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THE THERAPEUTICAL RELATIONSHIP WITH THE MIGRANT: A CLINICAL CASE.

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Abstract

Introduction. *In the last few years psychiatric services increasingly interact with other and different cultural realities. In particular, migrants represent a fragile group at risk for development of psychiatric diseases. Cultural, religious and linguistic differences between medical team and patient could lead to diagnostic errors, therapy fails or lack of compliance and therapeutic alliance.* ***Case report****. M. is a 27-years old Gambian man, perfectly integrated into his new Italian town where he is living for four years. He is admitted to our psychiatric unit for psychotic symptoms, behavioral and mood disorders. After a few day of hospitalisation he claims to be possessed by Jinn, that is known in the Islamic culture as a spiritual entity able to influence human thoughts and actions.* ***Treatment.*** *During the hospitalization M. is treated with risperidone, lamotrigine, lorazepam, despite his mistrust in psychodrugs effectiveness. At the same time he starts ritual religious practices, known as "Tà widh". M. is discharged twenty-six days later. During these days different cultural and*

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religious approaches and therapeutic strategies will meet. ***Conclusions.*** *It is difficult to understand how much psychopatology is independent from culture in M. and other migrants like him. Mental health services should involve several professional figures and develop a greater knowledge of different cultures to provide a better treatment and obtain more outcomes.*

Introduction

The idea of disease for those who comes from faraway is different from that of western culture: to take care of migrants with psychiatric diseases, we have to deal with different ancient and ingrained cultures; it is as if we have to enter a different world or understand a different mindset.

Problems of people coming from other continents, such as Africa, have had experiences that are unknown to our and also involve “invisible” beings: the Jinns, the witchcraft, the spirits of ancestors.

In the last few years, in psychiatric services we have been dealing with the needs of an increasingly culturally different user: those with a history of immigration to our country.

On the other hand, it is known that psychiatric morbidity in migrants is greater than in natives, mostly for severe mental diseases, with a psychosis risk that is two times greater in migrants of first and second generation than in natives (Cantor-Graae & Selten, 2005).

Again, often migrants follow a different care path from natives: their access to mental healt centers is limited, so they make more use of emergency facilities and of hospitalizations for psychosis than natives (Lloyd & Moodley, 1992: Bhui, 1997; Bhui & Bhugra, 2002).

Many studies on psychosis, realized on migrants and based on the number of psychiatric hospital stays, highlight an excess of urgent hospitalizations and compulsory healtcare treatment.

This fact can be explained by the different ways of accessing to primary care of patients from countries with deeply different health sistems, for which the emergency room becomes the most usual way of access to psychiatric care, and it happen only when pathology is no longer contained.

Also, a psychiatric stay in emergency with the involvement of law enforcement is strongly associated with the lack of contact with their general practitioner, with the lack of support in familiar and social context or with difficoult social and economical conditions (Morgan et al. 2006).

Often, migrants therapeutic path is hindered by difficoulties in decoding their healt needs, due to important linguistic and cultural differences between doctor and patient.

So it is not uncommon to encounter misunderstandings and diagnostic errors, with the result of slowing down the therapeutic path and weakening the patient's adherence to treatment (Tarricone & Berardi, 2010).

Every culture provides symbols, beliefs, specific and different means to deal psychic suffering, and if it is significant, if you want to respond to the patient, you must be able to enter gently and respectfully into his internal world, actively using the culturally determined symbols, speaking his mental language: "The cultural system is made up of a set of statements concerning the nature and transformation of the person, of the dead, of the ancestors and of evil. There can be no psychic process without the existence of a cultural filter that orders, governs and provides the main tools for the person's interaction with the world" (Nathan, 1993).

Many patients who refer to the emergency areas of our hospitals report that they are possessed by demons, ancestor spirits or Jinns, all supernatural beings, or that they are victims of a spell or a voodo practice, undertaken by some dark enemy, by a family member or from an envious acquaintance.

These patients often exhibit somatoform symptoms, sensory hallucinations, hysterical or depressive neurosis pictures, up to, in several cases, persecutory mystical ideas that seem to fall within the psychiatric parameters of psychotic decompensation. Many patients and family members, coming from highly spiritualist cultures, attribute to psychic suffering an unusual explanation and representation for western culture. Only

by speaking the allegorical and magical language of this mental universe we can try to understand and cure. In this article, we will illustrate and discuss a clinical case of Jinn's possession.

CLINICAL CASE

Mohamed is a 27 year old Muslim patient of Gambian origin. He is good looking, polite and respectful. He arrives in our psychiatric ward sent to us by colleagues from the emergency room, accompanied by the operators of a reception center for migrants in which, from about three months, he works as a cultural mediator.

Collecting anamnestic information about Mohammed's life, at our first meeting, proves particularly difficult. With the help of the operators which accompany him, however, we are able to find some information: he has lived permanently in Italy for four years, where he arrives clandestinely together with hundreds of other migrants, after a long journey in the African continent and then at sea until landing near the Sicilian coasts.

Since then, despite the strong emotional stress shared by all the people who have lived the painful crossing looking for luckier lands, he seems to have quickly integrated into the community and society that welcomed him, carrying out all sorts of tasks right away, showing himself always well disposed and good at learning new manual skills, engaging in the study of Italian and attending specific language courses with excellent final results.

The volition, dedication and good functioning of the young man will allow him to obtain the title of cultural mediator, work he has done for a few years at a migrant center in a Sicilian city, from where he is transferred, about a month before our evaluation, at a similar facility located in our city.

Sensitive to the needs of others, he joines, from December to January, a humanitarian relief mission to earthquake victims in the center of our peninsula.

He comes to our evaluation for the manifestation of a clinical picture that began about three weeks before, apparently suddenly, in the absence of prodromes, according to

what reported to us by the manager of the community where Mohammed regularly works. Those who know him are very alarmed by the succession of the symptoms presented: obstinate insomnia, oscillations of consciousness, dissociative-like episodes, catatonic expressions and behavioural oddities.

At the psychic physical examination at the entrance he appeares lucid, vigilant, norm-oriented on the spatio-temporal parameters, on the somato-psychic self and on the object parameter. However, speech is stunted, at times jammed, and the patient shows alarmed, suspicious, some time scared. Even if he is collaborative and behaviorally adequate, the content of his thinking is scarcely accessible.With much difficulty and slowness we manage to bring out the presence of feelings of guilt, of inadequacy that relate to a depressive mood orientation. During the first interview, no alterations to the sensory-perceptive sphere are appreciated.

During the stay, Mohammed begins to show less distrust towards health personnel: addressing certain issues remains complex, a state of inaccessibility remains with respect to certain elements of his discomfort. The details of his trip to Italy will never be revealed, making it too painful to evoke his memory.

He says, however, that he is a political refugee, that he has been unjustly subjected to a period of prison detention because he was considered an opponent of the political regime of the time, that he suffered numerous violence, that he was tortured and that he feared for his life, both to think that he no longer wants to return to his own land, which he therefore leaves not for economic reasons. He says he was adopted together with his younger sister by a couple who already had another child and is said to be extremely attached to the blood relative who now takes care of the grandson, Mohammed's son, aged seven, in Gambia, born from a relationship ended some years ago. He never talks about his parents, biological parents, or adoptive ones, and the relationship with his stepbrother is described as poor, weak. They rarely speak to each other, especially since he lived in America, where he would work as a doctor. His family did not approve of Mohammed's escape, deeming her an admission of guilt.

The existence of a Jinn in Mohammed's life is revealed to us after almost a week of hospitalization. According to their religion and culture of belonging, the Jinn are spiritual entities without corporeality and they are "good" or "bad". “Good” Jinns pray

in mosques or live in people's homes, taking on a protective role. It is therefore necessary to respect these figures and avoid offensive behaviors, such as throwing leftover food on the street, as they could feed on, or throwing water out of their own home, as they could be inadvertently hit. The bad Jinn, however, flee from places of worship and are turned away from reciting the verses of the Koran because they reject the word of God.They favor dark and silent places, and because they are ethereal figures, they tend to penetrate people body and to control their thoughts, emotions and behaviors. They often do these things when they are more in contact with their own intimacy, therefore when they are naked, forcing you to practices condemned by religion, such as masturbation or inducing erotic dreams. The choice of the person to possess is not accidental: usually Jinns choose fearful people or, on the opposite side, people destined for a glorious future in order to counter it. According to Islamic religion, Jinns or Geniuses are real creatures, spiritual entities capable of influencing human beings on the physical and psychic level, up to possession. According to Littlewood's definition, it consists in the belief that a supernatural being introduces itself into a man's body controlling its actions, will and identity, altering them. This phenomenon is interpreted by our western culture as a delirium. (Khalifa & Hardy, 2005)

Possession's manifestation can be manifold and differ according to the culture of belonging, although the starting point remains religious. According to Whitwell and Barker, the word "possession" can be used with two different meanings: the first one concerns the invocation of the "supernatural", the second one is applied to different states, such as a syndrome characterized by headedness of the state of consciousness, a modification of the tone of voice with amnesia, or a trance state induced within a place of worship.

The Qur'an makes several references to the Jinns. According to the sacred text, they live alongside other creatures but are not part of human world (Khalifa & Hardy, 2005). The jinn belong to a dimension that is not that of men and their name derives from the root "Janana" which means "to cover", "to veil" or "to hide", as they are hidden from the view of man. They are able to see but are not perceptible to the human eye. They too are equipped with intellect and therefore are able to choose between good and evil. They live in caves, deserted places, cemeteries and darkness. According

to Sakr, they can also marry, reproduce, eat, drink, die, take on different forms and move heavy objects while being inanimate. Possession by Jinn can induce epileptic seizures or make language incomprehensible; the possessed subject is unable to think or express himself according to his will (Khalifa & Hardy, 2005).

In the case of possession, the healer, who must have a great faith in Allah, has the role of allowing the expulsion of the Jinn, which occurs in three possible ways: remembering God and reciting the Qur'an; blowing into the mouth of the possessed subject; cursing the Jinn and causing it to disappear or physically hitting itself, being some healers convinced that it can feel pain (Khalifa & Hardy, 2005).

Clearly in psychiatry, possession by Jinn must be interpreted in the greatest perspective of a combination of psychopathological but also anthropological, cultural and sociological elements (Khalifa & Hardy 2005).

Mohammed tells of having perceived its presence already once arrived in Italy but of not having been sure of a possession by the same. At that time, Mohammed used cannabinoids, a practice that would keep a Jinn away from an individual.

During the hospitalization in our operating unit, is set an initial therapy with haloperidol 1 mg / day, lorazepam 2.5 mg / day, increased respectively 3 mg / day and 7.5 mg / day. On the 5th day of hospitalization, the neuroleptic is replaced with risperidone up to 4 mg / day, associated with lamotrigine up to 50 mg / day. At the same time there is a progressive relational openness of Mohammed, the willingness to refer to the Jinn and to what has been said above, and the marginalization of psychic tension. Unconfident about the real action of the psychiatric drugs, possession is indicated by him as the only explanation of the psychic suffering presented at the entrance and in the days before, so much so that he believes it necessary to address his grandfather, a "healer", a marabut (Muslim spiritual guide) in order to remove the presence of the spiritual entity.

Therefore, he starts praying for whole nights. A few days after entering our ward, he receives indications from his ancestor about the rituals to be performed daily for the only purpose of getting free from the Jinn: this is the so-called "Ta 'widh". This form

of healing develops starting from the fact that the Holy Book, the Koran, is given the power to heal; it provides for the production of writings on paper or on cloth, rolled up and keep on themselves or, as in the case of Mohammed, of transcripts with inks details, based on edible substances, placed in a plate or cup containing water. The ink dissolves and the patient drinks the remaining water. Another method is to engrave Koranic verses, invocations, single names, letters or numbers inscribed in magic squares directly on cups that have a rise in the center and from which the patient drinks (Guardi, 1997).

Day by day, Mohammed's symptoms become increasingly blurred. During their frequent visits, the operators who collaborate with Mohammed make known to us a leaked news, which they temporally correlate to the onset of the psychopathological picture of the boy: shortly before, photos of Mohammed with a girl would have circulated. This data will never be confirmed by Mohammed himself or by the operators. What will emerge after several talks will be exclusively some advances by this woman, already sentimentally committed, towards Mohammed and the feelings of guilt and shame that had concerned him because of this fact, which he considered unbecoming, to receive appreciation from one person linked to another.

It is difficult to estimate how much culture and psychopathology can be considered as split entities, in this case Mohammed has never stopped practicing his treatment rituals, but at the same time he has always shown good pharmacological compliance, in the firm belief that each people is different, even though in the full awareness that not everything he explained to us about the Jinns was acceptable to us, as it was not part of our beliefs. He trusted in the validity of our intervention but the religious base, from which he believed, required the use of the Ta 'Widh rites.

Mohammed was discharged after twenty-six days, in conditions of clinical compensation: there was a marginalization of the dereistic contents, lived with less emotional investment, a reorientation of the thymic register, a greater opening on the relational level and the regularization of the chrono-biological rhythms. It was made diagnosis of schizophreniform disorder and was recommended a therapy based on risperidone 3 mg / day, lamotrigine 50 mg / day and lorazepam 7.5 mg / day. At the end of the hospitalization, was proposed a charge at the clinic, in order to continue the treatment and carry out a psychodiagnostic study. Mohammed, however, had

neglected the outpatient checks and we do not know whether or not he kept the compensation obtained.

REFLECTIONS

The clinical case of Mohammed provides a starting point for reflection on the understanding and care of the migrant, as well as on the complexity of an integrated taking charge in a condition in which psychopathology, culture, religion, lifestyle habits embrace each other.

Littlewood (2007) has suggested that possession is an explanatory model used in some cultures to interpret diseases, especially epilepsy and psychiatric disorders. This is especially true for cultures of Muslim faith, in which the interpretative model based on the possession of the Jinns is rooted and finds its origins in pre-Islamic Arabia. (Dols, 1992). Littlewood stresses the indispensability, for the caregiver, to consider how the explanations that patients give of their symptoms include cultural elements. In some cases, therefore, it is not appropriate to contradict the beliefs of patients and their family members about the reality of possession by Jinns; the local Imam or a social worker belonging to the same community of the patient can be the means by which carrying out a more culturally appropriate management. Littlewood stills suggesting that psychiatrists should "propose each treatment (including medication) as something that, according to clinical experience gained by the doctor, can protect against spirit attacks" (Littlewood, 2004).

In the disease experience, understanding the cultural context represents a fundamental point for diagnostics and clinical management. The concept of belonging to a cultural group with its beliefs, myths, rites, should not, in this sense, be underestimated, since it encompasses the canons of a group identity that does not share only history, geographical location, religion and language but also a set of adaptation strategies, knowledge, assumptions, resilience skills and relational modalities that can influence requests for assistance, the approach to therapy, to the therapist, management and classification of the disorder (DSM 5).

DSM IV had already provided a useful framework for placing some information on the characteristics of an individual's mental health problem and on the way in which he relates to history and the cultural context, the Guide for cultural framing. DSM 5, which also includes a real evaluation approach scheme, the Interview for cultural background (IIC), also provides an updated version, articulated on the evaluation of four categories:

- cultural identity of the individual

- cultural conceptualization of suffering

- psychosocial stressful events and cultural characteristics of vulnerability and resilience

- cultural characteristics of the relationship between individual and clinician

The IIC consists of 16 questions that the clinician can use in order to obtain information during a mental health assessment related to the influence of culture on the clinical picture and care. It is a semi-structured interview that focuses on the individual's experience and the social context of clinical problems. Through the same one tries to focus the point of view of the individual and of the social network that surrounds him with the ultimate aim of avoiding stereotyping and assessing how the subject interprets the experience of illness and expresses the request for help (DSM 5).

CONCLUSIONS

Faced with a clinical case such as Mohammed's and many others similar to his, it is natural to ask what is the right strategy to be able to understand psychic suffering in the context of the patient's cultural identity. The psychopathological framework is strongly imbued with beliefs, cultures, religion, uses, which are profoundly different from that of us psychiatric operators, so it is necessary to improve the trans-cultural comprehension skills of mental illness, as well as the cultural competence of doctors, psychologists and of all social and health staff.

The necessary competence is not only the "cultural" one, although this is preliminary, but rather the knowledge of the totality of the social, political and cultural context,

from which foreign citizens come, and within which their vicissitudes of suffering have often taken shape, as well as multiple events that take place in host societies where have been often reproduced challenges, violence, uncertainties, conflicts and stresses that have influenced the genesis and manifestation of the ailment we take care of.

It would be desirable that the cultural mediator, a very important professional figure could improve communication, to have accurate and specific skills. This training, which should be extended to all the professional figures involved in the treatment process, should increase critical awareness to deal with uncommon topics, clinical pictures, read symptoms and signs differently and reduce the cultural and relational distance between foreign users and services mental health. Ethnopsychiatric training should promote a constant commitment by mental health workers to their practices and diagnosis, investigating social, political, symbolic and religious origins that have contributed to determining the mental disorder in the foreign citizen.

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