The Role of Culture, Values and Trauma in Shaping Abnormal Bodily Experience in Migrants

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Massimiliano Aragona

4.1 Introduction

In most cultures, somatization is a common idiom of distress. However, the way somatization is expressed varies between persons and across cultures. Psychologically, there are theories linking somatization symptoms to cognitive biases in selecting information or to deeper problems in symbolization. Many researchers believe that traumatic experiences have causal power in determining neurocognitive modifications. Largely unexplored, however, is exactly how culture, values and trauma interact to shape abnormal bodily experiences.

It is this shaping that I explore in this chapter through four brief ideal-typical (and carefully anonymized) clinical narratives. Taken together, these show that such shaping may occur in different ways, facilitating, genetic, plastic and interpretive.

4.2 Narrative Histories

1. *MD was a 30-year old Bangladeshi man. He emigrated to Italy after a natural disaster leaving his wife and sons in Bangladesh. He presented with worries about economic issues affecting his parents and sons. He did not talk about himself, complaining only of bodily symptoms, in particular a sense of burning in his stomach. A gastroenterologist found no pathophysiological reason for these symptoms. Worries, difficulty in concentration and learning, sleep difficulty, weakness and low mood, were other symptoms that were later found to have been present. It was only with time, when he started to trust the doctor and to understand that he would not be judged negatively for his symptoms, that he*

M. Aragona (✉)
Italian National Health System, Rome, Italy

Mental and Neuro Sciences, Rome, Italy
e-mail: email.aragona@gmail.com

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started talking about the other phenomena. It then became clear that his symptoms had started with a loss of energy consequent on nocturnal emission. His initial response to this was an acute anxiety reaction, with tachycardia, sweating, and related symptoms. His first idea was about something morally wrong, but soon he focused on the medical symptoms (see discussion below on culture for the effect of semen loss on bodily energy). *He felt exhausted but unable to sleep. Starting from this first episode, he developed enduring weakness and loss of appetite. Then when he tried to eat something he felt burning pain in the stomach, and this was the main initial symptom presented to the physician.*

Transcultural psychiatrists would easily recognize here a typical culture-bound syndrome (the so-called Dhat), typical of the South-Asian regions. This patient (as is usually the case) failed to admit the full array of symptoms on his first visit, complaining only of the burning pain.

2. *Shafia was a 40-year old Pakistani woman. She was dressed in typical clothes, and arrived crying. A staff member of the migrant reception center where she was housed together with two sons (aged 11 and 14) accompanied her. In her face sadness and hopelessness were easy to detect. She had a severe headache and was unable to find the energy to talk. During the interview, she made no eye contact and remained with her head reclined on the shoulder of the person accompanying her. She had arrived 2 months earlier to rejoin her husband who had been in Italy for 10 years. In Pakistan she had lived with her husband's family where she felt loved by her mother-in-law as well as by her husband's brothers. She worked as a kindergarten teacher and felt herself to be well regarded by the members of her community. Her husband regularly sent money to Pakistan, where he periodically returned to visit his family. During the last visit he was confronted by his mother who told him it was time to take responsibility for his family: he had either to definitively return to Pakistan or take his family to Italy with him. In the end he decided to activate the procedure for family reunion. But when his wife and sons arrived in Italy, they discovered he was living with another woman. He segregated them in a room, without permission to go out, and started beating his wife for trivial reasons. After 1 week he abandoned them near the airport, where days later they were found by a police officer and taken to a centre for women victims of family violence.*

Clinically, Shafia had major depression with secondary headache. She was treated with antidepressants but these had little effect. With time, a different picture emerged: despite depression, Shafia was exemplary in the way she cleaned and ordered her room, as well as in the education of her children. Nevertheless, when she had to be active in order to find a job or to follow the procedure for the renewal of the permission of stay, lack of energy and abulia (lack of will) became incapacitating. In discussing this difference of energy depending on context, it became clear that for Shafia wellbeing was a matter of being in the right social role in the right way. She was ready to understand that in a reception center cleaning the room and doing services was valued, but had no idea that in Italian society you are expected to become active in order to receive what you deserve. With time, she understood the difference and became more flexible, with

self-determined activation to reach what she needed. That she had become flexible enough to orient herself in the new society became clear when she, a Pakistani woman, asked an Indian male friend for information and support about a job. Correlatively, her depression and headache had disappeared.

3. *Pretty was a 43-year old Ugandan woman. She presented with a very severe headache recurring over 3 years. Several physicians had visited her, a Nuclear Magnetic Resonance and an EEG were negative, and the diagnosis was still undetermined. Several therapies had had little or no effect. During the interview, it was clear that although her headache was the presenting problem, many other symptoms were present as well: intrusive post-traumatic thoughts and memories, hyper-arousal, negative ideas about herself, with regrets and depression, difficulty in sleeping, nightmares with a post-traumatic content,* etc. *Eventually it emerged that in her home country Pretty had discovered and reported corruption in the school where she was a teacher. She had subsequently been kidnapped, beaten and sexually abused before managing to escape and leave the country. Unfortunately, like many other migrants coming from the Sub-Saharan regions, she had to cross Libya, where she was again kidnapped and sexually abused several times.*

   It was after her arrival in Italy that Pretty' headaches and the post-traumatic symptoms began. The headache episodes were typical. They occurred in therapy when she was asked to remember the traumatic events in her past and were associated with changes in her facial expression: retracted lips, teeth clenched, brow lowered, eyes part-closed, weeping. All these symptoms including her headache disappeared within a few minutes, leaving only a sense of feebleness, when Pretty was reassured that she did not have to talk about her experiences there and then (they could be picked up it in another session, or perhaps not at all), with the focus of the session shifting to practical issues in her everyday life.

4. *Godwin was a 23-year old Nigerian man. His father was a fetish priest, a traditional priest with the role of mediating between the spirit world and the living, particularly in health matters. In this role, Godwin's father had to perform rituals sometimes including violence against other people. When he died, Godwin was required by the law of the village to take his place (fetish priests are often selected from specific families 'possessed' by the god). He refused, but this was not accepted because it could have caused misfortunes to the community. As a consequence Godwin was threatened with death. He left the village, and, in turn, being afraid he would be found in other cities, the country. In Libya he was kidnapped, tortured and sold as a slave. In that period he became constantly watchful, afraid of everything, and unable to sleep because the memories of his horrifying experiences of violence continuously came to his mind.*

On arrival in Italy Godwin experienced initial relief of his symptoms. After a while, however, intrusive thoughts about the Libyan experiences returned and he experienced further sleep disturbance. He took 2 or 3 h to fall asleep, because of intrusive memories of the Libyan experience, with rumination and hyper-arousal. When he was finally able to sleep, he suffered recurrent dreams, starting with the image of his father offering fruits, and then changing with an increase of

emotional tension and the feeling that undefined persons were touching him, trying to throttle him. When asked about his own interpretation of this, Godwin said that it was the spirit of his father persecuting him because he had refused to take the place he was born for. The fruit (in his dream) was an invitation to rejoin the group, and the attack was because of his refusal. The people touching him in his dream were perhaps the other members of the sect in the village. He knew that all this could not be real but at the same time believed that someone in his village may have made a ritual to recall his father's spirit and that this was the reason for his suffering. He had come to Europe in the hope that the distance would be enough to prevent the magic influence touching him: but sadly he had found that its power was strong enough to be effective even at this distance.

4.3 Discussion

In this discussion, the role of trauma, values and culture will be considered. There is of course an overlap between culture and values. The latter, interpreted generally as what is important for or matters to the person, are clearly part of culture. But the reverse does not always apply. If we consider as cultural everything that has a meaning (a signification), then values refer only to those aspects of culture that are significant (that matter, that have importance) to the person concerned. Thus, values are a subset of all cultural items. Traumas may appear as something more objective, but they have a psycho-traumatic role depending on the way they are personally experienced.

Clearly, all three factors, trauma, values and culture, are important in any given case. In this discussion, however, I will focus on values. This is partly for reasons of space and partly because of the relative neglect of values in earlier publications.

Trauma. All cases experienced at least one severe traumatic experience in their life. However, they were different. In case 1, it was a natural disaster that acted as a migration push factor adding to already precarious economic conditions; in case 2, it was a matter of intra-familial violence and abandonment in a foreign country; in cases 3 and 4, we have the (unfortunately typical) severe, long-lasting and repeated interpersonal violence in Libya, but also torture and sexual abuses in the subject's own country (case 3), while in case 4 in the country of origin, there were menaces and threats to life albeit without direct physical violence.

These cases together illustrate the established finding in the literature that traumatic experiences may have different roles and clinical effects depending on the kind of trauma, the contextual situation, the characteristics of the person involved, the possibility or impossibility of giving meaning to the experience and so on. In our cases, the traumatic events have a pathogenetic role in cases 2, 3 and 4, although only in 3 and 4 do we find a typical post-traumatic reaction that takes the form of PTSD. This means that the pathogenetic effect of traumatic experience is often but not always typical; in some cases (like case 2), it causes other kinds of reactions, depending on other factors involved that will be discussed below.

Values. The values permeating these four stories are potentially infinite. The following selection is based on my own perception of their relevance for the cases under discussion. Other selections are of course possible but I hope these—and in particular the conflicts of values they illustrate—will indicate the important though neglected role of cultural values in the aetiology, presentation and management of somatizations in different reactive mental disorders.

In case 1 (the Bangladeshi man with a sense of burning in the stomach following nocturnal emission), there is a conflict between ethical and religious duties on the one side, which give value to sexual purity and restraint, hence forbid sexual relationships outside marriage, and, on the other side, the fact that a young man who remains alone for a long time normally has sexual needs that can explain nocturnal emission. In this case, the value conflict was largely implicit—the patient had the initial ephemeral idea of a moral conflict with consequent anxiety and guilt but this was soon replaced by a preoccupation with bodily functioning. Here, we can say that the value conflict has a pathogenetic role, because it is one of the causes from which the phenomenon arises: i.e. nocturnal emission is the key experience that makes possible the following onset of the Dhat syndrome, a necessary although not sufficient cause (cultural factors are also required).

In case 2, there are several conflicts of values, two of which seem particularly relevant in this context. The first is the conflict we imagine took place in Shafia's husband. For years, he lived a double life, husband and father working abroad on one side, while on the other side he was the partner of another woman in Italy. The first life is in line with traditional values that are common in Pakistan; the latter could be normal in the Western country in which he is living but clashes with the values of his country of origin and must be kept secret. In fact, nobody in his family would understand and accept his "Italian" behaviour. The balance achieved (a public identity and a secret one) fails when he feels forced by his mother to accept his wife and sons joining him in Italy. We can never be sure, but both the violence and the unplanned abandonment of the family at the airport suggest he was totally unable to find a way to manage his internal conflict, i.e. only impulsive acts were available to discharge the tension. This first conflict of value, in Shafia's husband, has no direct pathogenetic effect but it is what makes it possible to delineate a contextual situation in which interpersonal violence emerges as a possible way to escape the tension.

The second conflict of values emerging in this case is that between traditional, society-centred identity and individuation. Shafia will react to what happened according to her culture (see below) but in the new context, where a more direct activation is required, this way of behaving is not appropriate. It is around this conflict of values (i.e., "Do I stay in my place or do I activate to have what I need?") that psychotherapy will contribute to help Shafia to change her stance in order to be able to act in ways more useful for her life in Italy.

In case 3, the values initially clashing are Pretty's honesty against a social context where corruption is frequent and shared by many actors. A second conflict is between universal rights that guarantee to victims of violence like Pretty the right to request asylum in Europe, and the European political pragmatic agreements with

Libya that condemn hundreds of sub-Saharan migrants to sexual abuse, torture and other forms of re-traumatization. If Pretty had been allowed to arrive in Europe directly from a sub-Saharan state, instead of crossing Libya, at least the second part of her terrible experience could have been avoided.

Finally, there is the conflict between the interviewer's need to know her history (that *must* be presented to the territorial commission entitled to decide about her asylum request), and Pretty's need to avoid such memories. In this last case, the values involved in the pre-migration context and in Libya are those that contribute to create a social environment in which such extreme forms of interpersonal violence can take place. They have no direct pathogenetic role (the traumatic experiences are those responsible for the onset of PTSD), but it is clear that in different social contexts, this story would probably not begin at all. The third one, instead, i.e. the conflict between socially construed expectations that she has to tell in detail what she experienced, and her distress in trying to do so, has a direct pathogenetic role in the emergence of headache as a conflict solution, allowing the patient and the interviewer to stop the enquiry into distressing memories.

In case 4, there is the conflict between, on the one side, the traditional spiritual beliefs of a society and the social roles stemming from them, and, on the other side, the individual refusal by the patient to take up these roles. There are parallels with the previous case: the conflict of values has no direct pathogenetic role but creates the contextual preconditions for the story; and there is the traumatic experience in Libya with the same conflict of values arising. Finally, there is in this case an interesting conflict within the patient himself: on one side, he rejects traditional values and does not accept his inheritance of his father's role; on the other side, his interpretation of his symptoms is based on traditional beliefs like those he had refused. It was not possible to investigate this conflict more deeply during our meetings, so I will refrain from speculating about the role of this deep internal conflict in the pathogenesis of his problems.

Culture. Case 1, the Bangladeshi man with Dhat, is an example of a typical culture-bound syndrome in which culture has a clear pathogenetic effect. In case 2 (of Shafia, the woman beaten by her husband), culture has a pathoplastic role, i.e. it is not at the origins of the psychopathological reaction but it shapes the symptoms according to the cultural background. This is why she showed no improvement with antidepressants but did improve (slowly) when she started to reflect about her attitude and came to accept the idea that in Italy a woman must be active in pursuing her goals. In the case of Pretty (case 3), culture does not have a primary role, the symptoms (including the headache) being typical reactions to severe interpersonal violence. Her headache for example has to be seen as part of an avoidance mechanism that is frequent and phenomenally similar in many traumatized patients, often independently from country, ethnicity and culture of origin.

Finally, Godwin (case 4), the man who refused to be a fetish priest, presents yet another way in which culture may enter into the construction of mental symptoms, namely in a modality we could call "pathointerpretation." Godwin presents the full range of typical post-traumatic symptoms, including sleep disorder and nightmares, but he reads them through the cultural glasses of magic influences. Godwin's interpretation thus has a significant role in shaping what medical anthropologists call the "illness," i.e. the subjective experience of being ill, the disease as seen from the standpoint of the patient. This is again important for the effectiveness of treatment Only if the "illness" experienced by the patient is in accordance with the "disease" as the physician sees it from his professional standpoint, will good collaboration and compliance be possible.

4.4 Conclusion

This chapter discusses four narratives where trauma, culture and values contribute in different ways to how bodily experiences are shaped. These factors may be pathofacilitating (creating a social context which is necessary for the experience to take place), pathogenetic (taking a causal role in the onset of the psychopathological reaction), pathoplastic (shaping the form such a psychopathological reaction takes) or pathointerpretive (different interpretation of the same symptoms depending on the patient's beliefs).

While previous accounts have recognized the roles of trauma and culture, the four narratives presented in this chapter illustrate the importance also of values, including cultural values, in the aetiology, presentation and management of somatization disorders. As a consequence, the therapeutic approach in any given case has to be adjusted depending on the particular way all three factors interact in the patient's construction of their mental distress.

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4.5 Guide to Further Sources

Please see the following for further reading on the links between culture and trauma:

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