Migration and Torture in Today's World
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Migration, Violence, Mental Health
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Abstract This chapter discusses psychopathological issues related to migration in general, and to the so-called 'forced migrants' in particular. The latter are those migrants who are forced to flee their countries to save themselves from violence. As a consequence, they are more at risk for mental health issues due to the lack of a migration project (which is a resilience factor in migrants) and to the psychotraumatic experiences they suffer. We will describe the psychopathological reactions in traumatised persons, the effect of re-traumatisation they suffer during the migratory trip, and the role of Post-Migration Living Difficulties occurring in Italy in worsening the mental health of asylum seekers. Moreover, a brief section on the effects of the COVID-19 pandemic on these persons will be added, focusing on mental health service utilisation. Finally, we will discuss the difficulties of the Italian National Health Service in adequately healing these persons, and the indication given by the Italian National Guidelines to create services dedicated to these topics.

Keywords Migration. Violence. Mental health. Psychotraumatology.

Summary 1 Introduction. – 2 Traumatisation and Retraumatisation. – 3 Outcomes of Torture and Mental Health Violence. – 4 Welcome the Traumatised Patient. – 5 Health Policies and Guidelines for Welfare Protection in Italy.

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The stranger separated from his fellow citizens
and his family
should receive more love
by men and gods
(Plato)

1 Introduction

> *Heimweh*, this often fatal disease, has not yet been described by doctors… The German name indicates the pain of those who are far from their homeland, and who fear they will never see their homeland again. The French, observing the Swiss struck by this misfortune in France, coined the definition of *mal du pays* (disease of the homeland), and, since it has no name in Latin, I thought of calling it, from the Greek, *nostalgia*, from *nòstos*, the return to the homeland, and *àlgos*, pain and suffering.

This is how the Swiss doctor Johannes Hofer described, in his doctoral thesis of 1688, a disease that he observed among the Swiss mercenary soldiers, with whom he carried out his work as a doctor. Not only has he coined a term that since then has effectively described that particular sentiment of one who leaves a dear environment, but has also given what is probably the first psychiatric codification of a pathology of migration. Furthermore, as a therapy for a psychiatric disease, he proposed a social intervention: the transfer of the patient to his homeland. In Hofer's *Dissertatio Medica de Nostalgia* there are already *in nuce* the elements later recognised as essential in modern immigration psychiatry: a decisive role is played by the experience itself to migrate, and by the conditions in which migrants live; consequently, even curative and rehabilitative interventions cannot ignore the social aspects in order to be effective (Mazzetti 2008).

Apart from this Hofer's precedent, however, it is from the nineteenth century that clinical observations on the mental health of immigrants begin to find a regular space in scientific publications; however for many years they presented essentially anecdotal characteristics, and up to the mid-twentieth century they seem above all to have contributed to creating and maintaining stereotypes and prejudices against migrants, often presented as subjects with a certain tendency to psychic instability and vulnerability (Ranney 1850; Foville 1875; Ødegaard 1932). These ideas contrast, even before the subsequent scientific evidence, with common sense, if we consider that in the history of humanity the sedentary lifestyle is to be considered the exception, rather than the rule, given that the species *homo sapiens sapiens* has been, during the approximately 130,000 years of its history, mainly nomadic.

In recent years, the scientific literature has rather focused on identifying those factors capable of promoting, or vice versa endangering, the mental health of migrants, while, in parallel, an attitude of attention to different cultural sensitivities, which has gone by the name of "ethnopsychiatry" (Devereux 1970). This term refers to the treatment of psychic suffering contextualised in the patient's cultural references: it is a definition that we do not like very much, because we believe that no good psychiatry can neglect the patient's culture, and the term *ethnopsychiatry* therefore risks by one side to be a tautology, and by the other side to assume that there may be a psychiatry that does not take cultural references into account.

As for Italy, for example, which for about a century and a half became a land of emigration (between the nineteenth and the twentieth centuries) and then from the mid-1980s returned to its historical vocation as a place of attraction for populations on the move, clinical observations and scientific research are relatively recent, precisely because of the historical interval in which Italy has forgotten its immigration characteristic to become a country of emigration, for a period short in human history but long if compared to the average life of human beings, so as to forget a historical reality that is more than millenary.

The observations therefore began to develop from the 1990s onwards: the data collected in the course of numerous epidemiological investigations made it possible to define what has been called the "healthy-migrant effect" (Costa 1993; Geraci 1995). That is: immigrants leave their country healthy (which is quite obvious, considering how demanding the migration path is and how it requires good health to be faced), and healthy usually arrive in the host country. These observations, which are based on studies of the early 1990s, have been regularly confirmed later (WHO 2018): there are not significant pathologies import among immigrants in Italy. These figures, valid for the comprehensive immigration epidemiology in Italy, proved to be valid also in psychiatry: the rates of hospitalisation for mental diagnoses among immigrants have been particularly low, despite what we might have to suspect, considering the risk factors related to the migration experience.

With regard to health in general, the clinical-epidemiological observations have, if anything, made it possible to detect, based on the characteristics of hospital admissions of the immigrant population compared to the Italian ones, that the living conditions in the host country have the greatest impact on health. In other words, immigrants get sick in Italy due to the living conditions in which they live: for example, they show significantly higher hospitalisation rates than Italians for accidents, because they are more concentrated in the most dangerous working activities (Geraci 2001; Osservatorio nazionale sulla salute 2005-18; INAIL 2012).

Similar observations have also been made in the psychiatric field: the 'Post-Migration Living Difficulties' (PMLD) seem to play a role in the genesis and maintenance of post-traumatic reactions, maladjustment and somatisation, regardless of other risk factors, including traumas suffered at home before departure (especially with regard to forced migrants) or those suffered during the migratory journey (Aragona et al. 2011; 2012a, 2013; 2020a; Mazzetti 2008; Aragona, Geraci, Mazzetti 2014; Barbieri et al. 2021). These observations suggested researchers to focus primarily on understanding migratory dynamics, and how they affect the mental health of migrants, to identify protective and risk factors that can affect them.

These considerations, which have maintained a substantial validity for over twenty years, however, seem to need some adjustment linked to the phenomena that have occurred over the last few years, during which we have observed a change linked both to the socio-demographic characteristics of newcomers and to their migration processes. In 2011, with the 'North Africa Emergency' (after the Arab Springs), in Italy the usual economic migration movement changed, becoming essentially based on refugees, who arrived after a prolonged, often extremely hard, migratory trip (Idos 2012).

Those who work in the sector have also witnessed an increase in the number of coming people with a low level of education, often illiterate, and with histories not only of psychotraumatology but also sometimes of social marginalisation prior to migration. The reasons for this phenomenon are not yet completely clear, and we also lack data able to accurately compare, and on large numbers, demographic data as the education levels of new arrivals with which of the immigrants previously arrived in Italy, a population with medium-high education levels (Coccia, Pittau 2016). With all the necessary precautions, given the lack of systematic data, however, it seems to us possible that a lowering of the level of education in new arrivals could also constitute a health problem, being able to influence the "health literacy", a key factor in health protection (Sørensen et al. 2012; 2018; Karnick 2016; Paasche-Orlow et al. 2018; Ward, Kristiansen, Sørensen 2019).

In the same years, moreover, it was possible to record (Da Silva et al. 2016; Baglio et al. 2018; Aragona et al. 2020b) a change in the immigrants' admission rates in Italian psychiatric hospitals, which deserves some comment. In general, in fact, in Italy hospitalisation rates for psychiatric pathologies among foreigners were traditionally lower than those among nationals. This dynamic remains unchanged even in recent years regarding the global migrant population. If, on the other hand, the population of young males is selected from the countries from which forced migrants seeking asylum currently arrive, it can be seen that after 2011 the rate curve of this subgroup rises, greatly exceeding both that of other migrants and that of Italians. In essence, it is as if in this population there was a greater vulnera-

bility that leads people to hospitalise more often, and this coincides temporally with the disintegration of the Libyan Republic, with the consequent chaos that has led to an increase in departures (including people who had not planned to come to Europe) and an increase in severe traumatic experiences in that country (imprisonment, beatings, forced labour, malnutrition and dehydration, physical and sexual abuse and violence, torture). Furthermore, it has been seen that in the group of inpatients from the areas from which refugees leave, the most frequent diagnosis is not 'schizophrenia', as in the other groups, but 'unspecified psychosis', as if psychiatrists implicitly report that they are facing atypical psychotic presentation. Here too, the data do not allow a more accurate analysis, but it is reasonable to think that at least part of these psychoses may be part of a particularly severe post-traumatic reaction, as is often observed in tortured people (Aragona et al. 2020b).

The data from the Italian Ministry of Health (on which are based the quoted researches) do not report the educational level of the inpatients, or their status (asylum-seeker, refugee etc). However, the data are sufficient to suggest that something new is happening in that population, that the mental health profile is no longer as good as that of migrants who arrived in previous years, and that this poses a challenge to the national health system. This suggestion has been supported by a qualitative survey conducted on a sample of social and psychiatric workers in Italy:

> From the interviews carried out both with the NGO professionals, with long experience in the treatment of psychopathologies among migrants, and with psychiatrists operating in the national health system, a different typology of the current migrant has emerged who often presents with a psychic substrate already compromised, with a reduced resilience and without a clear migratory project. (Medici Senza Frontiere 2016, 11; transl. by the Authors)

2 Traumatisation and Retraumatisation

Migration itself is a complex event that can be experienced in a traumatic way (Mazzetti 2008). However in psychotraumatology when it comes to traumas, or rather potentially traumatic events, it is customary to refer to those events that the person directly undergoes or of which he or she is a witness, or of which he or she becomes aware if it concerns a relative or a close friend, characterised from "death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (American Psychiatric Association 2013, 271). This definition covers a very wide spectrum of possible events: natural disasters, accidents, episodes that occurred in battle, as-

saults, public and private violence etc. In these cases, migration, especially if it occurs in the difficult conditions mentioned above, can constitute, as we shall see, a retraumatising event.

Today, due to the geopolitical upheavals in many African and Asian countries, more and more each of these events may have occurred to applicants for international protection. In addition, there is often a specificity linked to the fact that the suffered violence (which prompted the person to flee one's country, the so-called 'forced migration') was intentional. This means that someone perpetrated brutal acts aimed at inflicting pain and/or death for defined purposes, on someone else, in a voluntary and conscious way. This entails a greater peculiarity of trauma, also defined as "extreme trauma" (Herman 1992; Van Der Kolk, Courtois 2005; Van Der Kolk et al. 2005; Viñar 2017): repeated interpersonal violence, practiced voluntarily by a person and/or a group, in a situation of deprivation of freedom.

The symbolic example of this type of experience is that of torture, defined by the UN as

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. (United Nations 1984, Art. 1, part I)

In addition to torture, the intentional violence that deeply undermines the dignity of the person (for example, enslavement or trafficking) is defined "inhuman and degrading treatment", even if not perpetrated by public officials. Many migrants who land in Italy and almost all applicants for international protection report having suffered events of this type, especially before leaving their country (in this case the trauma acted as a 'push factor', that is, a factor of expulsion and push towards migration), as well as during the passage in transit countries (violence, kidnappings, detentions, rape).

These events are potentially traumatic, because there has been a significant difference between exposure to psichotraumatic events and actual prevalence of Post-Traumatic Stress Disorder (PTSD). This means that if on the one hand the trauma event itself causes a complex of psychological reactions, on the other hand there is no relationship of necessity between trauma and PTSD. In other words, there is no direct cause-effect relationship, but another series of factors intervenes, including the characteristics of the person exposed to the

trauma, his psychological defences (resilience and coping capacity), his cultural, family and religious affiliations, the way in which he or she integrated the event into his or her own subjective and cultural experience, and the meaning it gave it.

Furthermore, the development of a real PTSD also depends on the context in which it occurred and on the events that followed the trauma: some of them can mitigate the traumatising aspects, while others instead constitute a dramatic chain, which further complicates the outcomes. Indeed, studies agree in suggesting that there is a quantitative effect linked to the onset of the syndrome, whereby the greater the number of traumas suffered, the greater the relative risk of developing PTSD (Mollica et al. 1998a; 1998b; Rasmussen et al. 2007; Turner et al. 2003; Aragona, Geraci, Mazzetti 2014). The nature of these traumas, linked to the ferocity (as perpetrated by another individual) and the will of violence, causes more serious effects and makes the victims more vulnerable to the aforementioned Post-Migration Living Difficulties (PMLD).

This introduces us to the concept of 'secondary traumatisation', by which we mean the reactivation of the traumatic experience through new events. Indeed, this is a recurring fact in the experience of traumatised migrants: they not only had to undergo severe traumatic experiences before departure and/or during the journey, but after their arrival in Europe their vulnerability exposes them to further traumatisation, both for the insufficient protection of the reception system (for example, immigrants housed in overcrowded centres where friction between groups of guests is more likely to occur), and for the traumatic situations linked to the new internal barriers (for example, the migrants, often families with elderly people and children, who on the Balkan borders have been shot rubber bullets and tear gas, or who are left in the cold without adequate support in unlivable refugee camps), and because some of the people leave the circuit reception (for example, who move away before being registered, or the holders of protection who at the end of the period of protection end up on the street in a condition of social marginalisation, which makes exposure to new abuses and traumatising experiences more likely).

These events, in addition to having a possible intrinsic psychotraumatic effect due to their severity (i.e., the violence against women victims of trafficking), are often pathogenic because they reactivate the original traumatic experience with which they are associated, for example the traumatic reactivation of the tortured person who has a *hyperarousal*: the hyperactivation of the sympathetic nervous system with the release of stress hormones when he or she has to go to the police station for administrative reasons, because the police uniforms remind him or her of the perpetrators of the trauma. These potentially retraumatising experiences are then associated with other vital post-migration difficulties (boredom, discrimination, poor access to services, bureau-

cratic delays, concerns for one's own life and that of family members, fear of expulsion, poverty etc.). All these events are parts of the PMLD.

Research shows that PMLDs have a defined pathogenic role. In particular, it has been demonstrated (Aragona, Geraci, Mazzetti 2014) that in refugees and asylum-seekers suffering for more PMLD there is an increased risk of developing a PTSD, with greater severity of symptoms, resistance to the therapeutic process and difficulties in the process of social integration.

In general, a trauma suffered in the country of origin, together with conditions of discomfort in the host country, tends to worsen the level of psychopathological suffering. And it should be emphasised that if reducing the risk of pre-migration traumatic experiences is complex, and requires a long work at international level against inequalities and conflicts in many areas of the world, it's simpler to intervene on post-migratory life difficulties. Given their high frequency and the impact exerted by them on the mental health of migrants (and consequently on the possibilities of social integration and on dangerous behaviours), it is important to act immediately on the reception policies, in order to reduce risk factors and possible secondary trauma. This would offer advantages not only to suffering migrants, but also to the host society, facilitating the integration processes.

3 Outcomes of Torture and Mental Health Violence

The intentional violence referred to in the previous paragraph has, as mentioned, an intrinsic and specific psychotraumatic effect. Through our experience we know that victims of torture hardly reach mental health services. They access medical assistance more easily as carriers of a discomfort that takes varied forms: unclear malaise, resistant headaches, somatic disorders without pathophysiological finding, insomnia, irritability. Even if sometime the most serious symptoms can be observed: depression, dissociative phenomena such as flashbacks, memory disorders (amnesia, difficulty in memorising new experiences), substance abuse, self-harming behaviours, suicide attempts.

The specific psychiatric disorders of victims exposed to a trauma is the Post-Traumatic Stress Disorder. According to the DSM-5 (American Psychiatric Association 2013, 271-4) the psychotraumatic reaction is characterised by a certain number (fixed in the manual) of the following symptoms:

- Painful, intrusive, involuntary and recurrent memories of the traumatic event. The person may appear to be absent at times, while inside there is a struggle between disturbing thoughts and memories, and the active and ineffective effort to reject them.
- Alteration of consciousness, with real dissociative reactions (like flashbacks) in which the individual feels or acts as if the

traumatic event were recurring. From the observer's point of view, in these cases the person appears freezed, as if he or she were no longer in contact with the surrounding environment, occupied by images or sounds, vivid or nuanced, in which the traumatic experience is re-acting in all its drama and with the corresponding emotional experience.

- Inability to remember important aspects of the traumatic event (a phenomenon which also falls within the dissociative alterations of the state of consciousness, in this case due to dissociative amnesia).
- Physical and/or psychological suffering facing stimuli that symbolise or recall the traumatic event or one of its aspects. It is often a source of secondary retraumatisation. This causes the person to try to escape this suffering by trying to avoid those external elements (people, places, conversations, activities, objects, situations) that can recall and activate memories, thoughts or feelings associated with the traumatic event. For example, for a person tortured by the military in detention centres, a trigger could be being in front of law enforcement or uniformed personnel, in situations where the person has to answer questions or an interrogation, which brings them back to re-live past experiences. This sometimes involves unexpected difficulties in the normal completion of procedures necessary for asylum-seekers: people who are unable to go to the police station (where there is the office in charge) to start the practice; others who get stuck during the discussion of their application because they feel they are being interrogated, and so on.
- Sleep disorders, with difficulty to initiate or maintain sleep, or almost complete lack of sleep, because of brooding or intrusive thoughts, unable to relax. When in the end, exhausted, they succeed, after a while there are recurring nightmares. Post-traumatic nightmares are characteristic, because the content and/or affect of the dream are directly linked to the traumatic event. Eventually these sleep disturbances deplete the person's energy, with important repercussions in daytime functioning.
- Negative beliefs or expectations about yourself, others or the world (e.g., "I am bad", "I cannot trust anyone", "The world is a very dangerous place", "My nervous system is ruined forever"). Sometimes these distorted thoughts relate to the causes and consequences of the traumatic event and lead the person to blame themselves or others (e.g., patients may feel guilty that they are the only survivors, or that they were the cause, perhaps with their own political commitment, of the suffering of their own family members).
- Persistently negative emotional conditions (e.g., horror, anger, guilt or shame); marked decrease in interest or pleasure in do-

ing things; feelings of detachment or estrangement from others; persistent inability to experience positive emotions.
- Hyperarousal, which is part of a normal and evolutionarily healthy reaction in situations of real danger, and which becomes pathological when the nervous system continues to be activated despite the fact that the dangerous situation is no longer present. In a more general framework of hyperactivity are inscribed various post-traumatic symptoms such as irritable behaviour and angry outbursts, dangerous or self-destructive behaviour, ongoing hypervigilance with excessive startle response (people who 'click' suddenly a negligible noise). It should be noted that apparently unmotivated outbursts of anger could be alarming manifestations that are often not recognised as a possible expression of post-traumatic suffering.
- Difficulty concentrating: a very important symptom because it negatively affects the integration in the host country (learning the language, a new job etc.), due both to the drowsiness resulting from the insomnia mentioned above, and to the fact that intrusive thoughts disturb cognitive processes.

However, it should not be assumed that PTSD runs out clinical psychotraumatology. In fact, there are other ways in which patients can manifest their suffering, with partial symptoms, that is, not such as to configure the entire clinical picture of PTSD, or with symptoms that may appear isolated, for example attitudes of social withdrawal and isolation; fear and anxiety crisis, or aggression and/or self-aggression; disturbances in concentration, thinking or memory (which can be suspected, for example, in case of difficulty in learning the language of the land of asylum); depressive syndromes that sometimes culminate in suicide attempts; somatisations, that is, non-specific physical symptoms not justified by a detectable organic pathophysiological alteration; paranoid attitudes and hallucinations. As mentioned above about psychiatric hospitalisations, psychotic symptoms often pose problems of differential diagnosis, because they can lead to the prescription of inappropriate and sometimes iatrogenic therapies. For example, a lack of differentiation between schizophrenic and post-traumatic hallucinations (Maggiora, Aragona 2020) can determine excessive and useless use of antipsychotics.

In recent years the question of recognising or not a particularly serious clinical picture that Herman (1992) had defined "Complex PTSD" has entered in the nosographic debate. It is the disorder observed in particular after intentional violence and in conditions of prolonged coercion, and which is characterised by a multiplicity of somatic, cognitive, emotional, behavioural and relational symptoms. In this case, severe somatoform disorders, marked dissociative phenomena, intense and prolonged depressive reactions, distrust and

suspiciousness in interpersonal relationships and disorganisation of personal identity are observed:

> All the structures of the self – the image of the body, the internalised images of others, and the values and ideals that lend a sense of coherence and purpose – are invaded and systematically broken down. (Herman 1992, 385)

With respect to the somatic expression of mental suffering, Italian research (Aragona et al. 2008; 2011; 2012b) shows that:

a. At least a quarter of patients (25.6%) visited in primary care services dedicated to migrants present a somatisation syndrome, with important consequences for the therapy. For example, mistaking a somatisation for inflammatory pain involves the inappropriate prescription of anti-inflammatories, with the risk of chronicisation and possible iatrogenic damage.
b. Not all migrant groups somatise the same way, there being a higher frequency among the South/Central Americans and Africans.
c. Contrary to expectations (that those with low education could have a greater difficulty in finding the words to express suffering on a psychological level, and therefore tend to express it through the body), in migrants no significant correlation was found between education and somatisation.
d. Women somatise more than men, but this does not seem to be linked to biological differences because this difference is not present in all the groups studied: this only happens in Caucasians and in South/Central Americans, while this gender difference does not appear to be detectable in Africans and Asians. Therefore it is not being a woman in itself, but being a woman in a certain geographical/ethnic/cultural group that influences the frequency and type of somatisation.
e. Patients are not clearly divided between those who somatise and those who express discomfort with mental symptoms (*somatisers* vs. *psychologisers*), because the data indicate that there is a high correlation between somatisation, anxiety and depression, which therefore tend to coexist.
f. Finally, and it is the most relevant data here, migrants who somatise are more likely to have PTSD, almost all PTSD symptoms are more frequent in somatisers, and the number of post-traumatic symptoms increases significantly the risk of having a somatisation syndrome.

Somatisations can therefore be a sentinel symptom of a hidden post-traumatic pathology: the traumatised person may not talk about his post-traumatic suffering (sometimes simply because he or she does not know that it can be cured, other times out of shame, or due to

the avoidance of which we have spoken above), which remains invisible, while he or she may ask for help for symptoms that experiences in their bodies. It is therefore important that the doctors, as well as the professionals who deal with assistance, are prepared to grasp in the somatisation the indicator of a possible violence suffered.

As somatisation, as well as alcohol and substance abuse can be connected to a deep malaise, the outcome of extreme violence: indeed, many migrants have told us that the alcohol is like a self-therapy to silence, in the intoxication's dizziness, the thought brooding or the *hyperarousal*, of which we spoke above.

Another area of great interest linked to post-traumatic symptoms, and typical of asylum-seekers and refugees, concerns cognitive functions. In fact, having undergone important intentional trauma leads to problems of concentration and memory, both of fixing and recalling autobiographical memories (Petta et al. 2018). In particular, in asylum-seekers and political refugees with Post-Traumatic Stress Disorder and depression, a difficulty in accessing specific memories of their lives was found (Graham, Herlihy, Brewin 2014). This phenomenon, referred to as "Overgeneral Memory", can result from the interruption of the recovery process of the memory trace, whose research is truncated at a general level without allowing access to more specific memories. A role can be played by ruminations and therefore also by intrusive thoughts, by information coding deficits, by the avoidance of painful emotions related to traumatic events or by executive control problems. Major discrepancies, especially in the peripheral details of autobiographical memories of asylum-seekers have been found, on the memory of two events, one traumatic and other nontraumatic (Herlihy, Scragg, Turner 2002). Finally, the mastering of executive functions also appears to be altered in asylum-seekers and refugees with PTSD (Ainamani et al. 2017; Kiaris et al. 2020). These experimental studies have the limit of testing patients with instruments that usually have not undergone a process of cultural adaptation, so it is possible that there are biases in the reported alterations. However, there is some consistency with what is reported in clinical-epidemiological observations. For example, Nosè et al. (2018) evidenced that concentration problems emerge among the most frequent symptoms in Italian reception system refugees (in 22% of the people admitted, and in 60% of those who report psychological difficulties), while Petta (2019) reports difficulties in attention, learning skills and planning respectively in 14.8%, 12.6% and 10.1% of the asylum-seekers and refugees hosted in reception centres.

4 Welcome the Traumatised Patient

A reception based on a favourable environment for the relationship with the patient has therapeutic value, because it allows the person

to recover his or her dignity by redescovering his or her capacity for interpersonal relationships.

The structures hosting traumatised people, either as a residence or as a place of assistance and care, should be quiet and comfortable, so as to suggest a domestic environment. In particular, the first reception activities should be carried out by people without uniforms, dressed in plain clothes; this choice can represent a first moment of reassurance for our patients because some of them, who have suffered violence from police or military forces, may have emotionally intense reactions in front of people in uniform, due to traumatic experiences and consequent *hyperarousal*.

The place where medical examinations, physiotherapeutic or psychotherapeutic treatments take place, waiting rooms and other spaces must be clean, well furnished, welcoming, reassuring, with a domestic and familiar atmosphere. It is necessary that the patients have the feeling of being in an environment they can control and therefore it is useful that the doors are open/openable and (especially at the first encounter) they are introduced in the various rooms, the toilet, places, have a drink etc. For everyone, but especially for those who have experienced traumatic experiences of forced confinement or of coercion, it is crucial to feel free to move around at ease.

Places with noisy stimuli can easily irritate patients, because of their high *arousal*, and in particular those noises that recall the experienced trauma, such as a suddenly opened door, that can recall the opening of a cell in prison, a prelude to a torture session. By night awakenings or anxiety crisis are frequent, especially if patients live in overcrowded and noisy rooms.

It is useful for the services to be 'low-threshold', that is, easy to access, with formalities and bureaucratic steps reduced to a minimum. It is necessary that not only the environment but also the relationship with traumatised persons is reliable, with a strict respect for timetables and commitments, asking for consent before any action (for example, semiologic manoeuvres in course of a medical examination, a phone call etc.) because these behaviours help to rebuild human relationships based on trust.

Staff must be effectively formed to handle even relational unpleasant stimuli, such as aggressive behaviour or fits of anger: the relationship with the patient must then be 'resilient', capable of tolerating attacks and frustrations, and at the same time welcoming, inclusive, empathic, delicate and with availability of time. It is necessary to offer support and encouragement to the patient, without paternalism, but in an equal relationship.

Such an attitude will become easier for us if we keep in mind that, despite their perhaps modest appearance, our patients are people who have been able to overcome extraordinary challenges, and who above all deserve our admiration for their courage, their determina-

tion, their tenacity. Asylum-seekers and refugees, in fact, have generally successfully coped with vicissitudes and difficulties out of the ordinary, which required courage and extraordinary fortitude.

Communication can be difficult both because victims of violence and torture may have impaired ability to concentrate and attention, and due to limited knowledge of the local language, with an understandably high risk of misunderstanding. Even for this it is necessary to offer ample time for conversation, explaining each step, giving information that is not required but which could be useful, verifying the interlocutor's understanding, actively offering space for questions and clarifications.

At the time of filling in the medical record it is necessary to inform patients about confidentiality of what will be said, that they are free to answer or not to the questions, that they are invited to ask for explanations, they can get up and even leave the interview at any time. They must feel of being free, and really be free. This initial process certainly requires a little extra time, but it puts at ease our patients and fosters a relationship of trust.

Drugs prescription often requires caution, because the victims of intentional violence (due to the difficulties in concentration and memory mentioned above) may present irregularities in the intake of drugs, due to forgetfulness or misunderstanding of the dosage. Sometimes creative solutions are needed by clinicians, such as writing with their own hand the dosage of the drugs on the packs, or preparing small single-dose packs with the date and time of each intake, or adapting the prescription to allow the drugs administration only once a day. The goal is to reduce the possibility that the patient gets confused and, for those who are guests of reception centres, to allow the delivery of therapy by the operators of the structure (so that compliance is improved, the risk of abuse or inappropriate way of taking the drug etc.).

That said, a psychopharmacological intervention has the limit of not being decisive but it can still be very useful in reducing the most disturbing symptoms. Thus, it may be helpful to prescribe drugs that help restore the sleep-wake rhythm, that decrease arousal and impulsivity in patients with irritability, that support mood and reduce the intrusiveness of post-traumatic thoughts. A separate discussion concerns the use of antipsychotics, potentially useful in cases of psychotic decompensation (often in the form of delusional *bouffée*), but at times with the risk of abuse by clinicians. It should be remembered that some post-traumatic phenomena may resemble primary psychotic symptoms, but their clinical characterisation, prognosis and their treatment are different, so inappropriate prescription of antipsychotics should be avoided.

We want to emphasise that the reception constitutes not only a delicate moment with refugees but also and perhaps above all an opportunity: the first approach with the team that will take care of them, the patients will feel welcomed and feel they are in the right place

to express their difficulties and find relief. A warm and respectful welcome is the sign of a hospitable and open attitude to the other, not only capable of promoting effective care, but also a rehabilitative function, because it means recognising and meeting the person as a precious and unique human being, with his or her history and dignity.

5 Health Policies and Guidelines for Welfare Protection in Italy

Italy has regulated and structured a system of protection for asylum-seekers of great political and social significance. Also, from the point of view of public health, Italy has a good tradition in the protection of immigrants and refugees. Since 1995, policies and regulations have taken into account the foreign population, even in conditions of social fragility and legal weakness, defining a highly inclusive legal body (Marceca, Geraci, Baglio 2012). In recent years, however, this focus on hospitality, protection and safeguarding has undergone a significant downsizing (Geraci 2018; 2020).

Following the increase in landings and evidence of significant numbers of psychologically traumatised people, on 24 April 2017 the decree of the Ministry of Health on "Guidelines for Assistance and Rehabilitation Interventions as well as for the Treatment of Mental Disorders of Holders of Refugee Status and Subsidiary Protection Status Who Have Suffered Torture, Rape or Other Serious Forms of Psychological, Physical or Sexual Violence" was published in the *Official Gazette* of the Italian Republic, with the related health interventions to be carried out (Ministero della Salute 2017). The "Guidelines" aim to protect those seeking international protection who are in particularly vulnerable conditions, creating the conditions for the health of the victims of traumatic events to be adequately protected.

Table 1 Early identification and taking charge of victims of intentional violence: *who*, *where*, *how*

Social workers of the reception structures	**Doctors and psychologists reception facilities or the NHS**	**Psychiatric services or other structures recognised by the NHS**
In everyday life	*In an appropriate setting*	*Integrated multidisciplinary interventions*
Observation of 'sentinel symptoms' after specific training	Interview possibly with the support of specific tools	Confirmation of diagnosis and treatment

The "Guidelines" emphasise that applicants and holders of international protection are a population at high risk of developing psycho-

pathological syndromes due to the frequent incidence of stressful or traumatic experiences. They are people forced to leave their country generally to escape persecution. They can also escape from contexts of generalised violence caused by wars or civil conflicts. Furthermore, during the migratory journey, they are often exposed to additional dangers and traumas: exploitation, violence and aggression (including sexual abuse), malnutrition, inability to be treated, psychophysical humiliation, detention and rejections. The traumatic events that affect them have serious consequences on their physical and mental health, with consequences on their well-being, their families and the community. According to the "Guidelines", in order to provide an adequate response, the Italian health system must pay attention to emerging needs, groups at risk of marginalisation, fairness of the offer to ensure healthcare in line with the necessity and in compliance with constitutional principles. It is necessary, therefore, to plan adequate tools in order to assist this new multicultural audience, heterogeneous, marked consistently by trauma. A reception adequate to the complexity of needs, and the protection of the rights of applicants for protection, requires a reorganisation of the health services, by defining procedures and competences and by training the staff, which is difficult given the limited resources available (in fact, dedicated economic resources are lacking).

With regard to mental health, the aforementioned ministerial guideline for taking charge of patients who have suffered torture or other serious forms of psychological, physical or sexual violence, identifies specific health interventions for the different phases of the process of protection. The document highlights some key aspects of reception and care, such as the early identification of mental health needs, the recognition and accessibility of rights, the adequacy of the setting and the development of skills through training activities aimed at the personal.

The Regions must implement the indications received and for this reason some ministerial projects have been proposed. At the time of writing these pages (March 2021), only the Lazio Region with Resolution no. 590, 16 October 2018, "Indications and Procedures for the Reception and Health Protection of Applicants for International Protection" (Regione Lazio 2018), took up the national document, following its formulation, recalling its principles and adapting its indications to the regional health system. Each health unit involved must monitor the implementation of multidisciplinary paths, drawing up an annual qualitative-quantitative report on the activities carried out and on the main problems encountered at the clinical, organisational and training needs level, to be transmitted to the Health Department of the Region, with particular reference to the issue of the health of victims of intentional violence and torture. From the other Italian regions, nothing.

The Italian scenario of mental health among refugees requires complexity of analysis and intervention. The demographic characteristics of the migratory movements in Italy seem to have changed in

recent years, and this inevitably requires data and analysis that we do not fully possess to understand in detail what is happening, how these changes are affecting the health of the applicants for protection and what could be the most effective protection interventions.

The first indicators show that the demand for psychiatric care by these immigrants is increasing, even if the qualitative characteristics of the phenomenon still appear not fully defined. However, the recognised risk factors for the mental health of immigrants seem to be on the rise, according to what is possible to know about recent flows.

As regards the offer of assistance, the psychiatric services appear to be in difficulty, for organisational and clinical reasons. A first problem is that the characteristics of the users make the need for competent translators particularly difficult to meet, because mediators in less known African languages are frequently needed, given that the low level of newcomers' education is often accompanied by a lack of knowledge of the official languages of their countries (English, French or Portuguese). Furthermore, in the psychiatric and psychological setting the mediator has a key role, for which skills are needed that are not limited to linguistic competence, for which mediators must receive adequate training. Finally, many healthcare unit still lack procedures that make the call of the mediator a fluid act, so that clinicians sometimes feel powerless in the face of linguistic-cultural barriers. It should be emphasised that often the lack of mediators has negative consequences on the modalities of assistance (Tarsitani et al. 2013), therefore it is necessary that these obstacles will be overcome.

A second problem is that the psychiatric services, already understaffed in many areas of the country, also suffer from a lack of specific expertise, both in psychotraumatology from intentional violence (a sector of relatively recent psychopathology), and for the cross-cultural competence. The Italian Ministry of Health "Guidelines" for refugees and asylum-seekers victims of torture and other forms of intentional violence should fill this void at the organisational level, supporting health units in creating appropriate treatment procedures. Training courses have to be organised for professionals, and must be appropriately funded. However, the fact that the law prescribes the implementation of the guidelines within the already lacking ordinary funding, i.e., without additional economic resources, make difficult to reach the goal, given the decreasing number of mental health operators in the Departments of Mental Health in many areas of Italy. Yet, even though the situation may appear difficult, and even frankly daunting, the firmness in looking with realism at the current situation can only increase the skills of the reception system in Italy. And, as it often happens, facing difficulties proves to be an opportunity for the growth of the overall assistance and health services involved, with potential positive effects on the whole system.

Finally, it should be emphasised that mental health services cannot operate as islands, detached from the social environment in which they operate. As we have seen, the post-migration living difficulties greatly worsen the mental health conditions of our patients. In many cases they even create stress and suffering that in the event of a less rough migration probably would not have arisen. All this was further exacerbated by the pandemic, which affected especially people who were already in disadvantaged social conditions (unemployed, precarious workers, illegal immigrants, asylum seekers still awaiting definition of their request or who has been rejected etc.). Networking with social support services to mitigate these difficulties and promote better living conditions is an essential aspect of mental health assistance, not only to treat sick people, but also to prevent the onset of suffering in those who, although arriving in Italy after very painful experiences, have shown good resilience skills and have not yet developed psychopathological symptoms.

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