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The Mental Health of the Migrant Patient: Between Medicalisation and the Expression of Social Suffering

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Abstract

This article analyses the Italian social and health services accessed by migrants suffering from mental disorders. The aim of the article is to identify the effective accessibility of care facilities, and the dynamics of discrimination, negotiation, and dialogue that come to life in the interactions between socio-health workers and migrants. The article is based on the fieldwork research I conducted in a province in Northwest Italy between 2019 and 2020, in the network of the mental health services. The research was based on a mixed-method approach, and first analysed the epidemiological data regarding access to mental health services by the migrant population and the prevalent diagnoses. Subsequently, I carried out 22 discursive interviews with various professionals who work in this sector. In the light of the data collected, two main issues emerge: (a) the negotiation carried out by professionals between the social pressures for a return to a form of repressive psychiatry and the cultural expression of social needs stated by immigrant patients, and (b) the problematisation of the distinction between social suffering and mental disorder. Both issues refer to the process of medicalisation of mental health. The paper discusses the phenomena mentioned above through the analysis of the empirical material collected, and in relation to the scientific literature on the subject.

Keywords: immigrants' mental health, medicalisation of social suffering, cultural meaning of health practices.

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1. Introduction

The mental health of the immigrant patient represents a total social fact as its analysis intersects with different dimensions, such as organisational, economic, cultural, and not least political. While a substantial literature has in the past analysed this phenomenon according to the paradigm of otherness (Sayad, 1999), the contemporary characteristics that migrations have assumed are related mostly to the paradigm of heterogeneity (Quaranta and Ricca, 2012). As Georg Simmel (2013) already stated with regard to the figure of the foreigner, the migrant brings with them experiences and values that can be traced back to different social contexts, but that are not mutually exclusive. The result is therefore an image of the migrant's identity as a multiple self (Goffman, 1967), in which the migratory experience represents a fracture between past and present, capable of fuelling suffering and psychological distress (Fassin, 2011) which gives life to a process of incorporation (Csodas, 1990). At the same time, the migratory experience can become a resource capable of supporting the people's agency, motivating them to carry out their life project (Ortner, 2006). The cultural expression of the migratory experience, together with the suffering experienced by living conditions in the country of arrival, which is often characterised by hardship and discrimination (Massey and Sánchez, 2010), does not always find full attention in our social and health organisations. In fact, in recent years the latter have been affected by increasingly evident processes of standardisation of the processes of coding and treatment of mental illness and discomfort (Conrad, 2007). The lack of congruence between the cultural expression of the suffering experienced and its diagnostic interpretation opens the way to a constant process of negotiating care practices and the meanings associated with them (Beneduce, 2016).

This article analyses this negotiation process starting from the organisational dynamics that affect the accessibility of mental health facilities by the immigrant population while questioning the point of view of the social and health staff. First, I will reveal the results of the epidemiological investigation of a local nature (conducted in a province of the Northwest Italy), which has highlighted a differential use of mental health aids by the immigrant population. This, in conjunction with COVID-19 pandemic, has activated an over-use of emergency services, such as the Emergency Room (ER), to the detriment of other local services, such as Psych-Social Centres (PSC). Second, I will analyse the problems relating to the accessibility of socio-health organisations which affect daily care practices, and which involve that socio-health workers meet immigrant patients more and more repeatedly in acute and serious conditions. Frequently, these patients are experiencing situations of bias in work and housing allocation, as well as family hardship. The socio-health workers have to deal with a poor adherence by the immigrant population to therapeutic prescriptions, there are frequent cases of return to the country of origin, the interruption of treatment, and sometimes new access to emergency services. These dynamics affect the difficulty in identifying the distinction between social illness and mental disorders. In response to these phenomena, various trends are observed. On the one hand, an increase in the medicalisation of the mental health of the foreign patient can be detected, along with a social pressure for psychiatry to resume operating a social control function, as it has done in the past. On the other hand, there is a questioning of the standardising approach characteristic of biomedical semiotics and the experimentation with syncretic therapeutic interventions, which take into account different therapeutic cultures, therefore appearing to be more personalised, and able to favour active participation by the patient.

2. Methodology

The empirical study was carried out from June 2019 to September 2021 in a province in northwest Italy with a high rate of migration. A mixed-method approach was adopted. The first phase of the research involved conducting a local epidemiological survey, which took into account the territorial phenomenology of migratory flows, as well as the repercussions of the organisational structure of the health and mental health services.[1] The second phase of the research involved the use of the discursive interview technique. This methodological choice was motivated by the desire to document health practices and the symbolic meanings associated with them. A theoretical sample was chosen that reflected both the heterogeneity of professional profiles and the organisational structure of the services. Thus, I collected 22 discursive interviews with diverse professionals who worked on a daily basis in various capacities in the mental health services network.[2] I selected professionals who were mainly in touch with immigrant patients. I interviewed five psychiatrists, three psychologists, ten social workers, two nurses, and two cultural mediators operating as community educators. The professionals interviewed worked in different territorial centres, which in the regional context of the survey are arranged according to a hospital-centric model. The Department of Mental Health is in fact placed under the administration of the Local Health Care Area,

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[1] The epidemiological data refer to the years 2019 and 2020. They have been taken from the database of the Local Health Care Area. The analyses have been developed in collaboration with the Epidemiological Department.

[2] In this article I give a number to each professional interviewed in order to illustrate the different points of view clearly.

and access to mental health services passes through two doors: the Psycho-Social Centres (PSC) and the Emergency Room (ER). Other care services are the psychiatry wards and residential and semi-residential services, such as therapeutic communities and day centres, as well as the Addiction Treatment Service (ATS). The interviews lasted approximately 60 minutes, and were carried out in person at the workplaces of the professionals (five PSCs, three psychiatry wards, two semi-residential services, three psychiatric communities, four ATSs, and five municipal social offices). The interviews were concentrated on thematic issues such as: the culture and history of the service, interprofessional collaboration, the phenomenology of the users, and the limits and resources of the interviewees' professional actions. The empirical material was transcribed in a digital format, and analysed according to a procedure of theoretical coding and constant comparison of the analytical categories (Glaser and Strauss, 1967). I mainly used the focus coding technique and, in the codes that were generated, I identified the main categories that contribute to the synthesis of the data through the construction of homogeneous families of meaning. Finally, I looked for connections between the macro categories in order to weave an analytic choreography that was consistent with the empirical case. In this report, a confidentiality protocol has been applied to allow personal data and sensitive information to be concealed and to ensure the anonymity of the subjects involved. The interviews were originally in Italian, and I have translated them into English.

3. The epidemiological survey: the over-representation of mental disorders among the migrant population

International epidemiological studies (Blackmore et al., 2020; Close et al., 2016) attest that immigrants have better physical health conditions than the indigenous population; this is the so-called healthy migrant effect, which occurs especially in the first months and years of residence in the country of arrival. In the field of mental health, however, the immigrant population seems to suffer to a greater extent from Common Mental Disorders (CMDs), especially depression, Post-Traumatic Stress Disorder (PTSD) and to a lesser extent, anxiety and severe psychopathological disorders. These disorders mainly affect refugees, asylum seekers, and the female immigrant population. Based on the global research on refugees and asylum seekers, conducted by Blackmore et al. (2020), it appears that 31% of the subjects interviewed suffer from disorders associated with PTSD. The same percentage also applies to depression, while 11% of subjects suffer from disorders associated with anxiety and 1.5% suffer from psychosis. While the disorders associated with depression and PTSD remain unchanged for those who have resided in the country of arrival for more or less than four years, the disorders associated with anxiety tend to decrease over time. Another global survey on the immigrant population has been conducted by Ciara Close et al. (2016): on the basis of the data collected, depression disorders affect 44% of respondents, while anxiety disorders were diagnosed at a rate of 40%. Finally, the percentage of PTSD disorders varies between 25% and 36%. The strong incidence of CMDs on the immigrant and asylum-seeking population is evident when we take into consideration the data processed by the Word Mental Health Survey[3] which shows that, as a proportion of the global population, the disorders associated with depression are 12%, and the number with PTSD are equal to 3.9%. Only anxiety and psychosis affect immigrants and refugees to a lesser extent than the rest of the population: 16% and 3%, respectively.

Conducting epidemiological studies of a global nature involves the use of highly standardised research tools, which risks causing excessive medicalisation in the interpretation of the data (Maturo, 2007; Bova and Lusardi, 2022b). It also risks causing cognitive limits, such as the failure to investigate effective health services' accessibility (Tognetti Bordogna, 2004), as well as the conditions in which care practices take place (Cardano, Giarelli, and Vicarelli, 2020). Therefore, local studies – which are able to integrate epidemiological data with qualitative research on care practices and their interpretation by the interested parties – are particularly fruitful. Starting from this consideration, I conducted an epidemiological analysis concentrating on a province of Northwest Italy with a high migratory rate.

Northwest Italy is one of the European regions with a higher migratory rate, and the immigrant population is equal to about 11% of the residents, constituting almost 40% of the total number of immigrant residents in Italy[4]. Empirical research shows that immigrants access mental health services mainly through emergency services, such as the ER. While in 2019, immigrants behaved similarly in comparison to the Italian population, in 2020, in conjunction with the COVID-19 pandemic, an over-representation of the immigrant population in accessing the ER was observable. The most representative diagnostic categories concerned disorders related to addiction (11%) and anxiety disorders (14%); in addition to this, it should be noted that there were a high number of diagnoses that were of specific childhood and adolescence disorders (14%), however, these were associated with an adult population.

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[3] https://www.hcp.med.harvard.edu/wmh/, accessed 25.03.2022.

[4] https://www.istat.it/storage/ASI/2021/capitoli/C03.pdf, accessed 28.03.2022

With regard to access to PSCs, we can say that the immigrant population as a whole was under-represented compared to the Italian one. The prevalent diagnoses were related to severe adaptation stress reactions (13%), depressions (13%), and psychotic disorders (6%). Access to the Psychiatry Ward (for acute treatment), as well as to residential and semi-residential services affected a small number of immigrant patients. Diagnoses of psychotic and personality disorders were prevalent, and have also increased over the course of 2020.

From the epidemiological analysis, I have identified some data that confirm the international trends set out above (regarding the prevailing diagnoses) and others that enrich the overall picture. As also emerges from the territorial survey, the immigrant population accesses mental health facilities in a different way. The foreign population is over-represented in the emergency departments, such as the ER, while in the social reintegration services, such as day centres or PSC this population is scarcely present[5]. In addition to this, the immigrant population tends to postpone access to territorial mental health facilities, and this causes an increase in acute and multi-problematic conditions. Finally, there are numerous very generic diagnoses, such as specific disorders of childhood and adolescence, which when associated with an exclusively immigrant adult population, would seem to indicate a serious difficulty in interpreting and communicating between immigrant patients and medical staff.

4. The negotiation between medicalisation and the social and cultural needs expressed by the patient

As emerges from the epidemiological survey, the immigrant population seems to encounter various barriers to access to services, associated with the standardisation of care pathways and the processes of stigmatisation affecting mental health. These barriers often lead to poor compliance by the foreign patient to therapeutic indications, and raise the risk of abandonment of the treatment path leading to continuous relapses, which in turn increases the use of emergency services. Access to health services by the immigrant patient, rather than representing a threshold passage, seems to lead to the initiation of a negotiation process (Bruni, Fasol, and Gherardi, 2007) in which health professionals mediate their actions between conflicting tensions. On the one hand, they respond to the organisational needs of ensuring standardised diagnoses, and guaranteeing the efficiency of the system. On the other hand,

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[5] It should be remembered that in the months of March–June, 2020, access to the ER was limited by the authorities to reduce the chances of contagion due to the COVID-19 pandemic. Nonetheless, the numbers of the immigrant population accessing it did not decrease.

they give voice to the request, expressed by patients, to give space to the cultural expression of social suffering associated with past and current biographical experiences (Kirmayer and Sartorius, 2007).

The negotiation that starts leads to an image of mental disorder as a process of attention, interpretation, narration, and social presentation of the relationship with one's self (Csodas, 1990) and not as a mere organic dysfunction, as instead is understood in the processes of medicalisation (Bova and Lusardi, 2022b).

By medicalisation we mean the interpretation of phenomena and behaviours that do not belong exclusively and mainly to the clinical environment, such as diseases or disorders (Conrad, 2007). The difficulty in identifying diagnostic investigation tools that take into account the complexity of the migratory experience emerges from the analysis of the interviews. As reported by the same operators, the use of highly standardised research tools, which are compiled in self-report mode by the interviewees themselves, involves some cognitive limitations, such as the lack of in-depth study of the living conditions of the interviewees, as well as translation problems related to the interpretation of personal moods. This problem is also present in international studies (Blackmore et al., 2020; Close et al., 2016). The choice to organise the responses according to standardised diagnostic criteria, in addition to producing high error rates, does not allow for the overcoming of the absence of isomorphism between the cultural expression of a mood and its clinical interpretation (Devereux, 1970). Actually, malaise and diagnostic categories are not two corresponding systems, as the first derives from a complexity of experiences, intersubjective relationships, personal interpretations, and cultural references (Quaranta and Ricca, 2012); and the second emerges from abstract criteria, born from a specific tradition of thought (positivism) and transmitted within a scientific community (Lusardi and Tomelleri, 2018).

The specificities and cultural differences of the migrant patient amplify the distance between the organisational system and the needs of the subject, so much so that therapeutic paths seem to evolve positively only when the foreign patient behaves and has a similar condition to the Italian patient. As psychiatric community educator (n.1) has said: *'We say that we reach the objectives when the foreign patient is not so different from the majority of patients with that diagnosis, and therefore we do not encounter further problems'*. In recent years, the degree of standardisation of diagnoses, procedures, and protocols has significantly increased. Some professionals interviewed read this process positively, as it guarantees the existence of certain references on which to base their work (Lusardi and Tomelleri, 2018).

> In recent years, regulations, protocols, [and] timelines have changed, but I think this is right. It is right to have process frameworks, methodologies, and

> outcome indications. It is right that there is a standardised numerical indication of how the person is doing, which takes into consideration the quality of life, the pathology, the working and family dimensions. All this is elaborated in an issue that gives us an indication of the person year after year (psychologist n.1, PSC).

Medicalisation involves the frequent use of pharmacological therapies (Lusardi, 2019), but also the hyper-specialisation of treatment intervention, which is unbound in eating disorders, post-partum depression, adolescent disorders, and others, thus forgetting the holistic nature of mental distress.

In the case of foreign patients, the pharmacological and hyper-specialist approach clashes with the ambiguity that involves having different cultural references. In this sense, the reaction with the country of origin, where part of the family often resides, represents a further element of complexity. In fact, the desire or the possibility to return to the country of origin can give rise to a strong tension between the attending physician, the socio-health worker, and the foreign patient.

> There is a bit of ambivalence: they rely on us, but only up to a certain point. Because this cultural part is not undermined, it remains and becomes difficult even for the patient who finds himself in the middle, between what the psychiatrist tells him and what the family tells him at home. I remember the case of a Cameroonian woman: she was stuck between the impossibility of returning to Africa in order not to leave her children here alone and [to] stay here in Italy alone with all the suffering that this entailed. He has had very long and numerous hospitalisations. In fact, we are always at the starting point. Powerless. Foreign patients often return to their country of origin for periods, sometimes they do not return and therefore perhaps they are better there, sometimes they return after the traditional treatments are not served (psychiatrist n. 1 from the Psychiatric Ward).

Being between different cultural contexts and leaving open the possibility of returning to the country of origin, perhaps in search of traditional treatments or more simply family support, can, within the therapeutic path, produce a stalemate, a sort of grey zone. In light of this problem, several interviewees admitted the inadequacy of traditional tools for diagnosing and treating psychiatric disorders, and the incompleteness of clinical and social training, which often does not provide tools for interpreting the cultural component of the expression of a mental disorder. As a psychiatrist (n.2) working at the Psych-Social Centre noted: *'Faced with migrants, psychologists and psychiatrists find it difficult to diagnose, they do not know how to name all those disorders that are linked to a cultural* *imprint. Each disorder has a specific way of manifesting itself, the way in which the patient communicates their discomfort, but these ways are completely different for cultural context'.*

In some cases, the socio-health workers interviewed aim to bridge the cultural and interpretative distance with the patient through a pedagogical approach. The idea is that there is a correct interpretation of the symptoms and application of the treatment, and it must also be transmitted to the foreign patient and to members of their family. This perspective underestimates the structured and structuring nature of medical knowledge (Bourdieu, 1972) as the bearer and transmitter of its own culture and reference values. This social worker (n.1) seems to have a pedagogical approach: *'With these families it is very difficult to act because some behaviours are read according to their culture, and it is necessary to help them to read correctly. Even for psychic discomfort there is a difficulty in reading correctly, or as an illness, because they often have a mystical reading, which involves witchcraft, and instead must be accompanied, also thanks to cultural mediation, to a correct reading'.*

Remaining anchored to the cultural paradigms of one's discipline, psychiatry, by amplifying its positivist approach, leads to an increase in the rates of abandonment of the therapeutic path and the impossibility of designing treatment pathways with which the patient will comply (Kleinman, 1988). The main issue seems to be the knowledge gap between oneself and the patient. The lack of knowledge is bidirectional: the patient does not fully understand the setting of the therapeutic path and the indications that are provided to them, and the social and health professional is unable to understand the patient's experience with respect to the social and personal evaluation of the malaise they are experiencing.

The poor adherence that the interviewees found by foreign patients to therapeutic indications determines various relapses and, in some cases, can legitimise the return of repressive psychiatry. Several professionals interviewed reported perceiving strong social pressure, expressed by law enforcement agencies, courts, and even families, on the return of repressive and controlling psychiatry (Molodynski, Rugkåsa, and Burns, 2016). This trend is particularly visible in relation to the foreign population, which compared to Italians is less protected in terms of formal rights and social support networks, as well as being more frequently characterised by conditions of poverty and the presence of active addictions or criminal conduct. As a social worker (n.2) practising in a Psych-Social Centre has said: *'Everyone has their claims: patients, family members, general practitioners and a concept of psychiatry that achieves social control is returning. We have patients who are offenders, and we see that the magistrates use the PSC as a social control, while we should keep an exclusively clinical function'.* As emerges from the selected extracts, this coercive tendency comes as much from the public apparatuses as from the family network, which, driven by the desire to protect the deviant individual, however, risks inexorably repressing self-determination.

> It is precisely the family members, unlike what happened in the past, who expect when we meet in the emergency room after a person has had a decompensation that we guarantee compulsory hospitalisation and that we guarantee that he has not acted [in a a way] that could harm. So they ask us to do further violence on a person who already feels crushed, and if the family does not work with the therapist it becomes very difficult to achieve something. My feeling is that we are being re-channelled forcefully into the role that the psychiatrist had before Basaglia[6] to ensure that there are no anomalous elements in society, that they are not visible and that they do not wreak havoc in society, and that they do not create risks for others. And it is a situation that unfortunately is increasingly so (psychiatrist n.3, PSC).

There is a direct and reciprocal relationship between repressive psychiatry and medicalisation: control over the patient is asserted thanks to the tools of medical science; this control ensures that organisational standards are maintained that are functional to the needs of the health system (Molodynski, Rugkåsa, and Burns, 2016). The professionals interviewed appear to be aware of the negative drifts that can arise when mental health care is transformed into a form of social control, and they therefore initiate a process of negotiation that gives voice and space to the needs and protection of the immigrant patient. In undertaking this path to promote the patient's self-determination, it is of fundamental importance to understand culture and health as two interconnected dimensions (Kirmeyer and Sartorius, 2007), involving processes of a biological, emotional, cultural, social, economic, and, not least, political nature (Farmer, 2003).

The care work in the field of mental health is not necessarily attributable to hyper-medicalised practices, but it can lend itself to a dialogic approach, in which the operator uses personal resources and less medicalising treatment tools (Cardano, Giarelli, and Vicarelli, 2020). The dialogue and the reconstruction of the biographical path of the migrant person represent the fundamental elements on which to base the entire treatment intervention. As psychiatric community educator (n.2) has noticed that *'Some interventions failed due to difficulties in communication or because pieces of history were missing and these experiences no longer belonged to anyone'*.

The establishment of a dialogic relationship with the patient is functional not only with regard to the reconstruction of their biographical experience, but

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[6] Basaglia Law or Law 180/1978 is the Italian Mental Health Act which determined a large reform of the psychiatric system in Italy. Law 180 established the closure of all psychiatric hospitals, which were replaced by community-based services as the Psych-Social Centres (PSCs).

also to the enhancement of the personal resources they have at their disposal (Beneduce, 2007). In this regard, the closure of many branches and the suspension of some welfare services, which occurred during the first months of 2020 as a result of the so-called first wave of the COVID-19 pandemic, in some cases was also the opportunity to rediscover the resilience capacity of the users (Bova and Lusardi, 2022a). For instance, a nurse (n.1) has observed: *'During the COVID-19 pandemic we remained closed and we also saw that some users had [more] resources than we expected because they managed to manage themselves, and even at the family level they had more resources than we thought".*

The enhancement of personal resources and the establishment of a dialogic approach represent only a first step within a more radical path of health organisation reform towards an approach that better integrates culture, society, and health from a cross-cultural perspective.

> Work has to be adapted, but we also have to adapt when we work with foreign patients. In some cases, [this is] because those born in Italy of foreign parents feel more Italian than parents who have remained tied to the values of the country of origin, and then you have to work on this conflict. Or you … [encounter] foreign people well integrated with school and family, but the other compatriots did not accept this, and then they enter into crisis. To learn how to help foreign patients in a way that works for them, one must understand but above all adapt (psychiatrist n.4 in a psychiatric community).

Many professionals have perceived the need to suspend their judgement, to take more time than that foreseen by the protocols, in order to observe and possibly better understand the dynamics with which they are confronted. In this sense a social worker n.3 has said: *'Over time, we have had the need to take into consideration the culture of the country of origin, for example with respect to parenting skills. And therefore, before sending an evaluation to the judge, it is necessary with some foreign families to undertake information paths regarding educational or punitive behaviours which in Italian culture are considered legitimate and which constitute a crime'.*

Furthermore, several people interviewed reported episodes in which they were willing to compromise and modify practices to meet the needs of the foreign patient, and to establish a relationship of trust with them. The mediation undertaken by the professional and the patient allowed the planning of syncretic therapeutic paths, which made use of tools and resources drawn from different care traditions (Beneduce, 2007).

> I remember a patient from Niger who did a series of rituals to purify food and which he shared with his mother, but I had some doubts about his behaviour. I had to admit him to the Psychiatry Ward and there I was afraid of having played the relationship and instead we recovered and mediated. I

> accepted that he maintained some ritual that was part of his tradition. Now he is fine, and has also started working again and the fact that we managed to keep him here at PCS and with his family for six months was important to give him a supporting structure, but the matter is that he really wanted to get his life back. He partially accepted our directions and then did as he felt right, went back to Niger, and then came back and stayed with us. At one point he brought his brother… I didn't understand what function it had because he just listened to what I said and approved of it. In the end, however, he returned to being a presence, as De Martino[7] says, he regained possession of his life also because for some time we did not allow him to get lost, we kept him on the ground (psychiatrist n.5 PSC).

To sum up, the reflection evident in this paragraph concerns the difficulty that many socio-health workers encounter in establishing a dialogue and in obtaining compliance with their therapeutic indications. The communicative distance seems to arise from the poor correspondence between a traditional and highly standardised diagnostic systems and the personal ways of expressing social and cultural illness by foreign patients (Csodas, 1990). The absence of isomorphism between these two systems (Devereux, 1970) is amplified by the tendency, evident in recent years in the healthcare context, to further standardise diagnoses, protocols, and procedures (Conrad, 2007; Maturo, 2007). For some professionals this trend represents a positive dynamic, as it can provide certainties in a highly complex relational context (Lusardi and Tomelleri, 2018). For other professionals, on the other hand, it is particularly important to counter this trend, as it feeds the pressure, emitted by some sectors of society, that psychiatry will return to reassert, as in the past, the function of social control.

The first steps towards questioning the current organisational structures and the cognitive paradigms underlying them (Bourdieu, 1972) arise from taking more time to observe and understand, from expanding training. It could be also important to including the study of a transcultural approach to health, and to use more frequently the cultural mediation. In this way social and health professionals could become more aware of the close link that unites culture and health (Kirmeyer and Sartorius, 2007). The challenge is to find new forms of mediation and dialogue with the migrant person within personalised support paths that reconstruct the migratory path, and which allow the person to participate in collaborating to create syncretic care interventions, thus enhancing therapeutic resources from different traditions (Beneduce, 2007),

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[7] Ernesto de Martino, Italian anthropologist, philosopher, and historian of religions. He studied how rituals and magic thinking are an expression of subaltern culture.

without necessarily subscribing to the protocols envisaged by the medicalising approach.

5. The problematisation of the distinction between mental disorder and social illness

As emerges from the epidemiological analysis, there are rare cases in which foreign patients spontaneously go to mental health services, such as PSC. In most cases, the first contact takes place either by access to the ER, which can also lead to hospitalisation in the Psychiatric Ward, or allocation by other municipal welfare services. As this psychologist n.2 working in a PSC confirms: *'There are foreign patients and they usually arrive when the disease explodes, they are a bit reluctant to arrive, especially for some nationalities. They often come from sending some other service, such as the social workers of the municipality. Not all patients stop, as soon as the symptom subsides a little, they tend to detach more easily and refer to the family network and fellow countrymen'.* Furthermore, very frequent channels are those of the school and child protection to the municipality of the residence of the family.

The social workers interviewed have on several occasions said that most of the contacts with immigrant service users are related to the request for income supplement contributions. However, on the occasion of the generic interviews in which the economic situation of the family making the request for assistance is examined, the social workers have said that they have refined their ability to identify the latent needs of which the user is often not aware, and that once these have been identified, they are sent to a PSC for further information. For instance, this social worker n.4 said: *'If in the interview I detect elements to be investigated, I take charge because sometimes the person brings a problem but there are other problems upstream that in my opinion need to be investigated, and maybe the person did not have the tools to identify those problems upstream. Obviously, the work works if there is adhesion on the part of the person, otherwise there is little to do'.*

The engagement of the population by means of economic subsidy has become increasingly frequent in recent years, and, because of the COVID-19 pandemic, contributions to support income have increased through easily accessible tenders (Bova and Lusardi, 2022a).

However, it is often not easy to distinguish between mental disturbance and social illness associated with particularly stressful living conditions (Kai Hou et al., 2020). Conditions that occur in the migrant's country of arrival can also lead to serious marginalisation (Massey and Sàchez, 2010; Di Napoli, Gatta, and Rossi, 2017). In such situations, sometimes the users with whom the social workers interact are able to act in a strategic way, making it possible for them to achieve some economic or social objectives, passing through the channel of health protection or protection of the family unit (Fassin, 2011).

> I realised that this lady had greatly altered the family cross-section in which they lived, characterised by great economic difficulties. She played the part of a lonely woman with children with an inadequate husband. Then I discovered that there was no negative relationship with her husband, but she had manipulated the services by activating improper resources, without going so far as to declare their true need, which was economic. We had completely fallen for it, and when I understood I asked her for an appointment and then she left the facility with the children because she was afraid that we would take the children away. I reproached myself for not having communicated my intentions correctly, and I wondered how much the linguistic, cultural, and communicative aspect had an impact (social worker n.5).

As emerges from this excerpt and subsequent ones, when social malaise seems to be the predominant condition rather than mental distress, the relationship between patient and services can be abruptly interrupted once the desired legal, working, or housing conditions targeted by the user have been established.

> I remember a 20-year-old Moroccan boy who spent the day at home, where no one cared about him because there were so many, and therefore he also skipped meals and was really closed. Then he came here to the community, and then [this] was followed by the day centre and we started a work project in a greenhouse, and he played in the football team. Then we got to the point of making an application for housing in a municipal house where the whole family has moved. From there, however, he abandoned everything, he was so happy with the disability money and divested everything. In his own way he is fine, he was looking for a status and rights as a patient and we did not hinder him, and we decided not to force him (psychiatrist n.4, psychiatric community).

As we know, the legal status of the foreign person or refugee can remain unstable for several years, both due to job insecurity (which affects the non-renewal of the residence permit), and due to long bureaucratic processes characterised by a high degree of arbitrariness (Fassin, 2011). This precariousness affects the wellbeing of the foreign person, as evidenced by the survey conducted by Massimiliano Aragona et al. (2020) regarding Chinese immigrants residing in Italy: the decrease in social suffering is related to obtaining a suitable residence permit.

In some cases, however, the living conditions in the country of arrival, marked by economic hardship, social isolation, and poor integration in the community context, are so stressful that the keystone seems to be the return to the country of origin. This is the case described by this social worker n.6 of the Addiction Treatment Service: *'A few months ago we followed a young person of 35, a drinker and a group was created around him with Caritas, employer, community volunteers. In the end they decided to get him a plane ticket and with the TFR[8] he returned to his country and now he is fine, if he came back here, he would start to feel bad again'.*

The stressed living conditions that the foreign population faces every day can be categorised as part of the Daily Stressor Model (DSM), which is composed of precarious living conditions, reduced social capital, processes of stigmatisation, poor accessibility to welfare services, and discriminatory conditions (Kai Hou et al., 2020). As emerges from the international literature, social suffering increases according to the length of the stay in the country of arrival, mainly due to the living conditions in the host country (Kai Hou et al., 2020). In fact, the reciprocal relationship between Pre-Migration Traumatic Experience (PMTE) and Post-Migration Living Difficulties (PMLD) seem to concur in determining an improvement or worsening of the person's well-being; not all those who have been subjected to trauma develop serious illness, while stressful living conditions seem to have a more significant statistical correlation (Di Napoli, Gatta, and Rossi, 2017). While in previous interview excerpts we have seen numerous situations in which the therapeutic relationship is interrupted once the desired social support is obtained, we now analyse the numerous situations in which the take-over by social and mental health services starts a negative spiral that sees the patient's condition deteriorate, and that involves the dismemberment of the family unit, as well as the chronicisation of the condition of dependence on social support. As this nurse n.2 points out: *'We have a lot of difficulty in closing the treatment pathways. Sixty per cent of the people present in rehabilitation facilities have a very high average age, and have been followed by services for many years, so they should not be in rehabilitation facilities, but assistance. Assistance means, home, occupation, and activity'.*

In the interviews collected, the situation is described in which the attachment of the foreign patient lasts for a long time, but in the manner of continuous relapses, which require emergency interventions every time, and which do not evolve into social reintegration and assistance paths.

> I remember a Senegalese patient who was sent from the Municipality because he was abusing alcohol. The Juvenile Court also intervenes because the second child is Down syndrome and it was difficult to make him understand what this child had. The Juvenile Court had found a community for women and children, but they didn't want him; he got angry and went to the

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[8] It refers to the lump sum payable on retirement.

> community to threaten, and then they moved the mother and children to a community in another province. He began the path with us, and we tried to make him understand that he must not drink to be able to see the children, and in the meantime, he has been in five communities. In the meantime, he has become diabetic, has liver problems and we give him civil disability, and once a month he is allowed to visit his family. With an Italian family it would never have been possible to divide a family nucleus in this way because no lawyer, defender of the parents, would accept such a thing. We have done a lot for this family, but we got it all wrong. Sometimes we do things because they are right to do, but we don't ask ourselves if it is right for us or for them (social worker n.7, ATS).

As emerges from this interview excerpt, it seems that some support dynamics are triggered automatically, with little regard for people's self-determination or respect for family unity. The procedures are launched regardless of the critical judgement of the operators and their evaluations, often producing results opposite to those desired. Sometimes these automatic procedures arising from diagnoses and support measures risk increasing the dependence on services and encouraging the processes of stigmatisation (Farmer, 2003; Massey and Sanchez, 2010) whereby the migrant population is more easily labelled as problematic and marginal compared to normal social integration processes (Tognetti Bordogna, 2004). A social worker n.8 interviewed ironically commented: *'We make the joke that when a child enters here, he never leaves without a diagnosis, even when he could save himself from a label. Most of the diagnoses we issue are linked to behavioural dysfunctions and relational fatigues with the social context that also have a neuropsychiatric value. These dysfunctions could often evolve in a positive way within a positive environmental and context, without the need of a clinician intervention'.* The stigmatisation can apply to children of school age, and therefore is 'forced' to go through the mesh of the state (as in the case of the previous interview extract), or it can unhinge the balance within a family unit, or discredit a subject in relation to the community to which they belong, as in the following excerpt taken from an interview with a psychiatric community educator n.1: *'I remember the case of a Kosovar girl with whom we had a lot of difficulty in building a relationship with her and a dialogue with the family, and we could not make her feel better. She said that if she stayed still in the community her family would no longer want her'.*

Operators seem to be aware that they are acting on a very dangerous ridge, which on the one hand falls towards stigmatisation, and on the other towards dependence on welfare services (Fraser and Gordon, 1994). In the social and health professionals' intentions, this path is still directed towards the care and social inclusion of patients and users who come into contact with their services, but the path does not always achieve the desired results.

> Accessing our service is very stigmatising, they come to us, and we attach an identity. Sometimes this can be beneficial because after they join our service, they know we never leave them, we have patients in care for 15, 20 years and they don't use drugs anymore, but they know that if they end up in the hospital, the ward first calls us. We have established near family ties. In fact, sometimes they make incongruous requests, which they should make to the general practitioner (social worker n.7, ATS).

As we have seen, access to mental health services rarely occurs due to the spontaneous application of the foreign patient, more often the foreigner is connected by the territorial welfare services for economic needs, or accesses the Psych-Social Centre after being sent by the Emergency Room, following an acute episode. The municipal social workers say they have a sort of 'careful look' which, during routine meetings for the request for financial contributions, leads them to detect the latent needs of the users, which can be needs of a presumed psychological or psychiatric nature. Not always after the first meeting with the social workers the users remained in relation with the mental health services, sometimes health protection is used in a strategic way to obtain social protection, to which they would not have had access otherwise. The question became the incidence of living conditions in the country of arrival (Post-Migration Living Difficulties-PMLD) on the suffering of the immigrants (Aragona, et al., 2020); living conditions are often characterised by job insecurity, social isolation, and low inclusion (Di Napoli, Gatta, and Rossi, 2017). Engagement by the local welfare and health services is not always able to respond to the suffering caused by these living conditions, but rather, at times, activates negative spirals of 'wedging distress' and an increase in dependence on services (Fraser and Gordon, 1994). The multiplication of these processes, in turn, favours the stigmatisation of the foreign population, considered in itself multi-problematic. From the narration of the operators interviewed, it emerges that some dynamics of assistance are triggered independently of their will and their critical judgement. These dynamics affect minors and adults, and often lead to the dismemberment of the family unit (who are distributed among different residential communities and wards). Faced with the phenomena just described, it becomes particularly complex to identify the distinction between mental disorder and social suffering (Fassin and Rechtman, 2009).

6. Conclusions

In this article, I analysed the dynamics of negotiation between social health professionals and the immigrant population in the context of mental health care practices. At the end of the analysis process I identified and isolated the main care practices implemented, and the symbolic meanings associated with them. The grounded method of analysis allows light to be shed on the domains of everyday life and an understanding the social world of the study to be obtained, but without generating a theory.

Three conceptual abstractions emerge from the research which form part of the negotiation process: *accessibility, medicalisation*, and *wedging*.

Accessibility can be considered as a relational process in which the immigrant patient interacts with the National Health System (NHS) in the different Local Health Care Areas. This process can be influenced by various factors, such as the culture and needs of the organisation on the one hand, and the variables which the patient is subject to, on the other. Among the organisational needs of the NHS we find efficiency and the need to standardise user behaviour, in order to reduce the waste of resources (as much as possible) associated with the variability of human behaviour (Bruni, Fasol, and Gherardi, 2007). Protocols, communication codes, selection criteria, and diagnostic evaluation are then elaborated. In relation to the NHS, the immigrant has their own variables associated with their socio-demographic status (including whether they are in possession of a residence permit), the epistemological models relating to illness, wellbeing, and care of their own body, and familiarity with the organisational systems of the Western states. Finally, social variables are of considerable importance, such as being inserted in proximity networks (i.e. ethnic or neighbourhood networks), and having activated contact with other welfare services (Tognetti, Bordogna, 2004). The relation between these two systems – that of the healthcare organisation on the one hand and the expression of personal needs on the other – can determine a disconnect that manifests itself through the patient's perception of not finding adequate answers to their care needs. On the part of the socio-medical staff, there is a serious difficulty in communicating and interpreting, manifested by the release of very generic and standardised diagnoses, such as the specific disorders of childhood and adolescence, which are diagnosed in an exclusively immigrant adult population. The widespread practice of understanding the migratory experience as a clinical risk factor seems to emerge (Fassin and Rechtman, 2009).

The *medicalisation* of the migratory experience seems to be caused by the failure to question the cognitive and interpretative paradigms of bio-medical semiotics, as well as by the lack of flexibility of the health organisation in adapting its responses to the needs expressed by users (Bova and Lusardi, 2022b). The problems related to the accessibility of mental health services, together with the lack of willingness to adapt the interpretative and therapeutic tools to the users' phenomenology, seem to sharpen the gap between the network of mental health services and immigrants. Immigrant people with mental disorders therefore tend to postpone access to the network of services, and tend not to adhere to therapeutic paths, which are perceived as excessively standardised because they are medicalising. The worsening of mental distress and the deterioration of social conditions in multi-problematics, also due to stressful living conditions characterised by job and housing precariousness (Aragona, et al. 2020), as well as the high rate of abandonment and overuse of emergency services, favours the *wedging* of the condition of the immigrant patient (Fraser and Gordon, 1994). From the first access to local welfare services or to the emergency room, the immigrant person or family unit enters a negative spiral in which both social and health workers and immigrants often lose control. This process increases the degree of dependence on social and health services, and augments the stigmatisation of the immigrant population, which is perceived both by operators and by society as being in itself multi-problematic (Farmer, 2003).

In conclusion, in relating to foreign users, health professionals can incentivise health organisations to overcome a partial interpretation of the universalist principle, which in treating different people equally, risks determining inequalities and repressive interventions (Bruni, Fasol, and Gherardi, 2007). In responding to this challenge, some fundamental steps could be: greater phenomenological knowledge of behaviours and needs expressed by users, a simplification of bureaucratic procedures and the development of more inclusive services, a better social–health integration through the participation of actors from civil society who are able to create bridges with the community and, last but not least, the setting up of capable organisational infrastructures, which stimulate the activation and freedom of choice on the part of users (Ortner, 2006). The anthropologist Arjun Appadurai coined the term *voice* (Appadurai, 2004) to express the constant dialogue between memory of the past and orientation to the future, tradition and aspirations, personal dimension and community; to support this ability to aspire to a better future, a collective practice and a social context capable of encouraging the effective participation of each person are needed, in a renewed universalist horizon.

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