

Translating Fanon in the Italian context: Rethinking the ethics of treatment in psychiatry

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Abstract

Based on two years of ethnographic fieldwork at the Centro Frantz Fanon, an ethnopsychiatric clinic in Northern Italy, this article traces the theoretical and clinical genealogy of Italian ethnopsychiatry as it is conceived and practiced at this clinic. The clinic draws explicitly from the work of Fanon and French ethnopsychologist Tobie Nathan. This genealogy provides a basis for reflection on the ways in which current ethnopsychiatry re-articulates older questions about difference and healing, culture and suffering, and the political dimensions of psychiatry. Although ethnopsychiatry is currently focused on the care of migrants, key issues related to the impact of colonialism on mental illness and the recognition of cultural difference characterized the Italian debate long before the 1980s when increasing numbers of migrants and political refugees started to arrive in Italy.

Keywords

Basaglia, de Martino, ethnopsychiatry, Fanon, Italy, migrants, Nathan

“Culture is conflict.”

(Psychologist, Centro Frantz Fanon)

The mental health of immigrants in most European countries and in North America raises interesting and unresolved questions about psychiatry, a discipline that remains a critical frame for exploring legacies of colonial violence and post-colonial transition (Keller, 2007). In Italy, ethnopsychiatry and its objects of inquiry offer privileged windows into the experience of migration of postcolonial

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populations and its effects on the ethics and politics of therapeutic treatment. In this article, I examine the position of a group of Italian ethnopsychiatrists on the use of culture in the therapeutic setting. My reflections are based on two years of ethnographic fieldwork at the Centro Frantz Fanon, a clinic in Northern Italy that offers psychological support to immigrants, refugees, torture victims, as well as to Italian social workers, religious people, and volunteers who work with them. My aim here is twofold: 1) to situate the clinical practice of this group of ethno-psychiatrists within the larger landscape of Italian psychiatry and medical anthropology, and within theories of domination and culture developed by Frantz Fanon and Tobie Nathan; 2) to reflect upon ethnopsychiatry as a contested field that raises a series of complex questions about migration, mental health, citizenship, identity, and thus opens up the possibility to rethink clinical work as a political space, for both migrant and Italian patients alike.

Ethnopsychiatry's legacy has been traced back to the works of colonial doctors such as John Colin Carothers and Octave Mannoni (Beneduce, 2005; Beneduce & Martelli, 2005), and in Italy to the experience of community-based psychiatry, Gramsci's political thought, and Ernesto de Martino's anthropological research (Pandolfi & Bibeau, 2005). While my contextualization of this clinic follows a similar historical and textual trajectory I also turn to authors who have addressed the colonial and post-colonial implications of psychiatric interventions both in Europe and in the ex-colonies. In this article, I create a conversation between texts and passages of interviews with ethno-psychiatrists in order to elucidate their clinical use of culture, and to situate the political dimension of this kind of clinical work within larger debates on mental health and difference. While showing the importance of ethnopsychiatry's interventions, I also point to the implications of using cultural material in the therapeutic setting, and the risks of failing to subject psychiatric categories to a real critique when the focus of therapeutic work is exclusively "the other."

In Italy, access to health care is a legal right of citizens and non-citizens alike. Despite this fact, there remains a significant disparity in access to services. In the text of the National Health Plan (2002–2004) the Department of Health denounces what it describes as "a substantial lack of flexibility in the offering of services in the face of the new health problems of these new groups of clients" (Beneduce & Martelli, 2005). After the closure of the mental hospital, psychiatric services in Italy have been increasingly community-based in an attempt to limit the risks of medicalization and the stigmatization of mental illness. Nevertheless, in practice, access to mental health care has often been off-limits for migrants. As a result, alternative spaces of psychological and psychiatric care – such as the Centro Fanon – have been designed and made available exclusively to migrants and refugees. These independent initiatives have received public funding without, however, being recognized in their own right as part of the public health system.¹

They remain marginal to the domain of public policy and stand as a critique of the institutional structure of health care.

Clearly, ethnopsychiatry operates from its inception within the domain of political action. The recent heated debates on ethnopsychiatry in Europe show that speaking about culture in relation to suffering and therapy is a highly controversial topic, which risks generating accusations of racism (Beneduce, 2007; Benslama, 2000; Fassin, 2000; Nathan, 2003). Reasons for this tension and controversy can be found in the history of psychiatry (Beneduce, 2008a), but questions of culture, mental health, and power relationships have re-emerged today despite the fact that ethnopsychiatry and transcultural psychiatry position themselves in opposition to colonial psychiatry.² On the one hand, culture is an increasingly politicized domain of public discourse, inasmuch as it is through the language of cultural difference that the relationship between immigrants and receiving countries is articulated; on the other hand, ethnopsychiatry, because it is committed to the treatment of migrants, refugees, and torture victims finds itself within a highly politicized terrain in which questions of citizenship and borders, mental health and rights intersect in complex ways.

The Centro Frantz Fanon was established in 1996 by a group of psychiatrists, psychologists, anthropologists, and cultural mediators as a political response to the multiple forms of discrimination migrants and asylum seekers faced in Italian public institutions. Part of a revival of clinical ethnopsychiatry in other European countries, this center is conceived of as a site in which, through the incorporation of different etiologies of mental suffering and healing approaches, a strong counter-discourse to normative psychiatry is produced. In the context of ethno-psychiatric treatment, the patient's cultural background provides therapists with a framework for a new practice of listening in which the patient's claims to the magic and the supernatural as constitutive orders of subjectivity are taken seriously and often used as therapeutic tools (Beneduce, 1998).³ What is at stake here is the question of difference in relationship to healing and suffering, and its potential to critique institutions and colonial experiences.⁴

Tobie Nathan's clinical experience in France has had an important impact on the Italian context.⁵ While the Centro Fanon draws from Nathan's goal of re-connecting migrants to their culture of origin as a therapeutic technique, other philosophical traditions – such as phenomenology, existentialism and, in anthropology, the work of Ernesto de Martino – and the experience of *psichiatria democratica* and the legacy of Franco Basaglia also influence the Centro's clinical approach. The specificity of Italian ethnopsychiatry can only be understood against the backdrop of the debates around the de-institutionalization of the mentally ill and the radical critique of public institutions initiated by Basaglia, and the de-institutionalization movement in the early 1970s (Pandolfi & Bibeau, 2005). Crucial to the Italian context in general is also the work of Antonio Gramsci on the complex relationships between hegemonic and subaltern cultures, and on the role of the intellectual in creating a field of political action that could involve the subalterns in the definition of what counts as politics. Moreover, Frantz Fanon's denunciation of colonial power relations and the violence embedded in institutions

represents the theoretical ground on which the group of practitioners and cultural mediators base their reflections on discrimination and race, and devise training for mental health practitioners and social workers who work in public services (Beneduce, 2007). In the clinical practice of ethno-psychiatrists at the Centro Fanon, these legacies intersect in interesting and sometimes contradictory ways.

The conundrum of contradictions: Basaglia and his psychiatry without *manicomio*⁶

Interviewer: Doctor Basaglia, to conclude, are you more interested in the patient or in his illness?

Basaglia: Definitely in the patient!⁷

The recent revival of ethnopsychiatry in Italy has its roots in a long standing Italian intellectual critique of public institutions. Franco Basaglia embodies this critical tradition of politically engaged mental health reform originating in the 1960s and 1970s. Recognized as the leading figure of the democratic psychiatry movement in Europe, Basaglia (1924–1981) became the director of the Trieste mental asylum in 1971 where, together with a group of colleagues, nurses, and social workers, he started a systematic and consistent critique of mental health institutions and the violence embedded therein.

According to Basaglia, the solution to the closed and violent structure of the mental hospital was to be found not in humanitarian gestures that increased the degree of dependency between reformers and patients, but rather in questioning the power relationships that characterized the practice of institutional psychiatry. Basaglia interpreted mental illness as a socio-political problem and envisioned a public psychiatry able to comprehend suffering and social misery outside of the hospital walls. Influenced by the work of Foucault's and Goffman's work on the asylum (1961), Basaglia offered a complex analysis of the interrelation between mental illness and society's response to the management of suffering. This critique set the foundation for a process of self-reflection on the part of mental health practitioners and led to the abolition of the mental hospital in Italy in 1978.

For Basaglia, the *manicomio* (asylum) was a microsocial architectural space that reproduced perversions in human relationships and created an illness specific to itself: institutional psychosis or institutionalism (Scheper-Hughes & Lovell, 1987, p. 11). The institution foreclosed any possibility of listening to, and empathizing with the patient's life world:

In order to truly face "illness," we should be able to encounter it *outside* of institutions. By this I mean, not only outside of the psychiatric institution, but *outside* of any other institution whose function is to label, codify and fix those who belong to them into roles. Does there really exist an *outside* from where to take action before institutions destroy us? Can't we, instead, deduce that what we know of the "illness"

appearance is always, anyway, its institutional appearance? (Basaglia, 1968, p. 374, *author's translation*)

By highlighting the institutional construction of mental illness as a “disease,” Basaglia radically questioned psychiatrists’ practice and their social role and responsibility vis-à-vis patients. Influenced by existentialism and the phenomenological approach to mental illness developed by Binswanger and Minkowski, Basaglia’s political and ethical efforts were focused on a re-evaluation of the encounter between doctor and patient that the asylum denied and made impossible due to its hierarchical and closed structure. To enter the life-world of the mentally ill, one had to break free from the situation of oppression instituted by the asylum and its apparatus of control. Bracketing illness also meant suspending diagnoses and paying attention instead to the suffering hidden behind them. The diagnostic apparatus kept the psychiatrist from exploring what was behind symptoms and the expressions of suffering. Basaglia wrote: “[...] we believe that in order to have a relationship with an individual, it is necessary to establish it independently of the label by which the person has been defined” (1968, p. 31, *author's translation*).

In my conversations with ethno-psychiatrists at the Centro Fanon, Basaglia’s legacy was often evoked as central to the contemporary setting of clinical interventions with migrant patients. Simona Taliani, a psychologist trained in ethnopsychiatry and medical anthropology with experience of field research in Cameroon, once explained to me that by bracketing diagnosis the patient was allowed to be a competent historian of his/her own life and memories. In her words:

We provide a clinical space where we put diagnoses and psychodynamic interpretations aside in order to listen to what the other has to say about his/her malaise. [...] Our methodology is meant to accompany the person in exploring all the etiologies that they have in mind. [...] In this way, we are engaged in a political effort to see the other as a political subject that has something to say about their story and history.⁸

In line with Basaglia’s teaching, diagnoses are seen as an expression of the hegemonic power of the institutions which foreclose a real therapeutic encounter.

For Basaglia, the phenomenological approach allowed psychiatrists to expose themselves directly to patients’ life-worlds. Empathy with the patient allows for the creation of “a terrain of encounter, of reciprocity and dialogue from which emotion is not absent, and which allows one to find a path from which to start a therapeutic relationship” (Basaglia, 1981, p. 4, *author's translation*). As Taliani explained to me, ethnopsychiatry positions the patient as a political subject “not because s/he is a victim of human trafficking or of torture, or an asylum seeker, but because they tell us about their suffering in their own terms, by using their mother tongues and local etiologies.” This means that in the ethno-psychiatric setting the patient is in a position where power dynamics are for a moment inverted, “because the most competent one is not the doctor but the patient herself.” This is a different therapeutic relationship than the one imposed by the institution, and it allows for a

different kind of empathy with the patient's symbolic and psychic life. As she put it: "the use of the mother tongue in therapy sessions is not because we are anthropologically sensitive to the patient's cultural difference, but because the mother tongue is a political instrument to say certain things." While the use of patients' mother tongues was originally introduced in psychotherapy to improve the doctor-patient relationship and to bring relevant material from patients' cultural background, it became a way to empower non-western patients in western health care systems (Rechtman, 2006).

When the phenomenological analysis was no longer sufficient to explain the class nature of illness and the larger social and political context that determined its modes of expression, Basaglia turned to Gramsci and other Italian Marxist thinkers who were engaged in finding a new language to address social change. Understanding madness not as a mere social product as a positivist logic would explain it, but rather as a complex nexus of contradictions (institutional, ideological, ethical, medical, political, social) that find their expression in the bodies of patients, questioning the structure of medical knowledge itself, its practices and representations – all these goals allowed Basaglia to bring to the fore the issues relating to psychiatry and its relationship to the law.

The traditional asylums were still governed by the 1904 law which positioned psychiatry within the criminal justice system, assigning it the function of *custodia* (control, custody) rather than of *cura* (care). Basaglia was one of the main advocates of the 1978 Law 180 (known as "*Legge Basaglia*", Basaglia's Law), which ratified the closure of the *manicomio*, prohibited building new asylums, and promoted the organization of a community-based psychiatry through mental health centers. By involving the community in changing cultural attitudes towards deviance, this law also changed the relationship between psychiatry and the legal system, and ended the exclusive management of mental illness by doctors. It confronted the old contradiction between *custodia* and *cura*, between control and treatment, and it redefined the institution as a positive space in which a different kind of encounter could take place.⁹

In my fieldwork at the Centro Fanon, I was interested in the ways in which the political dimension of Italian community psychiatry intersected with the cultural approach of ethnopsychiatry. Roberto Beneduce once explained to me how the Centro came into existence and the motivations, both clinical and political, behind it:

In one way or another there was a desire on our part, not to lose sight of the legacy of Italian community psychiatry. From our point of view, that legacy was not at odds with the opening up of the cultural area, therefore the political and the cultural, going slightly against a tradition that had been very strong in Italy. It wasn't easy to bring together the political and the cultural in the clinical work with immigrant patients because even the most sensitive Italian psychiatry never intentionally developed its medical anthropological intuitions. When Basaglia critiques the mental illness statute, he is doing medical anthropological work *avant la lettre*, and at the beginning of the

1960s when he takes up phenomenology, there is a critique of mental illness that is anthropologically rooted – only that all these things are dispersed and re-channelled into a single critical analysis of institutions.¹⁰

According to Beneduce, directing the critique to institutional settings prevents one from seeing how mental illness is constructed and reproduced not only inside the psychiatric institution, but also in the social imaginary. For Beneduce, focusing on the social dimension of suffering was the “undelivered promise of the writings of some psychiatrists and psychoanalysts between the 1960s and 1970s.” An immigrant himself from the south to the north of Italy, Beneduce drew both from his personal and professional experience to translate Basaglia’s legacy into a way to work with the immigrant population.

The critique of institutional violence and the relationships of domination within institutions that characterizes Basaglia’s (1968) work echoes Fanon’s (1963) unveiling of the institutional roots of violence in the colonial context. However, Basaglia contrasted Fanon’s work in the psychiatric hospital in Algeria with his own. It was in Algiers that Fanon clarified his position as a politicized psychiatrist by realizing that the doctor-patient relationship is always defined by the system. Since the so called “therapeutic act” is an “act of silent acceptance of the system,” Fanon saw revolution as the only way to act against the institution. Basaglia wrote:

Fanon was able to choose revolution. We, for objective reasons, are prevented from doing it. In our reality, we still need to continue to experience the contradictions of the system which over-determines us, by managing an institution which we deny, by performing a therapeutic act which we refuse, by preventing that the institution – which as a result of our very action has turned into an institution of subtle and disguised violence – continue to be *only* functional to the system. We attempt to resist the flattery of new scientific ideologies which tend to hide those contradictions which it is our duty to make explicit. *We are aware of the absurdity of this wager: we want to keep values alive, while non-rights, inequality, and the quotidian death of man are turned into legislative principles.* (1968: 379–380, author’s translation, italics in original)

Basaglia’s idea was to work from within the conundrum of the system in order to address the contradictions of an institution that he fundamentally rejected. The constant process of undoing psychiatry from within differed from Fanon’s engagement in the revolution. Basaglia thought that a revolution from within the institution could discard the very assumptions underlying its existence. He called this project “*l’utopia della realtà*” (the utopia of reality). For Fanon, on the other hand, revolution required the radical rupture and negation of the mental institution by stepping outside of it, which he did by resigning from his position as a clinical psychiatrist in the hospital in Algiers.

Italian ethnopsychiatry and the debates that animate it issue precisely from the political engagements initiated by Basaglia and the movement of *psichiatria democratica*. The vigilant critique of state institutions, coupled with the urge to reform

public services in the domain of public health, still characterize Italian ethnopsychiatry. While this more politicized approach to illness and healing was at first oriented towards the economically and politically marginalized, since the early 1980s, ethnopsychiatry has increasingly addressed marginalization and domination through a specific focus on migrant communities. It argues that health care for migrants is a political issue rather than a strictly medical one. Basaglia's legacy provides a backdrop for the work of contemporary mental health practitioners committed to providing psychological support to migrants, and it shapes the political debates arising from the epistemological uncertainty that mainstream psychiatry is forced to confront in the treatment of migrants.

When Foucault (1994) wrote about the great reforms of psychiatric power and thought over the last century, he argued that they placed the power relations embedded in psychiatry at the center of the field and fundamentally questioned them. Great reforms are attempts to displace power, to unmask it, and nullify or eliminate it. As Foucault observed: "The whole of modern psychiatry is fundamentally pervaded by anti-psychiatry, if one understands by this everything that calls back into question the role of the psychiatrist formerly charged with producing the truth of illness in the hospital space" (1994, p. 45). Several antipsychiatries have traversed the history of modern psychiatry and contemporary Italian ethnopsychiatry operates within the field of Basaglia's version of antipsychiatry.¹¹

Ernesto de Martino: *The End of the World* and the question of cultural apocalypse

Another central thinker in the genealogy of Italian ethnopsychiatry, who contributed to the questioning of western diagnostic categories and apparatuses, is Ernesto de Martino (Bartocci & Prince, 1998; Beneduce & Martelli, 2005). Trained as a religious historian, and renowned as a philosopher and ethnographer, de Martino engaged in a serious re-evaluation of the intersections of history, religion, psychoanalysis, psychiatry, anthropology, and political theory. De Martino's reflections were influenced by phenomenology, Marxism (through the work of Antonio Gramsci), and Benedetto Croce's historicism. His work, in the 1940s, anticipated many of the epistemological concerns that lie at the heart of current ethnopsychiatry, including questions of mental health, diagnostic categories, and the conundrum of difference.

Above all, de Martino pointed out the importance of a political engagement on the part of the ethnographer in regard to his/her object of inquiry. Although his initial interest was in colonial societies, he later shifted his ethnographic focus to the marginalized of his own society. His fieldwork in rural southern Italy continued a tradition of anthropology "at home" pursued by Italian researchers (Seppilli, 2001). According to de Martino, certain magic-religious rituals and therapeutic techniques in western societies were deeply linked to both hegemonic and subaltern logics of power and domination between different socio-economic classes. The ethnographer had the responsibility of illustrating these logics in all

their complexity. De Martino focused on the study of rituals of possession and on their meanings for the individual and for his/her relationships with society.

His first book, *Naturalismo e storicismo nell'etnologia (Naturalism and Historicism in Ethnology)* begins with a reflection on the crisis of western civilization and a call for a critical analysis of the history of the West as a fundamental goal of ethnographic work. His philosophy was later referred to as “*etnocentrismo critico*” (critical ethnocentrism). De Martino argues that our study of the ‘other’ necessarily entails a critical analysis of our own analytical categories. In *La fine del mondo (The End of the World)*, an unfinished manuscript published posthumously in 1977, de Martino returns to this idea of the un-doing of western categories of analysis through the encounter with the ‘other’. When we consider our categories of observation, he writes, we encounter a paradox: by employing them in the study of the ‘other’ we will only see projections of ourselves in the alien; on the other hand, by not using them, nothing can be observed. To resolve this paradox, the western ethnographer must be aware of the historical context that produced his categories of analysis in as much as they are not pertinent to other cultures. Through this *epoché*, we question western categories of observation and contribute to anthropological knowledge. (1977, p. 410).

When ethnopsychiatrists at the Centro Fanon refer to de Martino’s contribution to their practice, they acknowledge the importance of inhabiting this *epoché* which allows for the possibility of listening – within the space of the clinic – to the different etiologies that patients resort to. The experience of migration often creates a limbo in which several explanations of symptoms are possible and appropriate. For instance, in the case of a Nigerian woman who was referred to the Centro by the public department of mental health where she had been diagnosed with schizophrenia, the ethnopsychiatric group suspended that diagnosis and asked the patient in what terms her symptoms would be described in Nigeria, by her family, others in her village, and by her healer. Other etiologies used to understand her experience, including the language of possession and witchcraft, of devotion to Mami Wata, and different forms of ties associated to voodoo rituals, were discussed in the therapeutic process.

As Piero Coppo (2005) has pointed out, ethnopsychiatry is first of all a method that allows for different etiologies to be evoked and used in the clinical encounter. Ethnopsychiatry then is not a subfield of psychiatry but a way of reconceiving the clinical response to the patient. The encounter with alterity – be it ethnographic or psychopathological – asks for a radical revision of the disciplines that history has produced. Ethnopsychiatry looks at psychiatry as a historical product, a culturally shaped *savoir-faire* among others (Coppo, 2005). This kind of revision resonates with de Martino’s invitation to critique Western consciousness.

Throughout his work, de Martino was concerned with what he terms the “*crisi della presenza*” (crisis of presence) of modern civilization which involves the place of the individual within society. The “crisis of presence” refers to the existential anxiety that one might be effaced by situations that challenge the individual’s ability to handle external and internal realities. Influenced by Heidegger, Sartre,

and Hegel's master-slave dialectic, de Martino developed his own understanding of what it means to be in the world (Saunders, 1993). In *Il mondo magico* (*The Magic World*) (1948), de Martino first introduced the "crisis of presence" through a discussion of the Malaysian context. He described the experience of *latah*, the dissociative state in which a person becomes vulnerable to external influences, imitating and echoing others, and generally losing the boundaries of his/her own personality and sense of self (see Simons, 1996; Wazir, 1990, Winzeler, 1995). In this crisis, "the distinction between presence [as consciousness] and the world that makes itself present crumbles" (de Martino, 1948/2000, p. 93). He refers to the subject's risk of no longer being in the world, of "not being-there" ("*il rischio di non esser-ci*").

Although de Martino seems to be interested in the "crisis of presence" more from existential and historical perspectives than from a strictly psychoanalytical one, in an article entitled "*Crisi della presenza e reintegrazione religiosa*" (Crisis of presence and religious reintegration) published in the philosophical review *Aut Aut* in 1956, he establishes a parallel between certain instances of loss of presence and mental illness. The person suffering from a mental illness may lose his/her ability to engage dialectically with the world and to relate to the object as outside one's self. The subject loses his/her ability to relate to the world symbolically and instead identifies with it. At the core of this crisis is the anxiety that "underlines the threat of losing the distinction between subject and object, between thoughts and action, between representation and judgment, between vitality and morality: it is the cry of one who is wobbling on the edge of the abyss" (de Martino, 1956, p. 25).

De Martino assigns the function of resolving the crisis of presence to religious rituals which re-establish the ties between the individual and the social, and re-anchor the subject within the symbolic order through what he calls a "cultural redemption" (*il riscatto culturale*). Religious and magical rituals help people overcome the sense of loss and alienation experienced within the crisis of presence by providing the subject with a structure that allows the re-establishment of boundaries between him/herself and the world. Traditional and religious therapies aim at reintegrating the individual into the community. Idiosyncrasies are translated into the mythical narrative and in the structure offered by rituals (Beneduce & Martelli, 2005, p. 376). In this sense, de Martino's reflections are a prelude to contemporary ethnopsychiatric practice which figures religious rituals and the vocabulary of magic as therapeutic. Encouraging patients to perform rituals that are meaningful to them, as well as referring to the language of witchcraft and possession are among the therapeutic modalities that ethnopsychiatrists apply in their clinical work. These experiences are often described by clinicians at the Centro through the category of "culture" and are represented as therapeutic tools. As discussed in more depth later in this article, allowing for alternative modalities of healing and suffering within the ethnopsychiatric setting can have an ambivalent outcome: while creating an alternative space to public healthcare institutions, it also risks reifying magic-religious practices by confining them to the domain of "culture" as a static field which can be turned into another diagnostic category. While knowledge of cultural difference is important for clinicians, it is also crucial to let the individual's

psyche find its own paths within and outside of the constraints imposed by culture (Rechtman, 2000).

De Martino was in conversation with several Italian psychiatrists and psychoanalysts on the question of the crisis of presence and its pertinence to psychopathology and clinical work, including Giovanni Jervis (1994), Bruno Callieri (2001), and Michele Risso. Risso, who is considered one of the pioneers of Italian ethnopsychiatry for his clinical work in Switzerland with immigrants from Southern Italy, was profoundly influenced by the work of de Martino on magic, evil eye, and bewitchment. Risso contributed in fundamental ways to the psychopathology of migration and to contemporary ethnopsychiatry's attempt to situate symptoms within a larger historical, cultural, and political context (Risso & Böker, 1992).

In de Martino's work, the crisis of presence figures not only as an existential category which produces anthropological understanding, but it also addresses the broader question of the historicity of man. The crisis is linked to the question of "cultural apocalypses" (*apocalissi culturali*) which de Martino develops in *La fine del mondo*. Here de Martino reflects upon the uncertain boundaries between the pathological (and individual) and cultural dimensions, between the psychological register and the historical-anthropological temporality of being. Pandolfi and Bibeau (2005) argue that de Martino's project is the first attempt in anthropological theory to reflect on these issues from multiple angles: on the one hand, he considers the macro-dimension of cultural apocalypses and, on the other hand, he is attentive to the micro-dimensions of the catastrophic event, or the risk of self loss and of pathology. An exterior catastrophic event can put the sense of self in danger but this crisis can also be translated into a return to the world in ways that were previously unimaginable. Nonetheless, subjectivity is inherently at risk of losing itself. It is precisely this dimension of risk, both ontological and historical, that for de Martino constitutes subjectivity.

In *La fine del mondo*, de Martino sketches the first critical analysis of psychological and psychiatric categories, thus anticipating recent medical-anthropological critiques of diagnostic criteria and their application within the context of Italian ethnopsychiatry. He points out that cultural psychiatry can illuminate the links between psychological disorders and the failure of culture's task of holding the individual and assigning meaning to events. According to de Martino, a transcultural approach to psychiatry serves a double purpose. Not only does it allow for a study of the socio-cultural dimensions of mental disorders and the recognition of the effectiveness of traditional, culture-sensitive therapies, but it also has important epistemological implications inasmuch as it contributes to critical approaches to the diagnostic categories of psychiatry as a whole. When ethno-psychiatrists at the Centro Fanon describe their process of assessing the patient's psychological condition, they refer to their "prudent use of psychiatric diagnoses," as one ethnopsychiatrist put it. The aim is to let psychiatric diagnoses be undone and questioned by the patient's own metaphors, interpretations, and worldview (Kirmayer, 1999). In this way, multiple models are at play and provide different angles on symptoms and experiences, without reproducing or getting caught within a hegemonic

discourse on mental health. Practitioners at the Centro view diagnosis as an exploratory process to learn the patient's interpretations rather than to label symptoms (Giordano, 2008).

Colonial psychiatry, postcolonial disorders, and contemporary ethnopsychiatry

Categories of psychiatry and medicine have a history of their own which shows that they played a decisive role in the confrontation between dominant and dominated cultures, even when they aimed at fostering cultural sensitivity. In the name of respect and sensitivity for difference, old power dynamics can re-emerge under different disguise. For example, the ethnopsychiatrists I interviewed are aware of the striking continuities between the viewpoints and diagnostic categories of psychiatry in the colonies and of contemporary health practitioners working in the public system with migrant patients in Italy. The debates that most animate ethnopsychiatry today remain inextricable from colonial and post-colonial situations where relationships of power between colonizers and colonized have produced certain interpretations of mental illness and cultural difference.

During colonial and decolonization times, psychiatry and psychology contributed to the processes of culturalizing racial representations and essentializing cultural difference. These processes still constitute a risk for ethno-psychiatric practice today. Several studies of indigenous populations conducted by psychologists and psychiatrists from the 1940s to the 1960s marked the birth of ethnopsychiatry and gave it a specific ideological tone. In the early 1950s, John Carothers' analysis of the Mau Mau anti-colonial movement in Kenya as a violent behavior whose matrices were cultural was one example of psychiatry's collaboration with the colonial power structure in order to understand indigenous mentalities and behaviors to better govern them (Carothers, 1953). Carothers (1954) interpreted the Mau Mau's deviance and opposition to colonial governance as "traditional," as an expression of local "customs," or, in other instances, as a psychological reaction to the conflicts produced by the encounter with European powers and their ways of being "modern." In this way, the political dimension of these acts of resistance, and the historical subjectivity of the people involved in such movements, were completely leveled to the order of cultural difference or psychopathology. The construction of a racial and cultural stereotype of the African served to legitimize and justify colonial power, as well as to reduce local movements of resistance to psychopathology (Collignon, 1997; McCulloch, 1995; Vaughan, 1991). In the colonial context, psychiatry doubled its function of control by reducing historical dynamics, political revolts, and conscious acts of resistance to the existing colonial power to "symptoms" of various nature: a complex mix of dependency on the colonizer, conflicts deriving from the exposure to the colonizer's culture, and the speed of the transformation of traditional models into European ways of being "modern."

Other examples of studies conducted on the mental health of the colonized populations had very different political implications from Carothers' work on Kenya. During the decolonization movements some psychiatrists and psychologists defended the colonized. Octave Mannoni in Madagascar and Frantz Fanon in Algeria, for example, were actively engaged in a radical critique of colonial power and the relationships of domination and racism established by it. Although sympathetic with the Malagasy rebellion against the colonizers, Mannoni interpreted the suffering and rage that followed the imposition of forced labor and the Malagasy revolt in psychopathological terms as "the congruence of two personality crises" (Bloch in Mannoni, 1950/1990, p. xi). He identified the dialectic between the "inferiority complex" of the colonizer and the "dependency complex" of the colonized as the underlying dynamic that defined their relationship. According to this dialectical relation, Europeans projected their fears onto the local populations while the Malagasy, in turn, projected onto the whites a dependency which mirrored their relationship to their ancestors and the hierarchical religious structure according to which the dead represented a moral authority (Cole, 2001; Roudinesco, 2005). While the Malagasy saw in the "colonial fathers" the equivalent of their ancestors who protected and dominated them, the colonizers interpreted this form of dependency as the expression of the black's inferiority and subordination to their rule. According to Mannoni, the colonizer translated the Malagasy sense of dependency into an inferiority complex in order to legitimize the relationship of domination and abuse of the colonial power.

Recent ethnographic reflections on colonialism have shown how colonial encounters were characterized by a tragic comedy of errors and misunderstandings in which each group's uncertainty about the other confirmed pre-existing anxiety and stereotypes (Beneduce, 2008b; Mbembe, 1997; Obeyesekere, 2005; Peel, 2003). The nature of the misunderstanding at the root of Mannoni's interpretation brings us back to a crucial question in ethnopsychiatry: how is culture used and manipulated to make sense of difference, even in situations in which this very appeal to culture conceals rather than explains the dynamics of power and domination at the heart of conflicts? Maurice Bloch, writing on Mannoni's work, argued that the reason for this misunderstanding was Mannoni's arrogance:

It is not the racist arrogance of the white man [...]. It is the arrogance of the psychoanalyst or anthropologist, who unthinkingly comes to indulge in the different but no less objectionable claim to superiority that his professional knowledge apparently gives him. [...] Ultimately, Mannoni disguises his ignorance of Malagasy motives only by substituting other motives deduced from theories originating in the highly specific intellectual tradition of his own culture. (1950/1990, pp. xviii–xix)

This is precisely the critique that, a few years after the publication of *Prospero and Caliban*, Frantz Fanon developed in *Black Skin, White Masks* in order to respond to Mannoni's interpretation of the colonial encounter. Fanon argued

that Mannoni psychologized the colonial situation and reduced the conflicts between the colonizer and the colonized to a sophisticated dynamic which kept the colonized in a position of dependency. While Fanon recognized the honesty of Mannoni's study of "the extreme ambivalence inherent in the colonial situation," he also denounced the tendency, characteristic of psychological research in general to lose sight of the real (Fanon, 1952/1967, p. 83). Fanon subscribed to that part of Mannoni's analysis which broached the problem of colonialism not only as the "interrelations of objective historical conditions," but also as the "human attitudes towards these conditions."

Fanon contested the assumption that the origin of certain complexes – such as the inferiority complex of the Malagasy – was latent in the colonized from childhood and that the encounter with the white man only allowed it to manifest itself. He argued that this attempt to make the inferiority complex something that antedated colonization echoed psychiatry's mechanism of explanation according to which "There are latent forms of psychosis that become overt as the result of a traumatic experience" (1952/1967, p. 85). Instead, Fanon looked at the colonial situation both as the emergence of a particular encounter between "the white" and "the negro" that "only a psychological analysis [could] place and define" (p. 85), and, most importantly, as the expression of racism which needed to be confronted from a militant position of denunciation rather than from a purely intellectual analytical position. Fanon wrote from the position of an engaged anti-colonialism which he expressed in his writings and practice as a psychiatrist. He argued that the colonial encounter needed to be analyzed not only from its pathological roots, but also for its political, economic, and cultural implications. This more nuanced approach was lacking in Mannoni's work.

The problem that emerges from these debates is that colonial psychology and psychiatry seemed to erase the political meaning of behaviors, struggles, movements of resistance, and rituals. Cultural difference was invoked in place of the political. In this context, the meanings of culture, along with its contradictions, paradoxes, and dynamics are often distorted. This same problem applies to certain versions of ethnopsychiatry today. The risk of using culture as a way to flatten the political dimension of suffering has its roots in the colonial context. Nevertheless, the colonial context also gave rise to the work of militant doctors like Frantz Fanon, who attempted to show the interconnections of the political and cultural implications of suffering and domination. The Centro Fanon's clinical work is inscribed in this line of therapeutic and political intervention.

Culture as therapeutic trigger or impossible home: Fanon and Nathan in conversation

In *Black Skin White Masks*, Fanon denounces the trauma induced by the gaze of the white man on the black man. Colonization creates a form of alienation which is experienced by the black man as an interior disintegration. The gaze of the white

person turns the body of the black person into a speechless body, powerless in its silence: "I am being dissected under white eyes, the only real eyes. I am *fixed*" (Fanon, 1952/1967, p. 116). Overnight, Fanon writes, the Negro's customs and the sources on which they are based were wiped out "because they were in conflict with a civilization that he did not know and that imposed itself on him" (p. 110). In *Toward the African Revolution*, Fanon explains that the consequences of this dialectic are the sense of guilt and inferiority experienced by the black man. In order to avoid feeling guilty and inferior, the oppressed gets caught in two possible patterns: he either proclaims his unconditional adoption of the new cultural models, or he irreversibly condemns his own culture.

Colonization produced a fracture in identity, something Fanon conceived as irreversible. This fracture echoes de Martino's "cultural apocalypses" and the experience of the "crisis of presence." Colonization, as a disruptive event, brought about the "liquidation" of the natives' systems of reference, cultural patterns, and ties to the past. This process – which with de Martino we can interpret as a radical loss of oneself and of one's presence to the world – causes alienation in the colonized who are reduced to the "inferior race" that denies itself by absorbing the convictions, doctrines, and attitudes of the "superior race" (Fanon, 1964/1967, p. 38). In the colonizer's language, this alienation appears under the name of assimilation. In the dialectic of non-recognition which is inscribed in the colonial encounter, the black self is a construction of the white man and he is fixed in the image of himself that the white mirrors back to him. This process of mystification intrinsic to the colonial situation, produces simulacra of the past, of the disappeared culture of the colonized, which becomes inaccessible precisely because it is reduced to a lifeless copy of itself.

Not with impunity, however, does one undergo domination. The culture of the enslaved people is sclerosed, dying. No life any longer circulates in it. Or more precisely, the only existing life is dissimulated. The population that normally assumes here and there a few fragments of life, which continues to attach dynamic meanings to institutions, is an anonymous population. (Fanon, 1964/1967, p. 42)

What does it mean, for Fanon, to get disentangled from the web of alienation produced by the white man's gaze in the black's image of himself? According to Fanon, disalienation or emancipation from the perverse relationship established by colonialism cannot happen through a return to origins because the culture that once existed has been transformed by the presence of the colonizers. There is no culture, custom, or tradition to go back to because they have been obliterated by the white man. To become emancipated by the colonial situation one has to take responsibility for this fracture and start anew, free from the web of images and copies of one's self projected by the other, to create something different. "I am not a prisoner of history. I should not seek there for the meaning of my destiny. I should constantly remind myself that the real *leap* consists in introducing invention into existence" (Fanon, 1952/1967, p. 229).

Fanon interprets all ties to the past or attempts to recuperate a relationship to the origins as still other moments of alienation which repeat the process of becoming stranger to one's self. Emancipation takes place by cutting ties with the past, with a culture that has been contaminated by the encounter with the colonizer. Freedom is attained by rejecting the system of domination and it implies another rupture, almost a second act of self-effacement and self-destruction. The search for emancipation in the past is a "retroactive operation" which encases man in a dead culture, in "the culture put into capsules" (Fanon, 1964/1967, p. 42). This process is not a creative act of re-appropriating one's own origins, but a further act of self-destruction because that culture has been destroyed and erased by the domination of the white man. Going back to it is to revisit the event of alienation and to re-inhabit it with no possibility of revitalizing the original situation. In order for the revolution to happen, African people must not be guided by the past, but by the present and the future.¹²

When I asked Roberto Beneduce why he named the ethnopsychiatric center after Fanon, he explained that the similarities between the increased numbers of documented and undocumented migrants in Italy in the early 1990s and the colonial situation described by Fanon was so striking that his name imposed itself on a clinic whose goal was to bring together political engagement and clinical intervention for post-colonial populations facing different forms of institutional racism.

The figure of Fanon seemed central to me, not as a metaphor or as a rhetorical image, but because he had succeeded in bringing together the contributions of psychoanalysts with the historic problems of language [...]. That is, the psychoanalytic subject in its relationship to history, and therefore the limits of a traditional approach with the battles of history and with the problems brought about by the relationships of force between colonized nations and colonizing nations. (Interview conducted in Turin, March 21, 2003)

Fanon's work had a great appeal to the group of ethno-psychiatrists and cultural mediators led by Beneduce in the late 1990s for several reasons. First, Fanon's reflection on the colonial situation allowed them to frame the issues related to the mental health of migrants within the question of the post-colonial and psychiatry's colonial legacy. Moreover, Fanon provided a method to think about the relationships between psychoanalysis, history and subjectivity, and to address simultaneously the socio-historic and psychic dimensions of experience as contingencies that have an impact on people's being in the world.

Along with Fanon's work, Tobie Nathan's clinical work with migrants in the outskirts of Paris and his writings on therapy are also central to the work of practitioners at the Centro Fanon. At the Centre George Devereux, Nathan and his team designed a form of therapy for migrants and their families which took into account their own systems of classification and expression of mental illness. Nathan was influenced by Devereux's approach to the relationship between culture and psychiatry according to which "bare facts" always belong to at least two

different discourses that complement each other but can never be held simultaneously (Devereux, 1978). Ethnopsychiatry positions itself at the intersections of psyche and culture and explores the frontiers between the two without trying to explain one level of discourse in terms of the other. Ellen Corin has pointed out that for Devereux and Nathan, “culture and psyche are doublets or homological structures containing the same basic elements governed by analogous mechanisms” (Corin, 1997, p. 347).

Clinical work with migrants raises the problem of what therapeutic techniques and theories are appropriate to apply. Since patients and therapists do not typically share the same therapeutic and epistemological frame, it becomes crucial to find a “space of mediation” in which to negotiate a common therapeutic frame. Nathan introduced the idea of organizing therapeutic groups composed by multiple professionals: western mental health practitioners trained in psychoanalysis, practitioners from other parts of the world who speak the patients’ language and are familiar with healing practices of their countries of origins, and cultural mediators (Nathan, 2003, p. 68). The composition of the therapeutic group is aimed at facilitating the move from one etiological theory to another without interrupting the flow of speech within the therapeutic setting. The idea underlying this therapeutic strategy is that how patients position themselves vis-à-vis cultural material, how they manipulate and re-interpret it, has diagnostic and prognostic implications. Moreover, acknowledging the legitimacy and epistemological accuracy of other cultural interpretations (other than the ones articulated in western conceptions of mental health) has proved to ease the patient’s speech, and to unlock associative chains that contextualize symptoms within a personal and collective history (Corin, 1997). This approach prevents the patient from getting caught in one hegemonic discourse on suffering, provided by western psychiatry.

In this therapeutic setting, western mental health practitioners, practitioners from the patient’s country of origin, and cultural mediators collaborate in the definition of the diagnosis. The presence of a mental health practitioner from the patient’s country aims at recreating a familiar cultural environment to facilitate the expression of the symptoms, and allows use of the patient’s mother tongue. Other ways of knowing and treating mental disorders among migrants are incorporated into the ethnopsychiatry session. Magico-religious practices such as prayers, healing through protective amulets, exorcism, and chanting of devotional songs are an integral part of the treatment.

One of the central themes in Nathan’s work is the metaphor of culture as the womb. The womb contains and protects, but it eventually expels and forces us into a relationship with alterity, with the world other than the mother. In this sense, the womb is a space which articulates ambivalences having to do with confronting alterity, the other from the mother. For Corin, the metaphor of the womb allows us to think that “[...] just as the psyche is protected by a ‘membrane’ regulating exchanges with the environment, identity is enveloped by a second structuring membrane framed by culture from the outside” (p. 350). Displacement and migration can create a rupture in this “membrane” which facilitates the assignment

of meaning to different experiences. In Nathan's work, the purpose of therapy is to reconstitute this structure by re-anchoring the patient within his cultural background.

In his later work, Nathan has continued to think about the containing and structuring functions of culture and how it can be applied as a therapeutic lever, but he departs from the metaphor of the womb and turns to that of traumatism as the frame through which symptoms are interpreted and treated. His approach to clinical work is generally more oriented toward the effectiveness of certain healing praxis than toward interpretation. The performance of rituals, the fabrication of objects and amulets, the recitation of sacred texts are more central than the interpretative process of unveiling meaning starting from the patient's words, silences, dreams, and *actes manqués*. The attempt to re-anchor the patient in his/her own cultural universe serves the purpose of re-inscribing symptoms within a frame that assigns them meaning and of reorienting the patient within what ethnopsychiatry figures as "tradition." "Symptoms are like text without context," Corin wrote, and therapy attempts to reconstruct the context within which symptoms appear coherent (p. 352). In Nathan's work, this context is often referred to as the patient's "culture." Culture thus becomes a therapeutic tool for therapists. Reinserting the person into a cultural frame through eliciting traditional etiologies is thus the goal of therapy.

Nathan's conception of "culture" as a frame that can give coherence to experience differs considerably from Fanon's view that any attempt to return to an original culture is destined to reproduce alienation. I asked the ethnopsychiatrists at the Centro Fanon how much Nathan's model influenced their clinical practice and how they reconciled the divergent approaches to "culture" of Nathan and Fanon in the therapeutic encounter with migrant patients. In Beneduce's words:

Nathan's model influenced the birth of the Centro Fanon and my approach towards my patients a great deal, because the meaning of therapeutic trigger by way of cultural materials seemed extremely rich to me. When I say "therapeutic trigger of cultural material" – an expression from Devereux – I am referring to the waterfall of psychic and relational events that I saw emerging in the moment in which, with my patients I could evoke situations, say in Africa, which I had been able to personally explore in my work there. And they were events that multiplied every time I would evoke metaphors, places that they knew, that they had heard of, political figures from their national histories, references to people that were familiar to them. There was a kind of radical shift in the therapeutic scene.

While Nathan's psychoanalytic background strongly informs his approach to the ethnopsychiatric setting, he also believes that psychoanalysis is a hegemonic discourse not always apt to understand the complexities of patients' cultural backgrounds. In his book *Médecins et sorciers* (1996), he contrasts psychoanalysis with traditional healers' thinking which he considers to be more open to difference and able to re-orient the patient within a signifying frame.

Overall, Nathan is interested in the effectiveness of what takes place in therapy, in the processes of influence and suggestion which get activated within the therapeutic setting. In *L'influence qui guérit*, he argues that “the psychoanalytic apparatus, by its very organization, triggers processes governed by analogy,” even when the participants are not aware of it (Nathan, 1994, p. 120). The material setting itself – the objects used, the words pronounced, the rituals performed, the languages used – can produce more transformations in the patient than psychoanalytic theories of the unconscious and transference. The power of performativity inherent in rituals and words is at the core of the healing process. For Nathan, healing takes place when the therapist is able to inhabit different systems of thought and draw from different traditions of healing, and the patient is re-inscribed within his own belief system.

The paradox of Nathan's project lies in several aspects of his work. While on the one hand he describes the ethnopsychiatric setting as a “space of mediation” which allows migrant patients to negotiate their multiple belongings to different cultures and to re-articulate their relationship vis-à-vis “home,” on the other hand, he also engages in a project of re-anchoring patients within their past cultural traditions, regardless of the experiences of migration and rupture with that specific past. Therefore the ethnopsychiatric setting seems to mirror the polysemic and fragmentary nature of migrants' experiences and reference points; in this sense Nathan assumes a dynamic concept of culture as a domain in constant transformation. Nonetheless, the therapeutic strategy of referring patients back to their “culture” implies a static idea of culture as a homogeneous placeholder of meanings, behaviors, beliefs, and conceptions of health and illness. This second aspect of Nathan's conceptualization of culture is at odds with current anthropological debates and critique of the concept of culture. Anthropology's conception of the dynamic dimension of culture according to which conservation and creativity, continuity and rupture coexist tends to be overshadowed by Nathan's clinical application of this concept. A more dynamic approach to culture allows for new notions of the individual to emerge, one who is both embedded in tradition while at the same time rupturing and transforming it. The experience of displacement often intensifies the tensions between continuity and transformation, and exposes individuals to an often challenging negotiation between what is perceived as “tradition” and what is encountered as “new.”

One of the ethnopsychiatrists at the Fanon Center explained to me that in her clinical work the concept of “culture” was something extremely complex to utilize and that the difficulty lay in the impossibility of analyzing the clinical encounter according to a perspective that was simultaneously anthropological and clinical. She believed that when therapists used culture as a clinical tool, they got caught in a series of complex processes of reification, manipulation, and re-articulation of the concept. She explained to me that in some consultations it is necessary to essentialize the idea of culture in order to bring the patient back to certain stereotypes and homogenizing ideas of culture in order to create – or re-create – a structure within which one can find points of reference. Nonetheless, she added that in other

cases it is crucial to deconstruct the very idea of culture and free patients from culturally shaped forms of identification. Since ethnopsychiatrists at the Centro Fanon are also trained as anthropologists, they are faced with the dilemma of how to reconcile or keep separate the anthropological critique of culture and its clinical application. Do these orders of reflection belong to radically different ontologies, or can they inform each other? In the ethnopsychiatrist's words, such friction cannot find an ultimate resolution, and functions as a reminder for practitioners to the necessity of going back and forth, from the anthropological to the clinical and vice versa. In the clinic there can be moments when essentializing takes place and it may be soon after followed by a moment of deconstruction. These are different phases of ethnopsychiatric work all aimed at helping the patient create his/her own position within cultural representations and identifications.

The risk of Nathan's model is that, by focusing on cultural otherness and on the importance of traditional etiologies, the socio-economic causes and consequences of migration are neglected. While his approach includes a critique of the public health system, which refuses the foreigner access, and an attack on psychiatric knowledge which is unable to account for cultural difference, it inevitably risks naturalizing and reifying cultural otherness. Fassin (2000) has strongly criticized French ethnopsychiatry as a legacy of colonial psychiatry which still fosters the creation of ghettos in line with the republican idea of citizenship. He sees the practice of Nathan's ethnopsychiatry as a way to create a model of government which mirrors the colonial endeavor to control and marginalize the colonized in name of scientific knowledge and clinical intervention (Fassin, 2000, p. 238). I believe that ethnopsychiatry as practiced at the Centro Fanon opens up spaces of therapeutic intervention that are more complex than what Fassin portrays in the French context. It is not about creating ghettos, even though this may be one possible drift of ethnopsychiatry. In my ethnography, practitioners seemed to explicitly distance themselves from the lack of awareness of the political and social dimensions of migration that constitutes Fassin's main critique of Nathan's work. Beneduce once explained to me that in his clinical work it was crucial to foreground the suffering of the migrant as a political experience embedded in colonial and post-colonial experiences:

It is the patients, in a way, who ask me not to forget the fact that they don't have a passport, a job, or that they feel looked upon with disdain by the authorities, or by the social workers, or by the population, that they weren't able to feel comfortable when they were in France or in England because they remembered what their grandparents had told them about the colonial experience. That history and their current precarious position represent variables which are just as important as the cultural ones on which Nathan had constructed his fascinating work.

Working from within the tensions and contradictions of Fanon's reflections on culture and Nathan's use of the same concept creates a space for thinking critically about relationships of domination and their consequences for mental health

and healing. The combination of these approaches minimizes the tendency to reify culture on the one hand and, on the other, to reduce culture to a ruin of the past that is unattainable in the present. At the Centro Fanon, practitioners are inspired by Nathan's model of therapy inasmuch as the effectiveness of symbols and etiologies from the patient's cultural background are taken seriously, and culture is considered therapeutic inasmuch as it provides a context wherein symptoms acquire meaning for the migrant.

While for Nathan the political dimension of suffering is in the background of his clinical work and he mainly focuses on the de-construction of diagnostic criteria without looking at the larger implications of migration in the lives of the patients, Fanon's lesson forces us to face the concrete ways in which migrants are marginalized and suspended in a constant threat of not being recognized and legitimized within the receiving country. Fanon's approach to clinical practice allows the group at the Centro to always position their practice within the field of the political, in the sense of a political critique not only of psychiatry as an hegemonic discourse, but also of other ideological fields which influence the conditions of precariousness of migrants. The fact of not having a passport, a residency permit, or a job, does constitute an important variable in the clinical work, just as Nathan's analysis of cultural variables proves to be effective in curing patients. The challenge the Centro Fanon's group faces is to keep these two approaches together, in tension with each other, in the attempt to be vigilant concerning the risks inherent in either perspective and in the political context in which the encounter with the other takes place. As Beneduce has pointed out, this approach can be portrayed as "politico-therapy" (Beneduce, 2007, p. 89).

Conclusion: The politics of therapeutics

Ethnopsychiatry is haunted by the question of cultivating difference, of seeking the migrant's "truth" about his/her "culture." This effort is fraught with ambivalence. Such ambivalence concerns, on the one hand, the desire on the part of ethnopsychiatrists to recuperate the lost memory of the other, which they figure as the migrant's "culture." This compulsion to redeem the alterity of the migrant – which is often made invisible in dominant discourses on mental health – is fundamental in ethnopsychiatry and its institution as a counter political project aimed at restoring the often misrecognized archive of the colonized, the marginal, the migrant, the clandestine, and the abject. On the other hand, this project reveals itself as ambivalent in those instances in which this very recognition of the other's difference evokes discomfort and anxiety in migrants themselves. When "culture" is invoked outside of the original context for the purpose of including migrants within the boundaries of the receiving country, a complex process of inscription and assignment of difference occurs. It has not been the purpose of this article to outline the "persecutory dimension of culture" (Benslama, 2000; Giordano, 2008; Pandolfo, 2008), but I have tried to clarify the risk in ethnopsychiatric practice of reifying the idea of "culture". What figures as "culture" in the clinical encounter

may very well refer to homes that have become inhospitable and haunted by memories of violence and rupture, and that cannot be re-inhabited again, neither literally nor symbolically.

On the one hand, the ethnopsychiatric project does constitute a political effort to question universalistic conceptions of mental health and healing by opening up a new field of practice in which cultural difference becomes central; on the other hand, there is the danger of objectifying culture as the exclusive domain of the other and as a fixed container of meanings that does not allow for a radical questioning of institutional discourses on mental health and difference. Rosalba Terranova-Cecchini, a leading figure in Italian transcultural psychiatry, has identified this danger in Italian ethnopsychiatry. She has argued that current reflections on difference mainly serve the political debate about foreign immigrants. However, if reflection on difference is centered exclusively on the foreigner, it cannot challenge the dominant scientific models and practices of western psychiatry which, in fact, are influenced by transcultural processes (technological, scientific, ideological) in contemporary society (Terranova-Cecchini, 2002).

In light of the genealogy of Italian ethnopsychiatry that I have outlined in this article, I want to pose some questions which address the issue of difference beyond reflections about the migrant other. It is only by extending the same reflection on the question of difference to all patients that psychiatric criteria can be disrupted and questioned at their roots. Terranova-Cecchini's critique points to what may be seen as a limit in ethnopsychiatry: the fact that it may not allow us to face the silence and hidden "truths" about ourselves, our own archive on the colonial past and the various histories of Italian migration. By addressing the nexus of foreign migration and mental health exclusively, ethnopsychiatry risks avoiding questions about the estrangement from ourselves, and about difference within Italian society. What would it mean to regain access to one's own memory through the migrant? How to access a repressed truth which comes back in a different form through the encounter with migrants, to access the archive of Italian historical memory and identity, is, one of the challenges which ethnopsychiatry needs to confront along with the issues about the foreign other.

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Notes

1. The Centro Fanon receives funding from the municipality, the Province, Ministry of Health, and the European Community. Funding is usually granted on the ground of projects for the integration of migrants within Italian society which can last from one to two years. Therefore, financial aid is not guaranteed from one year to the next.
2. These questions are at the heart of contemporary Italian debates on difference and mental health that find their arena in a series of journals that were founded by clinicians and scholars concerned with issues of ethnopsychiatry and transcultural psychiatry. Among these, the *I Fogli di ORISS* emerged as part of the work of the Organizzazione Interdisciplinare Sviluppo e Salute (Interdisciplinary Organization for Development and Health: www.oriss.org), a non-profit that was founded in 1990 by a group of researchers and practitioners interested in the intersections of anthropology, medicine, psychiatry, and psychology, and engaged in development projects around issues of health and therapies in Italy and abroad. *Antropologia Medica*, the journal tied to the activities of the Italian Medical Anthropology Society (SIAM) that was founded in the late 1980s, is another site where conversations about ethnopsychiatry and medical anthropology have unfolded, and questions have been raised (<http://www.antropologiamedica.it/am.html>). In 1988, *La Ricerca Folklorica*, founded in 1980 and specialized in the study of subaltern cultures, devoted one issue to ethnopsychiatry that outlined some of the questions that at the time were starting to be formulated as a consequence of the increasing numbers of foreign migrants entering the country (http://www.grafo.it/html/scheda_folklore.asp?IDFolklore=17). In the 1980s, the issues of foreign migration to Italy and the challenges it posed to Italian institutions – in particular to the medical knowledge establishment – were beginning to come to the foreground of political debates, and, within academia, of theoretical conversations about the relationship to alterity and its consequences on integration policies. Journals and associations were created around these concerns, and new practices of therapeutic intervention emerged as a response to the new situation posed by the growing numbers of incoming legal and illegal migrants. In the 1990s, new services and therapeutic models started to be implemented inside and outside state institutions. The Centro Fanon emerged in this political and theoretical climate, along with other similar attempts to respond to the new demands.
3. Roberto Beneduce is one of the leading figures in Italian ethnopsychiatry and also the founder of the Frantz Fanon Center. He practiced for many years as a psychiatrist in the public health care system, and founded the Center in 1996 as a space of mediation between migrant patients and Italian institutions. He also trained in medical

- anthropology and joined the department of anthropology at the University of Turin (Italy). He conducts field research in Mali and Cameroon, and practices as an ethno-psychiatrist at the Fanon Center. In Italy, other clinicians and medical anthropologists who have been engaged in debates about ethnopsychiatry and transcultural psychiatry in various ways and with different modalities are: Simona Taliani (2006), Francesco Vacchiano (2006), Mariella Pandolfi (1990; 2005), Rosalba Terranova-Cecchini (1990), Tullio Seppilli (1989), Goffredo Bartocci (1998), Luigi Frighi (1992), Alfredo Ancora (1997), Pino Schirripa (1990; 2005), Giuseppe Cardamone (1990; 1996), Salvatore Inglese (1989; 1997), Piero Coppo (1996; 2005), Pompeo Martelli (2005, 2006, 2009), and Natale Losi (2000).
4. Although concrete responses in the form of culturally specific services to the demands presented by immigrant patients started in the early and mid 1990s, the terrain for this kind of sensitivity to difference in relation to mental health had emerged earlier as a theoretical problem. In 1984, within the School of Psychiatry at the University of Rome, Mariella Pandolfi and others founded the first Society of Transcultural Psychiatry as part of the Italian Psychiatric Society. Around the same time, in the context of the international conference of the Psychiatric Association, Pandolfi organized a workshop on transcultural therapies that gathered scholars and practitioners from different parts of the world. Among others, Ellen Corin, Gilles Bibeau, and Tobie Nathan were introduced to the Italian context where they were destined to play an important role in reflections on diverse forms of difference and therapeutic treatment. Starting from the early 1980s and thanks the pioneering work of Pandolfi, different schools of thought around transcultural issues in mental health met each other on the Italian soil: the North American schools of Harvard and Montreal, and the French school of Nathan (Giordano, 2005).
 5. In 1979, Tobie Nathan, psychologist and psychoanalyst of Jewish Egyptian origins, participated in the establishment of the first clinic in ethnopsychiatry together with Georges Devereux. Later, in 1988 he founded the Centre Georges Devereux, an ethno-psychiatric center for migrants linked to the Université Paris VII in Saint-Denis, on the periphery of Paris. He named the center after his teacher Georges Devereux from whom he had taken distance, both theoretically and clinically. In Italy, the work of Nathan and the experience of the Centre Georges Devereux are often invoked as models in conceiving and designing different techniques of treatment for migrant patients.
 6. The closest translation of *manicomio* into English is “mental hospital” or “asylum.”
 7. From the documentary by Sergio Zavoli entitled *I giardini di Abele*, produced in 1968 for the TV7 channel (quoted in Giannichedda, 2005, p. xxxi).
 8. From an interview conducted and recorded by the author in Turin, Italy, on 6 October 2003.
 9. Over the course of the last eight years, the changing political scene in Italy has taken up, at different moments, a much different approach on issues of mental illness and deviancy. During my fieldwork in Italy (2002–2004), the reform draft sponsored by the center-right Forza Italia deputy Maria Burani Procaccini during the right-wing government in 2001–2005 essentially promoted a discourse that describes mentally ill patients as subjects dangerous to themselves and to society and, therefore, as subjects who need to be controlled and disciplined. Thus the psychiatrist takes on a role of surveillance and psychiatry itself is conceived as a process of controlling. From this viewpoint, a “cure” becomes compulsory and therapy is replaced with control. Mental illness is pictured not as a form of suffering, but as a danger and threat. For a more recent account of the current state of mental health services in Italy and Basaglia’s legacy, see Martelli, P. (2006).

10. This and the following quotes from Beneduce are translated from interviews conducted and recorded by the author in Turin, Italy, on 21 March and 3 July 2003.
11. The anti-psychiatry movement, and Basaglia in particular, had a complex relationship with the Italian Communist Party. Giovanni Berlinguer, a major figure in the party at that time, visited the hospital in Gorizia and remained an important mediator between Basaglia's ideas and the Communist Party (Giannichedda, 2005, p. xxiii). Although Basaglia's political alliances within the party played an important role in the reform of the mental health system, he also interpreted the relationship between reality, ideology, and utopia in a way that differed from a certain revolutionary culture of leftist movements and from the Communist Party's program of reform. For these reasons, Basaglia is sometimes described as a solitary leader of a movement – the anti-institutionalization and anti-psychiatry movement – that recognized him as a leader but that only partially shared his vision (Giannichedda, 2005, p. xxx).
12. In his later political essays, Fanon seems to take a more complex position vis-à-vis the role of the past in providing tools to face the revolution and the process of emancipation from colonial domination. In *Towards the African Revolution*, he writes:

Rediscovering tradition, living it as a defense mechanism, as a symbol of purity, of salvation, the decultured individual leaves the impression that the mediation takes vengeance by substantializing itself. This falling back on archaic positions having no relation to technical development is paradoxical. The institutions thus valorized no longer correspond to the elaborate methods of action already mastered. [...] This rediscovery, this absolute valorization almost in defiance of reality, objectively indefensible, assumes an incomparable and subjective importance. On emerging from these passionate espousals, the native will have decided, "with full knowledge of what is involved," to fight all forms of exploitation and of alienation of man. At this same time, the occupant, on the other hand, multiplies appeals to assimilation, then to integration, to community. [...] The plunge into the chasm of the past is the condition and the source of freedom. The logical end of this will to struggle is the total liberation of the national territory. In order to achieve this liberation, the inferiorized man brings all his resources into play, all his acquisitions, the old and the new, his own and those of the occupant. (1964/1967, pp. 42–43)

Here, Fanon seems to argue that the past is not completely lost, that there remain some ruins that can provide the bases for a leap into the future and for the creation of a movement of liberation from the domination of the white man.

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