologico per eccellenza: enfatizzando questa citazione si possono evidenziare due risultati. Il primo è nella comprensione che i disagi psichici, nel paese di approdo, non necessariamente sono di tipo patologico. Il secondo risultato consiste nell'afferrare le ragioni sociali di un disagio e cercare, per mezzo di una etnografia pubblica (Tedlock B, 2005), di implementare la pratiche di cura rivolte ai migranti in una prospettiva transdisciplinare e transculturale.

Introduction and methodological notes: Inside cultures, inside witchcraft

The problem in today's society, from the individual standpoint rather than that of an anthropologist, is the lack of dialogue. In most cases, people listen to each other superficially, waiting to have their say without really listening to others. What is missing is the ability to listen at a deeper level; the ability to listen to those physically close to us who may be culturally worlds apart. The deeper issue is in the understanding of one another; understanding the Other as different and equal. The Other is seen as a symbolic representation of a past that they are afraid will return. The Other is seen as a scapegoat (Villa G, 2015) and a source of dissension, chaos and contamination.

From this standpoint and from a neo-colonialist vision (Latouche S., 1992) or 'sur-colonialist', as I prefer to say, Western categories considered objective are applied to all the peoples and cultures of the Earth. The idea that the Western concept of mental illness can be considered valid for all immigrant women, men and youth who arrive in Italy is be pure madness. Therefore, the need arises to understand different cultures more deeply and above all to really 'see' and not just 'look' at the depth of distress of people who bear these different cultural traits. For migrants, these hardships have cultural and religious significance due to culture shock, post-traumatic stress disorder (PTSD), various states of depression, and other divisions and ambiguities. Frantz Fanon believes that it is the interpretation and understanding of these cultural and religious differences and their significance that form the basis of successful therapeutic work on non-European patients

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Frantz Fanon's theory: an epistemology choice

Frantz Fanon (1925-1961), in his life, study and have is specialization in psychopathology of migrant and he was influenced during his studies by: Carl Gustav Jung and the cultural-symbolic approach on personality; Alfred Adler and the social dimension of psychological development and hegemonic and subaltern complex; the phenomenological approach of the body on the world by Merleau-Ponty. Frantz Fanon focus his attention on two principal issue: race and culture.

Fanon's most important books are considered: *Black Skin, White Masks* (1952), where the martinica's psychiatry explain the role of blacks people and *The Wretched of the Earth* (1961) where he relates his experience in the Algerian War, or war of liberation of Algeria, and the political trouble in Sub-Saharan area in Africa.

In Fanon's tought the colinised must be confronted by his role of dominated and subaltern by other people, the coloniser, the white, in another country or in his/her country. The topic in internal descant is on national liberation or indipendence or, in host country, social equality.

The fundamental thesis of Frantz Fanon is centred on concept of “double link” between coloniser and colonized. The hegemonic, the white European, is like a mirror where the black, African, find the ambivalence of the contact. This ambivalence is the core of Fanon's theory. The blacks consider himself black compared to the whites that looks at him/her and in the conception of what he thinks the white one thinks. In this case is a mirror where black sees itself in reflection in the look of the white colonizer.

Colonial and post-colonial. From the white sugar to *brown sugar*

The modern work of Frantz Fanon, a psychiatrist of Martinique origin, has great innovative potential which is valuable from two different perspectives: that of cultural and social work. When working with Muslim patients in the psychiatric hospital in Blida, Algeria, he carefully analysed processes and mechanisms of black and immigrant mentality. His observations led him to believe that failures with Muslim patients came from a lack of thorough cultural understanding. That is: Western institutions and Western treatment methods fall short in connecting with the cultural, social and healing context of other populations in general and that of the Algerian

Muslims in particular.

Fanon (1952) says:

As a psychoanalyst, I must help my client to become aware of their own unconsciousness, abandon attempts at hallucinatory 'whitening', and also act in the direction of changing social structures. (103)

The risk is to reify ways of thinking and interpretations that do not give voice back to the patient. The tendency, which is omnipresent, is to say: *migrants think that...* Or that because the patient is foreign and does not understand that we want to help them, does not think as they should. In this case, it seems to echo Bronislav K. Malinovski's words, when he argues that: "*the Trobrianders think that...*" Manifestations partially veiled in intellectual colonialism.

Serge Latouche (1992) has clearly defined the status of the modern, neo-colonised migrant. While in the past, the West with its colonial powers moved from old Europe to conquer (Todorov T, 1992; Diamond J, 1997) the people of Africa and the New World by various violent means, today the conditions are different. The French intellectual has always indicated that the new means of colonisation is the economy. In the past, one would arrive to other continents with a hunger for armed conquest directed at exploiting people and economic and environmental resources. In the modern-day, globalised world, "negroes", Fanon claims, are conscious of their race only when the white colonizer brings it to their attention. They arrive in Western countries with the will of redemption, but undergo a new type of colonialism: an economic one. They are the new slaves who, when they are fortunate enough to be paid at all, are paid a lot less than they should be and we do not even have to invade their countries because global diaspora carry them straight to the West.

From this perspective, the black or the migrant, mostly coming from countries that have already gone through the drama of colonialism, according to Fanon (1986) look for a connection, almost an identity relationship with many ambivalent traits of the white coloniser. Fanon calls this "lattificazione" or 'whitening' or the intention of becoming white and therefore being included in the colonisers' society. I prefer to use the comparison of white sugar and brown sugar. This metaphor of two different types of sugar in which only one is used to represent the entire human race, helps us comprehend the construction of whiteness, whitening or "hallucinatory whitening" as cultural constructs carried forth from the violence of the coloniser and by cultural models imposed by the dominant culture. Sugar is not born white; it was the desire of white colonialists in the Americas to refine it to make it more akin to their own appearance. Brown sugar is unrefined sugar or sugar without cultural "conditioning." To the same degree, it must be understood that there is no difference between refined sugar and cane sugar as there no difference between black and white, except in each other's eyes. It is the hegemonic race (Cirese AM, 2014) that makes the rules.

The ultimate goal, both for Fanon and for anthropology and the modern social sciences, is to liberate the subordinate (Cirese AM, 2014) from its inferior position, which when suffered is a source of destabilisation and personality split. The black or migrant's identity is shattered by their desire to become something else, different and "whitened" instead of presenting themselves in their own full dignity. Hence the Westerner's tendency to see expressions of distress as manifestations of mental, not cultural, disorders. The mental distress of the migrant then becomes a way to express suffering that is cultural in nature, such as identity self-defence and maintaining cultural traits and unique ways of resisting assimilation. Therefore, in the absence of an intimate understanding of the migrant's cultural traits, practitioners of Western medicine tend to diagnose that the migrant is ill and the Western vision of so-called mental illness is seen exclusively as a negative condition for the patient.

On the contrary, Giorgio Villa proposes to make the experience of delirium a positive one because it defines the patient's dignity. In this sense, those who elaborate delirium are in a process of emerging from their subconscious hidden parts, unresolved questions and "the patient is making a massive effort to re-emerge." (Villa G; 1990: 24)

Delirium, as demonstrated by the two psychiatrists, Michele Risso and Wolfgang Böker, in research they conducted on Italian migrants in Switzerland in the 1960's, has cultural traits. The migrant treats himself by the cultural means available to him, because he is distrustful of his new home culture, its medical methods and the psychiatrists present. In the case of the Italians in Switzerland the remedy of the magic ritual, to use the words of Ernesto de Martino, was to dissolve the cause of evil, or the evil eye. In this case, the Italian was distressed because the Swiss women weren't noticing him. The only explanation that the he, uncultured and most likely from the south, could accept was that he must have been a victim of witchcraft or of a spell, rendering him invisible. He was a victim; the victim of a curse. In this sense:

“the patient's conviction that a spell could be the source of his ills, is definitely acceptable, since the idea of suffering a morbid transformation from a magical influence was nothing unusual.”

And Fanon underlines, with a question that, in reality is more of an answer than a warning, speaking of his patients in the hospital of Blida:

“Is it because of misjudgement that we have we been able to imagine a Western-inspired social therapy could be of service to alienated Muslims? How was it possible to do a proper structural analysis when putting the geographic, historic, cultural and social context in brackets?"

From the totalising institution to the institution of establishing post-colonial dialogue

When Ernesto de Martino theorises the category of loss of presence, the scope is that of southern Italian culture, which is mostly a peasant culture. This is the same culture that emerges in Michele Risso and Wolfgang Böker's study. It is a culture that for the most part is considered archaic and attached to magical kinds of cultural traits (magic, fascination) with a deep sense of tradition. De Martino understands that if a person is convinced that they are a victim of the evil eye, a condition present in Risso and Böker's study, that person will experience mental and physical distress. But we, as social scientists, do not care if the evil eye is true or false; instead we care what makes such cultural traits emerge and which distress they represent.

In these moments of crisis and destabilisation when the historical, social, cultural and relational coordinates are shattered, one has a "loss of culture" and thus the possibility of finding cultural coordinates and re-emerging from distress is very difficult, like "drowning in a complete human shipwreck."

"Presence is the movement that transcends the situation into value" (ibid., 103). "Technical domination of nature and production of economic goods, organisation of social and political life, ethos, art, logos" (ibid., 110).

This "sinking" is amplified, like an iceberg destroying a fragile boat, from institutions, almost monoliths, where an abstract entity, like a Leviathan, which takes and doesn't give, consumes without experiencing satiety, and doesn't understand that on the other side there is a person and not someone to be dehumanised. This institution is the one described by Goffman and well-explained by Franco Basaglia, that has a need to punish rather than understand, that needs excuses for its own actions in accordance with an epistemology that by now, is old and obsolete, that reifies itself, that controls, punishes and doesn't try to understand. The idea is to deinstitutionalize the institution in a way that allows people to be truly helped.

Because there is nothing more colonial of an encompassing institution deaf to the voice of men and that doesn't become humble "in front of the culture that presented itself to our eyes. We turned to her, fearful and careful. "(Fanon F, 2005: 104)

The migrant is his body. Microtrauma of the borders

The following are excerpts from field notes taken in 2011 at a reception centre for unaccompanied migrant children:

A sixteen-year-old, N., from Bangladesh begins to complain of a stomach ache, then the stomach aches become constant as do the complaints. I've just arrived in the reception centre, the place in which I've worked for the last 4 years, and he comes over to me crying and asks me to give him medication or take him to the doctor. However, he only behaves this way with me and not with any other educators at the centre. My superiors heavily criticise me because they think that I am the cause of his behaviour when in reality, I am the only one that sees he is ill, not physically but psychologically.

I observe that N. is not, by nature, one to complain all the time. I defend myself because I see that he's sick. He starts vomiting, which causes injury and rupture of his capillaries and bleeding. He is admitted to the hospital, then he is sent home, then readmitted, in what becomes a long period of hospitalisations, and the diagnosis is unsettling: N. is healthy, very healthy.

I realise after about three months that he really cannot heal: healing would return him to non-being.

The immigrant is his body, writes Sayad. The lexicon that says he is still a poor immigrant does not allow anything more than expression through his body. The disease becomes central and from this pain, his re-individualisation is provoked. It is as if the body could speak and it could make new characterisations. This conceptual destitution and semantic poverty of the migrant's "concrete” language transform into symptoms; his pain materialises and in this pain, he recognises himself.

A new home country means that a person must deconstruct and recreate their entire internal system: their experience, values,

"compass points", language, belief system, the perception they have of themselves, and their personality.

Some scholars, including Michele Risso, stress how one can describe the whole process of adjusting to a new cultural context in terms of a daily series of micro-traumas and a lifelong process of conflict. There is a need, and not only from a strictly psychological point of view, to specify how one moves from a vision of trauma as a unique event characterised by its ''violence' to the psyche, to a vision of trauma as a series of events, such as a traumatic context, inspired by the concept of cumulative trauma hypothesised by Masud Khan.

The progressive micro-traumas 'transform' the psyche, making it even more vulnerable and increasing the risk of developing what Western medicine would call a mental illness.

Since cumulative trauma over the years can transform the psychic structure itself, one can consider overcoming the idea of constitutional psychic vulnerability.

In Khan's interpretation of the concept of cumulative trauma, it is throughout the course of childhood development that breaches in the psyche's protective barrier can occur. Cumulative trauma has its origins in the period of development in which the child needs and relies on the mother as a shield-barrier. When the mother falls short of serving in her protective role too frequently, shocks to the mind-body of the baby, who has no self-defence, constitute a core of pathogenic reactions. Ideally, we can shift this construct of environmental failure to that of environmental failure in a new home country, and we see that the path of the migrant is littered with stressful and painful situations, in line with what R. Moro called 'migration trauma'. The concept of migration trauma refers to a cultural notion proposed by Moro (1994-2002), who argues that if there is a failure in the correspondence between internalized culture and the external culture, the person is in a traumatic situation. "Internal culture" means the framework internalized by a person during his development process, while "external culture" means the culture of membership group. Between these 2 cultures there is a continous exchange process of exchange and mutual reflection, which allows the person to maintain alive and elastic its internal framework, thanks to the so called 'cultural shroud'(3) (Moro, 2009), a kind of psychic skin which allows a person to feel in harmony with its reference world, with values and shared cultural representations.

We assume a point of view that is intersectional, interdisciplinary and puts the experience of trauma in the context of what Moro prefers to call "ethno-psychiatry", which means an analytically oriented psychotherapy allowing for an interdisciplinary approach and includes psychiatry and other psychotherapies that are not analytically oriented. The anthropological discipline remains key to decoding the processes and cultural representations through which a people's individual suffering is expressed. The two key concepts of ethnopsychiatry are: the principle of psychic universality and cultural specificity. The expression "psychic universality" is the psychic functioning that defines the human being as such, and incredibly common to every person of any origin. The specific cultural concerns, however, refer to the particular cultural codes, which allow us to read and categorise the world, relate to the outside world, interpret and construct a specific meaning for life and events, and also to reach a unique definition, legitimate or illegitimate, of normal or pathological nature. Nathan speaks of living culture as individual processing and internalising one's culture of belonging, calling it "a psychic apparatus skin", constantly modified by the input of individuals, thus proving to be a dynamic entity in constant evolution. The concept of migratory trauma follows the concept of this cultural wrapper: if there is no correspondence between a person's internalised culture and the external culture surrounding him, the individual finds himself in a traumatic situation.

This paper demonstrates care and attention to post-colonial bias by not having classificatory fears, and by considering the origins of ethnopsy-chiatry. Discussing the origins and developments of ethnopsychiatry means returning to colonial psychiatry and to the representation it gave to the colonised 'Other' with his delusions and beliefs, his 'primitive' mind, theories that anthro-pologists built around the concept of the African family, and the alleged traumatic consequences of a sudden belated weaning of one's ethnicity, power rituals etc., which over the years, sometimes helped to correct or to dispel stereotypes and misconceptions of colonial psychiatrists.

In order to consider the relationship between mental illness and culture, within todays radically changed horizon, both in terms of history as epistemological, this paper presents a case study as part of a theoretical sampling of doctoral research in progress in the world of Unaccom-panied migrant children (MSNA).

(3) My translation (in italian involucro culturale)

The story of Frantz; a young Gambian in Molise.

This is a case study about a 17-year-old patient from the Gambia whose true name is not revealed as to respect his privacy, but whom we will call Frantz, in honour of Fanon. The following is an excerpt from an intensive interview with the Frantz's psychologist at the centre in Molise, when Frantz had been in Italy for less than one year.

M (psychologist) ... There was a case... I don't know if you can.... There was a case, I'll tell you about it to bring your attention to cultural differences and the meanings we attach to them... There was a boy...

L (interviewer): Yes, I'm very interested.

M: So, there was a boy who could see spirits.

L: Jijn or other spirits?

M: I don't know.

L: Ok, it doesn't matter.

M: Yes, so he saw spirits and this made him suffer greatly.

For example, when he was at school, he could not look his professors in the face because he saw spirits. In certain circumstances, he could not even look at the psychiatrists because he saw these figures, especially in the evening ... at dusk he saw them at the foot of the bed etc. ... etc. ...

The point is this: What meaning do we attribute to such a thing? Huh?

L: Right!! .....

M: What? Psychopathy ... schizophrenia ... right? A pretty serious illness! What should we do?

Ah, and then ... one of his beliefs was that the only thing that would cure him from this disease was ... as they say, an infusion, something ... a potion ... a potion that his mother had to send him ... but this potion was expensive, it was recipe of herbs that would take days and days of walking to gather and collect, and all these rites.

That's when I told you that dreams are built in that reality ... imagine a person who has built all their beliefs in that society, right? With those thoughts, with that way of thinking ... err ... then when inserted into a completely different context, they have no meaning, they have no significance ... and there you can -as they say- unmask the situation. I want to say that maybe there was already a fragility of depth but when the reference points are lost, it becomes so obvious!

When we went to a psychiatrist at ASL in Campobasso, it seemed to me that the psychiatrist had prescribed a massive dose of the antipsychotic Haldol ... The boy obviously felt all the side effects ... he was sleepy, he felt terrible .... and he did not want to take it.

Another psychiatrist, a doctor in Campobasso, reduced his dosage but said he still had to take the medicine for 3-4 months. In addition to that, we had to follow her advice which was to avoid stressful situations ... err .. but to him, for example, school was very stressful, so we felt he should be withdrawn from school, and he studied with our Italian teachers here in the centre and then ... he found this little job ... and now he is the guy who another educator said is the most integrated.

He was the boy who needed the most help, the most effort and commitment ... But he was also the case most representative of cultural differences. That is, a psychiatrist here reads something according to their own culture ... but the beliefs between the psychiatrist's culture and the patient's culture are different, the symbolic meanings of things are different and reality is not objective because we interpret it with our eyes ...

Frantz saw spirits appear on the faces of teachers, sometimes coming out of their mouths, and sometimes they accompanied him to bed in the evening. The whole community became invested in Frantz's case, especially the multidisciplinary team that took care of him and the other minors.

The Molise centre's coordinator, R., a receptive and competent young woman, started listening to her staff and tried to openly recreate what happened, including all possibilities. Some operators refused to administer medication to Frantz. The psychologist herself who was hard fought, called her practises into question time and time again. Even the cultural mediators did not seem aligned in one direction. Ethics and service accountability were a priority, and so was the protection of the boy and his psycho-physical well-being. Doubts and conflicts began to appear recursively. R. and her team were dedicated to carefully monitoring the evolution of events which went hand in hand with the boy's constant support.

Medical treatment and prescription drugs increased Frantz's suffering as his difficult episodes continued and even increased, and his malaise became pervasive.

The focus of the situation changed and Frantz became “the emergency”. A combination of factors - the sense of inadequacy felt by the experts following his case, the apparent ineffectiveness of his drug treatment, his overall mental and physical deterioration - brought R. to the conclusion that his case required further analysis by Rome's central service supervisor SPRAR. After much research and many

bureaucratic obstacles (which emerged in the interview with R., such as the difficult burden of all the procedures but above all, the responsibility and the sense of feeling abandoned by the social welfare system and health facilities) R. and Frantz headed to Rome and went to SaMiFo.(4)

Frantz was immediately welcomed by Professor Santone's team, the Mandingo mediator was ready, and R. was asked to leave the room. “For the first time,” said R., “the doctor didn't want to speak to the adult accompanying the boy because he didn't want any adult interference "

After a few hours, R. was welcomed back in the room and with Frantz present, the Professor gave his explanation of the situation: the boy was going through a particularly difficult period due to the fact that where he was attending school, he was the oldest student, he had no understanding of what was being said or what was happening, he wasn't able to find meaning in any of these events, and his performance anxiety was increasing because he felt ashamed of being of a different age and ability than the other students around him. These factors made him express his distress and suffering in the only way that he knew-recognised as normal, perhaps the only way he could reveal a state of severe pain.

This was illuminated by the example that R. reported to me: "if you see a black cat crossing the street and think it means bad luck, maybe you even do a little superstitious ritual ... no one is going to bring you to a psychiatrist, right!?".

Frantz began attending the centre's private school, the one organised by the internal L2 teachers, and also continued using the famous ointment sent by his mother. He began to improve and the previously described phenomena decreased until they disappeared completely.

The resolution of this tricky and delicate issue was achieved due to forward thinking, open-mindedness and a "healthy mistrust" of the eurocentric approach that pays little attention to the narrative of personal experience and is, perhaps, too crystallised in a culture based on medical evidence.

The reflection that R. shared refers to how we approach the problem: previously the approach was to a pathological manifestation, but SaMiFo's team took a holistic approach to the person instead. Different vulnerabilities should lead to different openings and sensitivities and 'Others', even if bewildering, are necessary for an authentic and respectful understanding.

Conclusion

The debate in contemporary Italy, on Frantz Fanon's thought, is centred on the topic of social and cultural identity and the different kind of care system in Occidental culture and the care system in non Occidental culture. The concept of cultural and ethnic identity is also a modality to know the phenomenological reality in modern era.

The cultural disease is a method to issue a divers kind of discomfort and the problem of cultural shock. The migrant, or diasporic, is “shooted”, in host country, from many social representations, images and stereotypes.

Frantz, the protagonist of our story is a minors that, in Italy, don't found the “cultural coordinates” to overcome the social-cultural trouble of diaspora. His method, a cultural method, is to take a part of his culture, the *jinn's* entity, to get over the discomfort.

(4) Service Health forced migrants in Rome. Salute Migranti Forzati.
Operators and cultural mediators (Astalli Center), operators of RM / A ASL, general practitioners. They offer to migrants: intercultural and interdisciplinary paths of care and support appropriate to the physical suffering, mental and social wellbeing of asylum seekers, refugees, victims of torture and deliberate violence.

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Treating mental health disorders related to migration and torture: the experience of MEDU Psyché open clinic in Rome

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NET

Treating mental health disorders related to migration and torture: the experience of MEDU Psyché open clinic in Rome

Background

It has been demonstrated that a large fraction of forced migrants has experienced torture or other cruel, inhuman and degrading treatments (CIDTs), a condition that may result in the development of traumatic-spectrum disorders or other psychiatric conditions.

Objectives

The goal of MEDU Psyché is to provide psychological and medical support to migrants who have developed traumatic disorders in response to torture and CIDTs.

Methods

MEDU has applied an integrated therapeutic project based on psychosocial support and cognitive psychotherapy.

Results

About 37% of MEDU patients had experienced torture, while 42% report other potentially traumatic events. Severe insomnia, mood deflection and traumatic memories are the main reasons to seek psychological support.

Conclusion

Torture and CIDTs are frequent among migrants seeking help for psychological suffering. Consistently, symptoms suggestive of a posttraumatic disorder are common among forced migrants.

Il trattamento della malattia mentale in relazione ad una storia di migrazione e tortura. L'esperienza del Centro MEDU Psyché di Roma.

Un elevato numero di migranti forzati che giungono in Italia dopo lunghi percorsi migratori sono stati esposti a violenze intenzionali, nelle forme della tortura. La tortura prevede una componente intenzionale e volontaria, in quanto il perpetratore sceglie di causare dolore e sofferenza alla vittima al fine di ottenere il proprio scopo. Questi due aspetti, unitamente al fatto che spesso gli episodi di tortura sono prolungati e ripetuti (ad esempio durante la detenzione), rendono la tortura ed i trattamenti inumani e degradanti eventi potenzialmente traumatici. Tali eventi, soprattutto quando associati allo scarso supporto sociale in fase

post migratoria, possono portare allo sviluppo del Disturbo da Stress Postraumatico (DSPT) o di altri gravi disturbi psichiatrici. Pertanto, una presa in carico tempestiva del migrante vittima di tortura è fondamentale al duplice fine di verificare la presenza di un esito postraumatico e di fornire una rete psicosociale forte e ridurre l'impatto dei fattori postraumatici. I dati disponibili sui migranti giunti in Italia negli ultimi anni di migrazione forzata dimostrano la presenza di esiti fisici e psichici di tortura e trattamenti inumani e degradanti in un'ampia percentuale di soggetti, con importanti ricadute sui processi di integrazione.

Muovendosi nell'ambito dell'assistenza sanitaria ai vulnerabili, MEDU ha sviluppato un progetto, concretizzatosi con l'ambulatorio Psyché, volto a fornire assistenza medica e psicologica, interventi di psicoterapia e supporto psicosociale ai migranti vittime di tortura e trattamenti inumani e degradanti che hanno sviluppato DSPT o altri disturbi legati al trauma. L'approccio terapeutico è prevalentemente impostato su tecniche di tipo cognitivo-comportamentale eventualmente implementate con farmacoterapia. Inoltre, è stata recentemente introdotto l'uso della Terapia di Esposizione Narrativa (NET), che si è dimostrata molto efficace nel trattamento del DSPT in questo tipo di popolazione. Gli interventi psicologici sono sempre affiancati ad un costante supporto nelle attività educative, di formazione e ricreative, soprattutto nei casi in cui è necessario facilitare la riattivazione comportamentale.

Da Gennaio a Novembre 2016, MEDU Psychè ha valutato 52 pazienti prevalentemente maschi, richiedenti asilo, di provenienza dall'Africa Occidentale ed ospitati dai progetti SPRAR. Una storia di tortura (definita applicando la convenzione ONU sulla tortura) era presente nel 37% dei casi, mentre la frequenza degli eventi potenzialmente traumatici (esclusa la tortura) era del 42%.i. La maggior parte dei pazienti presentava insonnia severa, deflessione del tono dell'umore e pensieri intrusivi relativi ad eventi traumatici.

In conclusione, l'esperienza di questi primi mesi di attività di Psyché ha permesso di evidenziare l'assoluta necessità di intervenire sul problema della salute mentale dei migranti nel territorio romano, data l'elevata frequenza di soggetti con vissuti traumatici, spesso caratterizzati da traumi ripetuti e continuativi, con componente inter-personale e caratterizzati da intenzionalità. Nonostante non necessariamente la presenza di tali eventi nella storia di vita porta a sviluppare un disturbo psichiatrico, è significativa la presenza di sintomi psichiatrici importanti ed invalidanti in questa popolazione. Tali quadri clinici hanno un impatto rilevante sull'accesso alle opportunità di integrazione, alimen-tando un circolo vizioso in cui la psicopatologia produce inattività, isolamento e disagio, che a loro volta diventano ulteriori fattori di vulnerabilità per l'esacerbarsi del disturbo mentale che li genera.

Introduction

In 2016, 181.436 men, women and children have landed on the Italian shores fleeing persecution, conflicts and poverty. As most of these people escape from situations that endanger their lives, they are defined as “forced migrants” (International Organization of Migration). Evidence and testimonies collected so far have shed light on the violence and abuses of unspeakable cruelty that forced migrants experience in their home countries and during the migratory journey. Such dramatic events often represent the *push factors* for migration (i.e. conditions that “push” a person or a group to leave the home country), but they also greatly affect the integration process in the country of destination. Indeed, intentional violence, torture and CIDTs are potentially traumatic events (PTE) in that they implicate “*actual or threatened death, serious injury, or sexual violence*” (American Psychiatric Association, 2013)) and even witnessing such events might induce a posttraumatic stress disorder (PTSD). Moreover, unlike other PTE, such as natural disasters, torture is intentionally inflicted by the perpetrators and has a strong interpersonal valence, as it implies that another human being chooses to cause pain and suffering to the victim (UN Convention against torture). Although going through a traumatic experience does not necessarily result in the development of PTSD or other trauma-related disorders, the intentionality and cruelty associated with torture, especially when repeatedly perpetrated, greatly increases the likelihood of developing a PTSD. Indeed, torture emerged as the strongest predictor of PTSD in a sample of refugees and conflict-affected persons, and the third strongest predictor of depression. Cumulative

exposure to potentially traumatic events (including torture) is another main predictor of PTSD and the strongest predictor of depression (Steel et al., 2009). Accordingly, the number of PTE positively correlates with the risk of having PTSD (Aragona et al. 2013). Some authors have also hypothesized that people who experience chronic and inescapable traumatic events might develop additional posttraumatic symptoms, such as emotional dysregulation, problems in the relation with others and most importantly, a distorted self-perception and the loss of their system of meanings (Complex PTSD; Herman 1992). “Complex PTSD” has been specifically associated with a history of severe interpersonal trauma, such as torture, in the adulthood (Palic et al. 2016). Beside PTSD, torture survivors are at high risk to develop anxiety and depression (Campbell et al. 2007). As the risk of PTSD and depression is positively correlated with the delay of taking charge after resettlement (Song et al. 2015), an early identification and taking charge of migrants with psychiatric vulnerability should be a priority.

Evidence provided by local and international Non-governmental organizations (NGO) has raised the issue of mental healthcare in migrants seeking asylum in Italy. UNHCR has showed that the number and severity of the conditions requiring psychiatric assistance among migrants have greatly increased along with the outburst of forced migration over the years (UNHCR,2016). Among forced migrants who have received a psychiatric evaluation by the MEDU team in Sicily and in the informal settlements in Rome, a psychiatric disorder was diagnosed in 82% of cases, of which 40% had PTSD and 15% Major Depressive Disorder (MEDU, 2016). Similarly, Doctors without borders (Medici Senza Frontiere, Msf) found that 60% of migrants hosted in the temporary reception centres (CAS) had a psychiatric disorder, which was PTSD in 40% of patients (Msf 2016). Consistent with the relevance of these data, the Annual Report on International protection in Italy has dedicated a focus to the treatment of psychiatric disorders in asylum seekers and to the impact of mental disorders on social integration (Rapporto sulla protezione internazionale in Italia- 2016). In order to standardize and improve mental healthcare in such a vulnerable population, the Ministry of Health has recently released updated guidelines for the treatment of psychiatric disorders in refugees and subsidiary protection holders that have experienced torture, rape or other types of physical, psychological and sexual violence (Linee guida per l'assistenza ai rifugiati vittime di torture, stupri o altre forme gravi di violenza, Ministero della salute, Marzo 2017).

A growing body of literature on migrants, refugees and asylum seekers has highlighted the role played by events occurring after migration in the development and maintenance of psychiatric disorders. The definition of post-migration living difficulties (PMLD) include those critical issues a migrant has to face while living in the country of destination, which are grouped in i) protection concerns, ii) issues related to access to health and welfare and iii) resettlement experiences. PMLD might both reactivate traumatic memories or interfere with the individual's ability to cope with the traumatic experience (Wenk-Ansohn 2007). Consistent with the link between PMLD and traumatic mechanisms, the number of difficulties experienced after migration positively correlate with the risk of having a PTSD, and PMLD are more frequent in PTSD than in non-PTSD patients (Aragona et al. 2013). On the other hand, a PTSD diagnosis significantly reduces the probability that a patient will benefit from an integration project, which in turn might further increase the impact of PMLD on the underlying disorder (Schick et al. 2016).

In line with the growing awareness on the link between migration, PTEs and psychiatric disorders, the European Union recommends a psychiatric and psychological evaluation to those who report an experience of violence and/or psychological stress and psychosocial counselling and support to achieve appropriate social conditions (Minimum standards for the reception of asylum seekers, Official Journal of theEuropean Union).

Methods

Admission criteria

Admission for a clinical evaluation at MEDU Psychè is granted to victims of torture, CIDTs and/or intentional violence and to migrants seeking help for severe psychological distress possibly related with traumatic experiences. Evaluation of eligibility is based on a patient's admission form that is provided by MEDU to the hosting structures. This form contains information on the legal, physical and psychological conditions of the patient, and a short questionnaire (the Protect Questionnaire, see below) that investigates the risk of having a posttraumatic disorder.

Objectives of the intervention

MEDU Psyche project has four main focus: i) provide medical and psychological treatment

to patients in order to avoid chronicity, and prevent the shift from psychological vulnerability to severe mental disorders, ii) provide psychosocial support aimed at enhancing integration and promote behavioural reactivation, iii) collect testimonies of the tortures, CIDTs and violence experienced by forced migrants to implement advocacy activity and iv) increase the knowledge on mental health care in migrants through research and training.

Organization of the intervention

Phase 1: RECEPTION

Upon his/her arrival at MEDU Psyché, the patient is introduced to all team members (clinical team, CL mediators, psychosocial volunteers) and to any person who is in the waiting room with the patient. The first session is dedicated to explain the role each team member will play in the therapeutic project. This phase is extremely important because many of our patients have never met a psychologist and are not informed about how a psychologist works to heal psychological suffering. On the second part of the session we focus on the multidisciplinary approach of MEDU Psychè to mental health care and we present all our clinical, psychosocial and leisure activities and the way such activities might contribute to improve psychological wellness. At the end of the session the patient is encouraged to ask questions.

The overall goal of this phase is to set the basis to rebuild interpersonal trust in patients who have experienced interpersonal violence (i.e. torture) and to attenuate the feelings of helplessness, which frequently develop following traumatic experiences, by actively involving the patient in his cure.

Phase 2: INFORMATION GATHERING

In this phase, we collect general information about the situation of the patient, including legal status and health care access. Moreover, we collect details about the migratory journey such as duration of the journey, costs and countries of transit. Through this “identification form” we also assess whether the patient has been kidnapped, arrested or detained during the journey and we investigate episode of torture, violence, water and food deprivation and other potentially traumatic experiences, although not in details.

The Protect questionnaire, which has been developed by MEDU to screen for posttraumatic symptoms, is administered in this phase. Protect is a 10-questions form that explores some key aspects of PTSD, such as intrusive memories and nightmares, sleep disturbances, problems in concentration, negative cognition and mood. Based on the Protect score, patients are classified in low, mild or high risk of having a PTSD.

The goal of this phase is to retrace potentially traumatic experience in the history of the patient and to assess whether those experiences have produced a posttraumatic reaction.

Phase 3: ASSESSMENT

Medical assessment

During the first few sessions, medical history is investigated. In particular, we collect information about past surgeries, infectious disease and any other organic disease. Also, we are interested in the psychiatric history of both the patient and the patient's close relatives. This information is critical to identify risk factors or vulnerabilies that might have contributed to the development of psychopathologies.

If the patient reports a history of torture or intentional violence, a physical examination is conducted in order to provide certified evidence of the scars. During the physical examination, the patient describes the circumstances surrounding the acts of torture and/or intentional violence (identity of the persecutors, type of violence, whether the episode of torture/violence occurred in the home country or during the journey)

Psychological assessment

Clinical interviews are conducted by a psychologist with the help of the cultural-linguistic mediator. Life history, familiarity for psychiatric disorders (including addiction) and psychological vulnerability are evaluated (i.e. conditions that might contribute to the development and maintenance of psychopathology). Moreover, current psychological status is evaluated based on the ABC model, which investigates dysfunctional beliefs behind negative emotion and feelings.

We also use psychometric instruments to evaluate Depression (through the Hamilton Depression Rating Scale; HAM-D) and PTSD (Weathers et al. 2013; PTSD Checklist for DSM-5; PCL-5). Moreover, we have recently introduced the Living Difficulties Questionnaire (LDQ; Silove et al. 1997) to analyse the impact of post-migration living difficulties on the development and maintenance of psychiatric disorders in migrants.

Phase 4: INTERVENTION

Intervention is based on a variety of techniques which include

- ***Psychoeducation:*** about the symptoms of PTSD and Depression. In particular, we explain to the patient how past stressful

experiences may produce severe and disabling emotional and physical reactions and how such experiences impact on cognition.

- ***Cognitive restructuring:*** aimed at challenging dysfunctional cognitions that underline negative emotional reactions. Cognitive restructuring may also be associated with NET (see below) in order to change negative beliefs about traumatic experiences and about the patient's reaction during the traumatic event.
- ***Mindfulness*** to increase tolerability to distressing emotional states (anxiety, anger) that the patients experience in response to past and current stressful events. Mindfulness is particularly useful as it is focused on the body, which makes it feasible in condition where more cognitive intervention are limited by cultural or linguistic issues.
- ***Pharmacotherapy*** in cases of PTSD and MDD that require pharmacological stabilization or in patients with severe insomnia.
- ***NET:*** we have recently introduced the use of NET in patients with a DSM-5 diagnosis of PTSD. We use a NET protocol based on *Schauer, Neuner and Elbert (2010).* Briefly, after having obtained stabilization, 10 weekly 1-hour session of NET are conducted. On session 1, the patient build the life line and put two different symbols to mark negative and positive life events. From session 2, the patient describes each of the events of the lifeline (exposition) while one of the therapists writes the story. Exposition to the event through narration induces physical and emotional reaction similar to those experienced during the trauma. By repeated expositions and through the help of the therapist, emotional activation progressively decreases and tolerability of traumatic memories increases. The therapist also helps the patient to recall the circumstances surrounding the traumatic event (day, time of the day, place, people that were with the patient and what the patient was doing before the event) in order to integrate the "hot memory" of the event with "cold", autobiographic information.

PSYCHOSOCIAL SUPPORT

Psychosocial support is available for all Psyche patients during opening times. We provide advice, support and orientation for job opportunities, housing, health services, education and training, sport and leisure activities. Moreover, we have recently started a Music Group that involves 10 patients from different countries who meet on a weekly basis at MEDU Psyche. The group is supervised by the psychosocial volunteer and a cultural-linguistic mediator who facilitate communication and sharing within the group. Another incoming psychosocial project is the "Buddy System" that consists in bringing patients together with local volunteers in order to enhance social integration and prevent isolation. A Buddy partnership might include the pursuit of a shared hobby or activity but also help for practical issues related to the asylum request or job search.

Results

From January to November 2016, MEDU Psyche open-clinic has admitted 52 patients, of which 3 were women ad 49 men. 28 were currently under treatment in November 2016.

Countries of origin

Among the countries of origin, Nigeria and Gambia were the most represented (8 patients each), followed by Mali (5 patients) Senegal and Afghanistan (4 patients each) and Eritrea (3 patients). Other nationalities include China, Pakistan, Palestine, Sudan and Sierra Leone (2 patients), Egypt, Ivory Coast, Libya, Mauritania, Democratic Somalia, Togo, Turkey (1 patient). Overall, most patients came from West Africa.

Hosting structures

Interestingly, the largest fraction of our patients (52%) comes from structures of the SPRAR system (Sistema di Protezione per Richiedenti Asilo e Rifugiati). The SPRAR system is made up of a network of local institutions that provide *"integrated reception", which includes orientation measures, legal and social assistance as well as the development of personalized programs for the social-economic integration"* (www.asylumdatabase.eu). Unlike the centres for primary assistance, such as the CARA (Centri d'Accoglienza Richiedenti Asilo) and the CAS (Centri d'Accoglienza Straordinaria), which host migrants for short periods of time after their arrival, SPRAR centres are intended to provide a global taking charge of the beneficiary. 21% of patients were hosted in the CAS while 28% of patients were referred to MEDU by other institutions or organizations, including Baobab experience (https://baobabexperience.org/), a local group of volunteers that takes care of forced migrants who do not have access to public assistance.

Torture and other CIDTs

We collected data from patients that have already completed the clinical evaluation, and we found that 37% have experienced torture

either in their home country or during the migratory journey. A potentially traumatic event was reported by 42% of patients, including episodes of intentional violence that did not met the UN criteria for torture. 15% of patients were still under evaluation at the time of data analysis. Overall, our data show a very high frequency of intentional violence among forced migrants who refer to mental health care services.

Psychiatric symptoms

Severe insomnia, mood deflection and intrusive memories about traumatic events represent the main reasons for which patients are referred to MEDU Psyché. In particular, acute and chronic insomnia are the most frequently reported symptoms. The development of sleep disturbances is often associated with the onset of nightmares whose content is related to traumatic events and cause intense feelings of anxiety and fear. It is to note that in our sample, anxiety is greatly enhanced by uncertainty related to asylum procedures. Mood deflection is also very common among migrants seeking psychological support and it is frequently associated with other depressive symptoms such as asthenia (weakness, debility), anhedonia (which include the inability to experience pleasure by doing enjoyable activities and/or the lack of motivation to engage in such activities) and loss of appetite. Suicidal ideation was found in a minority of patients, of which one had attempted suicide in the past.

The onset of unwanted, and intrusive memories about traumatic past events is a disabling symptom that most of our patients experience. Among posttraumatic symptoms, dissociative symptoms (depersonalization: experience of being an outside observer of or detached from oneself; derealisation: experience of unreality, distance, or distortion; dissociative amnesia) and dissociative reactions (flashbacks) are also present, although in a lower percentage than intrusive memories and nightmares. Problems in concentration are also part of the posttraumatic response and are common among our patients. Moreover, our patients often report psychosomatic symptoms, which are defined as physical symptoms in the absence of a physical cause and are associated with many psychiatric conditions including anxiety, posttraumatic disorders and mood disorders. Headache is a particularly frequent clinical finding among Psychè patients.

Psychosocial support

Although many of our patients already receive social support as part of their integration project, most of them require further psychosocial counselling and support by our clinic. In particular, most patients seek help to find education, training and jobs opportunities while only a minority seeks legal advice. The main reason behind the request of psychosocial support is the need to achieve a minimal, but significant from a psychological perspective, economic independence and to start recreating a routine of activities outside the reception centres. In patients with depressive symptoms , who need behavioural reactivation in order to break the faticability-depression-inability loop, psychosocial support is coupled with a cognitive intervention focused on making the patient aware of the high cost associated with inactivity, compared to the few benefits obtained.

Regarding the internal activities, so far, 10 patients have joined the music group and all show a good compliance and sharing attitude. The impact of such activities, which implicate sharing and adaptation, and work through less cognitive mechanisms, on the efficacy of psychological and psychotherapy treatments deserve to be further investigated. 1 patient is currently involved in the Buddy system

Discussion

Since its opening on January 2016, MEDU Psyché has evaluated 52 patients, mostly young men coming from Subsaharian countries. Results so far confirm the high incidence of victims of torture and/or CIDTs among forced migrants seeking asylum in European Countries. Indeed, 37% of our patients have experienced torture based on the UN Convention definition, which implies public officials being involved to some extent (i.e. as perpetrators or instigators). However, if we extend the analysis to other potential traumatic events (42%), the percentage of patients involved raises up to 79%.

For many patients, torture and CIDTs represent a push factor, which means that they have left their home country because of such cruelties. However, given the political instability of the countries of transit (see Amnesty International Annual Reports for further details), of which Libya is probably the most unstable and dangerous, many forced migrants have been exposed to multiple episode of intentional violence, torture and CIDT's during their migratory journey. Hence, as Libya is among the countries of transit crossed by almost all our patients, the probability that they have experienced repeated episodes of violence is very high.

This latter data is relevant insofar exposure to multiple potential traumatic events further increase the likelihood of developing severe posttraumatic disturbances, such as PTSD and Complex PTSD (Herman 1992, Aragona et al. 2013). Indeed, previous studies have showed that PTSD is present in a very high percentage of asylum seekers (Teegen et al. 2002; Teodorescu et al. 2012).

Within this frame, it is not surprising that most of the patients seeking psychological support at MEDU Psyché refer a wide set of signs and symptoms that are consistent with a posttraumatic response, although DSM-V criteria for PTSD might not be fully met.

Repetitive, unwanted and disturbing memories are extremely frequent among Psychè patients, and they are often associated with frightening dreams whose content is related to the stressful experience. Overthinking about past experiences heavily interferes with everyday activities and sleep, which in turn further narrows the repertoire of activities the person is willing to engage. Sleep disturbances, including insomnia and repeated awakenings during the night, are common clinical findings among traumatized migrants, and often requires implementation with pharmacotherapy. Similarly, medically unexplained physical symptoms (somatization) are often reported by forced migrants seeking asylum in Italy (MEDU, 2016), and somatization may be an indicator of an underlying posttraumatic disorder in torture survivors (Rohlof HG et al. 2014). From a clinical perspective, dealing with such physical consequences of traumatic experiences before moving to a more cognitive intervention might help to engage those patients who are not familiar with psychological and psychotherapy treatments.

Mood deflection is a frequent reason for seeking psychological treatment and it is a major challenge in the management of asylum seekers with mental disorders. Indeed, asylum seekers, especially those who have had denied their first asylum request, are likely to have trouble finding training, education or leisure activities. These aspects, together with the communication difficulties greatly interfere with a patient's commitment to engage in the integration process. In turn, behavioural inactivation further boosts apathy and isolation, thus maintaining mood deflection.

Also, in patients with trauma history, poor psychosocial support, in association with uncertainty related to asylum procedures, interferes with trauma healing and may produce reactivation of traumatic experiences (Wenk-Ansohn 2007).Within this frame, providing psychosocial support is not an option, but conversely, it is as important as psychological and psychiatric care. Hence, psychosocial intervention must be taken into account when planning the therapeutic approach. Consistent with this evidence, MEDU has worked toward providing patient-tailored psychosocial interventions that currently include a music group and a buddy program, in addition to a psychosocial desk working in collaboration with the clinical team.

As far as asylum procedures are concerned, fear of repatriation, uncertainty related to the asylum request outcome, length of the procedures and other variables associated with the asylum request significantly increases the risk of having a PTSD (Wenk-Ansohn 2007). It is to note that more than a half of Psychè patients currently are asylum seekers or they were asylum seekers at the time of their first evaluation MEDU Psyché. Therefore, the issue of living difficulties is extremely relevant in our sample and understanding the role of such difficulties in the development and maintenance of psychopathologies is critical. To this aim, we have recently implemented clinical assessment with a specific measure of PMLD, which explores the number and intensity of three blocks of PMLD (protection concerns, access to health and welfare and resettlement experiences) that are commonly experienced by forced migrants.

In conclusion, our experience thus far with forced migrants seeking asylum in Europe, further strengths the notion that these subjects represent a highly vulnerable population and should be treated accordingly. In particular, mental health conditions should be accurately evaluated. Indeed, given the well-established role of torture in the development of severe psychiatric disorders, and the high rates of torture and CIDT's survivors among forced migrants, psychiatric and psychological assessment and care must be considered as priorities. Also, as living difficulties in the country of destination represent risk and maintenance factors for psychopathologies, psychosocial support throughout the resettlement and asylum seeking process should be provided.

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THE ATHENA NETWORK

Network of psychological and psychosocial support for immigrants living in extreme situations. A global response to global problems

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The Athena Network is defined by 4 characteristics:

1. The Athena Network seeks to provide psychological and psychosocial support to immigrants in the areas of health and specifically in mental health.
2. The Network seeks to help those immigrants who experience extreme situations. The migratory process in today's world, for millions of people, is a process that brings with it a level of stress of such intensity that they exceed the human capacity of adaptation.
3. The Network aims to serve as a space for the exchange of information and experiences concerning activities and researches that aim to protect and improve the mental health of these immigrants.
4. The Athena Network is a non-profit entity and registration is free.

The name Athena evokes the figure of the Greek goddess who protected Ulysses in his long voyage, helping him overcome adversity and danger along the way. Athena is the goddess of knowledge and humanism, which are fundamental values of society.

The Network is made up of a group of health, mental health and psycho social professionals. We have made a personal commitment to the often difficult and sometimes tragic fate of millions of immigrants in the 21st Century. We believe that global problems demands a global response

The Network is an initiative of various institutions with a long history of experience in the work of immigrant mental health, which include the Ulysses Syndrome Programme of the University of Barcelona, the Health Initiative of the Americas of the School of Public Health at the University of California at Berkeley and the Minkowska Center linked to Paris V University.

The Athena Network was launched at the World Psychiatry Association Conference, "Migration, Mental Health and Multiculturalism" in the 21st Century, in Barcelona, October 30th to November 1st, 2010.

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