Ethnographies of new clinical encounters.
Immigrant’s emotional struggles and transcultural psychiatry in Portugal.

Key words: anthropology of emotion, critical medical anthropology, ethnopsychiatry, anthropology of pharmaceuticals, West Africa, Guinea Bissau, Archipelago of the Bijagós, African Diaspora, transnationalism.

Abstract: In a world of increasing human mobility, many health outcomes are shaped by interactions between care providers and care recipients who are embedded in different discursive practices and culturally based systems of meaning. In these consultations, operators and users often deal with a wide variety of unfamiliar health practices and behaviours. In these original encounters suffering is organized, experienced and expressed in terms of nested series of schemes involving pre-established knowledge about symptoms, illnesses, models of affliction and wider socio-moral notions of personhood and the Self. Acknowledging anthropological approaches to ‘emotions’ as a helpful theoretical tool for migration studies, I will focus the emotional experiences implied in migration and in the formation of diasporic identities. Based upon a two years fieldwork in a mental health service for migrants, this presentation underlines how the psychiatric interpretation of the emotional experience of displacement, homelessness and (non)belonging in migrants can be influenced by colonial legacies. These legacies - incorporated, despite the best of intentions, as a constitutive element of diagnosis and treatment into the therapeutic practices of psychiatric counselling - pathologize experiences and behaviours of marginalized people of non-Western origins, reproducing discriminative attitudes and institutional racism.

You came to me, Hippocrates, to give me the hellebore, giving credit to foolish men by whom my job is considered madness. I was writing about the harmony of the cosmos, the description of the pole and about the stars... If you, convinced that I was insane, had made me drink this medicine, my wisdom would have become madness and your art would have been blamed as responsible of creating folly.

(Letter of Democritus to Hippocrates; Hippocrates, 77, 79).

In a world of increasing human mobility, many health outcomes are shaped by interactions between care providers and care recipients who are embedded in different discursive practices and culturally based systems of meaning. In these new clinical encounters, operators and users often deal with a wide variety of unfamiliar health practices and behaviours. This paper - based upon my past experiences as an anthropologist in a Italian ethnopsychiatric centre and upon two years of fieldwork in a Portuguese transcultural mental health service and drawing on the

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life history of Milocas, a African immigrant woman - invites reflection on the unconscious reproduction of colonial paradigms in psychiatric settings, with the effect of maintaining and re-enacting persisting structures of inequality.

The goal is to highlight how the frequent failure of therapeutic interventions, could be interpreted as a consequence of the partial silencing of the voices of the migrants speaking about their very real afflictions, lived experiences and profound discontents, in a context of persisting colonial power relations.

**Milocas’ clinical history.**

This case is only a paradigmatic exemple constructed from a wider set of cases I worked upon in Italy and in Portugal to illustrate the possible misunderstandings in these complexe encounters. Obviously, all the names and some details of the history have been changed to preserve the patients’ privacy.

Milocas is a Guinean woman born in Bubaque, in the Bijagó Archipelago in Guinea Bissau, in 1971. Her mother left her husband when Milocas was born, and moved to Bissau to improve her economic condition. Milocas’ mother dreamt for her only daughter of a future in Europe, a good job and a rich husband: trying to offer her a better life was her greatest worry. With this purpose, according to Milocas, her mother made a deal with a European woman, a trader working between Africa and Europe, asking her to bring her daughter to Portugal, and promising to pay for this service. As agreed, Milocas moved to Lisbon and quickly found a job and a partner, from whom she had a daughter.

Eight months ago, Milocas assaulted a European woman because, according to her, she kept on observing her and wanted to kidnap her child. Milocas explained to the judge that she had attacked the woman to defend her child. The voice of a European woman, Milocas complained, continuously asked her to pay off the debt that her mother had failed to pay, with money or with her daughter’s life. As a consequence of her behaviour and of her bizarre declarations to the judge, she was directly sent to a psychiatric service.

Despite her internment, that voice has never left her in peace and she is very distraught as a result of these threats. She complains of continuous headaches and the unpleasant feeling of water entering her head through the fontanel. She also talks about gynecological problems, like pains in her womb and amenorrhoea. She also feels observed, and not truly free: everybody, she complains, asks her for things she cannot give, things she neither knows nor remembers.
She always feels threatened by the police, by the doctors, and especially by that European business woman her mother made the deal with. She maintains that the origin of her problems has to be attributed to this woman to whom her mother owes some money. She describes herself as a victim of this woman: “she is a witch”, Milocas says.

Months ago, before her internment, as the ‘white’ doctors did not believe in these things, she tried to solve her problem by consulting a *curandeiro* (healer) from Guinea Bissau, who knew how to deal with this kind of situation. He tried to cure her with purifying treatments and recommended her to give some offerings to the sea. Milocas accomplished these prescriptions, but she was still scared, afraid and uneasy. ‘I don’t believe in these things’, she says, ‘I’m Christian and I never wanted to establish a relationship with this business-woman’. Nevertheless she carried on with this treatment for three months. She was fine: she stopped hearing the woman’s voice as well as the noise of the water in her head, her headache was gone, while her menstruation and energy had returned. As she felt better, she decided to stop the treatment, that for her was too expensive: 30 Euro per week, and a lot of offerings to the sea that included expensive items, such as perfume or whiskey. Since taking this decision, she has felt worse again.

With the doctors at the psychiatric hospital, she complains about muscular spasms, feeling short of breath and of loss of identity. She says that she continually hears the business woman’s voice insisting that she pays off the debt. A few days before being interned in the hospital, Milocas had spent her entire month’s salary going by taxi from her house to the beach, struggling against the fear of drowning or of being swallowed up by the sea. Talking to the doctors, Milocas continues to accuse her mother, obsessed by the desire of a luxurious life, of being the cause of her afflictions: she ignored the rules of her society and separated from her husband, merely to satisfy her thirst for power and wealth. Through Milocas’ body, the angry voice of the business woman asks Milocas’ mother to pay off the debt: ‘You once promised me your daughter, so *you* are the cause of her suffering’. Interrogated about these affirmations, Milocas maintains that she doesn’t remember anything.

When Milocas arrived at the psychiatric hospital, the doctors considered her behaviour typically psychotic and suspected schizophrenia. As a consequence of this diagnosis, and despite her resistance, Milocas was forced to take drugs. The therapy (a high dose cocktail of different neuroleptics, including Nozinan, Haloperidol, Olanzapine, Sulpiride, Loxapine) was meant to suppress her mental creations. To the great dismay of the physicians, however, the
pharmacological therapy has not worked. After several months nothing has changed, except the fact that Milocas now looks like a zombie and expresses her uneasiness using the very discourse the physicians used to interpret her behaviour. ‘I am different from the others’, she says, ‘now I know that I am sick, that I am crazy. The physicians have told me that I don't know what is real, because I’m schizophrenic’. A diagnostic category, in other words a label or a model, is now for Milocas a fact, destined to mark her life. She is now looked upon as crazy or sick, not only by the psychiatrists but by herself as well.

**Mental Health Services for Migrants in Portugal.**

While generally speaking, Portuguese hospitals and health care centres have not developed specific practices for immigrants and there are no special facilities to which users can be referred, in recent years there has been an attempt to make mental health services for immigrants more culturally aware and sensitive. In 2004, the Portuguese Nucleus of Transcultural Psychiatry and Psychology, founded in 2002, inaugurated a culturally sensitive mental health care center for immigrants at the Miguel Bombarda Psychiatric Hospital. In Portugal, providing better services for immigrants has never been a public health priority: it was therefore both an innovative and significant experiment. Despite this commitment, the experience has been largely problematic. The encounter with the “cultural Other”, used to different therapeutical theories and practices, has revealed in effect a heavy legacy of colonial psychiatry\(^2\). This legacy - incorporated, despite the best of intentions, as a constitutive element of diagnosis and treatment in this case as in other centres in which I’ve conducted my past researches - pathologizes experiences and behaviours of marginalized people of non-Western origins, (re)producing discriminative attitudes. What interests us here, is how scientific knowledge and technological advances perpetuate the illusion of the superiority of Western psychiatry.

My fieldwork in psychiatric services and in other health centres for immigrants in Italy and Portugal has revealed how much racism and prejudice still mark mental health workers’ attitudes toward immigrants. Analyzing the emblematic case of Milocas, we might find

\(^2\) While I am revealing the colonial legacies of Portuguese psychiatry, I think it is important to place my own theoretical stance within the specific tradition of the democratic psychiatry European movement. In particular, I am heavily endebted to the thought of the Italian psychiatrist Franco Basaglia, who came to understand madness as a human expression of undifferentiated human needs and as an oblique act of protest against a society that defines difference as a deviance. His political and social agenda involved decriminalizing mental illness and unmasking psychiatric expertise as a justification for exclusion and confinement.
unexpected continuities between the viewpoints and diagnostic categories of colonial psychiatry and the current attitudes of health workers towards immigrant patients. The interpretation of Milocas’ behaviour as deviant and pathological, is not simply an act of individual racism or a consequence of ignorance. It is not my intention to say that all psychiatrists are racist or have colonial attitudes. The problems, in my opinion, lie much deeper than that, in the very definition of psychiatry as a scientific discipline, based on the assumption of the biopsychic unit of humankind, and therefore universally valid. This paper highlights the fact that it is the very functioning of the psychiatric system that is racist. All judgments of abnormal behaviour are rooted in conceptions of what an “ideal” or “normal” life should be, along with ideas about proper and improper forms of behaviour. Moreover, decisions regarding the normality of various behaviours are made by medical and psychiatric professionals. In this sense, I consider medical designations of this nature as social judgments, and the adoption of a medical model of behaviour, a political decision. The imposition of a norm and the classification of other experiences according to the rigid grid of psychiatric nosology has in fact an evident political meaning: the overlapping of meanings is a mirror of the overlapping of powers.

As such, the DSM (Diagnostic and Statistical Manual of Mental Disorders) and the ICD (International Classification of Diseases) are seen by many authors as neocolonialist endeavors: these two “bibles” of Western psychiatry, according to critics, declare certain behaviours as ‘deviant’ using ‘science’ and ‘truth’ as an excuse, irrespective of historical and cultural variability. Labels become facts, while local meanings are lost in the translation to a foreign, academic language, and are stigmatized because of the distance from Western standards of normality and rationality.

Milocas’ case provides an example of the complexities associated with culturally sensitive diagnosis. Psychiatrists’ diagnosis has identified the views and attitudes of Milocas as different and unacceptable, and so they declare her sick. Milocas’ concern about others always observing her, is considered as a symptom of a paranoid personality, without considering her illegal condition, the real experiences in her life related to racism or the cases in which she was racially categorized because of her skin color and appearance. Her references to the European business woman, that clearly allude to the cult of the water spirit called Mamy Wata diffused all along the coast of West Africa, is interpreted as symptoms of her psychosis. Milocas’ assertions about witchcraft or spirits are interpreted as symptoms of her paranoid personality based on “typical African superstitions”. Terms such as beliefs, superstitions or morbid suggestions, as opposed to
scientific knowledge, are used very often by the medical staff during the interviews to stigmatize her interpretations and practices. Paradoxically the transcultural mental health practitioners pathologize Milocas reflections reading them as inappropriate interpretations of her experiences or even worse as symptoms of mental health problems. Her bizarre interpretations in this sense, were considered incompatible with that "rational normality" psychiatrists were trying to restore, and were therefore targeted by therapy. Ironically, the goal of the self-defining transcultural staff was to "mainstream" the African patients into social and cultural "normality" as defined by the discourse of medicine and psychiatry. Milocas’ culture, in this sense, is pathological in itself and an obstacle to the goal of assimilation.

In this way, Milocas’ conduct is reduced to simple formulae, without any effort to embed it in wider semantic fields. The option of bargaining with the business woman who has so much influence and so much power, paying this debt with an adequate ritual, has not even been contemplated: on the contrary, the final goal of treatment has been simply to silence her voice. Milocas’ interpretation has been silenced, in favour of the Western ideas of normality, deviance, health and illness, implicit within the biomedical model. Institutional racism, in my opinion, occurs in many guises, but the imposition of a dominant culture’s beliefs and values over those of people from minority groups constitutes one of its most powerful variants.

What can psychiatry offer Milocas to replace her different identity and reality? Apparently, she has no alternatives: she is medicalized and interned at the hospital. Nobody has explored alternative explanations to provide an adequate answer to Milocas’ suffering: in her case, for example, notions of causality as sorcery and spirit possession might have been more efficacious healing paradigms, than the biomedical ones, allowing her a different future. The goal of many traditional healing practices is in fact to redefine the place of the afflicted person in her or his social group. In this case, for example, notwithstanding her actual suffering, Milocas’ affliction, if interpreted as a possession crisis of the Mamy Wata cult, might have found an happier conclusion, conferring a socially accepted status on her and acknowledging her outstanding attributes.

By this, I do not wish to say that a recourse to official psychiatry might not prove successful for immigrant patients. Many immigrants that I’ve interviewed have deliberately resolved to biomedicine in order to understand and find a answer to their suffering. In these cases, we can affirm, following Frankenberg (1988), that biomedicine is not hegemonic because it represents the dominant medical system, but because its domain is accepted and upelled by people. We
do not consult physicians because their social and medical views were forced upon us, but because we already share their views. In other words, those who turn to biomedicine do so not because they are passive victims of hegemony, but because the other possible explanations for their afflictions make not sense to them.

In addition, it is not my intention to deny the usefulness and especially the charm and the performative and symbolic efficacy of medicines (Van der Geest & Whyte 1991). My interviewees often find western drugs a very attractive option: the pill is a concrete object endowed with special healing powers, and a substance symbolically charged. Following Claude Levi-Strauss’ analysis of the efficacy of symbols, we can consider the drug both substance and symbol: for contemporary theorists of the symbolic efficacy of biomedicine, also the shared sense of the authority of scientific knowledge and of its objects produces its own healing effect.

The drug also objectified healing process and enhanced the perception of suffering as something tangible. The purifying treatments that the Guinean curandeiro prescribed for Milocas, share the same metaphorical logic, trying to remove the illness as an entity from her body. At the Psychiatric Hospital, in the same way, drugs can perform the same function. As Sjaak Van der Geest and Susan Reynolds Whyte affirm:

“the metaphoric movements of medicines in relation to psychiatric conditions are particularly revealing, because such conditions are especially difficult to communicate. (...) (Drugs) are ‘facilitators’ for establishing meaning and for communication. What Lévi-Strauss said about animals and plants in the essay on totemism applies to drugs in a psychiatric setting: they are ‘easy to signify’ (1963: 60). (...) Thus, communication about medication becomes communication about problematic and ambiguous experiences” (1991: 356).

Nevertheless, I think that Milocas’ symptoms constitute a challenge as they seem to require a different explanation to that offered by biomedicine. What I’m trying to say is that there are issues that make sense within a specific discourse and that, disconnected from this horizon of meaning, become senseless. I think that listening the ways in which subjects interpret their affliction is an indispensable strategy for understanding the multiple symbolic dimensions of suffering and the different cultural forms which might integrate the healing process. Illness narratives can be considered not only as moments of experience dramatization. They are true and genuine devices for the symbolic organization of the healing experience and of health process, playing a fundamental role in the creation of meaning through which the subjects try to objectify and make sense of their experiences.
Considering the Milocas illness narrative, in my opinion, Western diagnostic categories violate the local meaning of her experience, and thus the knowledge on which it is based. Furthermore, because Milocas’ behaviour and spiritual experiences are not plausible realities among mainstream psychiatric evaluators, psychopathology continues to be the only explanatory model.

Milocas’ clinical history is a paradigmatic example of the incomprehension and the presumption still marking mental health services for immigrants. Instead of relegating cultural aspects to the rank of incidental curiosity, it would have been necessary in this case to take into account the way in which Milocas and her reference group define and make sense of the situation she was living. Milocas’ case shows how the rigid structure of biomedical nosology can pathologize the experiences and behaviours of the others, regarded as alien, reproducing the already existing structures of social inequality.