A trans-cultural approach to clinical practice with migrants and their children in Europe and worldwide

Marie Rose Moro

Abstract

To adapt our care devices to the migrants and to their children is a major challenge in the European society and in the current world where the migrations are varied, numerous and sometimes violent. This text presents a model of welcome and care based on the psychoanalytical clinic and on the anthropology, starting from individual stories and care's narratives of migrants in Europe and refugees in Afghanistan. This hospitality is the major challenge in our clinical and social work as well as our contemporary society.

Key words: Migration, migrants's children, clinic, care, social work, welcome and hospitality

I think that Humanity does not need to be saved from itself, it is sufficient to let it be what it is. The world needs humans, not "humanists" (Devereux, 1981, p.20)

To leave home, family, friends, and language, to lose familiar smells, tastes and colours and migrate to another world, often alone, are experiences that are at once commonplace, timeless, and yet always extra-ordinary. Migration is not merely the reasonable, necessary journey of so many Ulysses, it is also of another order: it is enough to see the dazed faces of the men and women arriving on the borders of Europe, for instance from West Africa and turned back at the airport, or attempting to cross the desert through Mali, Algeria and Morocco to be washed up on the shore of Spain, distressed, exploited, sometimes dead. The necessity comes from outside, but also from inside. The modern traveller arriving in well-regulated Europe is more like a brave Don Quixote fighting windmills and adversity than a Ulysses, even if there is a purpose. And the journey continues on through Spain, Portugal, France, and beyond.

1. A history of encounters

Fascinating enterprises are first of all collective. When you describe an itinerary, you talk about the people who have supported you, the encounters that gave

purpose, and the reasons behind your determination. This may appear lacking in reserve, but it gives substance to ideas, and they become easier to apprehend and more alive. It also shows the energy required to bring these ideas to life. It then becomes clear that the commitment is not the result of clear choice, but arises from a sort of necessity, the absolute need to bring to life the essential elements of you itinerary. Pierra Aulanier, a pioneer in psychoanalysis, said very neatly that a psychoanalyst has within him/her an essential interpretation that he or she implements throughout his/her work and probably throughout life. This "essential interpretation" is derived from the person's own history and individual, family and social constellations, and also from the vagaries, breakdowns, transgressions and shortcomings of the person's life. Although the intention is not to go this far in this article – it would require a distancing and an outside view that I at present do not possess, nor wish to – I want to return to certain founding moments in my clinical and theoretical construction, I could even say in my co-construction since I believe in the interactions between self and the world, and in the creative impetus of this frequentation.

I would like to start with this unshakeable belief in the importance of encounters in the construction of self.

From old Castile to Paris

When I was a child and wondered why my father had left Castile, a magnificent, arid Spanish province; I made up stories that fluctuated with my imagination, but that I held to be true for a long time. My father left Castile around the age of thirty to "seek his fortune" in the existential acceptation of the phrase – to find his own fortune in the Latin meaning of "*fortuna*" (chance). He wanted his children to survive and do great things, in particular he wanted his children to become "doctors", which was impossible in conservative, reactionary Spain under Franco when one was part of the proletariat. He told the story himself many years after the journey in a fine narrative (Moro M.R, Moro I et al, 2004). But what has always perplexed me was how he came from ancient Castile to the depth of the French Ardennes region. As a child I had thus imagined that in the train that took him to France, on his own, he met a woman (why a woman?) who told him about the Ardennes region, and who told him that there was work there for valiant workers like him, and that this woman who had had faith in him had changed his destination and his destiny: instead of stopping in Paris where his brother-in-law already had work, he travelled on to Charleville Mézières, a sort of back-of-beyond. An encounter, an interest expressed in another person, a hypothesis on the person's

energy and determination, and you change a person's destiny, a lovely childish utopia which I still carry with me and which I believe is my therapist essence.

Of course I know today that this story is a family fiction, but if i believed in it for so long and was so attached to it, it was not merely romantic imagination, it was also utopian. I do believe in encounters that change the course of destiny, of life, of a cause, and I believe in the creative power of illusions.

A grandmother not fit to have children

My faith in the power of illusions was also something that was handed down to me. Two people come to my mind in this respect: Serge Lebovici, my master in child and adolescent psychiatry, and my paternal grandmother, Carlota.

To start with Carlota, as has become clear above she lived in Castile in an outsider quarter of a historic town on the Portuguese border. In my family, there was a taste for borders and places of passage. She lived in a poor quarter of the town where the proletariat accumulated, the quarter of the "*casas baratas*", the cheap housing. The housing in this quarter was state-owned, and allocated to homeless families. The housing was rudimentary, but remained in ownership until the householder's death. The housing then returned to the state. The houses comprised three rooms, one for living quarters which was the kitchen, one the bedroom where parents and children slept, and the third area was quarters for animals – at once a survival strategy for those that had the means to rear livestock and a source of heat in the hard winters on the Castile plateaus. Carlota had five children. When my father was about ten and his last sister had just been born, their father died, leaving Carlota alone with five children, no money and no trade to earn a living. She could have resigned herself: she too had had a difficult childhood, abandoned by her father who had gone to seek adventure in Argentina, and by her mother overcome by her solitude. But Carlota stood firm and took care of the children as well as she could. The children had to find work at an early age to enable the family to survive. But in the neighbourhood she earned the reputation of a woman "not fit too look after children". At every opportunity she disappeared, leaving the younger children in the care of the older ones, and where did she go? To the cinema! She loved films, dreaming, this other reality she saw on the screen, this form of creation. She needed the illusion, and also this transgression on order to survive. She was criticised, her lifestyle was reproached her and viewed as misconduct. But she pursued her own idea, she had her own life theory, those theories I am always looking for in my patients, and I

must admit, too, more generally among people that I meet, catch a glimpse of from time to time, or merely pass in the street.

I am fascinated by these life theories that each one of us attempts to shape, the centre of our subjectivity and our creativity. I look for them in my patients, too, as an essential object in any therapeutic encounter. I think that this concern comes to me from this "unfit" grandmother, who going against all the prejudice of the neighbourhood and Franco's Spain, would go to the cinema to find that necessary dose of illusion to go on living, as necessary as milk or bread, or even more so judging from her history.

Beauvoir, the "exotic" inheritance

The other encounter can be attributed to necessity, unless necessity is a form of chance. I was studying medicine and philosophy in Nancy in north-east France, this university town being close to the town where I grew up. I was very happy in Nancy, a welcoming city despite its outer austerity, an impressive city for its buildings, its squares and its monuments and nevertheless a city where students enjoyed living and studying. I was studying medicine in the wake of my father's mandate : "my children will be doctors" as he was forever saying. But alongside I was also studying philosophy to satisfy a passion that was much more personal and which developed during my last year in school, just before university entrance. It was not easy to change course at so late a stage in the school curriculum, and I must say that I had not envisaged this orientation, not only out of loyalty to my father, but also because I had not myself envisaged things otherwise.

I was taken with the idea of healing, I knew it and could not give it up for my own sake, and for the sake of my father and also my grandmother Carlota who dreamed of seeing me graduate as a doctor so that I could care for her. I therefore solved the problem by doing both. This is no doubt where I got the taste for doing several things at a time, for inhabiting different worlds, for establishing passages and links, for reconciling things that appear so different, and making difference and multiplicity into a way of living and thinking. I could already see myself as a "*médecin sans frontières*", travelling the world to practice emergency medicine and becoming a real "French doctor". At the same time philosophy was a real passion, the French philosophy of the Enlightenment that probes values with a sort of absolute certainty on its position in the world and an aspiration towards universality. In philosophy we dealt with values as being universal. It is easy to imagine how the

daughter of an immigrant like me could be fascinated with this quest for the universal, and by this philosophical tradition which appeared to have identified its universals. This training in philosophy taught me how to construct ideas and defend positions, but it also removed any complex relating to universality. The universal can only be reached through the particular.

This laid the way for my second parallel training. I studied psychiatry so as to reconcile medicine and philosophy, and I undertook the study of anthropology, shifting thus from the universal to the particular. In the meantime I had decided to move from Nancy to Paris, studying for my speciality in psychiatry in the capital city. This was an idea that had been latent for some time, but I was no doubt reluctant at first to launch out into the capital city because I had grown up in a village of 200 inhabitants. But the day came when Nancy came to appear too small for my illusions, I dreamed of talking philosophy on the pavements of the Café Flore, still inhabited by the shades of Simone de Beauvoir, and I found myself dreaming of other places, of cosmopolitanism, exchange, and encounter with people who were different, with different forms of knowledge, with otherness. And the teaching dispensed in provincial France suddenly appeared as too closed, not sufficiently multiform, not sufficiently open onto the window of the world. I developed a syndrome that I knew very well, having grown up near his birthplace, the Rimbaud syndrome. Of course, this is a syndrome that I have invented, but what I have not invented is that feeling that the poet describes better than I can, the call of the "elsewhere". And to quote the poet "*on n'est pas sérieux quand on a dix-sept ans*" (you are not serious-minded at 17) and I was only a few years older.

An iconoclastic uncle and a healer for grandfather

Thus I arrived in Paris with nothing but my suitcase. I started a course in psychiatry, and began to look for a psychoanalyst, and preferably a female psychoanalyst from outside Paris, these being the criteria I had set myself at the time. The course in Psychiatry, meanwhile, proved more eventful than I had foreseen. I was shocked very early on by the representations entertained by physicians and psychiatrists on the subject of migrants and their children, and I decided to "invent" approaches that would take account of the "otherness" of these people, an otherness that was so little understood by those wielding power. Thus I launched into the idea of a form of clinical practice committed to approaching migrants and their children differently. I began to talk about it among those around me, and a close friend said bluntly to me, "sorry to disappoint you, but the technique has already been invented for migrants, I am training in psychiatry in Bobigny, and in Professor Serge Lebovici's department

there is a psychologists who has developed a technique for ethno-psychoanalysis, his name is Tobie Nathan. Georges Devereux developed the theory and the method". Before I ever met them, the idea formed in my mind that if the technique with migrnts was now operational, I would learn it and turn my attention to second generation children, starting with infants.

I arrived as an intern in the child and adolescent psychopathology department in Avicenne hospital, and on the first Friday (his consultation day) I came upon Tobie Nathan in a corridor, and I politely requested:

"Would it be possible for me to attend your consultation so as to train in ethno-psychoanalysis?"

"And who are you?"

"The new intern in the department"

He answered directly: "It's not a matter of whether you can, you must!"

So there I was in a place that was to become essential to me, a place of nitiation. On the evening of the same day, I went to the Faculty where Serge Lebovici worked, across the street, and found him absorbed, but that did not deter me from approaching him and saying:

"Excuse me, sir, I want to do some research on the children of migrants under your supervision"[1].

"I haven't time to see you just now, but come to my place on Sunday at six and we'll talk about it".

I went to see the secretary to determine of this meant six in the morning or six in the evening: probably the morning she told me, in an absent-minded manner as if the question was irrelevant. I asked her for the address and the entry code to the building which she gave me readily. That evening I asked the same friend as earlier who was training with serge Lebovici and who had enabled the contact, if he thought the appointment was for was the morning or the evening: he told me without hesitation, "he'll be expecting you at six in the morning in his home, and I know he's never late".

[1] This was the Diplôme d'Etudes Approfondies (DEA) which in France precedes the PhD.

On the Sunday morning I set the alarm, and at dawn I was at his home at six sharp. It was he who opened the door, a small man with a bright twinkle in the eye. He considered me with some benevolence and said "Usually, they don't turn up!". And I thought to myself, I was right to come. He took me through a magnificent apartment and we sat down together in the kitchen. I hardly dared eat a thing. I observed that he was eating prunes, so I took one too. I took a sip of coffee, and suddenly we were at the heart of the subject. Serge Lebovici did not like wasting time. "So who are you?" I quickly told him that I was an intern in Bobigny and that I wanted to do research (a DEA) with him on the "vulnerability of the children of migrants", and I added as if it was an essential point "I myself am the child of migrants". But I soon tailed off, telling him that I found being with him rather daunting. He then stood up and said "You see, I am shorter than you are!", and he then added "Only you can do this work in France, so do it! Call on me on Monday and I will show you how to get data from some research that we are conducting and that could provide you with the basic material".[2]

He knew nothing of me, nor of my background, but he had said what it required to become my research supervisor and master, he had enabled me to believe that I could do it, with his support, in Bobigny, and that it was something that belonged to me.

I then set up in Avicenne Hospital, Bobigny, where I first of all became impregnated with the work undertaken by Tobie Nathan (1986) mostly with first generation migrants; subsequently I extended the system that he had established, diversifying and complexifying it, and above all I adapted it to second-generation migrants, and to infants, children and adolescents and their families.

Avicenne, the Andalusian: the spell

Let us now describe the Avicenne facility, situated in Bobigny, a northern suburb of Paris.[3] In consultation I was working with a team of co-therapists (physicians and psychologists, and also nurses, social workers etc) from numerous cultural and linguistic backgrounds, trained in clinical practice, mainly in psychoanalysis and with an initiation in anthropology. All week there are consultations with individual and groups of therapists. Being oneself a migrant is neither a condition nor

[2] The research in question was a study on ill treatment and deprivation in high psychosocial risk populations.

[3] To get an idea, see the film by L.Petit-Jouvet "*J'ai rêvé d'une grande étendue d'eau*".

sufficient to implement ethno-psychoanalysis. What matters is the experience of a form of "de-centring", and the will to become familiar with other cultural systems. The group enables the experiences of the different protagonists to yield their potential. It is the acquaintance with and the intimate practice of otherness and cross-cultural issues that are sought, rather than a frequentation of sameness: a Kabyle patient will not be received by a Kabyle therapist, the system offered being, by its very nature, cross-cultural and centred on this notion of otherness.

Patients from all over the world are received. Some from "black" Africa, some from the Maghreb, others again from south-east Asia, the West Indies, Turkey, Sri Lanka, central Europe and elsewhere.

A cross-cultural, cosmopolitan design

We receive most children and their families individually, with the help of a translator where needed, and in certain instances we recruit assistance from a group of co-therapists. Although this group pattern is only used in a minority of situations, it is the system that I shall describe in detail, as it is the most specific to our system. It is also the setting in which we have been able to experiment with new approaches, and the aspect that raises most questions because it is the most far removed from habitual practice in the area of psychotherapy.

A group of therapists receives the patient and the family (generally around ten co-therapists). In non-Western societies, the individual is interpreted in constant interaction with the group to which he or she belongs. This explains the importance of the group in therapeutic situations. In addition, illness and disease are viewed as events that concern not only the individual involved, but also the family and the group. Consequently illness is cared for according to a group functioning – either by the social group, or by a therapeutic community. The collective treatment of illness or disease enables a compromise between collective and family aetiology and individual aetiology.

Healthcare workers who refer the family generally take part in this consultation, at least the first session, since they possess a "chunk" of the family history. This active presence makes it possible to avoid the transcultural therapy becoming yet another disruption in the long and often chaotic itinerary of these families, who in addition often have a previous therapeutic history fraught with difficulties.

In addition to these functions – the culture-sensitive aspect of the exchanges and the therapy, the co-construction of a cultural meaning, the propping of the patient – the group also gives substance to otherness (each therapist being from a different cultural background) and converts this otherness into a therapeutic "lever" according to the meaning attached to this by Devereux (1972), that is to say a basis for the psychic elaboration. The mixing of men and women, of different theories and different ways of doing things, is an implicit part of the system.

Likewise, whatever the symptom leading to a consultation, whatever the age of the patient (infant, child, adolescent, adult) the family is invited to accompany the patient, as the close circle often hold the key to part of the meaning.

The journey through language

To explore processes in detail in their wealth and complexity, the native language of the patient can be present in the consultation if the patient so wishes. The patient has the option of speaking his/her mother tongue(s), and in this case a co-therapist with knowledge of the language or else an interpreter provide translations. It should be noted that what appears as efficient is to allow scope for shifting from one language to another, thus avoiding possible artificial relegation to a sort of "fossilised" mother tongue. According to the patient's desires and abilities, and the nature of the narrative under construction, he or she can use the option of reverting to the mother tongue or npt. It is indeed the links with language that are looked for.

Given the importance of the translation, were undertook a study of the different types of translation and interpretation in clinical situations. The first method, developed in collaboration with a linguist, S.de Pury Toumy, consisted in having patient discourse re-translated outside the therapeutic setting by a second translator from the recording of the consultation; this translator undertakes his/her translation in a situation that is very different from that of the consultation. The translator has much more time than in the "live" situation, being able to stop and think, return to previous utterances, or use various aides. But above all this second translator is not involved in the therapeutic relationship which completely alters his or her position (Moro, De Pury Toumi, 1994). Once the second translation is complete, the two versions were compared, and this showed up numerous differences between the translation on the spot and that made *a posteriori*, but it also showed that despite

these differences, the overall meaning of discourse was adequately shared by the triad patient-therapist-translator. This last finding clearly goes against the all too often voiced opinion that it is impossible to conduct a therapy with a translator. It is complex, certainly, but operating with a translator does work, and while the translator translates, the therapist has time to muse and to consider.

Beyond this overall finding, the study also evidenced the importance of several processes that have altered the way in which we work in a bilingual encounter. We interviewed the translator taking part in the clinical situation on what brought about these differences, which gave us better understanding of the part played by the translator in the system, and the choice and decision mechanisms at work in the course of the encounter.

Thus a "shared cultural knowledge" makes it possible to express things by way of suggestions and implicits, which is fundamental when broaching certain difficult subjects such as sexuality, intimate relationships between man and woman, and even between parents and children, and also, in republican France paricularly, everything that relates to religion.

Our task is first of all to fully realise that we are working on discourse that is translated and not uttered first hand (patient/therapist/patient), and hence it is discourse that is mediated by a translator, which means that the translator needs to be well integrated into the therapeutic system and therefore that he or she needs to be trained in transcultural clinical situations.

Finally the study evidenced, for the therapists, the importance of associations linked to the nonverbal aspects of language as directly uttered by the patient, even when the actual words are not understood. This exposure to the spoken language generates images and associations that are linked to the effect of words, their sound, rhythms, etc. The interaction occurs with the meaning, but also with the language and the other elements that it carries with it.

Thus translation is not a mere expedient, it is part of the interactive process in psychotherapy in transcultural settings.

The therapist too is a cultural being

In a system of this sort, in addition to mechanisms to analyse affective transfer and counter-transfer, a specific approach to the analysis of counter-transfer linked to the cultural dimension is required. This is another reason why this type of consultation is run with a group, since it is a more efficient way to analyse this cultural counter-transfer (Moro & Nathan, 1989). In practical terms, at the end of each encounter, the group takes time to detail the counter-transfer of each therapist in a discussion of the affects experienced by each, implicit aspects, theories and so forth that led them to think certain things (inferences) or to act in a certain way (interventions).

It is well known that Freud's real revolution was to have rendered the dynamics of transfer and counter-transfer operational. Since the elaboration of the classic model of the therapy framework, the utterance of the subject is established as a therapeutic act; what makes it possible is the bond between the psychoanalyst and the client, i.e. the transfer. Thus the transfer is a process whereby the unconscious desires of the patient become positioned within the psychoanalytical relationship. Devereux (1967) widened this definition to apply it to all the phenomena that occur in clinical settings and in research in human sciences. Transfer then become the sum of the reactions, explicit and implicit, that the subject develops with regard to the clinician or the researcher.

Conversely, the researcher's counter-transfer is the sum of all the reactions of the clinician, implicit and explicit, in relation to the patient or the object of the research. In counter-transfer there is, as in transfer, an affective and cultural dimension. Cultural counter-transfer relates to the way in which the therapist positions him/herself with respect to the patient's "otherness", the patient's ways of doing things, of envisaging his/her illness, and everything that makes up the patient's cultural being. For instance a Sonike man suffering from insomnia, and when he finally gets to sleep he has foreboding dreams; he consults a Sonike healer in Paris who tells him he had been attacked by a spirit or a genie, an ill-pleased ancestor; the healer or sage, he who is able to interpret dreams,

then asks him to make a sacrifice. When faced with narrative of this sort, what is my interior position or attitude? My response to the patient will result from this counter-transfer position. It will condition my ability to enter into a therapeutic relationship with the patient. Thus I must define the epistemological status that I ascribe to this type of material. The issue is therefore above all my interior attitude in relation to

these narratives and acts that are encoded by the culture to which the patient belongs. Cultural transfer and counter-transfer also borrow from history, from politics, from geography and so forth. The patient, and likewise the therapist, belong somewhere, they are part of collective histories that impregnate their reactions, and they need to be aware of this. If there is no analysis of this cultural counter-transfer, action may take the form of aggressiveness, misplaced affectivity, or racism. Thus for instance a woman therapist finds herself unable to interact with a North African man because conflict with him arises immediately – here it is the image of the status of women in the patient's culture that predominates the relationship; or again it could be some adolescent girl from the Maghreb who succeeds in convincing a social worker in her school to adopt an emergency procedure to have her place in a hostel because her father prevents her from using make-up. And the social worker, questioned on this haste, in all good faith will say "That's the way they all start, you never know where it will stop. If she's sent back to Algeria, it will be too late!". Decentring and the analysis of cultural counter-transfer are no doubt the two mechanisms that are the most difficult to acquire in this type of transcultural practice, but they are also the most valuable.

Another factor that is altered in this system is time: consultations last about two hours, which appears as the time needed to enable a narrative to be told in the first person, given traditional representations of time, encounter and the therapeutic itinerary.

Likewise, in general, follow-up takes the form of therapeutic consultations or short therapies lasting less than six months at a rate of one session a month or one every two months. Much more rarely in this group system, there are long therapies. But longer therapies can be conducted on an individual basis with one of the co-therapists if this is required after a few group consultations; the group consultations serve to give a cultural framework to the suffering of the family and to initiate the process. Longer therapies are sometimes conducted by a member of the team who accompanies the families alongside the group therapy.

Therapeutic efficacy

Present research in the field of ethno-psychiatry shows that this technique is well suited to clinical practice with migrants: it produces therapeutic results that are far-

reaching and enduring.[4] The existence of a complex therapeutic system that can be suited to any situation, the cultural de-centring that forces us to suspend diagnosis, all too often over-hasty when derived from of Western diagnostic categories (for instance, confusion between cultural material such as possession and delirium, the fact that melancholic affect can be missed when it presents itself in the guise of a cultural narrative centred on witchcraft), and the use of complementarist approaches: these are all elements that give rise to a multitude of aetiological hypotheses, which is no doubt in favour of efficacy within this system. Indeed, it has been shown in present-day study of psychotherapies that the ability of the therapist to alter his/her own diagnostic hypotheses is a factor favouring efficacy whatever the technique involved.[5]

We have, for our part, conducted several studies on the efficacy of the ethno-psychoanalytical technique for mother-infant therapies in transcultural settings (Moro, 1991; Moro, 1994; Moro, 1998), and for school-age children and adolescents who are children of migrants (Moro,1998, 2002; Deplaen, Moro et al, 1999). Besides the parameters already evidenced by earlier researchers, we have shown the importance of the elaboration of cultural otherness and of the co-construction of meaning with the family. We have also evidenced the impact of the exploration of the ontological, aetiological and therapeutic aspects of each situation on several components : the quality of the narrative, the importance of a particular, contextualised narrative for change to be brought about, the need to work on imaginary productions placed within the therapeutic relationship so as to reconstruct transmission from parents to children, and finally the value of working on internal conflict in children showing a degree of dissociation between filiation and affiliation. Thus this system of psychotherapy has components that are common to all psychotherapies such as the establishment of a framework, or the construction of a narrative, but it also has quite specific components required by the particular approach.

The final stage of this work is to construct links between these hypotheses of meaning, and above all to give the patient the opportunity to construct his or her own narrative on the basis of a variety of representations. Thus a care system that integrates the mental and cultural dimensions of any human dysfunction is not really, in my view, a specific system. It would be more accurate to say that it is a psychotherapeutic framework that is complex, resulting from a mix, enabling the de-

[4] For an exhaustive bibliography on this count, see Moro (1998) Edition 2000.

[5] On this subject, see Moro & Lachal (1996).

centring of therapists and thereby enabling cultural otherness to be taken into account, for migrant patients, certainly, but in fact for any patient, whether a migrant or not, whether in a cross-cultural situation of not.

Far from being an obstacle, a patient's mother tongue, his or her cultural representations, the cultural logics that underpin them, all become parts of the therapeutic framework and sources of creativity, both for therapists and for patients.

When should a transcultural approach be offered?

When should psychotherapy integrating the cultural dimension be viewed as necessary? Roughly speaking, we are in favour of two types of indication, whether for individuals, irrespective of age or for families, and whether for patients who have themselves migrated or for their children or even grandchildren.

The first indication concerns patients whose symptoms profile appears as a direct consequence of migration in the short, medium or long term; patients who present symptoms that are encoded culturally – they put forward a cultural aetiological theory such as witchcraft or possession; or patients for whom the symptom itself is coded by way of its very form : trances, communication with cultural beings etc.; and finally patients who explicitly ask for this cultural decentring – they refer to the need to revert to their native language, or to deal with matters belonging to the native country. These indications concern first and second generation migrants alike, wherever any one of these parameters is present. In all these indications, the transcultural system is liable to "manufacture" links between the two world to which the patient belongs (here and "back there"), and for migrant's children links between their parents' world and the outside.

The second indication, which is the most frequent situation in ours consultations, occurs when the patient has already been catered for in a more "classic" setting: transcultural psychotherapy is offered to subjects who are drifting between the western healthcare system (GPs, psychiatrists, psychologists) and the traditional system (healers whether in the country of origin or in France), but who are unable to find links between the two settings, neither of which trigger any form of elaboration or transformation of the situation. The therapy wis also offered to "drifting" patients of this sort who, following a chaotic healthcare itinerary, find themselves effectively excluded from any care facility. Finally, it is offered to patients who say they have

not been understood, who talk of misunderstandings and sometimes lack of respect towards them, which leads to dropping out of care or refusal, for the family or the child, of any new healthcare offer.

Finally, as with any psychotherapeutic technique, ethnopsychoanalysis acknowledges its limitations: general limitations, those of any form of psychotherapy; and specific limitations – the unpreparedness of patients and their families for the elaboration of a cultural identity that is denied and repressed; patients who have broken with the group to which they belong, or again patients who need an individual elaboration of their mental distress. In this last instance, we are liable to offer classic individual therapy, since the cultural material cannot be handled at individual level, it can merely be told so as to cast light on the narrative. The first consultation is used to negotiate the form of the care to be provided: individual, group, using this or that technique. The time scale is also negotiated – weekly, monthly, every two months is some instances. This initial consultation is used to define all the elements in the framework established.

Nothing magic, nothing exotic: links approachable by all

Thus cultural representations pre-form individual representations, and serve as a semantic channel for the construction of a narrative; they are the very foundations of narration. The meanders of human desires and conflicts contribute, here as in other domains, to the extraoprdinary diversity of humankind. The challenge is how to introduce this type of cultural representation into our care system.

There is nothing magic and nothing devilish about ethnopsychiatry: enthnopsychiatry, like any other psychotherapeutic technique, recognises indications and restrictions that need to be detailed, avoiding any muddying by ideological passions. Transcultural clinical practice is not a practice that is reserved for experts or those who have travelled. It belongs to anyone who has taken the trouble to undergo thorough training.

The issue of subjectivity

This raises an important question, that of the provision of an adequate framework reaching beyond the transcultural setting for certain migrant patients and their children: this framework is not essential for all migrants, but for some a cure will

not occur without it: the actual need therefore has to be properly assessed. Certain cultural implicits can be mentioned, which may not be shared by all, that can require adjustments, even in a non-specific framework. A *dual relationship* cannot be assumed for a patient from a non-Western culture in which the individual in envisaged in constant interaction with the groups to which he/she belongs (family, community, etc) A dual relationship can therefore be experienced as being violent or intrusive. When this is so, the elements that condition the person's private world and enable fulfilment of the person's subjectivity need to be reconstructed in collaboration with that person. It is then important to introduce the notion of the group by asking the patient to come to appointments accompanied by a person of his/her choice, and in parallel by arranging for the therapist to meet other persons following the patient (which is easier in institutional settings).

Likewise, the interview technique needs to be reviewed: the first issue is *questions* – any questions, but especially those on private or intimate matters (inside the home, relations with the spouse, and so forth) – and also questions on cultural aspects that patients may take for granted, such as polygamy or rituals. Indeed when these issues are worded as questions they suggest pre-suppositions on our part, since otherwise we would not be asking these qquestions. Questioning is a way of broaching things thatis often experienced as a form of violence, intrusive, improper, ludicrous or quite simply rude, because it does not comply with the cultural rules of the exchange – generational hierarchy, gender differences, the relative positions of children and adults and so forth. Questions are often misplaced, and it can be more useful to offer one's own representations so that a narrative can develop at the patient's own pace. Likewise, and again to favour the emergence of narrative, the cultural order of the family needs to be respected: in some cases it may be difficult to have access to the wife or the mother unless the husband has given his permission; from a desire to remain loyal to her husband a woman may not express herself freely. In cases of this sort, negotiation is required to enable the woman to come to a consultation, to the school or to the dispensary and talk freely. These examples should in no way constitute rules or a new straight-jacket for migrant men women and children. But it is important to become acquainted with these basic elements to enter into a negotiation on the framework in which therapy will be conducted.

There are of course other points, such as the introduction of the patient's native language, and the analysis of our own cultural counter-transfer. All of these issues can be broached whatever the care provision framework, wherever we reach the conviction that this can be efficacious. Here as elsewhere, thought precedes action.

The experience of difference

Other parameters derived from the transcultural framework can be integrated into non-specific settings, in accordance with the clinician's personality and how easy he/she feels with one or another aspect, or with the particular setting; for instance time aspects (length of consultations), the formation of a small group of co-therapists, or taking care to make a good start by constructing a cultural meaning that integrates the patient's hypotheses. But in order to gradually include all these modifications in our care and prevention systems, their relevance and efficacy need to be explored, either from the experience of others or by finding the means to experiment with them oneself.

In Avicenne, we all take part in these experiences and experiments, and this has been possible only because the transcultural consultation has become an extraordinary venue for encounter. It is a genuinely collective and cosmopolitan undertaking. My collaborators are now very numerous, some twenty permanent therapists and all the others who spend time there, and subsequently return to the field, to work in their native country or elsewhere. There are also numerous trainees or visiting professionals who bring new views on this therapeutic facility which is open to the community and the world; all contribute something more, something different, to the work underway in Avicenne the Andalusian.

The good fortune of having been able to work in this cosmopolitan setting, and my long-standing dream of becoming a practitioner "with no boundaries" have led me since 1987 to work with Médecins Sans Frontières; this enabled me to organise the first mental health mission within an international medical organisation (Moro 2002). It was Avicenne that gave me the strength to move further afield so as to test whether the methods experimented here had any relevance in other settings. Since 1987, I have worked in some twenty countries, and I have formed a "humanitarian" psychiatric intervention team in Avicenne (Baubet et al, 2003). Let us now take a look at one of these missions, the one to Kabul.

Bobigny and the world

A health post in the Pul-I-Charki refugee camp, housing what international terminology refers to as "returnees"; it is near Kabul and receives Afghan families in

transit returning to their country after twenty-five years of war, mainly from Pakistan.

On request from certain doctors, I saw several patients in consultation, in a fairly private setting in the area normally set aside for childbirth.

Ghosts in the baby's head

The baby has headache, says the mother. And indeed she has put a little bandage around the child's head to soothe him, and to signal where the child has pain. But how does she know that the child has headache, I wonder. I say nothing, at that moment it is the doctor who is conducting the consultation. He checks the child's neck, and finds no stiffness; he checks the temperature, it is normal; he asks if thechild has vomited, he has not. The young mother, who is already a widow, is carefully dressed and is wearing make-up, and the child is well cared for too. He has fever at night, she says; the doctor is doubtful about running a temperature only at night, but he understands that the journey is a long one, that they are weary, and if they ever they reach Mazar-i-Charif what will they find there?

He then turns to me and asks if I would like to see her. The young woman and her brother readily agree to meet me. They greet the interpreter. We move to another place to be a little more private. There are a lot of patients waiting and a lot of noise. The mother sits with the child on her knees, and her brother remains standing close by. I think to myself, he doesn't want to sit, he is watching over his sister and her baby and guarding them.

Before making further acquaintance, I ask her how she knows that the baby has headache. At this moment at the start of the interview she does not answer. If I don't understand, how will she explain it to me? The same applies as the interview proceeds, questions that presuppose that we do not know something are questions to which patients do not respond. And in general we ask too many questions anyway.

Zeineb's exile and despair

Zeineb (that is her name) talks in monotonous tone, sometimes looking at her brother now sitting beside her. Their father was killed some ten years ago. Their

mother was killed in shooting when she went to Kabul to apply for a pension following her husband's death. The brother and two sisters then decided to leave to rejoin a paternal uncle who had taken refuge in Pakistan. They had great difficulty locating the uncle. The uncle rather unwillingly agreed to take charge of his two nieces and his nephew. He decided to sell the shop in Mazar-i-Charif that belonged to the father so as to marry Zeineb, the elder daughter who was 14 at the time, to a Pakistani. Zeineb shows emotion when talking about this. She looks at her brother and says "My uncle sold me to a Pakistani as if I was a cow!". Zeineb was very unhappy in the Pakistani family, they ill-treated and insulted her, saying that "Afghan women were all raped on the journey, they are prostitutes". In addition, she saw very little of her brother and sister, which made her very unhappy. Her husband was much older, and she was his third wife. On top of this her husband was ill, and she told me quite directly that he was impotent. Very soon her mother-in-law began to reproach her with not having a child and being sterile. Zeineb knows she is not, but nothing could be said about her husband. She began to desire to have a child so as to be no longer alone in this foreign family that insulted her, and whose language she understood only imperfectly. She used to cry as soon as she was on her own, ran off several times to visit her sister and brother, but she was violently reprimanded by her uncle. She then decided to have a child with an Afghan man, a neighbour whom she liked, and whom she knew liked her. Her husband knew that the child was not his, but she did not care, she denied everything. Her husband beat her, hit her across the belly, insulted her. The baby survived and she gave birth to a fine baby girl whom she named after her own mother. Zeineb was filled with joy: with this baby that she had wished for against all and everyone, she will never be alone again. Her husband died of a heart condition a few months later. She then returned to her uncle's home with the child, as the Pakistani family would not hear of her – fortunately! she adds almost humorously. The uncle was rather put out, and there was no-one to remind him that he should abide by rules in these circumstances: war leaves room for transgressions and relaxes certain obligations, at the same time diminishing solidarity. The uncle then decided to "sell" the younger sister to another Pakistani who was asking for her in marriage. But the sister does not want this marriage, and the brother opposed the uncle. They quarrelled, and the brother and two sisters decided to return to Mazar-i-Charif. The younger sister died in the course of the return journey. She had diarrhoea and vomiting with high fever. She died and was buried in Afghanistan close to the Pakistani border.

Role play to exorcise suffering

Zeineb then looks straight at me and says: "You understand, I have headache and so does the baby". I do indeed now understand how she knows the baby has headache,

since it is a projection of her own pain. I wonder what "emergency" action I should take in the present setting, where I am certain I will not see her a second time. I say to her "I may be able to help you get out of your sadness and the bad thoughts you have had since the death of your sister. We are going to act a little play. I will play your sister, and you play yourself". The bother looks at me in great alarm, but Zeineb immediately understands the logics of the suggestion: "No! I will play my sister and you will play me!". And to signal her decision she puts the baby in my arms and remains standing. She then starts to play the part of her sister, reproaching me with having caused her death, with having killed her, with having made the wrong decision to leave and think only of myself. Once this guilt has been directly expressed she becomes more calm and adds: "But I understand your decision, it is better to die in dignity than to live like a coward!" She takes the baby from my arms, sits down and thus signals that the game is over. I have said nothing, it was not needed, what is essential has been said by Zeineb. She rises and leaves, concerned by things that need to be done in the camp. The brother, who thus far has said nothing, thanks me, thanks MSF (for having been in their path, and also leaves to collect the family money that the HCR is to give them.

I am staggered by Zeineb's words, by her courage, and her ability to use whatever she encounters on the way, whether the decision to have a child or the way in which she used the therapeutic setting. A fine "lesson of life" for those hearing her, and proof that, even in a transit camp, short moments just slightly removed from daily worries can gain significance.

A woman under a black shadow

The woman before me is not wearing a *chadri*, just a faded scarf and a black, worn-out, rather grubby dress. Although she is only forty, she appears a lot older. She talks in a resigned, very sad tone of voice. She says that she is not at all well, she cannot understand what has happened to her over the last eight months, everything is going wrong. She has headache, at the back of the head, and when it comes on she cannot do anything. It is very painful. The doctors in Pakistan gave her medicines, but they provided no relief. She left Afghanistan a long time ago, she can't remember exactly when. She lived in Pakistan for a long time, too long. She lost both her husband and her son. Before, she used to cope with everything, but now she no longer manages to do this. I ask her is she has consulted anyone who would know about these things. She answers as if it were a silly question, that of course she had. "I consulted an imam in Pakistan, and he said that it was a black shadow that had fallen on my family. He performed protections, but I have lost my strength,

I am weak. In Pakistan I had bad experiences. I want to forget". I ask her who is now the man of the family and she answers "no-one". She lost a number of children in infancy in Afghanistan, and during the war she lost her husband and her son, and left Afghanistan for Pakistan with her daughter. Once there, life was difficult with no man in the family, but she was strong and filled with courage. Thus she managed to reorganise her life there, weaving carpets with her daughter. Life was hard, but possible. But for the last eight months she has not had the courage to do anything. What happened eight months ago? About a year ago she married her daughter to an Afghan who lived near them in Peshawar. "It was high time to marry her, she was twenty-three", she says. Several times she had refused to give her hand, because she wanted to keep her close. She wanted to return with her to Bâmyân, where the family originated, and where the family house was situated (probably destroyed, but the land is still there, she says, with a spark of interest). Thus she was waiting to be able to return with her daughter. A year ago, the men in her community intervened to tell her that she must marry her daughter. Leila, her daughter, did not want to leave her mother either, but the time had come to marry and have children. Thus the daughter was married to a nice, gentle young man but whose family was not from Bâmyân. When the Afghan families began to return from Pakistan, the question of how this was to be managed was raised. The mother, sad and depressed since her daughter had left, saw no solution other than returning to Bâmyân. But her son-in law and above all his family did not see things in the same manner, Leila was to return to Afghanistan too, but with her husband to the Shamili plain. Our patient realised she was irremediably in her own, and that she would have to spend the rest of her life alone.

Uprooting and uprooting once again, my destiny

One morning she gathered a few belongings and left aboard one of the colourful lorries bound for Kabul. The day before she had said to her daughter: "I am leaving for Bâmyân to tell you father that life goes on through you and your children. Be worthy of our family". From Kabul she found her way to Bâmyân, probably to die a dignified death. "So that" she says soberly, "is why I am weeping". The war has taken her menfolk, and exiled her daughter. Migration upsets alliance patterns (marriage in particular) and inter-generational bonds. How is it possible to maintain the extended family model that enables solidarity links between generations when in the course of exile you have married your daughter to a man who is going to move elsewhere with his own family? This woman could not relinquish her native village because her husband and son were buried there; she had to see Bâmyân again. In addition the idea of living with her daughter and son-in-law seemed to her to be in contradiction with usual rules. Condemned to return to the family home or to die on

the way, she had nothing to fear, not death at any rate, but possibly loneliness. What can be done about this black shadow that has been with her since her daughter's departure, and that does not appear to respond any more to traditional practices than to medical treatment? I ask her this question directly at the end of the long, moving interview – I could indeed sense that we were reaching the limits of our psychological and medical action on these altered patterns of family links, the direct consequence of war. She says: "You saw me weeping in front of the other people, you brought me in here and I cried without feeling ashamed. You listened to me for a long time and you were not impatient with me. You can probably do nothing for me except enable me to return to Bâmyân a little less heavy-hearted than before. I have told you what Afghans go through when they leave their land". She blows her nose in her scarf, dries her tears, touches my hand and gives me a real smile. I say nothing more, suggest nothing more, I watch her leave with a determined step, and I say to myself, now there is only one thing to do to remain faithful to our commitment, and that is to tell her story and the story of the pain of Afghans who have left their native land.

Had there been any doubt about the value of particular narratives, of personal histories recounted in the course of an encounter or a moment of emotion, this woman under a black shadow who did not give me her name, Leila's mother (perhaps the identity she wanted to be known by), gives us a spectacular demonstration of what they can bring, in the first person singular.

These journeys between multicultural Europe and the upheavals across the world have given me a form of committed scepticism that finds its place and role in clinical practice day-to-day, with all that daily routine implies in terms of diversity, complexity, smooth sailing and rough riding.

References

Aulagnier, P. Se construire un passé. Exposé théorique, *Journal de la psychanalyse de l'enfant*, n°7, « Le narcissisme à l'adolescence », colloque de Monaco (sept. 1988). Paris : Le centurion ; 1989, 191-220.

Baubet, T, Leroch K, Bitar, D, Moro, MR (Eds), *Soigner malgré tout. . Vol. 1 : Traumas, culture et soins*. Grenoble : La Pensée sauvage ; 2003.

Baubet T, Leroch K, Bitar, D, Moro, MR (Eds), *Soigner malgré tout. Vol. 2 : Bébés, enfants et adolescents dans la violence*. Grenoble : La Pensée sauvage ; 2003.

De Plaen, S, Moro, MR. Œdipe polyglotte. Analyse transculturelle. *Journal de la psychanalyse de l'enfant* 1999 ; (24) : 19-44. Republié in : Geissmann C, Houzel D (Eds), *Psychothérapies de l'enfant et de l'adolescent*. Paris : Bayard ; 2003 : 642-60.

Devereux, G. (1958) *Ethnopsychanalyse complémentariste*. Paris : Flammarion ; 1972.

Devereux, G. (1981) De l'angoisse à la méthode dans les sciences du comportement. Paris : Aubier, 1988. *L'autre, Cliniques, Cultures et Sociétés*. Grenoble : Pensée sauvage Ed.

Moro, MR *Aimer ses enfants ici et ailleurs. Histoires transculturelles*. Paris : Odile Jacob ; 2007.

Moro MR, Moro I. et coll. (2004). *Avicenne l'andalouse. Devenir thérapeute en milieu multiculturel*. Grenoble : La Pensée sauvage.

Moro, MR, De la Noë, Q, Mouchenik, Y (Eds) (2004). *Manuel de psychiatrie transculturelle. Travail clinique, travail social*. Grenoble : La Pensée sauvage.

Moro, M.R., Lachal C. (1996). *Introduction aux psychothérapies*. Paris : Nathan.

Moro, MR, Lachal, C. (2003). Traumatisme psychique en situation de guerre. L'exemple de la Palestine. In : Lachal C, Ouss-Ryngaert L, Moro MR (Eds), *Comprendre et soigner le trauma en situation humanitaire.* Paris : Dunod, 221-42.

Moro, MR, De Pury Toumi, S. (1994). Essai d'analyse des processus interactifs de la traduction dans un entretien ethnopsychiatrique. *Nouvelle Revue d'Ethnopsychiatrie* 1994 ; (25/26) : 47-85.

Nathan, T, Moro, MR. (1989). Enfants de djinné. Evaluation ethnopsychanalytique des interactions précoces. In : Lebovici S, Mazet Ph, Visier JP (Eds), *Evaluation des interactions précoces.* Paris : E.S.H.E.L., 307-40.

Moro, MR. (1991). La construction de l'interaction. Fonctionnement des systèmes de représentations culturelles dans les psychothérapies mère-enfant. *Thèse pour l'obtention du doctorat de Psychologie*, sous la direction du Pr T. Nathan. Saint-Denis, Université de Paris VIII ; 1991.

Moro, MR. (1994). *Parents en exil. Psychopathologie et migrations.* Paris : P.U.F. 1994, (coll. Le Fil rouge). Deuxième et troisième édition sorties en 2002.

Moro, MR. (1998). *Psychothérapie transculturelle des enfants de migrants*. Paris : Dunod, 1998, (coll. Thérapies). Deuxième édition sous le titre Psychothérapie des enfants et des adolescents (2000).

Moro, MR. (2002). *Enfants d'ici venus d'ailleurs. Naître et grandir en France*. Paris : La Découverte ; 2002. Deuxième édition en 2004 chez Hachette Littératures dans la coll. « Pluriel ».

Nathan,T. *La folie des autres*. Paris : Dunod ; 1986.

Movies

About the Avicenne transcultural consultation (translated in english): Petit Jouvet L. « I Dreamed of a Vast Strech of Water», Paris, 2008. Producteur : Arnaud de Mazemat (abacaris@club-internet.fr)

Italian references

Baubet, T et Moro MR *Psicopatologie transculturale. Dall infanzia all'età adulta*, Roma : Koiné (à paraître en 2010).

Moro, MR, Neuman D, Réal I (Eds), *Maternità in esilio. Bambini e megrizioni.* Milano: Raffaello Cortina, 2010.

Moro, MR, De la Noe Q, Mouchenik Y, Baubet T, *Manuale di psichiatria transculturale. Dalla clinica alla società*. Milano: Franco Angeli, 2009.

Moro, MR. *Maternità e amore. Quello di cui hanno bisogno i bambini per crescere bene qui e altrove*. Milano: Saggi Frassinelli, 2008 .

Moro, MR. *Bambini di qui venuti da altrove. Saggio di transcultura*. Milano: FrancoAngeli, 2005.

Moro MR. *Genitori in Esilio. Psicopatologia e migrazioni*. Milano: Raffaello Cortina, 2002

Moro, MR. *Bambini immigrati in cerca di aito. I consultori di psicoterapia transculturale*. Torino: Utet libreria, 2001.

The Author

Marie Rose Moro is child and adolescent psychiatrist, psychoanalyst, MD medicine and the humanities. Training and author of philosophical writings, is the capocorrente current etnopsicoanalisi and transcultural psychiatry in France.

Mail: Mail: marie-rose.moro@cch.aphp.fr

www.marierosemoro.fr

Translated by Aldo Caselli

Funzione Gamma, scientific online magazine University "Sapienza" of Rome, registered with the Court Rome Civil (n. 426 of 28/10/2004)– www.funzionegamma.it