

MIGRATORY FLOW AND PSYCHIC TRAUMA

THE CASE OF AN ERITREAN YOUTH



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The migratory flow of people from Africa, Middle East and Asia to Lampedusa has become an phenomenal epic. Its white beaches and emerald waters don't only welcome groups of tourists coming from places such as Padania and Milan but unpredictable waves of “carrette del mare” embark upon land in the same port, packed with more and more migrant people. Infact, sadly, the crossing of the “canale di Sicilia” can be a tragedy: the drowned corpses of the clandestine, whose bodies are thrown into sea, belong by now to the daily news and signal the human and social drama of this phenomenon.



The number of the landings is multiplied every year, determining a migratory flow that involves about ten thousand people, which includes men, women and children. It's a complex phenomenon, whose causes and motivations can be demographic, social, political, economic, and psychological (high birth rates, political instability, poverty, famine, natural calamity, crime, “myth of the west and of Europe”). It often deals with the clandestine in the search for work, but frequently they are those people who seek political asylum.

The immigrants are welcomed at first in the island and then are brought by ship to Porto Empedocle to be finally sorted out to other reception centers or repatriated. Some of them, however, because of poor health and travel conditions, are hospitalized.

The case of an Eritrean political refugee

The clinical case that I describe here highlights some interesting psychopathological aspects of the immigrated person: the migratory event lived as trauma.

T. R., a 24 year old Eritrean, significantly manifests the problems and psychological aspects of a migrant youth. He reached Lampedusa through a “barcone della speranza” coming from Libyan coasts, after a dramatic trip. Then, from Porto Empedocle, he was urgently hospitalized in the General Hospital of Agrigento (in the "Medicine" Ward) for

“malnutrition, weightless, dehydration and panic attacks.” During the hospitalization he also received a psychiatric consultation, due to his restricted consciousness and eccentric behavior characterized by immobility or aimless movements. Because he didn't speak, he was considered a deaf-mute affected by dysphonia (after otolaryngologist consultation). T. R. gradually was considered a terminally-ill patient and consequently, was transferred to the Psychiatric Ward (S.P.D.C), where I work as Executive Psychologist. I evaluated his particular symptomatology.

Anamnesis and symptomatology

T. R. was hospitalized for 45 days. The anamnesis appeared to lack information as it was difficult to obtain personal and clinical data, information regarding his background.

Considering his psycho-physical state and the fact that he didn't speak, I paid particular attention to the clinical signs and his behavior. He appeared thin, dehydrated, the psychomotility was extremely limited (he chose to remain lying down or still), his consciousness was restricted.

The facial expression was perplexed, pained and sad.

The clinical picture (by ICD 10 parameters) revealed therefore a **psychogenic stress acute reaction**, determined by the shock of the migratory event (and therefore by the cultural shock) with the following symptoms:

- stupor, a severe slowing down of the psychomotility and gestures, poor visual contact, mutism without stimulus response. He didn't even utilized the analogic language (no-verbal communication). He had, nevertheless, orientation reflex and with his eyes he was able to follow the movement of objects in space;
- catatonism and eccentric postures;
- negativity and dysbulia: he opposed resistance to the instructions (for instance, if he was put on the bed immediately he threw himself on the floor);
- aimless and echopraxia stereotypes: repetitive imitation of movement (for instance, he mimicked the movements of the hospital staff).

The incidence of migratory problems, according to the cultural psychology and the cross-cultural literature, is due to trauma, cultural shock, eradication, and separation from the family. The migration is such a deep change that it can produce a great deal of psychological pain, so much more if the migration has been forced resulting in the migration becoming a trauma which produces psychological stress, feelings of impotence, loss of self-esteem, and intense emotions that emerge dissociated from language, in the form of somatic feelings and behavioral reactions.

Interaction hospital staff-patient

Initially the hospital staff, because of particular psychopathological condition and the difficulties in communication, tried to establish a contact with T. R. through analogic language, to enable him to be more collaborative. Then two mediators of the same nationality were invited to assist him that spoke the same language: a youth, called Michael, and a girl that came desultorily. T. R. didn't listen to them and didn't manifest feedback to their questions or discourses. The hospital staff seriously believed, therefore, that T. R. was deaf-mute.

I believe that the hospital staff's efforts while interacting with T. R. awakened the complexity of the phenomenon and the necessity for stimulation and help. Above all, with the fugitive foreigners this sensibility must be particularly vigilant and when we are not able to help them, we clearly have to reflect on this inadequacy and to assume an active position in the search for alternatives.

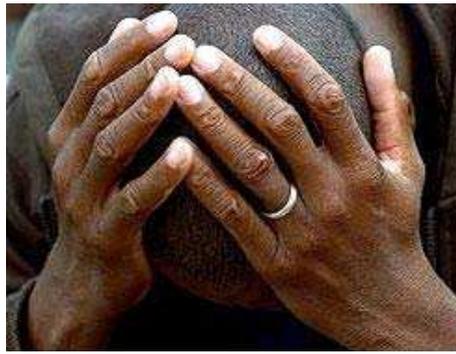
The case of T. R. has been addressed in team discussions. He was treated with pharmacotherapy.

In my interaction with him I maintained a patient and receptive attitude, using analogic communication. Gradually he manifested great collaboration, beginning from his movements and mimetic behaviors (he followed me while I walked, entered my office to sit, etc.). Certainly this cross-cultural interaction required strategies of versatile intervention to be on the same wavelength as the patient and his signs of non verbal communication.

Interventions and results

The progressive collaboration of T. R. allowed me to make some initial attempts of interaction with the use of pen and paper. Using the writing I tried to ask him brief questions in English to verify that he was familiar with this language. To my great amazement, grabbing the pen with difficulty, T. R. began to write the answers in English. Later he began also to draw (drawing of a house, of a tree, etc.). Through this intervention I have been able to finally know his anamnesis.

T. R. didn't know he was in Italy. He began to write his age, his birthplace, the village of Sesewe, and that he was single. I add that in Eritrea the phenomenon of the urbanization is modest, and the village remains a very vivacious social unity. He's Christian-Copt. His parents live in Sesewe. He has three brothers and two sisters; some of them live in Segheneiti, a South-East village of Asmara, where T. R. attended secondary school. He likes to study and he answered me that his favorite subjects in school were math, chemistry, history and geography.



From this new information it was possible to reconstruct the reason for his migration: T. R. became a deserter of the Eritrean army to escape the war, as do other Eritrean youth. The war between Eritrea and Ethiopia, which began in 1998, is for control of the Southern territories along the rivers Tacazzé and Mareb; it is a conflict for the borders and not an ethnic, religious or tribal war, or a war caused by a clash of power. The villages are searched for young people who dodged the draft, and the students are forced to enlist.

I discovered that the true enemy is not the Ethiopian army but the illness and famine that have decimated much of the young Eritrean population. R. Beneduce, in his writings, openly describes the psychic and social consequences of this war^[1]. There exists, in fact, a connection between war, migration, psychological uneasiness and psychopathological symptoms. The migration is a traumatic experience and crisis.

Therefore the Social Services of the Hospital and the municipality of Agrigento began the procedure for T.R. to acquire political asylum and to help him find a place to stay after his discharge.

From the manner in which T. R. furnished this new information and from what he said I was able to ascertain that his cognitive functions appeared normal. He thanked the doctors, affirming that he would never have forgotten their help: “God is the creator of the world and in second place there are the doctors”. He began to write more of his body and of his health, and he felt that he was progressively improving. To the question about its problems he wrote that he’s poor and needs money, that he’s a deserter of the Eritrean army. He added that he has friends in Genoa. It was still difficult to answer the questions I asked concerning his problems, his emotions, and his thoughts. When I attempted to examine the psychological aspects he laconically answered me that now, his head was free. He spoke instead of his body: “all of my body is improving”; or he answered the questions about typical Eritrean dishes or on his preferred sports, volleyball and soccer.

[1] R. Beneduce, *Bambini fra Guerra e Pace: il caso di Eritrea ed Etiopia. Uno studio sui bambini che hanno bisogno di particolari misure di protezione*, Firenze, 1999, 1-45.

Progressively T. R. started, finally, to use his voice speaking at first English and then, with the help of his Eritrean mediator friends, his own language. The comforting presence of the two fellow countrymen helped him to overcome the migratory trauma more easily. They gave him support and reassurance, reducing the feeling of social isolation and allowed for the expression of verbalized needs, fears and doubts. The progressive improvement helped, contemporarily, the hospital staff to modify the feeling and image of the impossibility to heal already built around him. After the discharge he was able to contact his friends in Genoa, who were first contacted by the Social Services and he went to stay with them.

The results of this intervention show the efficacy of the correct care of the migrant refugee, through an understanding of the difficult psychopathological symptoms.

Ethnopsychologic note

In conclusion, this case stimulated further ethnopsychologic reflection. The answers furnished by T. R. revealed other interesting information: the difficulty that he had in representing and describing his psychological life, the tendency to experience the psychological pain and somatic symptoms.

Could this difficulty justify the analogic language expressed by his body language? I asked myself if this difficulty, determined by the psychopathological condition and by the slow rehabilitation, could be connected to a particular cultural conception that represents psychological life, health and illness.

T. R. didn't know how to express his inner psychological state and the way in which he described his background was vague and nebulous. Body language and somatic suffering were the only means for his true expression.

The difficulty to recognize and to verbally express inner suffering is a characteristic sign of alexitimia, which literally means "affection without words" (from the Greek *a-lexis* "speech, word" and *thymòs* "affection, emotion"). It defines the incapability to verbally communicate emotions. According to the definition of F. E. Sifneos, introduced for the first time in 1972, *alexitimia* is an affective-cognitive disorder which describes characteristics of the psychosomatic patient and that, today, is thought to be characteristic of many other psychological pathologies. It deals with a psychopathological trans-nosologic dimension that finds its roots in the pre-verbal phase of the psycho-affective development of the *infans* which corresponds to a manner of psychic function that is both regressive and constitutional. It determines where and how the psychological block occurs. In it are gathered four fundamental characteristics: incapability to identify and to verbalize emotions and feelings, limitation of imaginary activity, "concrete thought" with poor elaboration of the background, somatization to avoid the conflicts or to express emotions.

The alexitimia can be primary or secondary due to stress, age or culture (it's present, in fact, in *post-traumatic stress disorder*). In this last case, due to cultural factors, the problem doesn't reside in the lack of emotional expression and experience, but difficulty to distinguish, in non-western cultures, between the affective and the somatic spheres.

In traditional cultures the somatic and the emotional components of healthy individuals aren't differentiated; the more traditional the culture, the smaller the distinction between organic and psychological illness. In western cultures this concept has been substituted by a mind-body dualism which attributes a meaning of health to individual expression and verbalization of personal experiences^[2]. Not only should the individual be able of to speak of his emotions, but should also know how to use an idiom related to the intrapsychic or interpersonal conflict which gives expression to his suffering. The reluctance to behave in this way must be interpreted as a psychological problem. The alexitimia is characterized by an incapability to rationalize and to express the emotions symbolically. Somatizations and alexitimia are considered pathological expressions that aren't very evolved.

The cross-cultural studies show, instead, that cultural differences exist in the experience and in the expression of emotions, especially in somatic expression of pain, which minimizes the psychic and emotional components.

There are cultures where verbalizing negative emotions is considered unsuitable (unacceptable individualism) or stigmatized. Thus the expression of physical pain becomes the only possible way of communication, using instinctual mechanisms inherent to our species.

The results of the research conducted by K. L. Dion (1996) on a sample of 950 students of both sexes from different ethnic groups, show that the specific signs of the alexitimia are greater in the group of non-western students.

Already in 1963 the French psychoanalysts Marty and M'Uzan had shown the importance of the concept "concrete thought" (*pensée opératoire*) to designate a type of mental function that doesn't exclusively belong to psychosomatic patients, but that is a part of human nature. In conclusion, for the majority of people the "concrete thought" or "alexitimic" isn't the result of psychological resistance, but is a conscious thought process that doesn't represent an evident bond between the somatic datum and the imaginary activity.

^[2] According to the Greek, about the origin of our culture, the psyche-soma relationship was represented indistinctly in a holistic way: for instance in the Homeric poems, in the medical school of Ippocrate, in the philosophical conceptions of Democrito, of Epicuro and then of Lucrezio, in the physical conception of Aristotle. Such representations of the psychological life were in contrast - always in Greek-Roman thought - with the dualistic vision of Pitagora, Empedocle, Plato and, late, of the Christianity.

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