

Proceedings

“Arrivals”: Narrating Migration through Images. The Use of Images in Post-Traumatic Therapy [†]

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Abstract: This essay wants to underline the importance of images as a tool to access traumatic memories of refugees. The authors propose a narrative technique (post-traumatic intervention model) using the power of images and their potentialities. *Arrivals'* images facilitate the chance to recall, narrate, accept, understand and hold complex and painful stories: they have the extraordinary ability to organize difficult events by placing them in space and time, giving the opportunity to “speak the unspeakable”.

Keywords: trauma; psychology; refugees; complex PTSD; images; psychotherapy; migration

1. Introduction

“Individuals and groups have always migrated to other lands in search of safety, nourishment, protection for children, ideological or religious freedom; or to escape war, political persecution or torture” ([1], p. 19). According to the international legal language, the term refugee refers to people forced to abandon their country in order to escape persecutions, violence or prison, or to avoid the risk of coping with them because of their nationality, religion, race or political ideologies [2,3]. During the escape they leave their homes and countries, facing several psychologically destabilizing events: exhausting journeys, new contexts, conditions of extreme poverty, absence of required documentation and uncertainty of seeing recognized their legal position in the country of arrival [1,4]. During the migratory route refugees are often exposed to additional dangers and traumas, directly related to the precarious nature of their trips: exploitation, violence, physical aggressions (including sexual aggression), malnutrition, psychological and physical humiliation, detention and rejections [4]. The traumatic events that these people face determine serious consequences both on their physical and mental health and on the wellbeing of their families and communities.

The percentage of people that has experienced torture, violations and abuses of human rights is constantly increasing [5]. “The real problem we face today on the health of those who land on our coasts is not represented by infections or contagious diseases, but from the psychological distress of these people” [6,7]. In order to provide an adequate response to this situation, it is urgent and necessary to create and improve an adequate psychological support oriented towards the basic needs of these people [8].

2. Refugees, Trauma and Mental Health

In the last decades, the psychological impact of violence has generated a major public interest. Various researches have started studying the effects of trauma on refugees and asylum-seekers [9]. Along with the increase awareness about the refugees' psychological conditions as a result of related traumas, a wider debate has emerged concerning what kind of psychological approach could be more effective in cases such as the Post-Traumatic Stress Disorder (PTSD) [10–14]. PTSD has been considered as a particular anxiety disorders for a long time. Up to the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) it was included in the specific chapter of "Trauma- and Stressor-Related Disorders [15]—an illustrative example of the growing importance of this field of study. In psychiatry, trauma can be diagnosed when the person presents specific symptoms due to the exposure to an "extreme traumatic factor which involves the direct personal experience to an event that can cause or which can lead to death or serious injuries, or other threats to physical integrity for itself or other people" ([16], p. 468). Memories connected to trauma, disconnected from any representation and lying outside the cognitive log [17], are reduced to bad sensations, images and automatic and rigid thoughts (thoughts that Janet defines as *idées fixes* [18]). These thoughts can affect the individual by somatic experiences, psychopathology, obsessive concerns and compulsory functions. Therefore, when we live emotions related to difficult and painful experiences, we are no longer able to take advantage of the existing cognitive patterns in the process of categorization of the experiences [19].

Literature often considers refugees as a population with a high risk of developing psychopathological syndromes due to the stressful and traumatic experiences they live. Due to different aspects involving migrants well-being, including the migration process, ethnic identity and genetic characteristics, research on mental health in the migration field is even more complex [20,21]. We are facing events able to break the continuity of the experience and alter the sense of identity; the migrant will face the loss of the daily routine and a fracture of the bond with its origins [22,23]. The migratory experience inevitably alters the structural links of a person, causing a regression to a previous childhood stage where the individual becomes subject (again) to primary needs, being defenceless and dependent—condition that get worse due with the unknown linguistic context [22,23]. Refugees and migrants are messengers of massive traumas and repeated violence that disorients their original cultural identity. They experience forms of traumatic experiences that belong to the so-called *extreme trauma category* [24]. The extreme traumas are traumas of interpersonal nature, repeated or prolonged in time, suffered under a regime of coercion or inability to escape [25]. Currently, it is estimated that 33–75% of the extreme trauma survivors will develop, during the period after the traumatic experience, a psychopathological disorder which will also affect the next generations (trans-generational torture) [26,27]. Extremes traumatic experiences may determine, in addition to the common symptoms of the PTSD, other specific and complex psychopathological consequences: psychological and somatic dissociative disorders, tendency to re-victimization, loss of the sense of security and the sense of self, hyper-arousal disorders, affective and relational disorders. This particular syndrome is currently recognized as a specific clinical-diagnostic entity, defined as "Dissociation PTSD or as Complex PTSD" [28–30]. The traumatic experience is not processed at a symbolic/verbal level and, therefore, can only be re-experienced through continuous flash-backs, nightmares, daily headaches, recurrent somatic pain, sudden states of despair and intrusive thoughts related to trauma. In the most of the cases, the psycho-pathological consequences of extreme traumatic experiences determine alterations of the basic psychic functions, with dissociative (psychological and somatic), mnemonic (autobiographical memory in particular) and identity disorders, as well as affective, relational and behavioural modes and capacities. In the absence of an early and appropriate treatment, the Complex PTSD tend to evolve, to get worse and even chronicle diseases [29,30]. The presence of a Complex PTSD that has not been treated makes difficult, if not impossible, the path of social integration and autonomy. Within the refugee population, the presence of individuals who have experienced torture or other violation, and abuse of human rights is constantly increasing [6,7]. Despite this, the therapeutic work is just at its primordial steps and is yet to be further decoded.

3. Most Common Therapeutic Interventions

The clinical and psychotherapy treatment with people who survived from a situation of extreme trauma has yet to be improved. This is especially due to the fact that they are exposed to different conditions affecting their mental health. This situation fosters the development of different approaches and psychological paradigms with the advantage of creating hybridizations of techniques already used and new practices of intervention.

3.1. Trauma- Focused Approach

One of the most widespread approach in the treatment and psychological support of asylum seekers is called *Trauma-Focused Intervention*. In this treatment, considered as part of the modern cognitive behavioural therapy [31], the discussion of traumatic experiences represents the therapeutic strategy aimed at the reduction of PTSD symptoms [32]. The Trauma-Focused therapy is based on mitigation of the typical PTSD symptoms. It teaches ways for coping with the symptoms, it avoids non-adaptive attitudes and rather suggests processing memories related to the traumatic events [31]. Recent reviews on psychological treatment of refugees show the effectiveness of the Narrative Exposure Therapy (NET), which involves the life-story of the patient, focusing particularly on the traumatic experience that caused the post-traumatic symptoms. During the narrative presentation, the patient is asked to describe in detail his/her worst traumatic events while s/he re-lives all emotions related to the event. Throughout the process, most patients get used to the emotional response related to the traumatic event and, by adding the reconstruction of the traumatic memory, such event leads to a remission of post traumatic symptoms. The focus is on integrating emotional and sensory memory to autobiographical narratives. The habituation would cause the reduction of stress levels as well as the details of the memory concerning traumatic events [33].

Contributions related to this type of approach are unanimous in highlighting how in the treatment of complex or extreme trauma it is necessary to create the appropriate conditions for the person to go through these traumatic episodes. The treatment indeed exposes the person to strong emotions and it creates a comfortable a space to restore the ability of regulating emotions and to imagining a positive sense of self and own life [34].

3.2. Ethnopsychiatric Approach

The *ethnopsychiatric approach* is composed by a plurality of theoretical guidelines and practices of intervention. It is addressed to people of different cultures, enhancing the cultural variables during the therapeutic relationship with migrants [35]. This approach takes bases from the French school of Devereux [35], which supports the *psychic universalism*—the idea that the human mind is not homogeneous given that it is filtered out by cultural expressions [36]. This approach also emphasizes the need of complementarity of therapeutic activities that can be translated as collaboration between psychoanalysis and anthropology [37]. Tobie Nathan develops these assumptions, insisting on the idea that migration itself is a traumatic event, eliminating the difference between the external cultural framework and internalized one [38]. Through migration, the cultural process (already part of the migrant identity) that guides beliefs, lifestyles and relationships, does not correspond to the shared values existent in the new hosting society. This contrast creates problems of cultural identity at various levels [39]. Nathan introduces the concept/practice of *group therapy*, which has been later recovered and improved by Marie Rose Moro. Moro has indeed improved group therapy including, in addition to the components already present in the system of Devereux (psychoanalysis and anthropology), linguistics, sociology, psychotherapeutic practices, philosophy and history. This pluralism of practices and disciplines dialogues very well with the system of relations constituent of the migrant, aiming to structuring therapies through networks. [36]. Within this therapeutic system, the main therapist guides the session, working with the history of the patient as a starting point, considering references to places, people, objects and actions. This is a retraction to facilitate the exposure of the problem and the possible way of solving it as if the migrant was in the country of origin. The main aim of this treatment is understanding the sense of sickness and suffering, for which

an external point of view is also important, and opening the field to the etiological evaluations and strategies which can enable to exit from the most problematic situations [36].

3.3. Multimodal Approach

The multimodal approach deals, at the same time, with different issues—such as the psychological functioning, the social and cultural adaptation, physical health and the psychosocial difficulties that refugees usually face. This approach comes from the recognition that refugees are exposed to a series of stress and challenges during their stay in the country of origin, the journey and the arrival in the host country [31]. Consequently, there is a need to take into account that the refugees need different measures to cope with the complex network of psychological reactions that can occur after the exposure to multiple trauma, as well as the following psychosocial stress, the problems related to physical health and to settle in the new country [31]. Supporters of this approach argue that it is necessary to consider the migrants' circumstances as a whole, supporting a methodology of intervention able to act on multiple levels and not just focusing on trauma—whether is be at an individual, family, community, or social level [35]. Psychological interventions may be general (direct or indirect) and may include assistance in practical issues and problem-solving techniques for individuals, couples, families, and communities [31].

4. “Arrivals”

4.1. Use of the Images in Therapy

The use of images in therapy has deep roots in history of psychology; the use of these can be found in the field of interventions that leads to eidetic psychotherapy, developed by Ahsen [40], characterized by an approach that uses eidetic images, specifically linked to the memories of the individual, and uses therapeutic techniques in order to create vivid images in memory [41]. Christoph and Singer (1983) adopt the use of positive images in treating phobias, suggesting that a clinical use of images would decrease the physiological effects derived from phobias [42]. In the context of psychodynamic, images are used in creation and administration of specific tests which investigate personality. They are called “projections” since they use ambiguous and unstructured stimulus, and the subject projects parts of itself, attributing them personal meanings based on their life experiences [43]. Dosajh (1996) upholds that one of the main advantages of projective techniques, which investigate the personality of the individual, is the capacity to overcome conscious defences of the individual and to allow privileged access to important information of which the subject is not even aware [44]. Also the relational systemic orientation—especially in the work of Rodolfo de Bernart and Istituto di Terapia Familiare di Firenze—uses images in psychotherapy, asserting that they help going beyond the verbal channels and reaching the affective emotional sphere of the individual, facilitating the emotional tuning between therapist and patient, and the use of the “Self” of both depending on the evolution of the therapy [45].

The use of images and non-verbal techniques is an effective tool to facilitate the access to difficult and traumatic experiences because it helps the narration, being themselves the container of emotions and feelings connected to the events. The image is the representation of what happened before the current moment of the narrative; it allows distinguishing what is happening in the present from what has already happened in the past.

4.2. “Arrivals” Procedure

To deal with the treatment of the serious condition of extreme trauma related to the migratory experience, it is necessary to join the best practices and the clinical indications of ethno-psychiatry with the current knowledge on post-traumatic mode of operation. In order to ensure an effective intervention, two paths have to be used. Our approach integrates all the abovementioned procedures into one, in line with the international and Italian guidelines of intervention on victims of torture and violence [8]. The work hereby presented bases its foundations on one aspect in particular: the suggestion of Tobie Nathan [39], who often underlines in his work the need of creative processes. By

respecting the patient's needs and time, the intervention aims to activate his vital parts. A creative intervention that is not rigid and unbreakable, but flexible and designed on the patient needs, without losing the structure needed to ensure stability and safety, is needed. According to the trauma treatment model shared by several authors, which includes a therapeutic structure divided into several phases, the “Arrivals” project is structured as follows:

- *Stabilization*: teaching the patient to restrain emotions and to access them within a tolerance state.
- *Narration/elaboration* (allowing, through images, access to implicit memories and narrating what before was impossible to narrate if not through emotional, cognitive and somatic expressions).
- Integration, return to life (restoring continuity to their story, without irreversible fracture and unbearable nothingness).

4.2.1. Stabilization Phase

The phase of stabilization is complex and multidisciplinary. It means at the handling of emotions in order to be able to understand the feeling and not just to react to the feeling. At this stage, the hospitality conditions (such as housing, sanitary, legal and social assistance), are crucial to reduce the alarm status of the person. They are put in place by the professionals and the psycho-educational process on mental functioning and trauma. It is fundamental to verify the basic activities of the patient: how and how much does s/he sleeps, eats, as well as the feeling of safety, which relations s/he is building, and so on. Building good hospitality conditions allows reducing fear and normalizing the symptoms, making smaller the feeling of not controlling own mind. This stage has duration that depends on the patient and does not necessarily finished with the beginning of the narrative phase. The capacity of the patient to control his emotions will be under a focus during the whole process.

4.2.2. Narrative Phase

The important feature of the narrative phase is the use of images. The images used in the procedure are taken from the graphic-novel “The Arrival” by Shaun Tan. Shaun Tan is an Australian author, son of Malaysian immigrants, grew up in a social environment full of migrants from all over the world. In his work, he tells us about migration. His work is accessible to anyone thanks to the power of his images, highly suggestive and little culturally connoted. Images do have access where words cannot go: human beings have always used images to tell what words could not. In the narrative of traumatic events and experiences we know that there is no narrative memory, but only emotional and somatic experiences. The latters are present and alive. The possibility of giving value to an image can be the opportunity to start elaborating these experiences. Through images these experiences can be out-taken and put in an external container, becoming something to work with. Being able to handle what you feel, to think about it, to give it a meaning, to control it and modify it. This enables the patient to find ways to cope with less suffering and keeping control with the extreme psychophysiological activations. The image is a necessary tool to safely enter their stories, to welcome that pain, to give meaning to these terrible experiences.

Rodolfo de Bernart and Katia Giacometti for more than 30 years have been studying the use of images in therapy [46]. They described how the image creates the indispensable distance, which enables listening, and consequentially produce an appropriate space where to develop emotions. The use of images also represents the construction of a protected environment for the user-operator relationship: the image becomes the work object of the most difficult experiences that can be narrated and described as something that is not internal to the patient or to the professional. Therefore, it allows a relationship of help in a safer environment, avoiding emotional contagion.

4.2.3. Integration Phase

The previous stages will give to the patient the opportunity to integrate in their own life narratives the experiences that once were indescribable and unmanageable. Thanks to the use of images, the patient is able to build his own life-story as a whole, without that vacuum which produces

terror and anguish. The aim of the project is to help the patient in the representation of his whole life through images without empty spaces.

This work matches the “guidelines for the assistance interventions in the field of care and rehabilitation as well as the treatments of mental disorders of refugees, and subsidiary protection status for whom has suffered torture, rape or other serious forms of psychological, physical or sexual violence” of the Decree of the Ministry of Health of 3 April 2017:

- “Each therapeutic process must include a first stage of stabilization with respect to the most disturbing symptoms (nightmares, impulsive crises, etc.). In the clinical relationship, the patient’s timings must be respected, e.g.,: not to immediately enter in the trauma stories if the patient doesn’t want to; work on the “here and now” of the relationship; to facilitate the reality, testing the possibility of accepting realistic expectations about what is happening” [8].
- “Whenever possible, to do a trauma-focused and trauma reactions work, which may include:
 1. Validation/re-elaboration of emotions in relation to the suffered trauma.
 2. Reconstruction of broken narrative continuity.
 3. Questioning the negative words instilled by the torturer and the negative sense of the self as result of it.
 4. Modulation of emotions and somatic experience, reinventing the continuity between experienced emotions” [8].
- “In many cases self-help groups and/or support groups can be activated, as well as rehabilitative activities that increase empowerment” [8].
- “Working on traumatic memories: detailed reconstruction through the free narrative of traumatic events in a protected environment. This stage enables the victim to elaborate the experience and integrate it constructively into one’s own identity. It can have a preparatory function for the hearing” [8].
- “Reconstructing links: improving relational skills and facilitating access to new interpersonal experiences” [8].

4.3. Method and Results

The “Arrivals” procedure has been tested over the last 5 years, in collaboration with immigrant hosts associations, in Bologna. As a protocol of intent, the welcoming associations report to the psychological team which users are requiring support (usually 1 out of 10), and those who have difficulty to return to daily life. The widespread symptoms framework reported by operators is often characterized by lack of sleep, difficulty in feeding, fear of people. Host organization operators—trained in recognizing some of the signs that will be verified during the first clinical diagnosis—give their guests the chance to meet the team, clarifying that nothing will be done without their consent, that they will be free to ask questions and be silent if they consider it appropriate.

The person will have the chance to acknowledge in advance the process in order to decide. This is the initial therapeutic intervention. In the first meeting, the team presents itself, explains how these meetings can reduce those disabling symptoms and illustrates the instruments and the steps of the process. During this phase, the team explains that the path is a volunteer choice and that there is the possibility to interrupt it at any time if desired, considering the possibility of being able to resume it later. The opportunity to decide by themselves on certain aspects of their life is an important signal that reduces the level of alarm and makes them feel owners of their choices. The project has been tested on many users. The experience of a meeting where they are welcome and are not forced to do or say anything, together with the possibility to work on reducing the disturbing symptoms (lack of sleep, nightmares, sudden terror, tension or muscle fatigue) helps 99% of users to decide to pursue the course.

Gradually, it is the time of the stabilization phase and narration through images, reminding the patient the possibility to continue or stop. In the narration phase is important to keep in mind the work done during the stabilization phase, without losing the created balance, or finding it again as soon as the user has the feeling of losing it. A ring folder is delivered, containing all the images of the

Graphic Novel “The Arrival” with the task of choosing all these ones considered useful to tell their story, before, during and after the migration journey. Contact with images is important: their evocative power and the easy access they have to implicit memories, immediately create a direct contact with the related memories and, thanks to the stabilization work and the presence and leadership of the team, will not fall into an emotional vortex without control. Once all the images necessary for the work have been chosen, the user is asked to place them as he/she wishes; the result is a drawing of person’s life story, for the first time in continuity, without voids or absences. After it is asked to start telling their story starting from the first picture. The images make a direct representation of the emotions, but defined into something that is physically external, limited in time. This external process helps in giving space and time to events and experiences, in building a “before and after” of those events.

The stabilization phase is mainly focused in learning how to regulate mental, emotional and physical activities, by organizing feelings in space and time and to understand that “what I am feeling right now is related to an event in the past, which is not happening now, now I am safe”. At the end of this phase, what we noticed is the improvement of the initial common difficulties in sleeping and feeding, and the decreasing of the anxiety symptoms. The narrative phase strengthens this previous work. At the end of each meeting, vital parts are activated by interacting with current conditions in order to make the patient understand that is possible to touch difficult and painful memories while feeling distant from the past events and feeling safe. At the end of the intervention, people are able to talk about themselves in the past, in the present and in the future: a first and important sign of integration of previously disconnected parts of the self.

4.4. Discussion and Conclusions

Several limitations should be taken into account before definitive conclusions from the present intervention can be drawn. Above all, the heterogeneity of the sample and of the sending criteria to the treatment, the lack of a pre- and post- treatment standardized evaluation, and the lack of a control group. Although limited by these several shortcomings, the results of this procedure confirm the expectations about the powerful use of images. Images facilitate the chance of recalling, accepting, understanding and situate complex stories. First, images help to recall traumatic experience: stored in implicit memory, these events can’t have the chance of being told and processed because they can’t access to narrative (explicit) memory [47]. Images can help to reach to the implicit memories, giving them the possibility of being verbalized [48,49]. Second, this narration permits to perceive, accept and handle these experiences as something that belongs to a dangerous past that has been overcome. Therefore, the image and its narrative allows the lived experiences to be placed inside the person life story.

In conclusion, images have the extraordinary ability of placing in space and time complex, rich and painful stories, giving the opportunity to speak the unspeakable by narrating what before was just felt and suffered.

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