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Psychologists' experience in mental healthcare services for migrant population in Italy: A qualitative study.

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ABSTRACT.

This qualitative research presents the results of an investigation conducted in Italy on a group of psychologists working in mental healthcare for migrant population. These professionals addressed problems characterized by complexity, in particular related to high level of trauma encountered among migrants and to intercultural aspects to consider in the clinical practice. The author, a physiotherapist specialized in mental healthcare, was interested in the investigation of facets related to psychologists' distress, secondary reactions, coping strategies and resilience, with a particular focus on the bodily reactions. The findings confirmed the presence of various phenomena of both positive and negative character, that could be linked to existing constructs described in scientific literature. The negative phenomena showed to be in relation to both objective stressors and subjective factors. The positive ones revealed the link between psychologists exposition to stressors and their growth at personal and professional level. Original themes that further emerged from the analysis were that of the body as a work-tool and that of re-humanization. The latter could be seen as the essence of psychologists' intervention, in responding to the extreme de-humanization which they frequently witnessed in migrant population. The theme of the body as a work-tool appeared to be strictly related to the constructs of body-awareness and embodiment. Besides the qualitative investigation by means of interviews, also a supplementary observation of body patterns was conducted that confirmed a remarkable level of physical affliction, evidenced in deviations from posture and respiration patterns. Thus, the results underpinned the relevance of the subject of interest, stimulating further investigations. Building on these findings, new research should override the limitations of this study that did not explore subjective characteristics and traits that also could have an influence on coping mechanisms and resilience of psychologists. By exploring the relationship between body phenomena, body awareness and resilience in clinicians, a possible goal of further research could be the contribution to the development of a prognostic tool and of a therapeutic concept, to be used with supportive function for the psychologists. The contribution of a body-oriented approach like that of Norwegian Psychomotor Physiotherapy could be worthy and should be considered.

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ABBREVIATIONS, FIGURES AND TABLES

Abbreviations

AIDA:	Asylum Information Database
AMIF:	Asylum, Migration and Integration Fund
CAS:	Centro di Accoglienza Straorinario (Extra-Ordinary Hosting Centre)
CBE:	Comprehensive Body Examination
CF:	Compassion Fatigue
CIE:	Centro di Identificazione ed Espulsione (Center for Identification and Expulsion)
IPRS:	Istituto Psicanalitico per le Ricerche Sociali (Psychoanalytical Institute for Social Researches)
IRCT:	International Rehabilitation Council for Torture Victims

NGO: Non Governmental Organisation
NSD: Norwegian Center for Research Data
NPMP: Norwegian Psychomotor Physiotherapy
PICO: Patient /Population /Problem - Intervention - Comparison /Control - Outcome
PTG: Post Traumatic Growth
PTSD: Post Traumatic Stress Disorder
STC: Standard Text Condensation
STS: Secondary traumatic stress
SESAMO: Servizi di Salute Mentale per Richiedenti e Titolari di Protezione Internazionale / (Mental Health Services for Applicants and Holders of International Protection)
SPRAR: Sistema di Protezione per Richiedenti Asilo e Rifugiati (Protection System for Asylum seekers and Refugees)
UNHCR: The United Nations High Commission for Refugee
VR: Vicarious Resilience
VT: Vicarious traumatization /Vicarious trauma

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APPENDIXES

1. INTRODUCTION.

This chapter describes a number of aspects related to the subject of interest, which is the experience of psychologists who work with migrant population in Italy. First the author's professional background and foreknowledge are outlined, followed by a synthetic depiction of migratory phenomena in general and specifically in Italy. The text will then focus on mental health problems in refugees and asylum seekers and on secondary phenomena occurring in clinician who work with this population. A number of relevant terms and constructs found in literature are presented, in the pertaining paragraphs. The description of many facets is due to the complexity of the subject and will lead to the formulation of the thesis' title and research questions, presented at the end of the chapter.

1.1 Author's background and subject of interest.

The interest for the thesis' subject stems from the author's professional specialization in physiotherapy in mental healthcare and from previous work experiences, in particular related to clinical treatment of migrants and refugees. The author had already treated migrant patients occasionally in his earlier clinical work experiences in Italy and Norway, some of them with histories of trauma and torture. A long permanence in Colombia in 2014, meeting professionals who worked with victims of intern conflict and observing the high level of exposition and burnout they were exposed to, stimulated the idea about the subject of this thesis. A subsequent work-experience in 2015/16 at a Red Cross treatment center in Sweden for migrants victim of war and torture, further fostered this interest. Furthermore, the author's first-hand experience of resettling can be considered as a relevant part of the background, knowing first-hand what it means to move abroad and to adapt to a new culture. The issue of cultural competence is definitely an interest of the author and a facet in this research, even if not the primary subject of interest.

As the following text will argue for, specific competences and skills are required to meet the health needs of this population who is highly affected by mental health problems and particularly by traumatic experiences. Before deepening these aspects the next paragraph will introduce the Norwegian psychomotor physiotherapy, to give a better understanding of author's professional specialization.

1.2 Norwegian Psychomotor Physiotherapy.

Norwegian Psychomotor Physiotherapy (NPMP) is a clinical method within the wider context of physiotherapy in mental healthcare. It was developed in Norway in the late 1940's-early 50's by the cooperation between psychiatrist Trygve Braatøy and physiotherapist Aadel Bülow-Hansen, then further developed in the following decades by clinicians and scholars in the field (Bunkan, 2010, p. 5), (Heller,2007). The term "Norwegian Psychomotor Physiotherapy" nowadays is used to indicate the method, the collegial group and the educational program given in academic institutions in Norway.

NPMP is electively dispensed for the treatment of a specter of problems where a body approach is indicated, e.g psychosomatic conditions, musculoskeletal syndromes, functional syndromes, states of anxiety and/or depression, eating disorders, etc… (Bunkan, 2001), (Thornquist, 2006). It can also be adapted to support patients with more severe psychiatric conditions (Bunkan, 2001), (Gretland, 2009, p.45-59). NPMP is characterized by core therapeutical factors that are common also to other approaches, as being person-centered, adaptable to the specific needs, foreseeable, empathic and process-oriented (Bunkan, 2008, p. 214-215), (Gretland, 2009, p.206-209). A central effect in NPMP treatment, similarly to other body-oriented therapy forms, is the enhancement of patient's *body awareness*. This construct will be described further on, due to its relevance. There are slight differences among NPMP practitioner in practical approaches and theoretical perspectives, but consensus is shared on the fact that the method is characterized by a unifying view of mind and body, where the latter is conceived as contextual, bearer of meaning and filled with lived experiences (Gretland, 2009, 20-21), (Kirkengen & Thornquist, 2012). Many scholars in NPMP rely on a phenomenological theoretical perspective as a basis for theirs reasoning and research (Kirkengen & Thornquist, 2012), (Øien, Iversen & Stensland, 2007). Phenomenology is a philosophical tradition where the French author Maurice Merleau-Ponty represents a key figure, with his theorizations and cornerstone essays arguing for the centrality of the body in human experience, the body that one "is" and "has" at the same time (Kirkengen & Thornquist, 2012), (Merlau-Ponty, 2012), (Øien, Iversen & Stensland, 2007). This theoretical basis gives a good framework for clinical reasoning in NPMP, that can delucidate both the peculiar "way of doing" in practice, as well as explain for the production of mainly qualitative research among scholars in the field. Some of these have anyway focused also on quantifiable findings in NPMP, developing specific body examinations

procedures (Bunkan, 2003), (Kvåle, Bunkan, Ljunggren, Opjordsmoen & Friis, 2010), (Kvåle, Bunkan, Opjordsmoen & Friis, 2012), (Sunsvold, Vaglum & Denstad, 1982). To name here is the *Comprehensive Body Examination* (CBE), a psychometric tool adopted for its suitability for the purposes and limits of this thesis. CBE will be described in the methodology chapter.

1.3 Previous research.

The first step in the process was to look at previous research through a preliminarily literature search, to gain a first overview of existing results and constructs. This was useful to orient to a more systematic search, done subsequently and with the support of competent personnel at the UniMet library service. The *PICO system* was adopted, o give a structure to the literature search (Kunnskapsbasertpraksis.no, 2018). PICO is an abbreviation that stands for: Patient/Population/ Problem - Intervention - Comparison/Control - Outcome, and it can be used to assist in defining inclusion and exclusion criteria in a literature search. In this case PICO was applied so to funnel to literature results on phenomena occurring to clinicians, in particular to psychologists treating refugees and migrants. Other professional groups were excluded in order to limit possible confounders e.g. interpreters assisting psychologists in clinical work were not included, even if these professionals too are exposed to secondary phenomena in trauma work (Splevins, Cohen, Joseph, Murray & Bowley, 2010). Comparison and outcome were not applicable, since the scope was not to look at the effect of particular clinical procedures. Table 1 below summarize the use of PICO method in literature search.

A preliminary search in the database Oria was conducted using relevant terms in different combinations, including material published in English language and within ten years limit (2007 - 2017). This showed the existence of a number of articles and books on the subject. Further searches on Oria, PubMed, Ovid and CINAHL databases were done using the MEsH terms of Compassion fatigue, Secondary traumatization, Vicarious traumatization, Secondary trauma, Vicarious trauma, Post-raumatic growth, Vicarious traumatic growth. Further relevant sources were retrieved in subsequent steps by checking the bibliography of selected articles and texts, and through personal communications with peers. Literature on constructs as body awareness, resilience and vicarious resilience was included later, since these constructs showed their relevance in more advanced phases of the research and writing process.

Table 1

PICO system applied in literature search.

PICO system	
Population / Problem	Psychologist, Psychotherapist
Intervention / Exposure	Aspects related to mental health work with migrants and asylum seekers. Search terms included: Secondary trauma, Vicarious trauma, Resilience, Vicarious growth, Compassion fatigue, Burnout
Comparison / Control	- Not applicable -
Outcome	- Not applicable -

The next paragraph will introduce several definitions pertaining to this population and clarify for the author's choice about the use of these terms.

1.4 Definition of migrant, refugee and asylum seeker.

The subject of this research indirectly addresses problems in the migrant population so it is relevant to describe related terms. The United Nations High Commission for Refugees [UNHCR] differentiates between refugee and migrant (United Nations High Commission for Refugee [UNHCR], 2016-b).

The term *refugee* indicates people fleeing from armed conflicts or persecutions, unable to return home due to life-threatening risks, and who are protected by specific international laws (UNHCR, 2016-b).

The term *migrant* applies instead to those people who leave their countries not due to life-threatening reasons: E.g. to search for better life standards, or for opportunity to get an employment or education, to seek for family reunion or other similar reasons, who will still receive protection from their governments in case of return to their home place (UNHCR, 2016-b). The indistinct use of the terms migrants and refugees, particularly by the media, can increase the confusion especially at cost for the category of refugees, who are entitled a higher level of legal protection from international laws (UNHCR, 2016-b).

Another term is that of *asylum-seeker*, that includes both refugees and migrants waiting for their request to sanctuary to be processed (UNHCR, undated-a).

Finally, a last term is used for those people forced to move due to armed conflict or violence but who still live within the borders of their countries, in this case they are defined as *internally displaced people* [IDP] (The UN Refugee agency - UNHCR, undated-b).

In this research the main subjects of interest are the psychologists themselves, while refugees, migrants or asylum seekers can come in the picture indirectly, as third person.

When writing this paper the impression was that it would have been difficult to strictly respect the definitions above described, also for the need to variety the vocabulary for style purposes.

The choice was therefore to use them interchangeably as if they were synonyms when generally referring to the migrant population, and to specify clearly when and if a distinction was needed or relevant. It was of encouragement to later discover similar considerations and editorial choices done by other authors (Cross & Crabb, 2010, p. 275).

1.5 The figures of migration, a brief overview.

In recent years the number of people who leaved their countries in search for a safer place or better life conditions has increased on world basis, reaching highest levels since decades due to war conflicts, political instability and adverse climatic changes (UNHCR, 2016-a). The UNHCR website gives regularly updated figures and statistics over the situation. In 2015 the number of people forced to migrate exceeded the record figure of 65 millions, of which about 21.3 millions classified as refugees (UNHCR, 2016-a). This trend further increased in 2016, a year when migrants hosted in different areas worldwide showed these percentages: North Africa and Middle East Countries (26%) the rest of the African continent (29%) Asia and Pacific (11%) Americas (16%) and Europe (17%) (UNHCR, 2017-a).

Since 2014 the country hosting most refugees worldwide has been Turkey with over 2,5 millions, a consequence of the catastrophic war in neighbour land Syria (UNHCR, 2017-b). Even if Europe hosted a smaller percentage of the overall numbers of refugees, the flux of immigrants to Europe steadily increased since 2011, reaching a peak in 2015 when many Syrians fled their land (Crepet et al., 2017), (Trovato et al., 2016), (UNHCR, 2016-a). Also, these figures show the shifting demographic composition of migrant population coming to Europe: While it was mainly from African continent before 2011, afterwards the quote of migration from Middle-East

countries increased and reached a peak in 2015, again due to war in Syria (Crepet et al., 2017), (UNHCR, 2017-a). Figure 1 below can help to get a visual impression of migration in 2015 included on aspect of mental health problems in this population, that will be discussed later. The next paragraph will deal with the phenomena of migration in Italy.

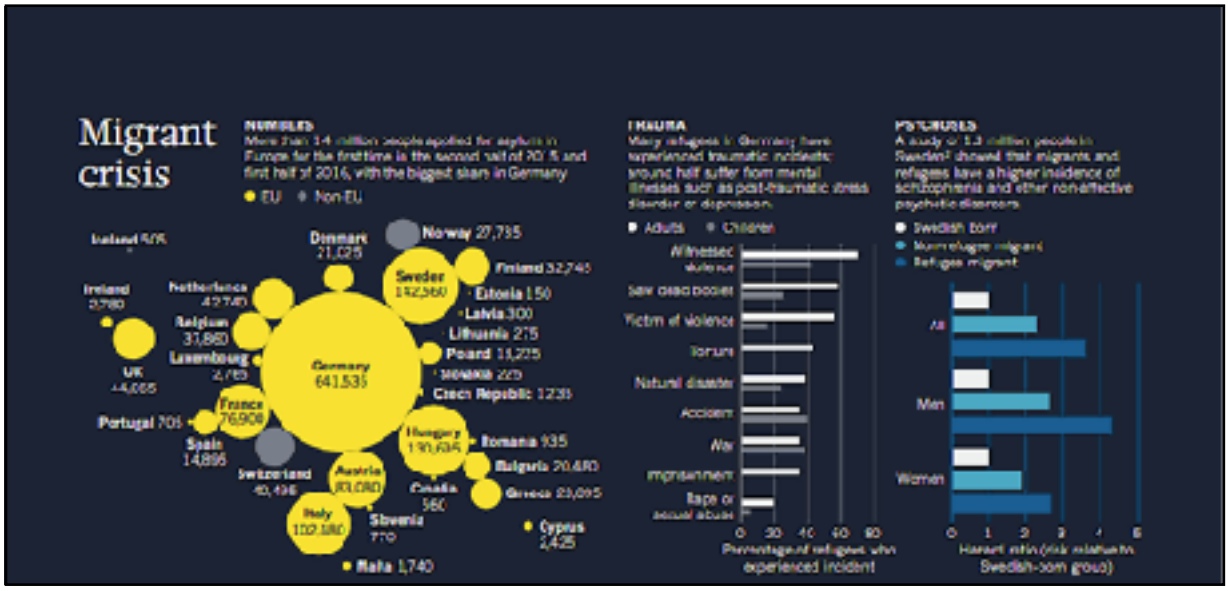

Figure 1. Migrant crisis. Retrieved from "The troubled minds of migrants" by Alison Abbott, 2016, *Nature,* (538), p.160. Copyright 2016 Mcmillan Publisher Limited, part of Springer Nature. Reproduced with permission.

1.5.1 Immigration in Italy.

Italy has been experiencing important migration flows in recent years especially due to war and political crisis in the Middle East and Mediterranean regions. This added to the previously existing, long-lasting migration fluxes from African countries, which in summer 2016 reached new record levels (UNHCR, 2018). Migrants arrive mainly by sea due to Italy's closeness to the northern African countries that border the Mediterranean sea southern coast, in particular Libya.

They come to Italy either to stay or more commonly with a plan to transit toward other countries (UNHCR, 2018). Most of them have undergone a long journey from their countries of origins, often through a dangerous crossing of the sub-Saharan area and landing to Lybia (Crepet et al., 2017), (Trovato et al., 2016). This country is still affected by a long-lasting unstable

political situation and weaken rule of law, that plays into the hands of criminal organizations and traffickers, which smuggle migrants by over-embarking shabby and unsafe boats then abandoned in the open sea, to wait for the Italian coast-guard, NGO's ships or occasional freighter to rescue them (Trovato et al., 2016). NGOs that rescue and give assistance to migrants coming to Italy have collected a number of direct accounts from migrants about the so called "Libyan inferno" reporting human rights violations as torture, sexual abuses, forced work-exploitation, detention and other brutal maltreatments (Oxfam Italia Onlus, 2017). During their flight to Europe migrants are de facto at the mercy of criminal gangs, warlords and smugglers, and they face a life-threatening trip that exposes them to violence, traumas and other stressors that can put their physical and mental health at risk (Crepet et al., 2017), (Trovato et al., 2016). Frequent news on Italian media is that of migrants rescued at sea, and not infrequently that of shipwrecks and tragic loss of human lives.

Also, an issue continuously reported by media is about the political dispute going on in the Italian government and between this one and the European institutions about how to manage the phenomena, since not all European member countries are willing to give their contribution and allow for a fairer redistribution of immigrants in Europe. This fact too led to the political deal signed by in February 2017 by Italy and Libya, committing this country to keep migrants in its detention centers, where appalling conditions are now denounced by human rights defenders (Amnesty International, 2018). These relevant aspects of legal, political and humanitarian character go beyond the main subject of this thesis. However, as the results will show they have consequences for the psychologists in their clinical work.

To recap, migration is a global phenomena of high complexity to address, concerning a heterogeneous population whose geographical and ethnical composition changes during time depending on different social, political and economical issues, that are strictly interconnected.

Migration challenges both home, transit and host countries at many levels, in their willingness to help and give protection or reversely by showing disinterest or even hostility towards the migrant population, an example being through appropriate adaptation of healthcare systems to meet specific needs (Bogic, Nook & Priebe, 2015), (Vostanis, 2014).

Peers in the field distinguish different migration phases and related stressors, which are the topics of the next paragraph.

1.6 Migration phases and related stressors.

Migration and resettling are experiences that can be extremely stressful even when not forced or preceded by trauma, and this can be challenging for the mental health of the migrant (Bughra & Jones, 2001), (Stompe, Holzer, & Friedmann, 2010, p. 23). In literature the migration process is often presented as a three phases process, especially for the purpose of epidemiological studies in this population: These are the pre-migration phase, the migration itself, and the post-migration phase (Bhugra & Jones, 2001), (Stompe, Holzer, & Friedmann, 2010, p 23).

Pre-migration phase is commonly characterised by complicated experiences related to war, to political, ethnical or religious discrimination or life threatening situations, to traumatic experiences and human rights violations or to socio-economical factors like poverty or lack of future perspectives, events that frequently force migrants and asylum seekers to leave their homelands (Bhugra & Jones, 2001), (Stompe, Holzer, & Friedmann, 2010, p. 25).

The second phase in the migration process, intended as the *intermediate phase* of moving from home to host country can also be extremely challenging or even life-threatening, due to the often dangerous journey where most migrants face high levels of physical and psychological stress and often experience or witness traumatic events or human rights violations (Crepet et al., 2017), (Varvin, 2015, p. 43).

When arrived in the host country the *post-migration phase* begins, commonly characterized by a long wait for bureaucracy to confirm or reject the asylum-seeker's application (Deutsche Welle, 2017). Language barriers and impossibility to work or study are among the hindrances characterizing the early stage of this phase, followed by bereavement for the loss of home culture and adaption to the new one, and often confronting with problems like discrimination or social exclusion (Bhugra & Wojcik, 2010), (Varvin, 2015). This phase is usually long-lasting, charged with specific stress factors that can have a cumulative effect on previous life events and traumas (Bhugra & Wojcik, 2010). Many authors highlight the importance to limit and reduce the post-migration phase stressors as much as possible, to prevent the development or the aggravation of mental health problems in this population (Harris, 2007, p. 93), (Herrman, Kaplan & Szwarc, 2010, p. 55), (Vostanis, 2014).

The next paragraph will look closer at the facet of mental health problems migrants, that psychologists in this investigation specifically address.

1.6.1 Migration and mental health.

Scholars in the field underline the fact that mental heath care for migrants is a complex issue to address, especially due to cultural aspects to be considered and to severity of traumatic experiences that are frequently presented to the clinician (Alayarian, 2007-a, p. 141-159), (Craig, 2010, p. 9-19). Common mental health problems encountered in this population are post-traumatic stress syndrome (PTSD), depression and anxiety disorders, and less frequently other as dissociative states, paranoid schizophrenia, psychosomatic symptoms, suicidal thinking, difficulty in regulation of emotional state (Alayarian, 2007-a, p. 141), (Bogic et al., 2015), (Butler, Warfa, Khatib & Bhui, 2015), (Vostanis, 2014).

There are anyway not univocal findings on the dimensions of mental health problems among migrants, since the number of stress factors and the range of potentially traumatizing experiences span in a wide specter, from lesser traumas to extreme ones like torture and dehumanising practices, making it difficult to quantify the extension of the problem (Hawkes, 2007, p. 97-110), (Turner, 2007, p. 29), (Varvin, 2015, p.132-143). A systematic review done by Marija Bogic and colleagues showed that mental health problems tend to persist even on long-term basis in this heterogeneous population, in particular for those escaping from war-stricken countries (Bogic et al., 2015). Another review from Butler and colleagues pointed out the inconsistencies in existing researches about the real impact and persistence of mental health problems in migrant population, highlighting the complexity of the phenomena and the need for more empirical research (Butler et al., 2015). Other factors too complicate the exact estimation of mental health problems in this population i.e. bias related to different social and cultural frames of reference, or co-existing problems as scarce integration and social isolation (Alayarian, 2007-b, p. xix), (Rucci et al., 2015), (Sandhu et al., 2013).

An issue to address is that of traumatic experiences, a relevant component of the clinical picture of many refugees, important not only for mental health implications but also for legal aspects in their process as asylum- and protection-seeking individuals (Turner, 2007, p. 35). Trauma treatment is surely a need for many in this population, but on the other side several authors underline that it is not always an immediate necessity and that the priority should be to keep in mind the broader perspective that includes cultural, religious and social factors which are relevant in order to sustain the patient's resilience, and to postpone trauma treatment when

protective frame conditions and stability in daily life and have been established (Alayarian, 2007-c, p.1), (Kanagaratnam, Pain & Payne, 2014), (Turner, 2007, p. 40-41). The phenomena of resilience will be analyzed further on in the text, since it showed relevance also for the psychologists here interviewed.

Another major difficulty that refugees and migrants have to face is the language barrier, and Alayarian underlines the constant risk for misunderstanding and inaccuracy when working with patients in intercultural communication, something that can challenge a good relation between patient and therapist (2007-b, p. xx). On the other side as Alayarian explains, an apparent lack of communication or information from these patients can be the only way for them to protect themselves from eliciting past memories related to painful or shameful experiences, as is the case in torture, rape or other inhuman mistreatments (2007-a, p. 146). Torture is a practice that aims at dehumanization and at disrupting trust in other human beings and in sense of life itself, and this can negatively influence also the trust of a torture victim in the clinician (International Rehabilitation Council for Torture Victims [IRCT], undated), (Rosenbaum & Varvin, 2007).

All the aspects here described give reason for how clinical work with migrant population requires specific competences and sensitiveness, in general and even more with seriously traumatized subjects as in the case of torture victims. Due to the complexity of problems to face, there is not unanimity among scholars from different orientations about what are the most effective models of intervention to help refugees and asylum-seekers, the discussion encompassing the appropriateness to use western-based diagnostic categories and therapeutical approaches (Alayarian, 2007-d), (Andermann, 2014). As previously mentioned, many authors seem to agree on the fact that quality in psychosocial support is a key aspect in mental healthcare with refugees and migrants, and that especially in the initial phase of resettling the focus should be on the strengthening of protective factors by means of psychosocial interventions, social networking and assistance in practical needs (Harris, 2007, p.81), (Bhui, Mohamud & Warfa, 2010, p. 287), (Thomas, 2007, p.46). This underpins the importance to reduce the resettling phase's stressors, to adopt a broader perspective of psychosocial intervention prior or parallel to trauma treatment, and to guarantee a good level of cultural competence among clinicians, in

order to better address the problems of the migrant patient. This last point deserves some specific considerations due to its relevance in the interventions with this population.

1.7 Cultural competence in mental health work with migrants.

A specific aspect in delivering quality mental healthcare for this population is that of *cultural competence*, a construct used to indicate good clinical practice with patients from other cultures (Andermann, 2014, p. 63), (Ruiz, 2010, p. 117-118). In mental healthcare it includes a range of items among which being aware of the phenomena of ethnocentricity, respecting the cultural specificities of the patient and being able to understand particular ways of expressing or manifesting health and illness (Kanagaratnam, Pain & Payne, 2014, p. 53), (Ruiz, 2010, p.118).

Cultural competence also encompasses the debate on the appropriateness of using occidental medicine theoretical frames in understanding of health-illness phenomena, and consequently there is discussion on what clinical methods to use, with refugees and asylum seekers (Klein, 2007, p. 178-179), (Koike & Lim, 2010, p. 161), (Thomas, 2007, p. 47). Perspectives and norms about how to cope with illness or traumatic events vary between cultures, ethnic groups or communities e.g. in collective or individualistic social and cultural structures (Bhugra & Wojcik, 2010, p. 217), (Varvin, 2008, p. 78). For these reasons, cultural competence also concerns the use of diagnostically categories, like the ongoing discussion of the applicability of the diagnosis of *Post-Traumatic-Stress-Disorder* (PTSD) in cultural contexts and social structures other than the western one (Alford, 2016, p 5-9), (Elsass, 2001), (Hinton & Lewis-Fernández, 2011).

For all the above arguments a flexible application of therapeutic principles and protocols is suggested in culturally competent care of refugees and migrants (Alayarian, 2007-a, p. 145), (Bughra & Jones, 2001), (Andermann, 2014, p. 61-71). Scholars in the field underline the importance to develop and implement mental health services that are suited to the specific characteristics of this population, by integrating cultural competence and multi-modal approaches (Varvin, 2009), (Vostanis, 2014).

Alayarian and colleagues describe in their text the experience at the Refugee Therapy Centre in London, where a psychoanalytic theoretical model constitutes the mainframe of their clinical work (Alayarian, 2007-b). These clinicians' experience is that the psychoanalytic approach has to

be adapted to be used fruitfully with this population e.g. because patients from other culture do not have the same mental metaphors as western ones and they present theirs sufferance differently, both in narrative descriptions and bodily representations (Thomas, 2007, p. 48-49). In this case it can be difficult to maintain the same settings and procedures of classical psychoanalysis that can crash with cultural habits and cause misunderstanding or unintended offence (Thomas, 2007, p. 48-49). The example given by Thomas is that of declining an invitation from a client to participate to a celebration, that can preserve the psychoanalytical settings but in the client's culture can be interpreted as offensive and so negatively interfere with the therapeutical alliance (2007, p. 49). Alayarian describes how their centre offers a cultural competent approach characterized by a caring and supportive environment, with culturally and linguistically adapted clinical interventions and psychosocial support in form of group-based counselling and supervision, educational opportunities and work-training opportunities, and how this wide approach has shown good results for the integration process of refugees with a damping effect on mental health problems (Alayarian, 2007-b, p. xix-xxii).

The previous paragraphs focused on aspects related to the migratory phenomena and mental health of migrants, to portray the many facets to address in clinical or supportive work with this population. The following paragraphs will instead look at phenomena affecting the clinicians.

1.8 Common challenges in mental healthcare work with migrants.

Clinical work in mental healthcare can in general affect practitioners, and this happens also to those working with migrants (Cross & Crabb, 2007, p. 275-285). This population presents however some specificity that can make the intervention even more challenging for clinicians, and put these at major risk for distress and secondary reactions (Cross & Crabb, 2010, p. 275).

Cross and Crabb identify two main aspects, the first one related to the specificity of the situations in which many migrants find themselves after fleeing, characterized by loss in its wider meaning, and a second aspect related to previous traumatic experiences (Cross & Crabb, 2010, p. 276).

The first aspect includes several elements among which loss of status, job, money, social network etc, problems of social order that are often unmanageable in a clinical context but that are nevertheless urgent in the patient's perspective and cause pressure to the clinician (Cross & Crabb, 2010, p. 283). These problems are mainly related to the acculturation process in the post-migratory phase, when the individual is still assuming and behaving from his /her original cultural frame e.g. coming from a more authoritative and hierarchical social structure, thus having strong expectations on the clinician to be an authority able to solve other problems than strictly the health-related ones (Cross & Crabb, 2010, p. 283). Another example given by Thomas is in interventions with youth and families, where a negotiation between therapeutic protocols and a cultural competent approach is needed in order to sustain the resilience of the single individual and of the family as a group (2007, p. 55).

This complexity can be challenging for the unexperienced clinician to address, even more if he/she lacks cultural competence, and it can contribute to the development of distress reactions (Cross & Crabb, 2010, p. 283). As Daniell clearly states: "The therapist will often feel greatly inadequate, being separated from the client by language, culture, and life experience" (Daniell, 2007, p.66).

The second aspect is related to the traumatic experiences that are frequently encountered in this population (Cross & Crabb, 2010, p. 278), (Varvin, 2015, p.132-143). Traumas can be massive, with devastating effects on an individual or whole communities, especially when intentionally perpetrated with the intent to create terror (Elsass, 2002) or dehumanize, as in the case of torture (Varvin, 2015, p.132-143). These events and the related narratives are commonly encountered in trauma work with refugees and can deeply affect the clinician, as clearly expressed by Thomas' words: "What is evoked in therapists who are working with refugees can at times be powerful and overwhelming" (Thomas, 2007, p. 49).

Another facet of the clinical work concerns the non-verbal communication between client and therapist, that happens via bodily signals (Daniell, 2007, p. 73), (Hawkes, 2007, p. 108). It is an important part of communication also concretely perceivable as body feelings, relevant in managing transference and counter-transference dynamics (Hawkes, 2007, p. 108). In chapter 3 where findings from this investigation are presented, this facet will be thoroughly explored.

A last aspect of relevance named in literature is that of clinician's empathy and expectations on the patient, that can affect the therapeutical relationships in forms that in psychoanalytical terms are ascribed to countertransference dynamics, influenced by clinician's personality traits or history of pre-existing trauma (Cross & Crabb, 2010, p. 283-4). *Empathic enmeshment* and *empathic repression* are two constructs used to describe opposite positions that the therapist can take in the therapeutic relationship, respectively of excessive closeness or excessive distance, both of them negatively affecting the process (Cross & Crabb, 2010, p. 283).

A number of constructs have been shaped, to describe the clinician's negative reactions to exposition to stressors as those described. The next paragraph aims at giving a portrayal of the most common ones, that were encountered in scientific literature.

1.8.1 Clinician's negative reactions: Concepts and constructs.

Working with traumatic or highly distressful material from patients can cause negative reactions, described by in literature by terms among which the most common are: Burnout, Compassion fatigue [CF], Secondary Traumatic Stress [STS] and Vicarious Traumatization [VT] (Baird & Kracen, 2006), (Elwood, Mott, Lohr, & Galovski, 2011), (Hensel, Ruiz, Finney & Dewa, 2015), (Smith, Kleijn, Trijsburg & Hutschemaekers, 2007). These constructs arose in the past decades from the work of different authors, reflecting the development during time of the research on this issue of importance for health professionals, in particular those working in mental healthcare and trauma treatment (Elwood et al., 2011), (Baird & Kracen, 2006). The different terms have often been used interchangeably or in overlaps, with a blurring effect on research findings as different authors point out (Elwood et al., 2011), (Hensel et al., 2015), (Smith et al., 2007). A clarification of these constructs frequently encountered in literature can therefore be useful.

Burnout: This construct was introduced by Maslach in 1982, to indicate an emotional exhaustion that can occur in any profession due to stress factors as excess of workload, organizational and personal conflicts and similar (Elwood et al., 2011), (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). It is a non-specific term that is not peculiarly correlated to healthcare professions, nor to clinicians working with traumatic material (Elwood et al., 2011), (Hensel et

al., 2015). Applied to this context and referring to his experience in work with torture victims, Pross writes that symptoms of burnout in clinician can include: “apathy, feelings of hopelessness, rapid exhaustion, disillusionment, melancholy, forgetfulness, irritability, experiencing work as a heavy burden, an alienated, impersonal, uncaring and cynical attitude toward clients, a tendency to blame oneself coupled with a feeling of failure” (2006, p. 1).

Vicarious traumatization (or vicarious trauma): Leaning on the constructivist self-development theory inspired from contemporary psychoanalysis and social cognitive theories, McCann and Pearlman in 1990 created this construct, to describe the harmful effects of traumatic material from the client on the therapist (Baird & Kracen, 2006), (Elwood et al., 2011). It’s therefore a construct specifically pertaining to trauma therapists (Hernandez-Wolfe et al., 2015). This construct focuses on the disruptive changes that occur in the therapist’s cognitive scheme when empathically engaging with trauma material from the patient (Rasmussen & Bliss, 2014). For these authors, changes can affect five specific areas, corresponding to human psychological needs in relation to oneself, to the other and to the world: Need for safety, trust, esteem, intimacy and control (Baird & Kracen, 2006). Vicarious traumatization occurs through cumulative effect of exposure to traumatic material, that gradually and negatively affects the above named areas (Baird & Kracen, 2006), (Elwood et al., 2011).

Compassion fatigue: The constructs of compassion fatigue and secondary traumatic stress highly overlap in literature even if the latter is used more generically while the first is supposed to pertain specifically to healthcare professions (Elwood et al., 2011). Compassion fatigue was a construct introduced by Figley in 1995 with the assertion of being a term more easily accepted by health professionals (Elwood et al., 2011). Even if not limited to trauma therapists, it has mainly been used in research on these practitioners (ibid, 2011). It encompasses the cognitive, emotional and behavioral changes due to work with victims of trauma that reduces the empathic skills of the clinician, a reaction that affectively is manifested with anxiety and fear (Hernandez-Wolfe et al., 2015).

Secondary traumatic stress: This construct was also introduced by Figley in 1995, parallel to that of compassion fatigue (Baird & Kracen, 2006), (Pross, 2006). It describes the development of PTSD-similar symptoms not only in clinicians but generally, in individuals as friends, family members and caregivers, as a natural consequence of helping traumatized subjects (Elwood et al., 2011), (Pross, 2006). The stressor here is "the exposure to knowledge about a traumatizing event experienced by another" (Elwood et al., 2011). Differently from long-lasting vicarious fatigue or burn-out secondary traumatic stress can occur quickly e.g. as a reaction to exposure to traumatic details in narratives, or to dissociative reactions witnessed in subjects who survived a disaster (Elwood et al., 2011), (Baird & Kracen, 2006). While the construct of vicarious traumatization focusses on cognitive phenomena, that of secondary traumatic stress includes a wider bunch of symptoms, similarly to that of PTSD syndrome (Baird & Kracen, 2006).

Preventive measures to avoid or contain these negative phenomena can purposefully be presented here at the end of this paragraph. Experts like Pross recommend that therapist working with traumatized patients should protect themselves through personal and organizational measures, as those listed in Table 2 below.

Table 2

Measures for prevention of burnout (Pross, 2006).

- Self care - avoid workaholism, time for hobbies, leisure, family and friends
- Solid professional training in diagnosis and (psycho)therapy
- Therapeutic self-awareness
- Regular self-examination by collegial and external supervision
- Limiting caseload
- Continuing professional education and learning about new concepts in trauma
- Opportunities for research and training sabbaticals
- Keeping a balance between empathy and a proper professional distance to clients
- Protecting caregivers against being misled by clients with fictitious PTSD
- Institutional setting in which the roles of therapists and evaluators are separated
- Social recognition for caregivers
- Overcoming financial and legal outsider status of centers
- Integration of centers into the general healthcare system
- Alliance with medical mainstreams and academic medicine

Note. Retrieved from: *Torture,* (2006), vol 16 (1).

Preventive measures as team work, supervision and collegial support are furthermore purposeful because different perspectives can lead to creative solutions in facing complex problems and challenges, with protective effects for the practitioners (Thomas, 2007, 50).

This quick look at preventive factors helps in introducing another set of concepts and constructs concerning positive phenomena, that also can occur to healthcare professionals.

1.8.2 Clinician's positive reactions: Concepts and constructs.

Several constructs have been coined to describe how clinicians affected by negative reactions to traumatic material can evolve positively. Terms that most frequently emerged in the literature search were those of "Vicarious Growth", "Vicarious Post-Traumatic Growth", and "Vicarious Resilience" [VR] (Barrington & Shakespeare-Finch, 2013), (Edelkott, Engstrom, Hernandez-Wolfe & Gangsei, 2016), (Splevins et al., 2010). It is purposeful to precede the sketching of these constructs by the description of resilience, a phenomena relevant for both migrants and for the clinicians as the findings in this research also will show.

Resilience: There is not a univocal definition of this concept that has been used interchangeably or overlapping with other terms like coping or self-efficacy, with blurring results (Southwick, Bonanno, Masten, Panter- Brick & Yehuda, 2014), (Ungar, 2012, p. 27-28). In physical sciences the term resilience refers to a characteristic of a material or object: "the quality of being able to return quickly to a previous good condition after problems" (The Cambridge Dictionary, 2017).

Definitions of resilience used in psychological and sociological sciences can differ depending on resilience being considered as a personal trait, a process, or an outcome (Southwick et al., 2014). Experts from various disciplines involved in research on resilience underline its complexity and the importance to study it from different perspectives, sinceit is a phenomena resulting from concurrent and interacting social, ecological and individual factors (Southwick et al., 2014), (Ungar, 2012, p. 28). Some definitions from different authors and sources can clarify these different facets.

The American Psychological Association gives this definition of resilience on its website: "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress - such as family and relationship problems, serious health problems or workplace and

financial stressors. It means "bouncing back" from difficult experiences" (American Psychological Association [APA], 2018).

Alayarian report this definition of the term resilience: "the ability to experience severe trauma or neglect without a collapse of psychological functioning or evidence of post traumatic stress disorder" (2007-c, p. 1).

In an article inspired by a panel hosting experts in traumatic stress research Southwick writes that: "determinants of resilience include a host of biological, psychological, social and cultural factors that interact with one another to determine how one responds to stressful experiences" (ibid, 2014).

Ungar too stresses the fact that resilience is something more complex than individuals' coping mechanisms and that in studying this phenomena it is fundamental to include the broader social and ecological contexts, with their embedded risk factors in which resilience takes form (2012, p. 27).

To summarize, many authors from different disciplines are interested in the phenomena of resilience, and most of them seem to agree in depicting it as the capacity of individuals or systems i.e. families, communities, to react and respond positively to stress factors and adversities of different type and intensity (Southwick et al., 2014), (Ungar, 2012, p.27). These authors converge in depicting resilience not as a static, acquired and pre-defined capacity, but rather as a dynamic feature that can be fostered and that is contextual i.e. influenced by a multiplicity of interacting factors (Southwick et al., 2014), (Varvin & Rosenbaum, 2014).

Vicarious post-traumatic growth /vicarious growth: These constructs are in practice synonymous. To better understand themit is useful to look first at the construct of *post-traumatic growth* (PTG), presented by Tedeschi and Calhoun in their publication in 1996 to describe the positive evolution that occurs in subjects that have been directly exposed to traumatic experiences (Manning-Jones, de Terte, & Stephens, 2015). Post-traumatic growth occurs in three subjective domains: Life philosophy, self-understanding and interpersonal relationships (Barrington & Shakespeare-Finch, 2013), (Manning-Jones et al., 2015).

The term *vicarious post-traumatic growth* indicates a similar outcome, but related to indirect exposure to trauma as happening to mental health workers or interpreters working with refugees (Barrington & Shakespeare-Finch, 2013), (Manning-Jones et al., 2015), (Splevins et al., 2010).

In a systematic literature review published by Manning-Jones and colleagues in 2015, a slight difference was found between these otherwise very similar constructs, in the sense that vicarious post-traumatic growth: "was found to be partially distinct from direct post-traumatic growth; subtle differences included a more abstract form of growth and professional enhancement was found to be a unique manifestation of change" (Manning-Jones et al., 2015).

In a study on vicarious post-traumatic growth among Australian clinicians who worked with refugees, survivor of trauma and torture, positive changes were found in the same domains as those identified in direct post-traumatic growth by Calhoun and Tedeschi i.e. in their life philosophy, self-understanding and interpersonal relationships: "the majority of participants reported that their work had changed their lives in profound and positive ways", (Barrington & Shakespeare-Finch, 2013). As these authors highlight, the main limitation of their study was in being cross-sectional, so possibly biased from previous trauma not related to the study context (ibid., 2013).

These scholars underline the need to conduct more research on the item of vicarious post-traumatic growth, in particular among practitioners working with traumatized refugees (Barrington & Shakespeare-Finch, 2013). Manning-Jones and colleagues too, in the systematic review above cited identify the need for more research and the limitations found in the literature they examined, due to: "a lack of appropriate measures, longitudinal research, and consideration of validity; discrepant results; small sample sizes; and the failure to account for personal trauma history" (Manning-Jones et al., 2015).

Vicarious resilience (VR): This relatively new construct presents similarities to the previous one of vicarious post-traumatic growth, yet it is directly related to the concept of resilience described above. It was first proposed by Hernández, Gangsei & Engstrom in an article published in 2007 presenting the results from a qualitative research on psychotherapists working with survivors of political violence in Colombia (ibid., 2007). These and other scholars conducted further qualitative research in the following years, especially on therapists working with refugees and torture survivors, deepening the exploration of the complementary and intertwined phenomena

of vicarious traumatization and vicarious resilience (Edelkott et al., 2016), (Hernandez-Wolfe et al., 2015). They describe vicarious resilience as a dynamic process resulting from exposure to both traumatic material and resilience witnessed in clients, and expressed by four major themes in the interviews: "change in the therapists' self-perception and their general outlook on the world, an altered spirituality, modified thoughts about self-care, and a new view on trauma work and on connecting with clients" (Edelkott et al., 2016), (Hernandez-Wolfe et al., 2015). Edelkott et al. postulate that vicarious resilience is a broader concept than vicarious post-traumatic growth: The latter focusses on the personal growth resulting form clinical work with traumatized clients in terms of personal positive changes in self-perception, interpersonal relationships and philosophy of life, while vicarious resilience also encompasses positive changes in therapists' practice or view on trauma work (ibid., 2016). These scholars sustaine furthermore the usefulness to introduce education and training about vicarious resilience for clinicians, especially for young and unexperienced ones, to prevent burn-out and foster development of resilience in them and in their clients (Edelkott et al., 2016), (Hernandez-Wolfe et. al., 2015). They also highlight the need for further research on this relatively new construct, inviting all those interested in trauma field to give their contribution from theirs specific professional frameworks (Edelkott et al., 2016), (Hernandez-Wolfe et. al., 2015). This encouragement was useful for the author, stimulated to explore this facet in he present research.

A bunch of negative and positive terms was presented in the previous paragraphs, trying to give a nuanced view of the different results found in the literature. To underline here is also the ongoing development of research in the field of trauma work and its effects on clinicians, as seen for the recently shaped construct of vicarious resilience. Trauma research focuses also on its bodily effects, which are the subject of next paragraph.

1.9 Somatic effects related to the clinician's negative reaction.

Rasmussen and Bliss sustain that poor attention has been given to understand the adverse consequences of trauma work on the clinician from a neurobiological perspective (Rasmussen & Bliss, 2014). In particular, they examined scientific literature describing stress effects on structures as mirror neurons, amygdala, sympathetic and parasympathetic systems, the

hypothalamus-pituitary-adrenal axis, the left and right brain hemispheres (ibid, 2014). Then, they integrated their argumentations with psychoanalytical theory and concepts, and applied these to the case of a social worker to contextualize their mainly speculative reasoning (ibid., 2014).

These authors acknowledge that highly advanced methodologies and competencies are needed to investigate these biological aspects, something that overrides most practitioners' expertise (Rasmussen & Bliss, 2014). Theirs opinion is nonetheless that: "awareness of neurological processes may help clinicians to gain a better appreciation for the biological reactions to affectively laden client material, that which lies beneath the surface" and that such understanding can contribute to the development of protective strategies (ibid., 2014).

In another article, Haase and colleagues, leaning on a marked biomedical theoretical perspective, describe the findings from a quantitative research project that investigated the relationship between interoception and resilience by means of neuroimaging and questionnaires, in subjects with self-reported low-resilience level (Haase et al., 2015). They define of *interoception* as: "the process of sensing body-state relevant information within the context of homeostasis" (ibid., 2015). Sensing of interoceptive stimuli occurs thanks to anatomical structures as peripheral receptors, afferent nervous fibers and other parts of the central nervous system, in particular the brain area of insula where different inputs from the body are integrated and converted as complex feeling state (Haase et al., 2015). Maintaining o restoring homeostasis is a key factor in recovery from stress i.e. in showing resilience capacities (ibid., 2015). These authors state that their findings: "provide evidence that LowRes [low-resilience] individuals have significantly less awareness and responsiveness to interoceptive signals" (Haase et al., 2015), and that training of body-awareness could be a potential intervention for these subjects (Haase et al., 2015).

From two different theoretical perspective, both the articles above cited highlight the tight relationship between resilience and body-awareness. A succinct description of this last construct and of the closely connected concept of embodiment is therefore given in the next paragraph.

1.9.1 Body awareness and embodiment.

The construct of *body-awareness* is very central to many body-oriented therapies but rarely a precise definition is to be encountered in literature (Mehling et al., 2009), (Mehling et al., 2011).

As Mehling et al. wrote, it "involves an attentional focus on and awareness of internal body sensations." (2009, p. 1). In the description given by these authors it involves the interoceptive and proprioceptive functions i.e. the sensing of informations coming from inner organs and body structures involved in posture and in movement (Mehling et al., 2009). The construct can have both a negative or positive conceptualization, depending on interpretations given by scholars from different areas of research (ibid., p.1). The first is especially the case of research on anxiety and panic disorders in medical and behavioral sciences, where it is conceived as an excess of attention to bodily processes and related to the phenomena of *somatosensory amplification* (Mehling et al., 2009). An opposite and positive interpretation comes instead from academic disciplines as philosophy, anthropology and linguistic, where scholars commonly refer to the kindred concept of *embodiment* (Mehling et al., 2009, p.3). This is described as "the felt sense of being localized within one's own physical body (Hudak, McKeever & Wright, 2007), a feeling of integration of body and mind, that can be disrupted by illness, trauma or other (Mehling et al., 2011).

Intended like this, the concept of body-awareness highly overlaps with that of *embodiment* (ibid, p.10). This is a key concept also in phenomenology and in particular in the thinking of the philosopher Merleau-Ponty (ibid, 2012) whose work established a conceptual frame on which a number of mind-body therapies are more or less explicitly inspired by (Mehling, 2011) including Norwegian psychomotor physiotherapy (Thornquist, 2006).

This long introduction aimed at giving a description of numerous facets that are directly or indirectly related to the subject of this investigation. The thesis title and research questions will now be presented in the next paragraph.

1.10 Thesis' title and main questions.

The author is interested in the investigation of the experience of psychologists, who work in mental healthcare for migrant population in Italy. The research will explore what these healthcare professionals think and feel, what do they struggle with, how they recognize, cope and prevent problems, what are the positive and negative aspects they mention.

The thesis' definitive title is: "*Psychologists' experience in mental healthcare services for migrant population in Italy: A qualitative study.*"

The main questions that this research will try to answer are:

- *How do Italian psychologists who work with migrant population experience their work?*
- *What are the positive and negative sides they highlight?*
- *Does this work affect them physically, and how?*

The next chapter will cover the methodological aspects.

2 METHOD.

This chapter will argument for the theoretical frame of reference, choice of design and ethical aspects of the research project.

2.1 Phenomenological frame of reference.

The author is inspired by *phenomenology*, a theory of particular interest when investigating phenomena as experienced and described from the informants's point of view (Järvinen & Mik-Meyer, 2017, p. 10), (Brinkmann & Kvale, 2015), (Malterud, 2017). As Brinkmann and Kvale explain, phenomenology was founded by the philosopher Edmund Husserl around 1900, thereafter developed by other scholars as Martin Heidegger, Jean-Paul Sartre and Maurice Merlau-Ponty (2015, 30). Phenomenology aims at reaching the *essence* of phenomena by investigating the life-world of the subject (Brinkmann & Kvale, 2015), (Tangaard, 2017). The term *life-world* means the world we live in and take for granted, the pre-scientific world of experiences, also called epoché by Husserl (Tangaard, 2017, p.84). In phenomenology it is decisive to start from this real world in order to describe phenomena as they are, and to

understand how this is done in practice two other key-concepts must be described, namely intentionality and reduction (ibid., p. 84).

Intentionality is considered by phenomenologists as the main feature of human consciousness, in the sense that this is always directed toward something (Tangaard, 2017, p. 84). Through intentionality we can gain access to different phenomena that we can describe from the meaning they have for our consciousness (2017, p. 82).

To reach the essence of the observed phenomena calls into question the role of the observer and the concept of *phenomenological reduction*, a movement toward the suspension of judgement on wether a given experience's content exists or not (ibid, p. 84). It is described also with the concept of *bracketing* indicating an attitude that the researcher has to consciously take in order to put his own foreknowledge and pre-understanding at side, or as Brinkmann and Kvale explain: "within parenthesis, in order to arrive at an unprejudiced description of the essence of the phenomena" (Brinkmann & Kvale, 2015, p. 31).

It is purposeful to contextualize all these concepts used in phenomenology to this research. The different facets of the experience of the psychologists are the phenomena in their life-world, that the author wants to investigate. According to the reduction principle, to reach this essence involves to be aware as much as possible of one's own pre-understanding and foreknowledge e.g. the author's previous work experiences, schooling and the fact of being a physiotherapist with a specialization in mental healthcare, all this had influence on the subject of interest and in particular the focussing on bodily experiences of informants.

The author took as much care as possible to concretely apply the reduction principle, in all phases of the research and particularly in field-work when collecting interviews (Brinkmann & Kvale, 2015, p. 30-35). A difficult arose for the author in relation to the phenomenological goal to reach the essence, which should be as free as possible from subjective interpretations. This stance is questioned by some scholars in qualitative research, particularly from hermeneutic oriented ones who sustain the impossibility for the researcher not to be submitted to own intentionality and interpretations (Tangaard, 2017, p. 100). The author faced this difficulty in particular during the analysis of data, and this will be discussed in paragraph 2.5 in this chapter.

2.2 Design.

The final design emerged at an intermediate stage. The preliminarily idea was to adopt a mixed design, aimed at testing for a possible convergence of result between qualitative and quantitative findings. The qualitative part was to be conducted through semi-structured interviews, while the quantitative part should consist of variables of body patterns collected through the Comprehensive Body Examination (CBE) psychometric scale, that will shortly be described.

Discussions with supervisors, peers and fellow students was useful to make clear that the risk for major bias in the quantitative part was high. Further reflection led therefore the author to give priority to the qualitative part as the main corpus of the investigation. At a more advanced phase the author decided to keep the quantitative part but merely intended as supplementary findings, not to be analyzed with quantitative procedures and with the limited purpose to present a first impression of this facet.

2.2.1 Qualitative part.

Data for the qualitative part were collected by means of interviews. Brinkmann & Kvale underline the importance to thematize an interview in a way that appropriately addresses the central focus of the study (2015, p. 132-133). Gathering information on existing research is a first step in this process (ibid., p. 134), to orient the researcher in the following structuring of the interview, that: “can have explorative or hypothesis-testing purposes” (Brinkmann & Kvale, 2015, p. 106). These authors point out also how familiarity with the theme to investigate is a key factor in order to formulate questions of relevance (2015, p. 133). As described the author of this research has long clinical experience as physical therapist in mental healthcare, inclusive with migrants, so familiarity with the subject of interest was on place.

The literature presented in the introduction chapter showed a scarcity of research on phenomena occurring in this particular group of mental health workers, in particular in Italy. This underpinned the relevance of the subject of interest, further confirmed by conferring with supervisors, peers, and in collegial milieu, and gives reason for the explorative purpose of the research.

Brinkmann & Kvale name also how the interviews take form in relation to context and interaction (2015, p. 63). Interview's questions can be characterized by having a more thematic or dynamic dimension, the first with regard to produce knowledge, the latter to sustain a good interaction (ibid., p. 157). Also, they state how questions can differ in character looking for spontaneous description, coherence or concepts (2015, p. 157).

Trying to keep in mind all these aspects and the theoretical frame adopted, the author formulated a preliminary set of questions. Discussions in the collegial group of students and with supervisors were helpful, in orienting the author to the final version composed of four main questions and a set of cues on possible secondary questions. Attention was paid to make formulations that were open but not loose, intended to gradually funnel toward facets of interest, to stimulate reflections that could provide data of relevance without forcing toward pre-conceptual phenomena. The interview guide is attached in Appendix 1.

2.2.2 Body examination part.

The examination of the body aimed at evaluating patterns that are commonly observed in NPMP method. The comprehensive body examination (CBE) is a psychometric scale used in NPMP, purposeful to collect this type of data. It is composed of four main domains: Posture, respiration, movement and musculature (Kvåle et al. 2010). It has shown good psychometric characteristics in a series of study, showing specificity in differentiating between different patient groups and healthy individuals (Bunkan, 2003). Its four domains includes sets of variables organized in sub-scales, evaluated by means of observation and manual testing by the clinician (Bunkan, 2003), (Kvåle et al. 2010). The clinician applying CBE has to be calibrated i.e. able to reproduce results in line with those of the golden standard (Bunkan, 2003). The author of this paper took several courses and practical trainings with a scholar in the field, in order to train and improve the level of calibration so to guarantee a sufficient level of reliability for the purposes of this part of the research. Conferring with peer helped in individuating those sub-scales that mostly fitted for the purpose (Bunkan, personal communication, August 2017). Posture and respiration were chosen as suitable domains to be included, while movement and palpation were excluded. This was considered as sufficient to gain that first glance expected from this set of data.

2.3 Recruiting, fieldwork and data collection.

The recruitment started by contacting different services and institutes involved in mental healthcare for migrants and asylum seekers in Italy. Two organisations showed interest and helped the author in the implementation of the project, a mental healthcare service for migrants in Milan and the "Psychoanalytical Institute for Social Researches" (IPRS) in Rome.

In the mental healthcare service in Milan the team coordinator selected four psychologist, three females and one male, all with sound experience in clinical work with migrants and asylum seekers with mental health problems, and all of them agreed to participate. Furthermore, the author was invited to participate to the team's weekly reunion where also other psychologist, a social worker, the team leader and the chief of the service participated, so gaining impressions also from this gathering of the whole team. The data collection at this facility was done in late September '17.

The other informants were recruited thanks to the IPRS, which was involved in a pilot project named SESAMO (translated: "Mental Health Services for Applicants and Holders of International Protection) see Appendix 2 for detailed information. The team of psychologists participating to the project was assigned the task to deliver support and supervision to the on-place professional teams, in different hosting facilities in the Italian territory. The goal of the SESAMO project was to develop a clinical model of intervention that could later be implemented on a larger scale, with a particular focus on the early detection of subjects at risk for developing severe mental health disorders. A preliminary visit was planned in June 2017 in combination with the seminar organised by IPRS in Rome where the author could present the research project to potential informants. A number of roughly eight-ten participant showed a preliminary interest and six of them later confirmed and were enrolled, five female and one male.

This group showed from start a higher variability in terms of work-experience in general and with migrants in particular. Some of these informants would have started to work only from June so it was necessary to give them time to be exposed to stress factors in order to ensure a minimum of relevance in the findings. For this reason the data collection was planned as late as possible, consistently with the scheduling of the whole research project, in late September and early October '17.

Comprehensively 8 female and 2 male psychologists were enrolled. This gender ratio corresponds to that of the profession in Italy (Giardina, undated). The group of informants also presented heterogeneity in age, work experience and duration of exposition to stressors, satisfactorily fulfilling the requirements for a strategic sample as suggested by peers in qualitative research, to strengthen the requirement for credibility and transferability in qualitative research (Malterud, 2017, p. 58-59).

2.4 The context.

Informants worked in different facilities that are part of the Italian reception system for migrants, which is not uniform and has undergone different reorganisation in past years as explained on the website of Asylum Information Database [AIDA] (Asylum Information Database, 2018). Both organizations above described ran their projects totally or partially through external funding. At the moment of the investigation they were supported by the European fund for asylum, migration and integration [AMIF] (Asylum Migration and Integration Fund, 2018).

The facilities where the informants worked constituted the physical contexts where their experiences took place. The context has a relevance in determining the type of findings that will emerge from an interview, as underlined by peers in the field (Kvåle & Brinkmann, 2015, p. 64), (Malterud, 2017, p. 24). Therefore a brief depiction is given here below of these three types of facilities and of the role of the interviewees, in order to give the reader a better comprehension of these frame factors.

The mental healthcare service was physically hosted in a hospital, but the psychologists who were part of the team worked as freelance, part-time consultants. Due to project funding, when a project was concluded periods without financial coverage could occur. Psychologists could then be asked to assure continuity in providing the service by volunteering, while waiting for a new project to start. They delivered clinical psychotherapy treatment to migrant population (asylum seekers or regularized immigrants) in need for mental healthcare. In the current project when interviews were collected, they focused mainly on acute cases, with a prevalence of serious PTSD. Through years this team developed highly recognized expertise and was often asked to deliver formation to other clinicians working with the migrant population in Italy.

The remaining group of informants coordinated by IPRS delivered their service in two different typology of facilities part of the Italian reception and hosting system, the CAS and the CIE, below described. Accordingly with the aim of the SESAMO project their role was not that of delivering clinical treatment but to offer supervision and support to both hosts and permanent teams already on place in the facilities.

CAS in Italian stands for "extraordinary hosting centres". These facilities where established in 2013 to face the migratory peak, overcoming the insufficient capacity of existing ordinary facilities run by the Italian State, the SPRAR system (AIDA, 2018). CAS are run by a specter of private actors, often cooperatives or other non-profit actors, and their number overruns now the ordinary facilities by about 1:10 ratio as reported by the non-governmental organization NAGA (NAGA, 2017). The enormous growth has made difficult to ensure a capillary control of these structures, and situations emerged in past years showing cases of bad management, misuse of funding and even infiltration of organized crime, facts that led to increasing critics on the policies and management, a responsibility of the Italian State. NAGA recently conducted a survey that clearly showed how reception continued to be managed as extraordinary in Italy and how the heterogeneity of the facilities, the scarce preparation in the managing bodies and the lack of a "perspective at the future" were structural elements that characterized this dysfunctional system (ibid., 2017). As the report highlighted, these elements had an enormous impact on the present and on the future of the migrants, among whom NAGA noticed an increase in vulnerable people such as unaccompanied minors and victims of trafficking and a growing and generalized fragility also in mental health conditions (ibid., 2017).

CIE, acronym for center for identification and expulsion, are part of the ordinary facilities run by the Italian authorities, so pertaining to the public sector. These are in practice detention centers where migrants who are caught as illegally being on the national territory are kept while waiting for their cases to be evaluated by the competent commission. CIEs are highly criticized as being dehumanizing places, since migrants here are in practice kept as in jail, for long periods characterized by uncertainty and inactivity as reported by MEDU, a humanitarian association of practitioners for human rights denouncing the inhuman conditions in these facilities (Medici per i Diritti Umani, 2015).

2.5 Methodological aspects related to the analysis of data.

Due to organizational reasons and tight deadlines, it was not possible to follow the ideal way to proceed i.e. to collect first one or two preliminary interviews and analyze them before proceeding with the subsequent ones, as suggested by scholars in order to test the relevance of the subject of interest and of the interview questions (Brinkmann & Kvale, 2015), (Malterud, 2017). Instead, parallel to the transcription of the first interviews the remaining ones were collected in a short two-weeks period. Even so, the impression the author gained from the first transcriptions was positive, indicating that findings had relevance and that the quality of results was satisfactory. This was later confirmed by the good quality of the whole set of data collected.

Interviews were recorded on an audio device, they had durations ranging from 40 minutes to over an hour. After that transcriptions were first made in original language [Italian] keeping both verbal content as well as those part of oral speech that were not easily representable in written form but that were laded with meaning, as silences, mimics, emotional nuances, etc… (Brinkmann & Kvale, 2015, p. 203-214). This material was then translated to English, maintaining as much as possible adherence to the full raw-text as in Italian, but prioritizing the meaning to be conveyed in English language. Subsequently the author repeatedly red the interviews to individuate significant parts, moving them under questions where they were more pertaining to. This iterative process made themes emerge and leaded to further reorganization of the whole text, from sets of questions to sets of preliminary themes.

Here the author entered the phase of text condensation, a central part in the analysis of interviews that along with the theoretical frame adopted meant to reach essences, formulated through key-concepts or themes (Brinkmann & Kvale, 2015, pp. 231-247), (Malterud, 2012). At this stage a tension emerged more and more clearly for the author, between the effort to remain close to the essence of phenomena while at the same time realizing that a subjective interpretation was always present, more or less evident. It was therefore of help to read in literature that a critic to the phenomenological proposition to reach the essence is shared by scholars, in particular from hermeneutic-oriented researchers that on the contrary sustain the impossibility not to do interpretations i.e. that the researcher's foreknowledge is unavoidably always in the background (Tangaard, 2017, 100). The author understands that there is also a large consensus among researchers, on the fact that results in qualitative research are a co-construction

emerging from the interaction between interviewer and interviewee (Brinkmann & Kvale, 2015, pp. 21-22, 63-65), (Tangaard, 2017, p. 100).

In the shaping of the design the author took also inspiration from the Standard Text Condensation (STC) method, a structured procedure developed by Malterud to facilitate the analysis of qualitative data (Malterud, 2012, 2017). When coming to the step of exact coding i.e. putting "labels" to text units (Malterud, 2017) a difficulty arose since many aspects showed to be complex and strictly intertwined, and some phenomena of opposite character closely correlated so complicating a precise categorization. The author felt that a strict adherence to STC's procedures hampered his thinking process and hindered the effort to remain loyal to the phenomenological frame of reference adopted, and a choice had to be taken if to follow thoroughly STC or not. Again, conferring with supervisors and fellow students was of invaluable help in orienting the author to take a personal stance, and decide to keep inspiration from STC without strictly following its protocol. It was also of support to find in literature that other phenomenology oriented peers have opposed to a strict systematization of the research process, and that there is room for personalized tailoring of designs (Järvinen & Mik-Meyer, 2017, p. 12-17).

To recap the previous paragraphs, the author was at his first experience in an interview-based qualitative research project, that showed to be challenging and at the same time an invaluable opportunity to learn. The author's foreknowledge and pre-understanding oriented him toward the subject on interest and to a design based on a phenomenological frame of reference and inspired by STC procedure. Before concluding this chapter, a last paragraph will provide a short description of ethical issues.

2.6 Considerations on ethical issues.

Ethical aspects are always present when researching on humans (Brinkmann & Kvale, 2015, p. 83-85), (Malterud, 2017, p. 211-212). Brinkmann & Kvale underline that in qualitative research based on interviews ethics has to be considered in relation to all the phases of the investigation (2017, p. 85-86). It concerns the purpose of the research, the way it is designed and conducted, how personal data are handled and the way results are obtained and presented to the scientific

community (ibid., p. 85-86). Aspects, that these authors suggest to reflect on when planning an interview research, concern the beneficial of the investigation, the informed consent, the confidentiality, the consequences, and the role of the interviewer (2015, p. 91).

Preliminary considerations were done by the author to identify ethical aspects and risks. These were considered as limited since the investigation was not focusing directly on patients but on psychologists, considered as allegedly trained in managing demanding interpersonal situations and verbal or emotional material potentially evoking intense reactions in them. Even if contained this risk was considered, in the formulation of research questions and of the whole design. A standard procedure had to be followed, by submitting the project description and the interview guide to the Norwegian Center for Research Data [NSD] which approved it and gave permission to proceed. NSD suggested potential risks that the author had not yet considered, regarding in particular the obligation to anonymity about third subjects i.e. migrants, in the collection and treatment of data, and precautions were therefore taken to follow these guidelines as close as possible. Anyway, it is to mention that even peers admit that uncertainty related to ethical aspects will aways be present at some extent in interview research (Brinkmann & Kvale, 2015, p. 93-97).

In this research project, the psychologists were recruited on a voluntary basis. They signed a written informed consent, where a detailed description was given about the purpose of the research, its design, potential risks for the interviewees, rules the author will have followed in treatment of data and personal informations and precautions taken to respect confidentiality. It was also specified that any participant would have been free to withdraw from the project at any time and without providing any justification, something that fortunately did not happen. In the written consent it was also clearly specified the risk that interview questions could elicit discomfort in the informant e.g. by reactivating demanding memories or traumatic reaction patterns. It was care of the researcher to remind the informants about their right to regulate the situation and pose limits to questions during the interview, as well as to give them possibility to contact the author afterward in case of need.

3 PRESENTATION AND ANALYSIS OF FINDINGS.

This chapter will present the findings from the interviews and body examinations. Its paragraphs reflect the main themes that emerged, highlighting a particular facet, or interesting phenomena. Argumentations are given blending presentation and analysis of findings, also on the correlation between these and the constructs presented in the introduction. This along with reflections related to trustworthiness of process and results obtained. The discursive text is complemented by summarizing tables.

3.1 External factors.

A first group of factors could be related to the bigger framework in which psychologists worked and described as being fully or partially external, having an objective character. All the informants presented some form for complaint related to this facet, emphasizing nuances that were specifically contextual for the single. To balance this negative view some also named positive sides, like the supportive role of working in team or of having good supervision and support, aspects related to the phenomena of resilience that will be discussed later.

The main negative external factors that emerged were: The emergency style of management of migration phenomena in Italy, the excess of institutional bureaucracy, the lack of coordination and fragmentation of work tasks, the lack of cultural sensitivity and scarce preparation among personnel in hosting centers, the self-perceived lack of cultural competence for some interviewees, the shortage of time and proper settings, the shortage of cultural mediators (interpreters) and the challenges met in the coordination of different professional roles.

These findings are summarized in Table 3 below. The following paragraphs will look at the main problems highlighted by interviewees.

Table 3

Factors of "negative" character.

Raw findings	*Effects*	*Cause /Relation to*	*Category*
- "Emergency" style of management of migration phenomena in Italy - High variability in migratory phenomena (different ethnicities during time) - Excess of bureaucracy - Lack of coordination in the network - Fragmentation of work tasks - Lack of stability in job conditions (project funding; temporary contracts, periods without financial coverage) - Shortage /inadequacy of proper setting (space, time) - Shortage of mediators - Witnessing lack of cultural sensitivity among other operators - Witnessing problems in hosting facilities (e.g. overcrowding in the facilities)	- overload - frustration - demotivation - sense of loneliness / isolation - psychosomatic symptoms	- Policies (Italian, European) - Management - Working conditions	**External factors** (not controllable, objective - that interfere with psychologists' work).
- Lack of specific formation for psychologists to meet the complexity in this population and its clinical problems - Stretching over own's tasks - Perceiving discrimination and stigmatization, directly or indirectly	- overload - frustration - sense of loneliness (isolation) - psychosomatic symptoms	- Issue of cultural competence / sensitivity - Issue of (adequate) formation	**Factors of mixed character** (objective and subjective)

3.1.1 An "emergency" management of migration.

The majority of the interviewees shared critics about the inadequacy of both policies and practical solutions adopted to manage the refugees crisis, a consequence of political decisions in Italy and in the EU. They reported an unpreparedness of the Italian government in managing the phenomena, in particular pointing out how emergency solutions that were previously introduced to face the apex of crisis in past years were implemented as if "ordinary" though no longer adequate. Other critics pointed out the shortage of professional resources and competencies, the lack of coordination between different entities and actors in the network, and the cumbersome bureaucracy. All these sort of problems were described by an informant as: *"Order of difficulties at systemic-structural level".* The emergency style of management was also reflected in the character of urgency of cases often presented to the psychologists, that negatively affected their main tasks of delivering adequate support or clinical treatments, as expressed in this quote:*"The difficulty is instead to be able to stop all this, to create a context and space, where to do ... the work of psychotherapy".* Interviewees at the mental healthcare service seemed to be particularly

sensitive about this aspect, but also those in the CAS and CIE reported a discomfort related to the condition of emergency and urgency they faced, as expressed in this quote: *"My perception is that reception system in Italy is… at least from what I can see… it is something that corresponds to an urgency, you know… to place these people and somehow manage a bit this wave… but what lacks is the construction of a work-model or a competency"*.

Psychologists also named the challenge related to the variability of migratory flows and of the ethnic heterogeneity in the population they met, acknowledging that migratory phenomena are objectively difficult to be managed. This fact, together with the high incidence of trauma in migrant population, call into question the issue of adequate formation and of cultural competence addressed in the next paragraph.

3.1.2 The need for adequate formation.

Informants almost unanimously concurred about the need to have theoretical knowledge and practical tools related to cultural competence, skills that all the different professionals working in this field should have. They witnessed instead an almost systemic lack of such competence among generic operators in the hosting facilities, with negative consequences in the management of single cases or of group dynamics as in CAS or CIE where a number of cultures meet and tensions arise also due to forced closeness, as in this quote: *"here… there's no people able to understand them, namely because of this ignorance… not theirs poor them… but ours, in managing and welcoming them… so… yes this competence is fundamental"*.

As another psychologist said, migrants coming from remote rural regions may not even know what a psychologist is, again underlying the need for adequate preparation in intercultural work.

Several of the interviewees had or were acquiring cultural competence by attending specific formation in the field of ethnopsychiatry, while those who lacked this competence reported a need to fill this gap, especially newcomers in this field or those with shorter experience in clinical work, as in this quote: *"At the beginning I was afraid not to see things in people, and that the irreparable could happen"*.

Apart from specific formation, what emerged was also the importance of the attitude in meeting other cultures with curiosity and openness: *"Not so much a didactic or predefined approach…it is more a position almost of curiosity and mental openness, most of all"*. Or again,

in this quote from an experienced informant: *"What I want to say is that before all techniques I think the most important is to build a relationship that is not re-traumatizing… not only the trauma the person experienced during migration, but related to the relationship with the patient, with this form for alterity"*.

Informants underlined that working with this population required a set of specific competencies including cultural and linguistic ones, and this can be best done through teamwork where the interpreter or cultural mediator is an indispensable partner. This teamwork requires good coordination and clearly defined tasks and professional roles, something that was not always the case in the informants' workplace. One of them reported an episode of misunderstanding and incautious verbal intervention done by a cultural mediator *"Another problem is the relation with mediators… because untilit is in English you can keep control, but when it is Chinese? … It is complex also working with mediators, because you have to trust them, no? … You should have time to build a relationship with them too, but often there is no way, no time for this"*. Not all informants shared this perspective and some other reported on good team coordination and internal cooperation, perceived as motivating and supportive: *"Mediators helps us so much in understanding the culture… in the therapy room, having a person of the same ethnicity, this helps so much…"*.

Several of the psychologists took specific formation on trauma and PTSD treatment, reporting high benefit both for their clinical interventions and to understand own bodily reactions, occurring in trauma therapy. Even so, trauma work remained challenging, as in this quote from a psychologist with long experience in the field: *"You can't be prepared… never, I think… to hear about torture and extreme violence"*. This informant pointed out that there is no path of study that can fully prepare to meet such facts of extreme character, and that it is mainly through field experience that one can get competence and grow: *"One thing is to read books, another is when the person shows you the signs on her body, of what she has experienced… because she possibly can't even speak, and starts to show you what she's not able to tell you"*.

The next paragraph will look closer at the problem of limits of professional role and tasks, highlighted by a number of interviewees.

3.1.3 Stretching over one's role.

Psychologists had different roles and tasks depending on the type of facility where they worked, either delivering therapy or support. Migrants can find themselves in different legal situations and steps in relation to the asylum seeking process and this can have a considerable weigh on the type of problem they present and need help for, varying in a range of clinical, psychosocial and bureaucratic-legal problems. Several interviewees said that they frequently had to stretch beyond the professional role and take others' tasks on their shoulders, addressing problems that should not pertain to them. A psychologist told that she used to conduct a sort of first medical screening when meeting a new migrant patient, to identify health problems that could require medical expertise: *"I got surprised when… for example, at this time I regularly meet a woman, that has been raped… and six months after she came to Italy she still did not have a gynecological examination, that is… to me the difficulty is also, almost to feel a little of responsibility for so many, many aspects… because you say, how is it possible that there is not a minimum of… like a plan that considers that part of health?".* Several informants reported a distress related to this over-stretch beyond their role and competencies that could also be perceived as a sense of loneliness and frustration, as in these two quotes: *"Often you feel a bit alone, like if you have to give something personally to compensate for the shortcomings of the system"* and again: *"This is frustrating, really frustrating, because you feel impotent… You know that you could do more if you were in a different condition, and this creates tension, uneasiness".* This aspect seems to be a facet of the emergency style of management previously named.

Another difficulty that was highlighted by some informants was the sense of exclusion and stigmatization that could affect them too, related to the kind of population they worked with.

3.1.4 Perceiving exclusion or stigma.

The fact that these professionals worked with migrant population with mental problems seemed to expose them to the same prejudices burdening these human life situations. Racism is both latently and openly present in the Italian society, at different levels of consciousness and manifestation (European Commission against Racism and Intolerance, 2016). Just by following the daily news it is possible to see how migration is a hot topic in Italian politics and society, met with opposite attitudes ranging from openness and inclusion to subtle forms of exclusion as

showing indifference or suspicion, to open hostility expressed e.g. in verbal language or even as it sadly happened with criminal acts (Giuffrida, 2018). Some of the interviewees referred how the stigmatization of mental illness and migrants seemed to affect them too. The following quote describes rumours heard by an interviewee, coming from other health professionals in the same building where the mental health service for migrant was located: *"So you are those of the ethnopsychiatry… we were terrorised, we already thought about people coming here with the machete"*, showing the latent suspect and worry for the migrant who is *"psycho"*, violent. The informant continued, reflecting over the working conditions previously described: *"It is like if we reflect the fact of not being allowed to stay, not being accepted, as our patients. It is like if the team reflects this thing… we are in part clandestine we too, because we don't have a clear definition… we don't have a place, we are here today but we never know if we will be here tomorrow".* Similar feelings related to experiencing or witnessing these more or less apparent discriminations were found among other interviewees, independently from where they worked.

This feeling of provisionality was also reflected in the lack of stability in employment conditions for the psychologists, due to job-contracts linked to external, time-limited projects and funding. It was reported as causing uncertainty and frustration among a number of informants, undermining the motivation to work as well as the continuity in the assistance to be delivered.

These framework factors could be grouped together and labeled as fully or partly objective or external, described as of negative character, being not clearly dependent from psychologists' subjectivity or under their direct control. They lay behind a considerable part of stress and overload for the majority of the interviewees, and could be put in relation to the construct of burnout described in the introduction. The type of facility where informants worked and the task they had seemed to determine some nuances in the level of perceived stress, while the common aspect they described was the negative relapse on the quality of help delivered to the migrant population. To underline here, is that informants largely agreed on the fact that their major difficulty was to deal with this category of problems. Dealing with the stories sometimes extremely dramatic of the migrants, seemed not to be the worst issue of concern for the interviewees. Even so, it was not easy to face such severe situations and traumas as the next paragraphs will show, covering aspects that were more clearly attributable to the clinical work.

3.2 Witnessing dehumanization.

Informants described an impact in the confrontation with the extreme experiences of these patients, observed in relation to all the different migratory phases described in the introduction.

In simple words, they witnessed *dehumanization* and the consequences it had on these human beings. The type of facility where psychologists worked showed to have an influence on the sort of problems they faced. The CIE (centres for identification and expulsion) in particular was described with terms as: *"an extreme place"*, a: *"a limbo"*, or: *"a prison",* and as an interviewee said: *"It's structured as a prison… there are bars, barbed wire, police, militaries"*.

Migrants hosted in the CIE can stay up to three months or longer periods in these facilities until their case has been examined, often ending with repatriation. As several interviewees confirmed, time here passes by in absence of perspectives, in empty days characterized by the constant fear of being expelled. This triggers anxiety and depressive symptoms, as well as the telling of distorted truths in an attempt to influence as much as possible the assessment of their situation in hope to obtain an asylum permit. About this last point an interviewee said: *"This is the difficulty, continuing to be objective in the work with any of them, welcome them as they are, accept what they tell you, without prejudice… this is the main difficulty that I'm experiencing now…"*. Feelings of guilt, of shame or indignation were shared by interviewees, to be part of this "system" and in their roles representing Italy, as in this quote: *"These structures as conceived and currently run, are a far more serious sentence than any other kind of sentence, for these people… How is it possible that Italy can find solutions like this?",* and again: *"Our state is guilty, is unable to welcome people. By trying to host them, it keeps making them suffering in a slow and lengthy way, really a trickle. I think this is an even more serious responsibility, of Italy, of the Italians"*.

Independently from the type of facility where interviewees worked, all of them faced dehumanisation in the narratives of extreme character they listened to. This content could have intense effects on the clinician, as in this quote from an informant in force in a CAS center: *"I really had these stories on me, everywhere… these stories, these pieces of lives, of rapes, of violences, of blood… everywhere… the level of the stories, they are shocking, extreme in all senses, and at the beginning yes… they influenced me a lot and I was physically devastated"*.

A finding that recurred frequently in interviewees' experiences was that these extreme histories were so afar from theirs reality to be sometimes perceived as unreal, with effects thatit is interesting to look closer at.

3.2.1 The "unimaginable".

An interviewee told about a case she followed of a migrant woman who lost her small children during the crossing of the Mediterranean: *"She was totally dissociated, so she told this fact without a tear, as if I already knew… but when I asked her, she said no, no, no children have fallen at sea… I got astonished, my first reaction was of not believing her, because in my experience, two children… that is, if you have two children they cannot fall at sea… if a child falls at sea you do something"*. The informant continued the narration this way: *"And then I got ashamed… and afterward trying to understand why I had this reaction of not being empathic… trying to give a sense to what happened to me right then… I tell you, a sense of disorientation during the interview, because you really loose your reference points…"*. This extreme reaction recalls the construct of secondary and/or vicarious trauma. It can also be put in relation to the construct of empathic repression, happening when an inner distance is triggered in the clinician as a self-protective reaction.

Another interviewee described the first impact with these narratives in this quote: *"It was the first time I listened to these stories of traumas and violences that you think can only exist in films, but then you realize that it is reality"*. The interviewer commented, spontaneously: *"yes, they're unimaginable"*, and the interviewee nodded, confirming: *"Yes, they're unimaginable"*.

All the informants reported about having being faced with such kind of narratives, independently from the type of facility where they worked or how long they had been in this field, a reconfirm of the high level of exposure of the migrant population to severe traumas.

Besides the feelings of indignation, incredulity and shame already named above, interviewees also described reactions as getting emotional during the encounter with the patients, having unexplained outbursts of crying afterwards, experiencing unjustified feeling of fear, feeling desperate, getting irritable outside the workplace, like getting *"hyper activated"*, *"on alert"*, or experiencing a *"frightening loss of concentration"*, a*"blurring"*, a *"frightening loss of contact with the body"*.

Globally considered, these findings show how informants were highly exposed to intense emotional and physical reactions, closely related to their professional role and tasks with this highly traumatized population. Also, a variability in physical reactions and awareness of body perceptions emerged in psychologists narratives, as well as different interpretations they gave of patterns of symptoms and evolution over time. The next paragraphs will look closer at these phenomena.

3.3 The psychologist's body.

A number of informants described generic psychosomatic symptoms that they put in relation to factors previously defined as external and that could be attributed to unspecific stress load e.g. neck pain, headache, muscular pain or abdominal symptoms, in a broad range of intensity spanning from almost absence of symptoms to really invalidating ones. As an example an informant described *"ferocious headaches"* often *"exploding"* after excess of work, along with a sense of fatigue, like having flue, or fever. Similar pattern of symptoms could be put in relation to the concept of burnout, and they were found among several interviewees. By focussing the interview questions even more, it emerged that informants quite neatly distinguished these types of reactions from other physical symptoms more clearly related to the constructs of vicarious trauma and compassion fatigue. They described such reactions with words like*"feeling displaced"* or: "*a fist in the stomach*" or again:*"feeling devastated"*. An interviewee said: *"I was full with pain, I really felt displaced, moved, excessively moved from these stories… like when you go out and a wind-cast hits you, and you feel that you are really pushed away by something"*.

Other reported symptoms where they seemed to mirror the symptomatology of the patient, especially discomfortable when experienced as dissociation, like in this description: *"There was this patient, telling about her story of sexual abuse, and then I felt my legs stiffening, immobilized… I couldn't move them… and it was really concurrent, so I somehow think that it had to do with what she was telling me, the way I was feeling this…"*. Or again, in another quote: *"Once, a girl was telling about violences she suffered in Libya… I felt like jolts when she was speaking… you get so identified in their stories, it just happens in a totally involuntary way"*.

These narratives describe immediate reactions of high intensity that are in accordance to the constructs of secondary or vicarious trauma, that can happen during or immediately after the exposure. The author thinks that cumulative effect to exposure to this kind of material could explain reactions as that previously described [see paragraph 3.2] that are more closely related to the construct of vicarious fatigue. It is anyway difficult to clearly distinguish reactions as more pertaining to vicarious fatigue or burnout, since the different types of stressors appear to be present at the same time for the majority of interviewees. Furthermore, they reported different patterns and levels of being affected, spanning from reactions on the spot to delayed ones, from very intense to very controlled or even to an absence of physical symptoms. The individual variability seem to depend also upon personal traits and work experience, factors that very probably influenced psychologists' coping strategies.

It is interesting to look here at the supplementary findings from observation of body patterns, since these are pertaining to the facet here described.

3.3.1 Findings from the body examination.

Considered as a whole, this set of findings indicates a considerable amount of physical overload, in form of deviation from the ideal reference pattern of posture and respiration as used in the CBE sub-scales. This goes interestingly hand in hand with the patterns described in the narratives, where anyway there are large differences that could quite reasonably be related to life-history events and to previous overloads. These could influence body patterns of posture and respiration too, something that is commonly observed in clinical work in NPMP, and interfere or overlap with the effect of stressors specifically related to the professional activity here explored.

This complexity could be put in relation to what said on interoception in introduction chapter.

Even with all the limitations described, the supplementary part of body observation seemed anyway to have some relevance, orienting to aspects that could be worth to explore better in future research.

Table 4 below is an attempt to summarize these findings which are not clearly attributable to the previously named "external" factors. Here too, it was not possible for the author to identify sharply defined categories.

Table 4

Physical and emotional reactions reported by interviewees.

Main raw findings	*Features / Interpretations*	*Synthesis*
- Muscular tension / Muscular stiffening - Headache - Hyper-activation - Blurring / Loss of concentration - Loss of body perception / Dissociation - Outbursts of crying - Abdominal symptoms, "A fist" in the stomach" - Other physical symptoms: "Jolts", "Being pushed"	• Experienced as negative • Experienced as positive when manageable: Access to counter-transfer; "A work tool"	**Presence / awareness of bodily reactions**
- Lack of physical symptoms or somatization phenomena (in the setting or delayed)	• Self-consciousness about scarcity of body awareness • Interpreted as good "resistance", "strength": Resilience ?	**Absence / unawareness of bodily reactions**
- Fear / Shame / Anger / Indignation - Sense of desperation / Demotivation - Feeling positively empathic - Feeling compassion - Feeling a "maternal" instinct; "Desire" to give a caress	• "Negative" and "Positive" emotions • Different levels of empathy	**Presence of emotional reactions, negative and positive ones**
- Control over emotional or physical reaction in the setting. Reactions are delayed, as: Fear / Outbursts of crying	• Variations in self-regulation patterns in the setting and afterwards	**Control (delay) of emotional reactions**

3.4 Evolution with time.

Findings showed an evolution with time that seemed to be in relation to the duration of exposure to stressors and to work experience, relevant to be analysed since one of the main questions addressed exactly this facet.

In the narratives, those informants who had longer work experience described a positive evolution during time, in terms of reduction in the intensity of symptomatology and increased body awareness e.g. a better ability to *"relocate things"* and to manage and contain secondary reactions, both in the setting and in general. They also described the development of better ability to put limits to work activity, in expressions as: *"unplug"* or: *"switch the phone off"*. An interviewee with a longer experience in the field described the evolution from an initial *"unconscious hyper-activation"* followed by headaches and exhaustion, confused as a capacity to work at high performance: *"Indeed this was a way, unconscious I think, first of all to perceive, probably empathically, the feelings, the emotions of the person in front of me"*. With supervision

and own therapy, the informant could develop a better awareness about this emotional and physical pattern, resulting in better self-regulation and a reduction in the intensity of symptoms, an evolution that took time: *"With time I understood that probably it was my way to react to the contact with all that suffering"*. Another informant, also with long experience, told about a period in life when personal problems interfered with the professional practice, negatively affecting the capacity to be empathic and feeling through the body: *"There was no room inside me for them in that moment… it is then that one has to stop… these reactions are part of the human body, they exist, they happen when you, as a psychologist or as any other healthcare professional, have your mind and heart clear from other problems"*. The interviewer followed up this affirmation with a secondary question: *"Then, if I interpret correctly… what happens to you at somatic level, do you consider this a positive sign?"*. The informant answered with an interesting metaphor: *"Yes,it is a thermometer that measures the level of empathy, maybe we can say this way…"*.

Therapists with shorter work experience, either general or specifically with migrant population, oppositely reported a lower affliction from physical symptoms and an apparently lower level of body-awareness. It is to underline that all of them reported clear consciousness at cognitive level of being exposed to highly traumatic material and of having a relatively short work experience, thus not being fully able to foresee what this exposition could lead to with time. One of these interviewees said: *"Up to now no… I feel I can tolerate stress well, so… or I will suddenly crumble one day, I don't know, maybe everything will fall down on me, but at the moment no, I must say…"*.

It is also interesting to remind here what said previously, how those psychologists who got specific formations on psycho-traumatology reported that this had great importance both in gaining a clinical tool and to understand better their own reactions i.e. indirectly their body awareness increased too, again showing the importance of formation as a protective factor.

Considered as a whole, these findings seems to indicate how exposure to stress and trauma witnessed in the migrants led in time to different pattern of reactions, where also individual traits, previous expositions and own trauma-history played in. All these factors could combine and potentially influence body awareness and pattern of somatization of the informants, confirming what reported in scientific literature.

From the analysis two other aspects also emerged, first that those psychologist experiencing scarcity of physical reactions were missing access to an important bunch of informations mediated by the body which other informants had. Secondly, this was reflected also in a different interpretation of the phenomena of resilience, an aspect that will be discussed later in this chapter. These interpretations from the author emerged mainly from the qualitative findings, but also the observation of body pattern seemed to sustain these hypothesis.

3.5 The body as a work-tool.

The analysis of interview questions focusing on body and physical reaction leaded to interesting findings, among which emerged the importance of the body as a work-tool. It's pertaining to name here the convergence among psychologists, in recognizing the body as the privileged channel of expression of patient's suffering: In general they reported to attentively observe somatisation phenomena, since often these patients tended to focus their narratives on physical symptoms. Here the informants underlined the importance of cultural competence, for a correct interpretation of aspects like that of attribution of meaning to symptoms. For example, one interviewee told about the different ethnic groups she was observing, how these manifested anxiety with peculiar patterns, saying that: *"It's something absurd"*, meaning hardly believable, like if cultural and ethnic belonging unconsciously influenced also toward preferential patterns of symptoms. Another interviewee told about trauma and body: *"The trauma freezes the ability for narration, so the pain is told through the body. There are indeed cultural aspects in the representation of the symptom, but the body is the body beyond the meaning that we put in it"*.

From these findings, the author infers that informants recognize the relevance of the body and its manifestation as something literally common to all humans and transversal to all cultures, a concrete resource to understand and get in relation with the patient.

The main aspect related the body as a work-tool, was however the fact that the therapist in turn could react through the body. High variability emerged among interviewees, but a number of those who experience somatisation considered it not only negatively but also as extremely important. An interviewee said that feeling through the body meant to have access to counter-transfer informations that could be used in the setting*: "These are among the most important informations, of counter-transfer, that is… and from this the work can begin"*. A concrete way to

use body information in the setting, was for the same interviewee to unveil the perceived symptom: *"I think that even unveiling it, sometimes, to the patient we have in front of us, that it can be a very powerful tool"*.

Where this ability to feel, to perceive on a somatic level was absent or scarce, there it lacked access to this specific "work-tool". This has not to be confused with lack of sensitivity and empathy in these psychologist: Somatization in patients was still attentively observed and described in narratives of clinical cases even from psychologist with low body awareness.

Some of them on the other hand interpreted the absence of somatization as positive, as a sign of resistance to vicarious trauma and of good self-regulation, as expressed in this short quote:*"Otherwise you would not get out of it"*. In these cases the lack of reactions at body level was experienced as functional to self-protection. When further asked to reflect about this absence or scarcity of somatization, some of these informants expressed uncertainty if this could be considered as a positive reaction or a functional mechanism to manage stress in the long run, like in this quote: *"I don't know, partly being now immersed in this situation I don't have the right distance to evaluate if with time… if this would lead to a situation of this type"*.

These findings are of particular interest in relation to the thesis subject and research questions and what emerges from the analysis is the presence or absence of the body as a work-tool. This can be connected to the very central concept of resilience, the theme of the next paragraph.

3.6 Resilience: The other side of the coin?

By asking psychologists directly or indirectly on their resilience and what it was fostered by, a quantity of reflections were stimulated. It appeared to be a difficult item to describe and no one of the interviewees took a stand on an exact definition.

There was unanimity among interviewees in considering resilience as a fundamental quality in their profession, as in this quote: *"Besides the specific situation with migrants… when working with mental illness, with serious mental illness, you are exposed to many things… so you have also to train to manage all this, to protect yourself from some situations"*.

Differences emerged instead when interviewees were solicited to reflect about where resilience sprung from, some considering it as mainly related to individual characteristics like in this quote:

"It depends upon personal features that not all have… It's a personality trait… I'm not saying thatit is genetic, but we all have a way to face life, our character…it is this that gives us the capacity to be resilient or not…"

Another psychologist reflecting about the resilience observed in Nigerian women put the accent on sociocultural contexts: *"There are many cases, really a lot… then one has to understand, where do these people come from, in what reality they live, right? But I tell you once more, I think that if those women came from other places, they would probably all be in a psychiatric ward".* Other informants highlighted the relevance of life experiences in the development of resilience: *"I believe that… yes, resilience is also influenced by experience"* and again: *"People who experienced the second world war… the big trauma, maybe our grandparents, they have a higher resilience compared to that of our sons, that haven't experienced not even half part of a trauma?".* As the question mark at the end of this statement shows, a level of uncertainty remained when reflecting on this complex phenomena. Other informants named the support network as key factor i.e. the family or social group, like in this quote: *"To me resilience in our patients is strictly related, and consequently even for us professionals since as we were saying we function similarly, it depends somehow from the network of basic relationships that one has".* This citation highlighted the importance of support network for the development of resilience in both patients and psychologist, an opinion that was widely shared among interviewees, as here expressed: *"I think I have developed it also thanks to the support of people with a higher competence than mine"*, or again in this quote: *"I'm lucky, I have a partner, a child… I know I'm lucky to have a supportive network around me, both at work and in private life".*

A number of informants described incredulity in observing the strength and resilience in these people who brought extreme stories with them. Some wondered where these people could find their strength and tenacity: *"Some have developed an ability to keep going on, that you see them there inside* [in the hosting facility] *they sing, dance, laugh, always smiling… I don't know, to me,it is also a cultural factor, they have a resilience, a survival instinct that goes beyond any limit, a strength…".* Another interviewee said:*"Only because they are here, they have goals, motivations… in spite of all that they have experienced, in spite of how they are being treated… to me this is a manifestation of resilience".*

These levels of resilience observed in migrants could paradoxically be confusing, almost as if the psychologists' theoretical and experiential apparatus shrunk when confronted with this extremeness*: "I think that if we Italian women, if we should suffer what the Nigerian women suffered, to me we would all be dead, or depressed, or taking drugs"*. Or again, in this other quote: *"Their pain does not comes through, it often emerges in their narrations, but not in the way they speak, in their symptoms… they have a level of resilience that is crazy"*.

Another interviewee explained it like this: *"They tell the story, in a painful way… but many of them have developed an armor, so when they tell you things they don't show any kind of emotion, they are totally detached"*. Here a doubt seemed to emerge in interviewees in this and similar findings, about what was resilience and what was dissociation, pathology? That is, the "tenacity" observed in these patients, the fact that they did not express pain, was this a sign of resilience, or was it an extreme need to defend themselves, a defensive mechanism or a dissociative phenomenon? Asked about this, an interview said: *"I think yes, it is a protective reaction, to protect oneself from pain, because it is necessary as a defense mechanism…"*.

Exposition seemed to be a key factor related to the development of resilience for the majority of the interviewees. An informant said: *"The therapeutic work puts you so much in connection with the person that her improvement becomes yours, and therefore it becomes an exchange, something that is built together"*, and again: *"Resilience is something that is built in the therapeutic path and becomes something also of the therapist, it is a common space"*.

This consciousness appeared to be less frequent among psychologists who had a shorter work experience with migrant population, while those with a longer one appeared to be in a more advanced phase in the development and awareness about own resilience. These had a wider perspective on their process over time, showing better insight in personal growth trajectory, expressed by concepts as being better able to put oneself in perspective, to resize own problems and difficulties, to comprehend their growth as a consequence of, and thanks to exposition to their patients' traumas. This reminds the author about the constructs of vicarious growth found in literature. An interviewee said: *"As I always say, it is one of the most beautiful works… there are thousands of problems, concrete ones, for which I should not stay here… in the sense that, everything is so precarious, and many more things…but I can't leave this job because it gives me so much… so much…"*. Another interviewee similarly said: *"To observe the other, the sufferance*

in the other, makes you somehow understand that your problems are more serious or less serious, it helps you to face them, it gives you the example, the strength".

These findings show both commonalities and diversities in personal opinions and conceptual understanding of what this phenomenon is, and what factors it is influenced by. They are summarized in Table 5 below.

Table 5
Main findings around resilience and vicarious resilience.

Raw findings	*Emerging characteristics*
- Different opinions on what resilience is. - No interviewees knew about the construct of "vicarious resilience". Interest for it. - Different opinions on what factors foster resilience: Individual factors, exposition to stress factors (included trauma), having support network… - Fundamental quality in psychotherapeutic work - Related to personal growth, as an ability and opportunity - Relevance of supervision for the developing of resilience in the therapist - To observe resilience in patients (migrants): Where do they get such a resilience? - Correlation with life history of the psychologist (persona factors) ? - What does resilience encompass? Faith, trust, strength as possible elements. Also motivation, stubbornness, tenacity…	- Resilience as a multifaceted characteristic. - Mixed subjective and objective factors contribute to resilience. - Vicarious resilience seems to be related to experience, exposition, personal characteristics.

The construct of vicarious resilience pertains to this facet. The author introduced it in secondary question in the conclusive part of interviews, and it showed to be unknown to all the interviewees.

3.6.1 Vicarious resilience, an interesting construct.

Some interviewees could not answer to the question about this construct admitting that they never reflected that much on the development of their own resilience, especially those with limited experience, as in this quote: *"I never reflected on this… maybe it is a limit, because having just started to work… I didn't even think about it… and I'm thinking about it for the first time now".*

Other defined it as a new and interesting construct, like in this citation from an experienced informant: *"vicarious resilience… I didn't know it and it is very interesting, and that's what I think I find harder to explain… to people who do not work in this field, that is… now that I have the term maybe I could"*. The same psychologist continued like this: *"many people I meet here are among the strongest people I know… they are suffering, they have symptoms, they feel bad… but they have a vital boost that I really seldom perceive in our countrymen… it makes me think about this… when I complain about my problems, or when I'm having hard times… I come here in the morning, I see these people, and I say, OK… you know, it just changes my perspective"*.

Prompted to reflect on the same construct, another interviewee with long work experience as psychologist but with limited experience with migrant population said: *"what I called resistance… that you rightly call resilience, maybe it has become…it is becoming… I hope it will become… something for all in the team… actually for all at the facility"*, meaning for the team but also for the migrants there hosted.

Also, in some interviewees past experiences seemed to be clearly related to the development of resilience. The term *"stubbornness"* recurred in the tellings of three interviewees and also the words *"trust" "faith"* and *"strength"* were named by an informant, as factors that contribute to a resilient attitude and connected to informants personal development, values and history of life.

Considered globally, what emerges as essence of these findings and in particular from the exploration of the positive sides and of the phenomena of resilience, was a theme that the author was inspired to name as "*re-humanization"*.

3.7 Re-humanization, the essence of psychologists' intervention?

The desire to contribute in reducing the effects of the de-humanization witnessed in migrants emerged as the driving force for psychologists' motivation to work, sustaining them to face the negative secondary effects and in the development of their own vicarious resilience. The essence of all this could be summarized by the theme of *re-humanization*. Psychologists described the tight bonds that characterized the therapeutic or supportive relationships with migrant patients.

Several of the informants said that they witnessed fewer prejudices in migrant population towards the work of the psychologist compared to autochthonous patients, and this could play a

role in these dynamics, as expressed by a psychologist in this quote: *"They almost put their lives in your hands"*. Frequently the relationship that was established had features describes as *"fraternal" or "maternal"*. In the narratives there were descriptions like: *"The desire to give a caress"*, or *"Almost like a friend"*. These dynamics /feelings appeared to lead to personal solutions in managing the interaction in the setting when this was needed, as in this quote: *"There are rules ok, but rules sometimes have to be broken"*.

These findings reveal an emotional involvement in the stories, something that could partly be put in relation to the construct of emphatic enmeshment presented in the introduction, except that this has a negative character since it indicates an excess of empathy from the clinician's side. In this investigation the findings did not bear such negative trait, revealing instead a phenomena with features as high emotional reward, that contributes to the fostering of motivation, of personal and professional growth and to the development of vicarious resilience among informants.

4 CONCLUSION.

This research investigated the experience of psychologists who worked in mental healthcare services for the migrant population in Italy. The author, inspired by his professional background and foreknowledge, postulated that interesting findings were to be expected, due to the high level of exposition of these professionals to a number of stress factors. The results potentially could show relevance for understanding the specific work situation of psychologists, and possibly contribute to an improvement. The research questions formulated in the introduction addressed the psychologists' experience in its positive and negative sides, how their work affected them in general and more specifically at physical level.

What clearly emerged from the analysis of findings was the high level of distress that most of interviewees experienced, related to different facets of their work. Also, a specter of individual reactions was encountered in patterns of somatization, coping mechanism and development of resilience, confirming the complexity of the subject investigated. Individual factors like previous life-experiences, personal traits and duration of work-experience coexisted and overlapped with

objective factors as work environment or assigned tasks, contributing to subjective variability in either negative or positive phenomena encountered among informants.

4.1 Psychologists' experience: Negative and positives sides.

Interviewees showed clear consciousness about the complexity of the issues to address and the severity of the traumatic material they were exposed to, even after relatively short periods of interaction with the population they served. Both negative and positive aspects were highlighted by informants, consistently with the constructs presented in literature and previous research.

A quantity of findings of negative character could be put in relation to the constructs of burnout, vicarious trauma, vicarious fatigue and compassion fatigue. Findings of positive character could be related to constructs as vicarious growth or vicarious resilience and to the original themes of the body as a work-tool and to that of re-humanisation, that emerged from the analysis.

Closely related to the construct of burnout were those stressors named as external or objective, that informants couldn't influence or control directly since these were mainly referable to public bodies' policies and/or to local management of work conditions and tasks. Psychologists quite unanimously expressed high level of annoyance and distress related to this group of findings, among which the emergency style of management of migration phenomena, the instability in working contracts, the hampering bureaucracy, the fragmentation of resources, lack of coordination and stretching over the professional role to compensate for systems' shortcomings.

This load resulted also in patterns of symptoms, either psychosomatic ones or more clearly of emotional character, with varying grade of intensity among informants. Partly counterbalancing this picture, positive findings also emerged from interviews, since some of the psychologists reported positive experiences like satisfaction about team dynamics and collegial support, partly giving another perspective than the dominant negative one.

The other group of negative findings encompassed factors that were named as internal or subjective i.e. more closely associated to the development of stress reactions intrinsically related

to the psychologists' professional role and tasks. Delivering mental healthcare interventions to this population exposed the informants to severe traumatic material.

These findings showed definitely a link between exposition and reported phenomenas that could be put in relation to the constructs of vicarious trauma, vicarious fatigue and compassion fatigue. As for the previous group of stressors related to burnout, here too a wide specter of reactions was reported, spanning from almost absence of symptoms to high grade of affliction, even with detailed descriptions of experiences of dissociative character.

Pertaining to this group were also those findings of positive character referable to the professional role and tasks of the psychologists, the majority of them describing interest, passion and gratification to work with this population. What showed up was that the challenges related to the severity of mental health issues and to the many competencies required were amply rewarded by the enrichment that this work intrinsically fostered in the interviewees both at professional and personal levels. The theme of re-humanisation appeared as a meaningful one, to explain the essence of psychologists' intervention. The response to the dehumanisation they faced happened through an intervention encompassing other elements beyond the "professional" ones, like showing a caring interaction, cultural sensitivity, motivation and dedication despite all the difficulties they listed.

4.2 Somatic effects of exposition.

Findings showed a relevant level of physical affliction among informants. Investigation of the pattern of symptoms through narratives revealed both recurring psychosomatic reactions of common character e.g. muscular tension or headache, as well as phenomena of vicarious trauma and dissociative reactions clearly experienced in the body.

Different interpretations and levels of insight emerged when informants were stimulated to reflect over the presence or absence of physical reactions and to a possible correlation in the development of their own resilience, with answers that spanned in a wide range. On one side some interviewees considered a balanced level of vicarious trauma or vicarious fatigue as a positive reaction, like a thermometer of the ability to be empathic and to have access to counter-transfer informations. Other informants instead interpreted the absence of physical symptoms as

a sign of subjective scarcity of body-awareness. On the other side, some informants considered the absence of symptoms as a sign of robustness and of good level of resilience.

The data from the observation of body patterns of posture and respiration, as from CBE scale, were considered as a mere supplement because of the stance taken in defining the purpose of this research and the adoption of a qualitative design. For this reason these data were not treated with any quantitative methods, just looked at globally. Even with such strong limitations, these findings too showed the presence of a relatively high level of somatic affliction in the majority of informants. Some findings from a few other informants showed on the contrary patterns with minimal deviations. More specific conclusion could not be formulated, other than it could be interesting to further explore the meaning of these findings in a hypothetical following study, to be conducted with an appropriate design.

An interesting theme that emerged from the analysis of the qualitative findings is that of the body as a work-tool. Having access to bodily reactions, if these were not too intense and disturbing, meant to had access to an important work-tool or to counter-transference informations mediated by the body, that could profitably be used in the setting for those informants who had this capability. This theme could be put in relation to the strictly connected construct of body-awareness, a feature that is influenced by personal and physical traits at individual level but that also can be learned and fostered i.e. in body-oriented therapy methods like NPMP.

4.3 Limitations and strengths of the study.

The enrolment provided a strategic sample of ten informants, representing breadth in terms of gender, age, types of hosting facilities, tasks and work experience. Individual characteristics, previous life-experiences, theoretical stance, duration of work experience and level of gained competence probably accounted for the breadth in findings. This could argue for the research's strength in terms of a satisfactory level of generalisation and transmissibility for the qualitative data. The same could not be said for the body observation data, but these were anyway presented as a supplementary part meant to give a first impression on this facet.

The informants gave in general a positive feedback about the purpose and conduction of this investigation, confirming the relevance of the subject and the focussing on bodily aspects. This was indirectly reconfirmed by slight reactivation of patterns of symptoms in some informants during the interviews, within acceptable and manageable levels of intensity and always giving them the possibility to self-regulate and moderate the conduction of the interviews if needed.

None of the informants complained about these episodes and none of them took subsequently contact with the author to ask for support or help.

A constructive critic from an informant addressed the lack of psychometric tools to explore relevant individual traits of the informants. The author was aware that this research did not investigate subjective factors that could have an influence in determining pattern of symptoms, coping mechanism and level of resilience. A stance had to be taken to guarantee the manageability of the project within given time and size limits, and choice fell upon the qualitative investigation of the subject as a priority. This critic was anyway useful, and should be considered, in the planning of possible further research.

4.4 Suggestions on further research.

The results obtained in this research showed the relevance of the subject and can open up for possible future investigations and developments. For example, it could be interesting to explore even deeper facets related to stress load, resilience, and their relationship to the level of body awareness in these clinicians. Here, the specific contribution of a body-oriented approach like NPMP and of a psychometric scale as CBE could be worthy and should be considered. A goal could be to contribute to the development of a prognostic tool and/or of a preventive program, to reduce the negative effects of overload and to foster the development of resilience in psychologists who work with migrant population.

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APPENDIX 1

INTERVIEW GUIDE

PRIMARY QUESTIONS:

1) *In your work, you meet migrants /asylum seekers, victims of trauma, and/or with serious psychiatric conditions or at risk of developing them. What experience do you have of your work? What challenges do you encounter?*
2) *Are patient's stories influencing you? How do you perceive them in your body?*
3) *If you have any symptoms, do you recognize a recurring pattern? Did it change over time? How?*
4) *What do you do to take care of yourself and prevent or recover from stress?*

POSSIBLE SECONDARY QUESTIONS (cues):

5) *How do you understand and how do you perceive physically the way in which patients somatize their stress?*
6) *What is the role of cultural competence (perspective) in the treatment of these patients?*
7) *What is (are) the theoretical perspective on which your clinical intervention is based? What are its' limits and advantages?*
8) *Have you experienced (secondary) traumas in your work?*
9) *These work experiences were positive for your professional and human development?*
10) *What are the protective factors?*

Other questions will be formulated on the spot, depending on content to follow.

APPENDIX 2

The SESAMO project.

Author's translation in english from the Italian website, date: 24/4/2017.
Link to the original document in Italian: (http://www.iprs.it/progetti/servizi-salute-mentale-migranti-richiedenti-titolari-protezione-internazionale/).

Acronyms:
- SESAMO: "Mental Health Services for Applicants and Holders of International Protection".
- ASL: "Local Healthcare Facility" (local unit of the Italian public health system).
- IPRS: "Psychoanalytical Institute for Social Researches".
- AMIF: "Asylum, Migration and Integration Fund" (established by European regulation n. 516/2014.

The SESAMO project coordinated by ASL ROMA 6 of which IPRS is a partner, is a project promoted by the Ministry of the Interior - Department of Civil Rights and Immigration, and funded by the IMAF in the course of action to promote the of health of applicants and holders of international protection in situations of psychological health vulnerability.

Thematic area: Immigration and discrimination

Scientific coordinator: Raffaele Bracalenti

Team members: Raffaele Bracalenti, Moreno Benini, Attilio Balestrieri

Financing: Ministry of the Interior - IMAF Funds 2014-2020 - Specific Objective 1 - National Objective 1 - "Enhancement of the 1st and 2nd levels in the reception system" - Protection of health of applicants and holders of international protection in situations of mental health vulnerability, also through the strengthening of institutional competencies.

Aims: To promote the early identification of signs of mental health problems of the most vulnerable individuals - with regard to the subclinical outbreaks of mental distress at risk of aggravation into major psychiatric disorders - through screening during the permanence of applicants for international protection in the hosting facilities, by the intervention of

multidisciplinary teams to address these individuals to specific territorial services for an early takeover by the psycho-social services;

To ensure the correct interpretation of the signs and symptoms of mental health distress of those people where the distorting effect of the linguistic and cultural barrier is a major difficulty to face, making the reconstruction of the psychiatric history a challenging task;

To increase the cultural competence (ability to respond appropriately to different forms of care needs) of the interventions and in the mental health services;

To promote a proper approach to the migrant's health, in line with the dynamic of migration, seen as a "process" starting from the conditions at origins and the reasons for the choice to migrate, then passing through the vicissitudes of the migration path and the equally complex consequences of the impact with the social structures in the countries of arrival.

Activities. The project is divided into the following activities:
A) Definition of the operational infrastructure of the intervention and creation of the network of actors: Establishment and preparation of the working group; Elaboration and sharing of the operational model with the services of ASL Roma 6; Stipulation of a “protocol of intent” with the operators of the structures for the setting up of the intervention; Identification of the network actors, sharing of praxis and language.

B) Knowledge of the context: Mapping of reception facilities for holders and applicants for international protection present on the territory of ASL Roma 6, and digitalisation (with a database) of the acquired data (figures, countries of origin, duration of stay, psychological needs, forms and typology of distress detected) in order to plan a more effective takeover (also by directing the users to the services that will have, - thanks to the database - an up-to-date picture of the amount of intervention needed);

C) Experimentation of the Intervention Model for Integrated Takeover: It contemplates the screening (detection of early or subclinical signs of psychiatric distress) in the facilities for applicants and/or holders of international protection, and handling in coordination with the territorial services within the six districts of the ASL Roma 6, bearing in mind that the multidisciplinary teams will not intervene as a substitute, but as a function of support and reinforcement of the already existing professional resources.

Central to the project’s design is the early intervention of multidisciplinary teams in the facilities, an operation that is quite opportune since it is often a difficult task for the facilities operators, due to a number of difficulties - especially of linguistic, cultural and relational order - to individuate those situations of mental health vulnerability and to address them to the specific territorial services for psycho-social takeover;

D) Monitoring of both the capacity of endurance and degree of empathy of the multidisciplinary team, and of the efficacy and responsiveness of the model for the functionality of the diagnosis and care path, through supervision sessions from which appropriate corrective action can be taken, also useful to the modelling of the intervention.”