Trauma and Migration: A Transactional Analytic Approach toward Refugees and Torture Victims

Marco Mazzetti

Abstract

This article presents a model for interpreting migration, a phenomenon that involves the relocation of a large group of people from their homeland and native culture to another place, an event that is usually experienced as traumatic. The author describes factors of resilience and vulnerability that affect the psychic health of immigrants and, in particular, the effects that these have on refugee populations. Due to the events that determined their migration, refugees are particularly at risk for psychotraumatological pathologies, and migration can have a retraumatizing effect. The specific psychopathological problems of traumatized refugees—in particular, those who have survived torture—are described from a transactional analytic perspective along with indications for the psychosocial management of their difficulties.

———

Migration

Although it may surprise us today, a settled way of life has been the exception rather than the rule in the history of the human race. Humans have always been a nomadic species, perpetually in motion. Today migrants constitute a huge mass of people on our planet. According to the United Nations Fund for Populations (UNFPA), 191 million people live in a country different from that of their birth, to which about 30 to 40 million illegal immigrants must be added (Koser, 2005; United Nations, 2006; United Nations Fund for Populations, 2006). If all of these people were put together, they would constitute the fourth most populated country in the world, after China, India, and the United States. In the European Union, there were over 27 million foreigners at the beginning of 2006 (Caritas, 2007), but this figure would perhaps double if people who were born abroad and have acquired citizenship in the host country were considered.

A good number of these immigrants are refugees. At the end of 2006, the United Nations High Commissioner for Refugees (UNHCR) (2007a, 2007b) was assisting about 33 million refugees, although of these, over 12 million were evacuees in their own countries of origin and, therefore, not technically considered immigrants. In the European Union, foreigners make up 5.6% of the total population. This percentage could well double with naturalization (Caritas, 2007). The consistent arrival of such a massive population has created a considerable challenge for the management of this formidable human resource.

Persons who provide psychiatric and psychotherapeutic assistance have had to take note of such relevant changes in the demographic field. Refugees, in particular, constitute a high-risk group. Among them are people who have survived torture, mass violence, and serious bereavements that leave signs of severe posttraumatic pathologies. New challenges that these individuals present to psychotherapists and others in the caring professions include the need to find operative, instrumental ways to function efficiently with multicultural clients and to respond adequately to the needs of populations that have been consistently disturbed by psychic trauma.

One promising new strategy is to consider the very event of migration from a psychotraumatological perspective. Devoto and Oli (1990) define trauma as "a sudden and violent emotion capable of provoking a permanent alteration of psychic activity" (p. 2020). In my clinical practice, numerous observations sustain the idea that migration represents an emotional event leading to a transformation of that type and thus can be considered a trauma.

I have yet to meet an immigrant (including myself, in my own experience of migration)

who is not able to remember vividly his or her first day in the new country with the lucidity and emotional participation typical of traumatic events, except for those cases in which the seriousness of the events led to dissociative defenses. In the experience of all those to whom I have spoken, migration has impressed on them an irreversible change in how they viewed themselves in the world, causing a true and real fracture between "before" and "after." This reminds us of the etymology of the term "trauma," which in ancient Greek means "wound."

For all those with whom I have spoken, the difficulties they experienced in migrating have been intense, even if ultimately these were overcome successfully and the experience was viewed as positive. For many immigrants, the migratory experience was viewed as an initiation trauma, that is, an experience similar to those more or less ritualistic tests that are undergone by adolescents or people changing status in certain cultures. The suffering that has been overcome becomes proof of success and leads to entitlement to or merit of a new social and psychological status.

That kind of personality development after trauma—when a stressful event, thanks to the crisis, may afford an excellent opportunity to widen the limits of one's life script—has been well documented in the literature (Allen, Bennet, & Kearns, 2004; Sironi, 1999; Tedeschi & Calhoun, 1996). According to this perspective, in the first part of this article I will describe how it is possible to approach the psychology (and thus the psychopathology) of immigrants in the same way that we approach traumatic events, taking into account relevant factors of resilience and vulnerability. In this way it is possible to arrive at an original reading of the phenomena and from this to develop promising intervention strategies. Such an approach can be particularly relevant for refugees. As previously mentioned, refugees are a fragile group and of particular interest to psychiatrists and psychotherapists. Approaching migration as a traumatic event allows us to identify the distinctiveness of refugees and also to understand the difficulties some of them demonstrate in adapting to their host country. As someone who works with immigrants, transactional analysis is my main frame of reference for understanding not only the intrapsychic dynamics and relational needs of these individuals but also for developing a wider sociocultural perspective that is useful in defining guidelines for intervention.

The second part of this article describes strategies for intervening with these patients. Such interventions focus on rehabilitation in a general, not just a psychotherapeutic, sense. Although space limitations do not allow for a discussion of specific therapeutic techniques here, there are also epistemological reasons for not doing so. I believe that the role of psychiatrists and psychotherapists goes beyond the one enacted in their professional offices. Patients are taken care of in the context in which they live. The ability to stimulate and create integrated networks of psychosocial assistance that are recursively synergistic with one another and capable of giving complex answers to complex problems is characteristic of good psychiatric practice. We can be excellent therapists not only in our psychotherapeutic offices but also through deciding to be social actors. Transactional analysis is, in my view, an efficient transcultural instrument (Mazzetti, 2007) that integrates well with this perspective because of its origins and traditions, which are closely connected to social psychiatry. Its organizational sensitivity and promising perspective with regard to the social-cultural dimension make it particularly appropriate for use with migrant populations and a psychosocial perspective.

Resilience Factors

The term "resilience" has recently entered the psychiatric lexicon. The word has distant origins in the material sciences, particularly metallurgy. The term denotes the ability of a material to resist impact and tension, thus maintaining its properties, or to recover those properties at the end of a traumatic event. The word "resilience" has been successfully transposed into the psychiatric field to express the ability to withstand traumas while maintaining good psychic health.

What aspects of resilience can help in managing migration trauma? Based on clinical experience and the scientific literature, there are

two main groups: aspects related to individual characteristics and aspects related to the person's migratory plan (i.e., a clear plan prepared before leaving one's own country). A third relevant group is related to the social supports the immigrant finds during the migration journey. Figure 1 presents a summary of these aspects pertaining to resilience.

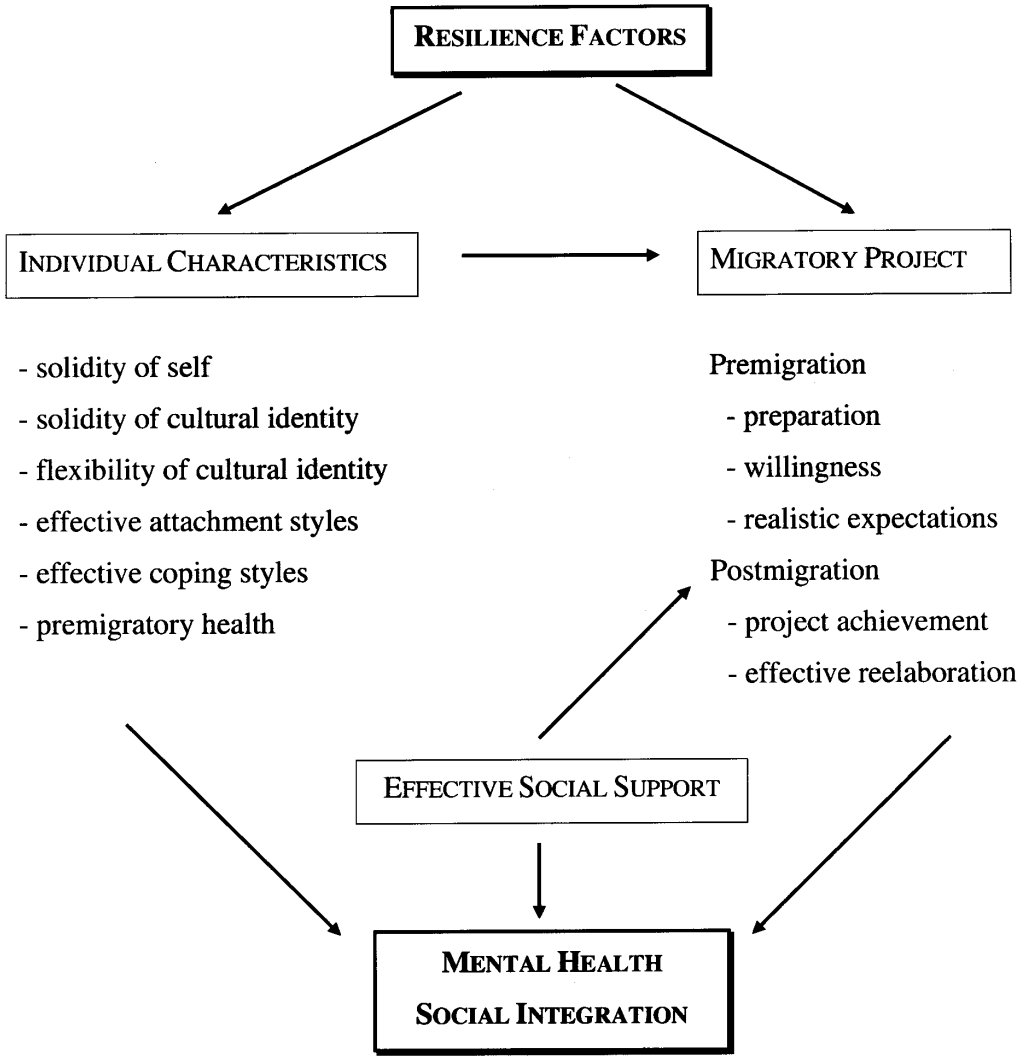


Figure 1
Resiliency Factors for Mental Health During Migration

Individual Characteristics. A group of positive individual characteristics may help a person manage migration trauma. However, proving this scientifically is problematic because it is difficult to construct research models that compare premigratory psychic conditions and the outcome of the migration experience in terms of the immigrant's mental health and social integration. This is also a well-known methodological problem in dealing with the psychiatric epidemiology of migration. Because each phase of the migratory process is characterized by many interacting socioenvironmental variables —some of which can put psychological adaptation seriously at risk—it is understandable that the vulnerability of immigrants varies depending on their premigratory characteristics and how the migration itself originated (Mazzetti, 1996).

The wide variation in the factors in play makes it difficult both to trace an epidemiological psychopathological profile of the immigrant and to identify the relative risk factors. Analyzing the literature on migration and mental health (Bhugra, 2004) reveals numerous methodological limitations (e.g., the heterogeneity of the samples from an ethnic, cultural, and migratory perspective; the diversity of the research settings and the evaluation instruments; the lack of long-term longitudinal studies; etc.) that explain the presence of contrasting data and make it difficult to extrapolate from one population to another and to generalize.

Evidence from recent decades suggests a slightly higher rate of some psychiatric disorders for immigrants, particularly schizophrenia (Bhugra, 2004). For more common mental disorders, such as depression (Bhugra, 2003), anxiety, and substance abuse, the data are less clear. Other authors suggest that rates of schizophrenia (and probably other disorders) are lower among immigrants when sending and receiving countries are socially and culturally similar and higher when they are dissimilar (Kinzie, 2006). Some evidence also exists that as time passes, immigrants tend to come closer to the epidemiological profiles of the host population. When considering individual characteristics, therefore, we refer to what we can observe in the clinical setting and to how much we can reconstruct during the period when patients are under our care.

Solid sense of self: Migration, particularly when it occurs in developing countries, leads through a series of difficulties that can be particularly intense. A solid sense of self can act as a positive filter that allows the more able, courageous, motivated, and healthy person to pass through these difficulties relatively unharmed. This resource, at departure, has a protective role in terms of mental health and constitutes a solid basis for leaving that can protect the immigrant, especially during the early phases of migration.

It is easy to see, however, that this filter essentially works with the so-called pioneers of migration, that is, those who are the first to leave intentionally and who are strongly motivated. This factor is reduced until it disappears in successive migrations (e.g., through family reunion), or it may even be inverted in the forced migration of refugees. A solid personality with the ability to know and understand oneself and others and with experience of success in life generally leads to good adaptation. These characteristics are consistent with the literature on psychotraumatology. Allen (2006; Allen et al., 2004) suggests that successful results following a trauma depend on the person's ability to mentalize, that is, to conceptualize oneself and others on the basis of each person's emotions and to behave in a consequent manner. Fonagy and his collaborators (Fonagy, Steele, Steele, & Higgit, 1994) claim that this is a key factor in promoting resilience. These characteristics (the ability to mentalize, etc.) successfully express the concept of a solid personality.

Solid and flexible cultural identity: Cultural identity can be defined as the capacity to recognize oneself in a coherent system of values and view of the world. Having a solid cultural identity is like departing from a secure "port," and with the help of good "instruments" it is easy to plan a route. Leaving with a fragile cultural identity is like departing at an unknown point in the middle of the sea, from which it is much more complicated to plan a route. A solid cultural identity helps the individual negotiate positively with the reality that must be faced in his or her new country and feel somewhat more

comfortable with self-chosen flexibility. In contrast, a fragile identity is frequently the basis of insecurity and fear that leads toward defensive closure and rigidity about adaptation. For example, immigrants with a fragile cultural identity often engage in obsessive religious practice to anchor themselves to a solid point of reference so that they can withstand the adaptative requirements of their host country.

Effective attachment styles: Evaluating the quality of attachment is a useful tool in ethnopsychiatry, having been shown to be valid transculturally. Attachment develops and is consolidated in a similar way wherever it takes place in humans (Schaffer, 1998). Secure attachment in adolescents and adults (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Simpson, 1990), which Main and her collaborators referred to as "autonomous" attachment (Main, Kaplan, & Cassidy, 1985), was shown to correlate with the life position of "I'm OK, You're OK" (++) (Boholst, Boholst, & Mende, 2005). Such attachment helps the person adapt to a new reality by facilitating the establishment of healthy new relationships in a new context. When we construct solid therapeutic relationships, we not only create a tool that is necessary for successful clinical interventions, we are also actively overcoming disturbances in attachment.

Effective coping styles: The capacity to cope —that is, more or less efficiently manage a traumatic event—is an individual characteristic. Everyone develops innate coping strategies and resources, these can also be learned, refined, and developed. In fact, helping people develop coping strategies is an important tool in psychotherapy with immigrants.

Premigratory psychic health: A history of psychic well-being prior to departure suggests a positive prognosis for managing the trauma of migration.

Migratory Plan. Having a migratory plan prepared in advance seems decisive in protecting immigrants' mental health (Frighi, Piazzi, & Mazzetti, 1993; Mazzetti, 1996) for two reasons. First, such a plan contains motivations that led the immigrant to undertake the difficult adventure of migration, and strong motivation spurs human beings to overcome problems. If the migratory plan succeeds, the immigrant is more likely to withstand considerable trials while maintaining his or her health. The second, deeper, and probably more relevant reason is that a migratory plan can provide the individual with a sense of history and help to maintain, through narrative, two images of the self: one premigration and the other postmigration. This helps the person avoid the fracture that often results from migration and provides meaning that mends the existential plot. Referring to the model proposed by Stuthridge (2006), we can say that the plan takes shape as a narrative capable of integrating different experiences of self.

When immigrants depart, they know they are leaving their homeland and their nearest and dearest, but it is only on arrival that they realize that they have said farewell to who they were before they left. The migratory experience profoundly affects the person's perception of his or her identity. One of the most important therapeutic challenges is to help the individual to construct a sense of continuity between the self before and the self after migration. The migratory plan can play a crucial role in this process because it encompasses the voluntary nature of the act and its planning. Its success depends on its being realistic and flexible so that it can be elaborated and adapted if the reality in the host country does not correspond to expectations. Not surprisingly, individual characteristics as described earlier can positively influence the creation and realization of migratory plans.

Adequate Social Support: Adequate social support can sustain individuals both emotionally and materially during migration, help them realize their migratory plans, and aid their social and psychological integration into the new context. This support can be provided by a variety of social actors, including family and friends who arrived previously and public and private social agencies.

Not surprisingly, the presence of family or members of the same cultural group in the host country significantly influences the level of social support, which can serve as a buffer and protects against the psychopathological effects of traumatic events (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007;

Brewin, Andrews, & Valentine, 2000; Gorst-Unsworth & Goldenberg, 1998; Schweitzer, Melville, Steel, & Lacherez, 2006). However, this factor may also, paradoxically, have the opposite effect by maintaining conditioning that can hamper social integration. This phenomenon has been observed especially in the second generation, when a family imposes a style of living and rules that belonged to the country of origin but that can slow or stall the natural integration of young people into the culture of the host country.

Social support, apart from being present, must also be capable of sustaining and promoting psychosocial integration effectively. Socially intense support is not always useful. For example, in the early 1990s a large migratory wave arrived in Italy from Somalia following social disorder and civil war there. The immigrating Somali communities were numerous and cohesive, and the social support they offered their members was intense. However, one consequence of this was the reproduction in Italy of the practice of infibulation (female circumcision), at the expense of some Somali girls. In these cases, the social support was clearly not beneficial; in addition to mutilating these children and provoking irreversible biological damage, the process set them apart from the experience of their Italian counterparts.

Vulnerability Factors

From a first glance at resilience factors, one can intuitively identify less protected groups of individuals who are potentially more fragile in terms of migration trauma. Among these are people who have migrated without a plan, that is, without a motivating factor that can protect them from the identity crisis that migrants face (Mazzetti, 1997, 2003). Such individuals are usually victims of enforced migration—refugees and asylum seekers—including family members reunited with immigrants (e.g., minors). These individuals (minors, other family members, refugees, and asylum seekers) sometimes must confront the trauma of migration under particularly difficult conditions, without a migratory plan or other significant factors that support resilience. Refugees and reunited family members may have major problems related to individual characteristics, given that the vicissitudes of life (e.g., persecution of refugees, children traumatically separated from their parents and other family members, etc.) have weakened them.

Figure 2 summarizes risk factors for the health of those who have faced the trauma of migration.

Individual Characteristics. These characteristics appear to be the mirror image of those described as resilience factors. Especially with refugees, their life experiences may have severely damaged their individual characteristics, particularly if they were victims of violence or torture. As we know, one effect of intentional violence (often deliberately sought by the perpetrator) is damage to the victim's sense of self, with the intent being to eliminate the person's coping mechanisms and break up his or her attachment dynamics (Sironi, 1999). With regard to the effects of violence on cultural identity, clinical experience shows that few people resemble each other more than do patients affected by severe forms of PTSD or other severe posttraumatic pathologies. It is almost as if their personalities, and their culture, have disappeared because the individual has been reduced to the most basic elements of human existence.

The effects of systematic violence have been masterfully described by the Italian writer Primo Levi, himself a victim of Nazism. His account of life in the concentration camp at Auschwitz, *Se Questo è un Uomo* [If This Is a Man] (Levi, 1947), introduces the phenomenology of victims of violence better than many scientific works. This is what French ethnopsychiatrist Françoise Sironi (1999) called "reduction to the universal," that is, the deculturization of the individual, separating the person from relatives and the human species itself. This process was also described by another French writer, Daniel Pennac (1990): "Torture not only consists of causing pain; it consists of crushing a human being, leaving the person desolate to the point of separating him or her from the human species, in screaming solitude, with nothing he or she can do about it" (p. 60). Torture, systematic violence, genocide, the subversion of one's world—as occurred in recent decades in Cambodia,

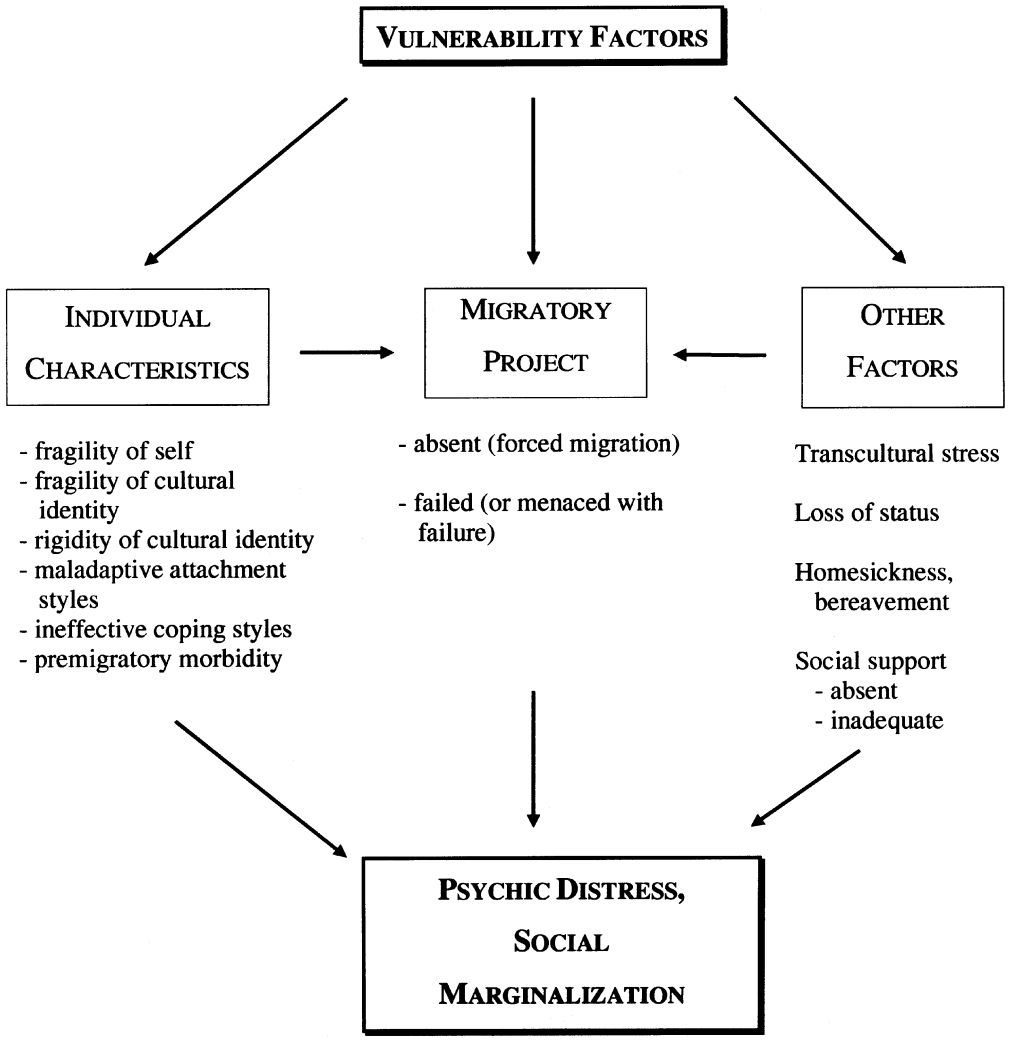


Figure 2
Risk Factors for Mental Health During Migration

the former Yugoslavia, and Rwanda, among others—has resulted, in many cases, in human beings who have been separated from their humanity, which is expressed through their culture.

Growing evidence suggests that immigrants who have experienced oppression, torture, and other forms of organized violence show high levels of psychic suffering (Kandula, Kersey, & Lurie, 2004; Kinzie, 2006; Rasmussen, Rosenfeld, Reeves, & Keller, 2007). Subgroups of refugees exposed to the traumas of war demonstrate high long-term psychiatric morbidity even after many years (Steel, Silove, Phan, & Bauman, 2002). And postmigratory experiences may make the situation worse: Often the

discomfort and psychiatric symptoms worsen after arrival in the host country. Epidemiological studies have shown that PTSD and depressive disorders are the most widespread and obvious diagnosable psychiatric diagnoses in refugee populations, with few differences between cultures. These disorders are often comorbid and significantly more prevalent in refugees compared to nonrefugee populations (Cardozo, Vergara, Agani, & Gotway, 2000; Kinzie, 2006; Mollica, Donelan et al., 1993; Mollica, McInnes, Saraljic et al., 1999; Victorian Foundation for Survivors of Torture, 1998). Other anxiety disorders, disorders of somatization, and other mixed symptoms of suffering are also common in these groups (Turner & Gorst-Unsworth, 1990).

In my clinical experience with immigrant clients, paranoid reactions are common and sometimes so numerous and relevant that it is possible to diagnose a true paranoid personality disorder. Unfortunately, no statistics are available to support or refute this impression, although this would be a useful avenue for further research. It has been impossible to discern whether these paranoid reactions, at least in part, existed prior to the trauma or whether they were a result of it. However, some elements suggest a causal relationship with the stressful event.

Moreover, with regard to premigratory morbidity, a solid dose-response association between trauma and psychic suffering has been well documented. Cumulative exposure to trauma (undergoing violence and torture, being forced to leave one's home, being close to shootings and explosions, oneself and/or one's loved ones being in danger of imminent death, etc.) corresponds to a rise in the risk of psychiatric morbidity (Cheung, 1994; Chung & Kagawa-Singer, 1993; Mollica, McInnes, Pool, & Tor, 1998; Mollica, McInnes, Pham, Smith-Fawzi, Murphy, & Lin, 1998; Turner, Bowie, Dunn, Shapo, & Yule., 2003; Rasmussen et al., 2007). This is consistent with what we know about the major vulnerability to trauma of those who have already suffered other traumatic experiences (Breslau & Kessler, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In refugees in war zones, the percentage of multiple exposures to such events is high (Turner et al., 2003), and they are thus often heavily deficient in individual characteristics and basic resilience factors when they arrival in their host country.

Migratory Plan. The value of a migratory plan in maximizing resilience and the increased vulnerability resulting from lack of a plan (especially among children and refugees) has already been mentioned. It can also be the case that immigrants who have a plan find on arrival that it was unrealistic, inflexible, or impeded for some reason (e.g., illness). It is, therefore, sometimes necessary to undertake "planning therapy" with immigrants to reconstruct this fundamental element of resilience. In this work it is key to recognize various aspects of such a plan. Although most immigrants are aware of economic motivations (e.g., finding a good job, earning well), they are often less aware of other components (e.g., re-creating a new life after a failed marriage, experimenting with being oneself in a new context, wanting to travel, freeing oneself from difficult family relationships, living in a context of civil and democratic freedom). With refugees, the question of a plan can be especially delicate. In most cases, there was no plan or one was developed only on departing the home country: to save their lives.

On the other hand, often hidden or unconscious fantasies about an improbable future can keep immigrants blocked. The fantasies are both social (e.g., conditions in their country of origin will change radically and everything will return to how it was) and personal (e.g., they will return to being exactly as they were before the trauma or escape). These "fantasies," described by Erskine and Zalcman (1979) in their work on the racket system, are a way to maintain a blocked script system. Similar attitudes were described by Allen (2006) among survivors of the 1995 Oklahoma City domestic terrorist attack. Unrealistic expectations tend to hook people into roles in the drama triangle and to serve as an obstacle to resilience processes.

Other Factors. Some risk factors threaten the success of the migratory project indirectly, while others appear as specific pathogenic noxae. Transcultural stress—similar to what anthropologists call "culture shock" or "acculturation stress" (Jamil, Nasser-McMillan, & Lambert, 2007)—is the accumulation of traumatic events

that accompany the immigrant's or refugee's reestablishment in the host country. Although the complexity of the stimuli makes it impossible to systemize them all, we can articulate aspects that may converge to create this complexity.

For example, many immigrants do not understand the language of their host country, and it takes a while for them to learn that new language, even though their survival depends on it. Nonverbal communication in a new culture is also complex and often even more difficult to decipher and learn than spoken language. Having a "foreign body," with somatic traits that immediately indicate foreignness, can result in immigrants being targeted with racist or marginalizing behavior that can, in turn, lead to common psychosomatic disorders (e.g., sine materia itching) (Mazzetti, 1996, 2003). The subversion of one's customs can also be confusing for immigrants and may lead to ethical crises. For example, imagine what it is like for someone from a country where women are totally covered in public to be in a Western city on a hot summer's day. The geographic distance from one's country of origin and, above all, the cultural distance, are particularly relevant in determining the level of transcultural stress (Kinzie, 2006). An example of this is the passage from a sociocentric society, in which the individual's personal identity is determined primarily by belonging to a particular group, to an ego-centric culture (typical of Western societies) with a strongly individualistic imprint. Another example is the passage from a rural to an urban setting.

Another risk factor is the loss of social status, which as a rule has a pathogenic effect, particularly among refugees. Many leave a high standard of living and high professional status (as health professionals, teachers, journalists, politicians, etc.) (Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997) to emigrate, and it is often hard to obtain recognition of their qualifications in their host country (Burnett & Peel, 2001a, 2001b). The refugee's mental health is thus put at risk by the union of past and present experiences. Added to the traumas suffered in their country of origin are the loss of identity and status and, at times, further violence, racism, and discrimination in their host country (Levenson & Cooker, 1999). In addition, poverty, with its well-documented negative effects on physical and mental health, is likely for immigrants and refugees (Connelly & Schweiger, 2000). Loss and bereavement are also extremely frequent, often in relation to specific people and always in terms of one's own land and socioaffective world (Mazzetti, 1999).

Social support is often lacking for refugees in particular, because they arrive alone, in a random manner, in a country that they have not chosen. Even when refugees move as part of a group (e.g., escape within a country or to a country nearby), those with whom they are fleeing may not be able to offer social support because they are also traumatized and suffering. For example, a study of Iraqi refugees found that the social variables during exile, particularly the presence of socioaffective support, was more important in determining the severity of psychiatric symptomatology than traumas undergone in the country of origin (Gorst-Unsworth & Goldenberg, 1998). One fundamental variable in the development of psychopathologies is separation from family (Bean et al., 2007; Schweitzer et al., 2006; Turner et al., 2003). It is no accident that difficult living conditions and social isolation have been associated with higher levels of depression (VanVelsen, Gorst-Unsworth, & Turner, 1996).

As a result of the factors just described, refugees are immigrants in whom the factors of vulnerability far exceed those of resilience. Under such conditions, migration can, and in my experience often does, act as a potent retraumatizing agent.

Transactional Analysis and the Trauma of Refugees

Transactional analysis is an excellent frame of reference for working with immigrants. It can help with assessment as well as intervention at three levels: personal (intrapsychic), interpersonal (relational), and cultural/social-structural (Drego, 1983, 2000, 2005; Massey, 1996, 2006). It is also effective cross-culturally (Mazzetti, 2007). While its intrapsychic and interpersonal applications are widely described in the transactional analysis literature, social-structural applications are still being developed

(Massey, 2006). Of course, with refugees, the social-structural aspects are of paramount importance.

Psychological trauma, from a transactional analytic perspective, constitutes a type of natural experiment that shows how decisive elements of life script may be established even long after childhood. The fact that strong emotional involvement may lead to a new intrapsychic resolution in order to survive a critical situation demonstrates what Cornell (1988) noted: "Major script decisions can be made at any point in life" (p. 281). Likewise, script injunctions (Goulding & Goulding, 1978, 1979) can also be established at any point in life. Masse (1995), discussing the treatment of PTSD, proposed that "in reaction to extreme trauma . . . a person can spontaneously regress to an earlier developmental age and make new decisions (redecisions) about self, others and the world" (p. 356). Perhaps, without necessarily thinking in terms of regression to an earlier developmental age, we can hypothesize events that significatively impact the neurological structures related to implicit memory and emotional life (thalamus, amygdala, hippocampus, and prefrontal cortex). These structures are most active in early childhood, but they continue developing through life and may be responsible for nonverbal learning experiences that establish injunctions. In such cases, memories are filed as affective states, sensorimotor modalities, bodily sensations, and/or visual images (van der Kolk, 1996).

Beslija (1997), who described doing psychotherapy with Bosnian refugees, wrote that the survival decision made by people affected by PTSD, when faced with intense trauma and fear for their life, is related to the injunction Don't Feel; they unconsciously decide to cancel their emotions and exclude their Child ego state. I also think this can occur in individuals with significant dissociative defenses and symptoms of avoidance, although in my experience it is rare. Rather, the script elements at play are different and occur not only in the presence of PTSD, but also with other clinical manifestations following trauma, such as depressive or anxiety disorders or paranoid or avoidant personality disorders.

When a person is unable to manage the impact of a traumatic event, he or she experiences a deep sense of insecurity that is translated into the injunction Don't Trust. Above all, the person cannot trust himself or herself to manage reality, and it is this inability to trust oneself that results in high levels of anxiety. Moreover, when the traumatic event is due to the cruelty of other human beings (usually the case with refugees) and not due to natural causes, this translates into a deep, generalized lack of trust in humanity as a whole.

Recognizing these dynamics can help us to understand the paranoid clinical picture that we sometimes see in patients who are the victims of violence. Those suffering from paranoia are not only defensive in relation to others but mistrustful of themselves, including their ability to protect themselves and to discriminate between people who are dangerous and those who are not. This profound personal distrust is sometimes induced in victims through torture (Sironi, 1999). Thus, I do not agree that such individuals have a Don't Feel injunction (Beslija, 1997). I think that people affected by PTSD and other posttraumatic disorders not only feel their emotions, they are invaded by them—even if they fight them or mystify them with racket feelings (e.g., instead of anger they feel fear, or instead of fear, they permit themselves to feel sadness). My view is that, rather than an excluded Child ego state (although some areas of exclusion might exist), these individuals have severe contaminations of the Adult ego state by the Child ego state, the former of which is unable to discriminate anymore or to give meaning to his or her emotions. Rather than Don't Feel, they have a Don't Think injunction, as in "Don't think about your emotions, don't discriminate, don't recognize them." The real challenge for traumatized individuals is to construct meaning for the experiences they have lived through. In this I agree with Stuthridge (2006), who asserts the importance of a coherent narrative about what has happened in order to heal trauma.

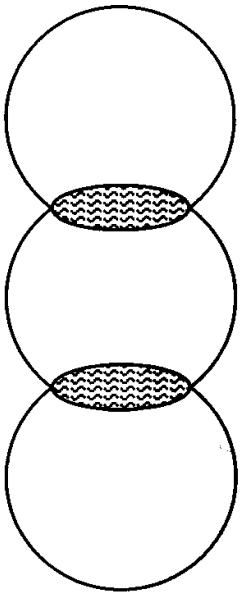
Therefore, I think that healing posttraumatic pathology must occur essentially at a cognitive level so the person can make sense of what happened to him or her, including making sense of

the persecutors' behavior and his or her own. Emotions are thus understood, explained, and made sense of rather than relived. This strategy also activates less resistance.

The drivers (Kahler, 1977; Kahler with Capers, 1974) that occur most often with immigrants who are of victims of torture and/or violence are "Be strong," as in "Fight with all your strength against what you are feeling," and "Try hard," as in "Try in all ways possible to keep your emotions at bay." In terms of structural analysis (Berne, 1961), these drivers are often expressed as a Parent contamination of the Adult that serves as a reminder that the person is not OK because he or she cannot control his or her internal experiences. This type of contamination plays a primary role in posttraumatic depressive symptoms. The overall framework is shown in Figure 3.

This violent battle against themselves absorbs so much of the energy of those who suffer from PTSD and other posttraumatic pathologies that there is often little energy left for healing. The patient fights against both memories and emotions, and doing so instills them with new energy. It is like what happens when a spring is compressed: the propulsive force rises. This is where it helps to take care of such people. The spring of their energy needs to be discharged, first by legitimizing their malaise as a normal reaction to abnormal events and then by helping them give voice and sense to their experience so that their psychic life can resume fully. The need for this caretaking reaches its apex with those who have experienced torture.

"Scientific" torture—which spread during the twentieth century and especially after World War II when experimental psychology provided it with a scientific basis—has the following goals:



Drivers: "Be strong," "Try hard"

Contamination: People without control of themselves are weak and without value.

Contamination: The world is a dangerous place. It is better to hide and not be seen.

Injunctions: Don't Trust, Don't Think
Decision: To survive I must always be alert and fight against my feelings.

Figure 3
Structural Pathology and Script Messages in Posttraumatic Disorders

1. To destroy the individual's self-confidence (by inducing the injunctions Don't Trust and Don't Think)
2. To destroy the individual's trust in others (through the injunctions Don't Trust and Don't Belong)
3. To convince people of their unworthiness to exist (thus inducing the injunction Don't Exist)

Torture aims to repeat traumatic events in an obsessively repetitive manner in order to bring the experience to an intolerable, self-reinforcing level. The final goal is to establish a process that feeds itself so that the individual, once freed from the torturers, continues the self-torture at an intrapsychic level.

The initial goal in this process is to create a situation of total impotence. Often, the first step is to arrest the person, put him or her in isolation (probably in the dark), and then "forget" him or her. The individual stays for hours or days without any external stimuli, tormenting himself or herself with fantasies about what might happen, all the time experiencing total impotence.

Physical violence usually follows. The person's sense of impotence arises from the perception that his or her own body has been abandoned into the persecutor's hands without any possibility of defense. The intent is to make the victim feel that he or she has lost all control. Often the violence is not even connected to an attempt to obtain information, so the person has no way to influence what is happening by, for example, confessing.

The persecutor also aims to create in the victim the conviction that he or she cannot even control his or her own thoughts. One of the most common methods used in this process is sleep deprivation combined with bizarre and illogical sensorial stimulation. Victims from the former Yugoslavia tell of being hung from poles and subjected to bizarre images during the intervals between sessions of physical violence. Others were surrounded by people who went about their business, ignoring the victim as if he or she did not exist (e.g., a couple engaged in sex in front of a victim as if he were not there). The goal is to bring the individual to the point of thinking he or she is going mad and has lost control of his or her cognitive capacity; thus he or she renounces thinking, having internalized the injunction Don't Think.

Another common technique is keeping the person constantly on the edge between life and death; fake executions are an example of this. The victim is brought before an execution squad, perhaps one that he or she saw execute someone else; the preexecution rituals are performed and then the persecutors shoot a salvo in order to humiliate the victim for his or her emotional reactions.

In addition to these techniques, which are quite successful in destroying the individual's self-confidence and faith in humanity (Don't Trust, Don't Belong), others are designed to convince him or her of his or her worthlessness, with the goal of inducing the injunction Don't Exist. A classic technique is to induce intolerable self-blame, typically by showing the victim how, because of him or her, other people have been ruined. For example, the victim may be forced to witness the torture of family members or friends while being told that their suffering is his or her fault. Victims from Latin America, Iraq, and the former Yugoslavia tell of being forced to execute relatives or friends with their own hands. The sense of blame and profound lack of self-worth induced by the torturers in such instances is often responsible for the not-so-rare suicides of their victims, even years after the traumatic event. Epidemiological data about such suicides are lacking, in part because the experience of torture victims is often nebulous and dark, and they attempt to hide themselves, to disappear, and not to seek help.

Persecutors have achieved their goal when their victims, psychically desolate, begin a vicious cycle of self-punishment that guarantees they will continue to inflict condemnation on themselves in the future. At that point, victims can be set free; they are no longer dangerous to those in power and will only harm themselves and their own cause.

Trauma and Migration

Although there is little research about post-exile factors that influence refugees' psychic morbidity, there is general agreement, supported by clinical experience, about the impact of migration. As mentioned earlier, refugees'

discomfort and psychiatric symptoms often worsen after their arrival in the host country. Those who have suffered psychic trauma are more easily traumatized if they are again exposed to stressors, which results in cumulative damage. As a consequence, traumatized refugees are thus not only more fragile as immigrants because their vulnerability factors outweigh their resilience factors, but they are also particularly at risk for psychotraumatology. Migration acts as a retraumatizing event in three main circumstances.

1. *The creation of a deculturalizing context:* Transcultural stress has its deepest and most violent effect on subjects who are already suffering a crisis of cultural identity because they have been "deculturalized" by violence, social subversion, and/or torture.

2. *Social solitude:* Asylum seekers are often placed with others on the basis of simply sharing the same judicial status. As a result, they have to cohabit with people who do not speak their language or share the same habits. This increases the sense of isolation and alienation from one's surroundings and can be retraumatizing for those who have lost all their social contacts as well as their most intimate personal relationships.

3. *Exposure to provoking stimuli:* Initial contact with the host country often occurs in the presence of military or police personnel. Exposure to uniforms for individuals who have learned to fear them, and who respond with arousal symptoms typical of PTSD, can provoke violent anxiety reactions. The places that often accommodate asylum seekers—which were sometimes built as detention centers (i.e., guests sequestered, bars on the windows, etc.)—can be retraumatizing for those who have been previously sequestered. In some cases, immigrants are even kept in prisons (Silove, Steel, & Mollica, 2001). Regardless of how comfortable the detention site is, keys turning in keyholes, the noise of cell doors opening and closing, and the sight of uniforms can evoke intense traumatic memories (Burnett & Peel, 2001a).

Another kind of stimuli that can be distressing to asylum seekers is the type of procedures they often must undergo, including repeated interrogations (often with an investigative, distrustful attitude toward the immigrant). These can bring back memories of past experiences of detention and police interrogation. Seeking asylum is an emotionally difficult experience; it often takes a long time and is characterized by the constant fear of being sent back to the country of origin (Sinnerbrink et al., 1997). Similarly, even apparently innocuous procedures such as medical exams can be retraumatizing for refugees; exposing one's body to other people who are dressed and having one's body manipulated by strangers can provoke sudden anxiety attacks in victims of torture.

Failing to remain aware of the risk of retraumatization can lead to results that are just the opposite of those sought in socio-rehabilitative efforts. For example, a refugee under the care of our service was offered a maintenance job in a cemetery. His duties included exhuming bodies in order to move them into smaller burial sites. He had fled his country, which was at war, and dreamed of corpses almost every night. It was no surprise, then, that the cemetery job aggravated his symptomatology.

Retraumatization—as a result of deculturalization, isolation, enforced repatriation, and stimuli evocative of a terrifying past—increases the risk of severe mental disorders that impair the refugee's ability to adapt to his or her host country and may have disabling long-term effects.

Intervention Strategies

The following welcoming strategies and interventions are considered to be effects of psychosocial networks and are based on psychotherapeutic assumptions, even though they may be carried out by various social workers. They are designed to reinforce the resilience factors listed in Figure 1 and to reduce the vulnerability factors listed in Figure 2. The strategies are summarized in Figure 4.

The mental health interventions outlined in Figure 4 depend only in part on psychiatric personnel and largely involve adequate social interventions. The goal is to establish and maintain OK-OK relationships; to respond in positive ways to needs for stimuli, contact, recognition, and structure (Berne, 1970, 1972); and to promote a positive stroke economy (Steiner, 1971).

INTERVENTION STRATEGIES

* *Choice/training of reception personnel*
* *Suitable reception areas*
* *Procedures to grant asylum*
  - clear, comprehensible, accessible, and rapid
  - commission trained in dealing with psychiatric disorders of asylum seekers
  - escorting during interrogation sessions
  - facilitate family reunification
* *Organization of specific services*
  - promotion of socialization
  - surveillance of psychic condition
* *Construction of services network*
* *Protection of cultural identity*
* *Offer of specialized psychotherapy*

Figure 4
Intervention Strategies for the Reception and Rehabilitation of Refugees

Choice/Training of Reception Personnel. The people who first welcome refugees or torture victims to their new country should be civilians, not military personnel or police. Even if the latter are well trained, seeing them can trigger anxiety reactions among PTSD patients. The challenge is to develop and maintain a healthy "I'm OK, You're OK" position, which is not always easy to do with traumatized immigrants. Reception personnel must be sufficiently trained to manage the complex relational stimuli that arise with asylum seekers. For example, sudden dysphoric crises and controversial comments are not necessarily a sign of an aggressive personality or an attempt to lie but may be symptoms of specific psychiatric illnesses.

Counseling by personnel who are competent to screen for psychopathological risk factors must be available to all. Actively offering such services is essential because refusing to ask for help is characteristic of the clinical profile and corresponding scripts of traumatized individuals. Medical assistance must also be provided by physicians with good relational skills. When someone who has been tortured is given a physical examination, the risk of severe anxiety

reactions is high; hence, the doctor and any assistants should take care not to set them off inadvertently.

Suitable Reception Areas. Apart from providing the basic necessities for personal hygiene, reception facilities should be peaceful areas where separate spaces are possible and rest is facilitated. It is common for trauma survivors to suffer from sleep deprivation because increased arousal causes frequent awakening and anxiety attacks, the latter of which are easily stimulated by noisy stimuli (people entering and leave the room, banging doors, etc.). These individuals need an environment in which they can have control. The goal is to offer them a structured setting in which they can feel secure so as to decrease their feelings of "not belonging" and "not trusting." Obviously, prison-like environments must be avoided.

Procedures for Granting Asylum. Countries granting asylum should provide clear, comprehensible, easily accessible, and rapid procedures for recognizing refugee status. Those who grant asylum must be trained to understand the difficulty asylum seekers have in telling their stories. Contradictions in a story can be signs of temporal disorientation, from which many victims of violence suffer, and not of lies. In my experience, some torture victims have been denied refugee status because they were unable to reconstruct their story with precision.

Allowing asylum seekers to take someone they trust with them to hearings can alleviate the emotional impact of the interrogation as well as any resemblance to police interrogations without legal defense; it also strengthens the sense of social support. Such procedures are invaluable in helping to treat script issues related to refugees' status. As Massey (2006) wrote, "Exploitation and abuses of power buttressed by scripts based on socialization supporting discounting being and doing along with conformity to aggressiveness and violence fortify negative social structures" (p. 143). Refugees are heavily imprinted by such negative social structures. They need healthy social structures to help them heal their destructive, socially induced script elements. Additionally, bureaucratic procedures for reuniting families need to be made quicker and easier for asylum seekers in comparison to other immigrants. Finally, asylum seekers must be provided with information about the advantage of having the appropriate medical or psychiatric certification (and how to obtain it) so that they can be successful at their hearing with the commission that grants asylum.

Organization of Specific Services. As mentioned earlier, programs for assisting refugees should provide specifically trained social and health personnel, and the services should be actively offered. The first aim must be to promote protected socialization and to address motivational needs (Berne, 1970) so as to restore healthy ways of structuring time (Berne, 1964, 1966, 1970, 1972) and exchanging positive strokes (Steiner, 1971). This goal can be reached in various ways: through discussion groups designed to help the person make sense of past experiences and share them in an intimate environment; through group activities (e.g., art therapy); and through language courses with instructors who understand the person's learning difficulties, which are often a result of psychic suffering. Throughout these activities, it is important to inform and reassure the refugees repeatedly that their difficulties are normal reactions to abnormal experiences and not a sign of personal weakness. Ongoing surveillance of refugees' mental health is necessary in order to offer immediate specialized therapeutic interventions when necessary.

Construction of a Service Network. Refugees often require many services: medical, psychological, social, and legal help; job training; and assistance in finding housing. These services should be organized as an integrated and interlocking network. Apart from the practical results this facilitates, it also helps to break through the refugee's social isolation and create a community to which the refugee can feel a sense of belonging, thus altering traumatic script conclusions. It is best to have a professional person (e.g., a social worker) as the main contact, someone who can act as a bridge between various services and can accompany the individual throughout the asylum process.

Protection of Cultural Identity. Once social and political conditions in the host country and the individual's health permit meetings with

other people from the refugee's country of origin, such gatherings can help strengthen or restore the sense of belonging to a community. National feasts and cultural activities, preferably in small groups with the support of the country of origin (if political conditions allow this), can provide important help, especially when repatriation may be possible.

Offer of Specialized Psychotherapy. Providing psychotherapeutic assistance requires not only specialists who are experts in the field of psychotraumatology but also people with specific training in intentional violence. Treating a victim of torture is different from rehabilitating someone after a road accident or an earthquake. The persecutor's intent to harm, as described earlier, has specific consequences for both the psychodynamics of suffering and the complexity of symptoms, making specialized interventions necessary.

Conclusions

Approaching migration as a potentially traumatic event allows us to offer clinical immigrant and refugee patients management strategies that relate to resilience and vulnerability. It also helps us to understand how refugees may be retraumatized after they arrive in their host country and enables us to plan specific protection strategies for the clinical management of their symptoms. Such strategies are based on integrating various psychological-social-health services planned from a psychotherapeutic perspective using transactional analysis as a frame of reference.

Significantly, the advantages of this broad way of thinking and operating has benefits beyond helping traumatized patients. It also benefits the societies that take them in, both because people who might otherwise become a burden on society are rehabilitated and because the networks developed constitute positive examples that can be extended to other groups needing social assistance. In this context, transactional analysis is valuable because, in addition to offering a theory of personality and a method of psychotherapy, it also provides a useful theory of organizations with promising social-structural dimensions and an effective cross-cultural tool.

Thus, by developing the integrated networks described in this article, we not only have become more effective at treating traumatized individuals (such as torture survivors), who a few years ago seemed incurable, but we are also curing our own societies and furthering our theoretical understanding.

Marco Mazzetti, M.D., is a psychiatrist, a Teaching and Supervising Transactional Analyst (psychotherapy), a member of EATA and the ITAA, and a university lecturer. He conducts his clinical, training, and research activities at the Centro di Psicologia e Analisi Transazionale and the Ethno-Psychiatry Service Terrenuove of Milan, Italy. He is supervisor and scientific director of the project Invisible Wounds for the care of survivors of torture at the Health Service of Caritas in Rome. He can be reached at Centro di Psicologia e Analisi Transazionale, Via Archimede, 127, 20129 Milano, Italy; e-mail: marcomazzetti.at@libero.it . *This article is an updated version of "Trauma e Migrazione: Un Approccio Analitico Transazionale a Rifugiati e Vittime di Tortura" [Trauma and Migration: A Transactional Analytic Approach to Refugees and Victims of Torture], published in 2008 in* Quaderni di Psicologia, Analisi Transazionale e Scienze Umane, *49, 21-53.*

REFERENCES

Allen, J. R. (2006). Oklahoma City ten years later: Positive psychology, transactional analysis, and the transformation of trauma from a terrorist attack. *Transactional Analysis Journal, 36*, 120-133.

Allen, J. R., Bennet, S., & Kearns, L. (2004). Psychological mindedness: A neglected developmental line in permission to think. *Transactional Analysis Journal, 34*, 3-9.

Bartholomew, K., & Horowitz, L. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 7,* 147-178.

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *Journal of Nervous and Mental Disease, 195*(4), 288-297.

Berne E. (1961). *Transactional analysis in psychotherapy: A systematic individual and social psychiatry.* New York: Grove Press.

Berne E. (1964). *Games people play: The psychology of*

human relationships. New York: Grove Press.
Berne E. (1966). *Principles of group treatment.* New York: Grove Press.
Berne E. (1970). *Sex in human loving.* New York: Simon & Schuster.
Berne E. (1972). *What do you say after you say hello?: The psychology of human destiny.* New York: Grove Press.
Beslija, A. (1997). Psychotherapy with refugees from Bosnia-Herzegovina. *Transactional Analysis Journal, 27*, 49-54.
Bhugra, D. (2003). Migration and depression. *Acta Psychiatrica Scandinavica, 108,* 67-72.
Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica, 109*, 243-258.
Boholst, F. A., Boholst, G. B., & Mende, M. M. B. (2005). Life positions and attachment styles: A canonical correlation analysis. *Transactional Analysis Journal, 35*, 62-67.
Breslau, N., & Kessler, R. C. (2001). The stressor criterion in DSM-IV posttraumatic stress disorder. An empirical investigation. *Biological Psychiatry, 50,* 699-704.
Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psycholology, 68,* 748-766.
Burnett, A., & Peel, M. (2001a). Asylum seekers and refugees in Britain: The health of survivors of torture and organised violence. *British Medical Journal, 322,* 606-609.
Burnett, A., & Peel, M. (2001b). Asylum seekers and refugees in Britain. What brings asylum seekers to the United Kingdom? *British Medical Journal, 322*, 485-488.
Cardozo, B. L., Vergara, A., Agani, F., & Gotway, C. A. (2000). Mental health, social functioning, and attitudes of Kosovar Albanians following the war in Kosovo. *Journal of the American Medical Association, 284*, 569-577.
Caritas. (2007). *Immigrazione: Dossier statistico, 2007* [Immigration: Statistical dossier, 2007]. Rome: Idos.
Cheung, P. (1994): Post-traumatic stress disorder among Cambodian refugees in New Zealand. *International Journal of Social Psychiatry, 40*, 17-26.
Chung, R. C., & Kagawa-Singer, M. (1993). Predictors of psychological distress among Southeast Asian refugees. *Social Science Medicine, 36,* 631-639.
Connelly, J., & Schweiger, M. (2000). The health risks of the UK's new asylum act. *British Medical Journal, 321,* 5-6.
Cornell, W. F. (1988). Life script theory: A critical review from a developmental perspective. *Transactional Analysis Journal, 18*, 270-282.
Devoto, G., & Oli, G. C. (1990). *Il dizionario della lingua Italiana* [Dictionary of the Italian language]. Le Monnier: Firenze.
Drego, P. (1983). The cultural parent. *Transactional Analysis Journal, 13*, 224-227.
Drego, P. (2000). Toward an ethic of ego states. *Transactional Analysis Journal, 30,* 192-206.
Drego, P. (2005). Acceptance speech on receiving the 2004 Eric Berne memorial award. *Transactional Analysis Journal, 35*, 7-30.
Erskine, R. G., & Zalcman, M. J. (1979). The racket system: A model for racket analysis. *Transactional Analysis Journal, 9,* 51-59.
Fonagy, P., Steele, M., Steele, H., & Higgit, A. (1994). The Emanuel Miller memorial lecture, 1992: The theory and practice of resilience. *Journal of Child Psychology and Psychiatry, 35*(2), 231-257.
Frighi, L., Piazzi, A., & Mazzetti, M. (1993). Caratteristiche socio-demografiche, salute psichica e fattori di rischio psicopatologico dell'immigrazione extracomunitaria a Roma [Socio-demographic characteristics, psychic health, and psychopathological risk factors of extra-EU immigration in Rome]. *Difesa Sociale, 72*(5), 183-200.
Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organised violence suffered by refugees from Iraq: Trauma-related factors compared to social factors in exile. *British Journal of Psychiatry, 172,* 90-94.
Goulding, M. M., & Goulding, R. L. (1979). *Changing lives through redecision therapy.* New York: Brunner/ Mazel.
Goulding, R. L., & Goulding, M. M. (1978). *The power is in the patient: A TA/gestalt approach to psychotherapy.* San Francisco: TA Press.
Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52,* 511-524.
Jamil, H., Nasser-McMillan, S. C., & Lambert, R. G. (2007). Immigration and attendant psychological sequelae: A comparison of three waves of Iraqi immigrants. *American Journal of Orthopsychiatry, 77*(2), 199-205.
Kahler, T. (1977). The miniscript. In G. Barnes (Ed.), *Transactional analysis after Eric Berne: Teachings and practices of three TA schools* (pp. 225-256). New York: Harper's College Press.
Kahler, T., with Capers, H. (1974). The miniscript. *Transactional Analysis Journal, 4*(1), 26-42.
Kandula, N. R., Kersey, M., & Lurie, N. (2004). Assuring the health of immigrants: What the leading health indicators tell us. *Annual Review of Public Health, 25*, 357-376.
Kessler, R., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*, 1048-1060.
Kinzie, J. D. (2006). Immigrants and refugees: The psychiatric perspective. *Transcultural Psychiatry, 43*(4), 577-591.
Koser, K. (2005). *Irregular migration, state security and human security: A paper prepared for the policy analysis and research programme of the Global Commission on International Migration.* Geneva: Global Commission on International Migration.
Levenson, R., & Coker, N. (1999). *The health of refugees.* London: King's Fund.
Levi, P. (1947). *Se questo è un uomo* [If this is a man]. Turin: Einaudi.
Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: A move to the level of representation. In I. Bretherton. & E. Waters (Eds.), Growing points of attachment theory and research. *Monographs of the Society for Research in Child Development, 50*(1-2, serial 209, pp. 66-104).

Masse, V. (1995). The treatment of post-traumatic stress disorder using redecision therapy. *Transactional Analysis Journal, 25*, 356-360.

Massey, R. F. (1996). Transactional analysis as a social psychology. *Transactional Analysis Journal, 26*, 91-99.

Massey, R. F. (2006). Freedom with responsibility: Interconnecting self, others, and social structures in context. *Transactional Analysis Journal, 36*, 134-151.

Mazzetti, M. (1996). *Strappare le radici: Psicologia e psicopatologia di donne e di uomini che migrano* [Ripping out the roots: The psychology and psychopathology of women and men who migrate]. Turin: L' Harmattan.

Mazzetti, M. (1997). A transactional analysis approach to adjustment problems of adolescents from immigrant families. *Transactional Analysis Journal, 27*, 220-223.

Mazzetti, M. (1999). Passio exilii: Rifugiati e salute psichica. Seconda parte: Il lutto [The suffering of the exile: Refugees and psychic health. Second part: Bereavement]. *Quaderni di Psicologia, Analisi Transazionale e Scienze Umane, 27-28*, 92-105.

Mazzetti, M. (2003). *Il dialogo transculturale: Manuale per operatori sanitari e altre professioni d'aiuto* [Transcultural dialogue: Handbook for health workers and other helping professionals]. Rome: Carocci.

Mazzetti, M. (2007). Cultural identities in movement in a world in movement: New frontiers for transactional analysis. *EATA Newsletter, 90,* 6-13.

Mollica, R. F., Donelan, K., Tor, S., Lavelle, J., Elias, C., Frankel, M., Bennet, D., Blendon, R. J., & Bass, R. (1993). The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps. *Journal of the American Medical Association, 270*, 581-86.

Mollica, R. F., McInnes, K., Pham, T., Smith-Fawzi, M. C., Murphy, E., & Lin, L. (1998). Dose-effect relationships between torture and psychiatric symptoms in Vietnamese ex-political detainees and a comparison group. *Journal of Mental and Nervous Disease, 186,* 543-553.

Mollica, R. F., McInnes, K., Pool, C., & Tor, S. (1998). Dose effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *British Journal of Psychiatry, 173,* 482-488.

Mollica, R. F., McInnes, K., Sarajlic, N., Lavelle, J., Sarajlic, I., & Massagli, M. P. (1999). Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *Journal of the American Medical Association, 282,* 433-39.

Pennac, D. (1990). *La petite marchande de prose* [The little prose seller]. Paris: Éditions Gallimard.

Rasmussen, A., Rosenfeld, B., Reeves, K., & Keller, A. S. (2007). The subjective experience of trauma and subsequent PTSD in a sample of undocumented immigrants. *Journal of Mental and Nervous Disease, 195,* 137-143.

Schaffer, R. H. (1998). *Lo sviluppo sociale* [Social development]. Milan: Cortina Editore.

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry, 40*(2), 179-187.

Silove, D., Steel, Z., & Mollica, R. (2001). Detention of asylum seekers: Assault on health, human rights, and social development. *Lancet, 357,* 1436-1437.

Simpson, J. A. (1990). Influence of attachment styles on romantic relationships. *Journal of Personality and Social Psychology, 59,* 971-980.

Sinnerbrink, I., Silove, D., Field, A., Steel, Z., & Manicavasagar, V. (1997). Compounding of pre-migration trauma and post-migration stress in asylum seekers. *Journal of Psycholology, 131,* 463-470.

Sironi, F. (1999). *Bourreaux et victimes: Psychologie de la torture* [Persecutors and victims: The psychology of torture]. Paris: Editions Odile Jacob.

Steel, Z., Silove, D., Phan, T., & Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: A population-based study. *Lancet, 360,* 1056-1062.

Steiner, C. M. (1971). The stroke economy. *Transactional Analysis Journal, 1*(3), 9-15.

Stuthridge, J. (2006). Inside out: A transactional analysis model of trauma. *Transactional Analysis Journal, 36*, 270-283.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*(3), 455-472.

Turner, S., & Gorst-Unsworth, C. (1990). The psychological sequelae of torture: A descriptive model. *British Journal of Psychiatry, 157,* 475-480.

Turner, S. W., Bowie, C., Dunn, G., Shapo, L., & Yule, W. (2003). Mental health of Kosovan Albanian refugees in the UK. *British Journal of Psychiatry, 182,* 444-448.

United Nations. (2006). *World population monitoring, focusing on international migration and development: Report of secretary-general.* New York: Author.

United Nations Fund for Populations. (2006). *Lo stato della popolazione nel mondo* [The state of the world population]. Rome: Author.

United Nations High Commissioner on Refugees. (2007a). *2006 global trends: Refugees, asylum seekers, returnees, internally displaced and stateless persons.* New York: Author.

United Nations High Commissioner for Refugees. (2007b). Richiedenti asilo e rifugiati nel mondo e in Italia [Asylum seekers and refugees in the world and in Italy]. In *Caritas Immigrazione: Dossier Statistico, 2007* (pp. 493-502). Rome: Idos.

Van der Kolk, B. A. (1996). Trauma and memory. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress. The effects of overwhelming experience on mind, body and society* (pp. 279-300). New York: Guilford Press.

VanVelsen, C., Gorst-Unsworth, C., & Turner, S. W. (1996). Survivors of torture and organized violence: Demography and diagnosis. *Journal of Traumatic Stress, 9*, 181-193.

Victorian Foundation for Survivors of Torture. (1998). *Refugee health and general practice.* Melbourne: Melbourne Printing Professionals.