Psychiatry and the refugee condition: fragmented services, fragmented relationships, fragmented people

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Abstract

In this paper, I attempt to evaluate and reflect on my work as a psychiatrist in a support structure for male victims of gender-based violence[2]. The aim of the service was to provide psychosocial support so that service users could receive an initial relief. One might say that it was focused on the need of a man who finds himself in a situation of fluid uncertainty to "gain a foothold", while, as it will be demonstrated below, the wider context seemed to also be fluid, with the services being as fragmented as the identities of the people I encountered. This paper serves a personal need to discern each time what is asked of (me) my role, and how I can resist the dominant biological reductionism that the dominant psychiatric narrative often imposes on me. It includes some theoretical points that helped me to position myself and closes with the conviction that all of this is just a "dead letter" if it is not accompanied by political action committed to the struggle for social liberation.

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[2] A psychosocial support program for migrant survivors of sexual abuse that began in August 2020, at the non-profit organization DIOTIMA, an organization for gender rights and gender equality, active since 1989.

I think that I must be as clear as possible right from the start in saying that I begin this reflection from the position that one cannot meet people in crisis, a crisis that often permeates and fragments every notion of identity and personal constitution, without confronting the crisis of the frameworks in which these people are included: crisis of the professionals accompanying them (to a certain extent) on the road to recovery, and therefore also my own personal crisis; crisis of the organizations that receive them; crisis of the host country. Moreover, this two-year experience has taught me, if anything, that the crisis begins at the very moment of the first encounter, and that consciously or unconsciously it involves fear and uncertainty of the encounter with the "stranger".

Zygmunt Bauman (2007) invites me to see this fluidity and to reflect on the fear caused by our time, which, fluid and unstable as it is, creates risks that we are unable to understand, approach their nature and thus determine ways to deal with them. To my own ears, it sounds familiar, as a fear I recognize from the moment of the (first) encounter. How to stand? What might happen during the 60 minutes of an encounter with a man? How do I introduce myself? Why am I afraid?

I talk about fear, and that is probably the main emotion described by the people I meet, which is associated with a plethora of "symptoms", which it would be wrong to attribute in a straight, linear way only to traumatic events, since they also have important political and historical implications. On the other hand, everyday experience shows that the dominant narrative is de-politicizing and de-historicizing, it attempts a homogenized, reductionist view where social, economic and political factors are silenced or obscured.

> "I'm drowning because hear the voices all the time. This has exhausted me. To cope, I walk long distances (...) The only thing that concerns me is that I often speak to myself. Those around me say I'm talking to myself; they're talking to me and I don't answer. In my sleep I jump awake too many times and I sit on the bed and talk to myself. I don't know that. The others tell me so. (...) I can't stand life in Greece... It's the hardest I've experienced in my life. The other day my body was stiff and I couldn't bend my body... moments of rigidity... it's like I'm going into anesthesia. I can't speak I can't open my mouth (...) I still have too much fear. When I walk down the street, I feel that someone is behind me and wants to hurt me. I wake up at night and I feel like someone is coming and is harming me."
> *F.*

Furthermore, the dominant discourse about victims of gender-based violence threatens to obscure things as it implies the existence of one or more perpetrators, thus rendering the abuse as something that is simply done by someone to someone else. A one-dimensional view of the "traumatic event" creates the risk of finding myself at the bottom of the reductionist well of psychologicalization and victimization. Pervasive bio-psychological determinism erases context and eliminates important questions: Under which circumstances and on what terms is violence perpetrated? Within which context? What is the threat each time? What could the meaning of

rape be, in the context of torture by police officers, for a politicized, rebel man from Kinshasa? What meaning might it have for a young gay man from Afghanistan to be gang raped in an Aegean concentration camp, just a few days after arriving in Europe, where he found himself, fleeing from his country of origin, because of his sexual orientation? What does the fact that these narratives rarely see the light of public discussion mean? Thank you, Michalis Katrakis, for your shocking short story about Moria (Katrakis, 2021: 55-73).

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Recognizing the risk

The network of critical psychiatry has pointed out (Bracken et al. 2012) that these and so many other questions with political implications risk being obscured through what has been called scientific and/or technological psychology and psychiatry, where priority is given to explanations through deterministic scientific models of the disturbed subjects rather than to meaning. There, the context is eliminated, resulting in answers through technological interventions based on scientific data. I wonder if I can get involved in a critical analysis of my profession, while continuing to work on change "from within".

In another historical turn regarding mental health issues, Franco Basaglia (2008:39) emphasizes that "the therapeutic act is revealed as a completely political act, insofar as it tends to reconstruct at a level of regression a crisis that is already taking place: that is, to reconstruct the crisis by causing a regression towards the acceptance of the causes that caused it".

What happens then in this era, when through closely combining the proliferation of therapeutic means and new technologies of intervention, imaging and classification, psychiatry has come to acquire an idealized conception of neutrality in its theories? How did it come to function as an enclosed and self-sustained machine that cultivates, for the sake public acceptance, a biomedical model of mental illness? Tanya Luhrmann (2000:8), in her analysis of American psychiatry, argues that "if something is in the body, an individual cannot be blamed; the body is always morally innocent. If something is in the mind, however, it can be controlled and mastered, and a person who fails to do so is morally at fault … Biology is the great moral loophole of our age".

Indeed, one would counter that all of the above overlook the fact that there are people who are in distress and often ask for help. Whatever the meaning, they need help and no matter how valuable the questions are, they do not get the person out of the predicament. It is true: sleep disorders, intense stress expressed in a variety of symptoms, physical discomfort (mainly headaches, chest tightness, fatigue and more), voices, disconnection symptoms, some so intense that make any conversation impossible, as the person gets lost with their gaze fixed on the void for a while.

> *"I have a very hard time sleeping. I fall asleep and wake up immediately. My head hurts and does not let me sleep. I have memories, thoughts that torment me... I sleep for a couple of hours but then I don't manage to sleep normally, like everybody else."*

C.

Very often, people also talk about ideas of death and suicidality and/or a manifestation of fear ranging from mild suspicion to intense paranoia with voices with persecutory content.

> *The sleeping difficulties, nightmares, visual and auditory memories, intense fear, sadness, profound grief, avoidance of interactions with others from his own country, persistent pain and disability and related functional difficulties – all for him, were the price of change, the human cost of challenging state oppression. The symptoms told a story, one he wished to be heard, not eliminated, alleviated or 'managed'. His suffering was often overwhelming, but he remained adamant: 'I am not sick, I am broken. They broke my body, they did something to my head... but I am not sick, I am in pain.'*
> Patel, N. (2011)

A dilemma I often encountered was "how can I (if I can) answer the need of a person for sleep (finally!!), without transferring the horrors of violence to technical jargon, and ignoring the suppression of fundamental human rights, even of his humanity, safe housing and so on. Of course, on the other hand, it is precisely this technical terminology that is requested when it comes to writing a report to the asylum service, using phrases such as:

> *The above symptoms support* a *psychotic disorder with a polymorphic and unstable clinical picture, in which perception disorders are evident, but may vary from day to day, or even from hour to hour*

Extract from a referral document for the Asylum Service

The question, says Patel (2011), is not rhetorical as often survivors of torture, men and women alike, describe their suffering and "symptoms" in detail, but not necessarily in the way psychologists and psychiatrists are familiar with:

> *They did things you cannot even imagine how they thought of – they forced drugs by pushing injections in me when I was tied and blindfolded, they pulled out my toe nails, one by one, they burnt me with cigarettes – all over my body, they pulled out chunks of my hair, they hung me upside down until I lost consciousness, they raped me, many of them, again and again ... they forced a baton and*
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> *broken glass inside me, beating me, saying disgusting things about me ... you become aware of every part of your body, like you never knew what pain it could give you. I do not want this body anymore – every mark, every scar, every pain – all remind me what happened, what I am ... a person inside this marred body, when people look at me, do they see me or my scars? Do they see the emptiness in my eyes? Do they see my suffering, my nightmares, the things I saw in prison – things I will never forget? What do you see? Do you see me?*

Standing on two boats is not safe and often opens up questions and poses ethical dilemmas. On the one hand, I listen to a story with multiple implications, and on the other hand, the same story is instrumentalized, vulnerability is psychologized to the point of acquiring a value to use as a form of "social currency", which will afford a "legal place" in the so-called "Europe of the peoples". On the other hand, the professional who listens (when and if he/she does listen), in turn, collects degrees and skills (hard and soft skills, in the HR market language) to find a place in the labor market.

In the end, "who encounters whom?" Who do the people I have before me have before them? Perhaps an important parameter is to maintain a constant awareness that there is not just a psychiatrist before them. I am not just a psychiatrist. After all, some of the people I met did not even know what the role of the psychiatrist is. How do I explain my job?

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Atmosphere of the meeting

In practice, the above invites us to create an atmosphere where the importance of culture and process is central, rather than the methodological (technological) tools or pre-designed responses. This does not cancel out any therapeutic, pharmaceutical, or psychosocial, interventions, nor the "tools" of intervention. It does mean, however, that, if, for example, a man complains that he cannot sleep, the answer cannot be focused solely on drugs.

It means that I need all those discussions that will initiate processes of "coexistence" and "co-action", where some people bring in their thoughts and rack their brains in order to face something (Anderson, 2012). Is it enough for a young, homeless Congolese man who has already been raped multiple times and sleeps in a park to find an answer in a drug that suppresses thoughts and feelings, and brings about a gradual relaxation? I cannot forget those narratives where the suppression brought about by a drug resulted to the (suppressed) man having his belonging stolen and/or being raped again. The drug is administered within a relationship and is taken within a network of existing or non-existent relationships; it is a drug and a poison at the same time. Moreover, without the effort to create this "joint" culture of coexistence and reciprocity, the drug can become a tool of disciplinary repression and make the sick person, as Franco Basaglia (2008, p. 56) says "attached to the passive role of the patient".

Harlene Anderson (2012), describes the (collaborative) atmosphere as a different attitude that requires us to reimagine the way we think about the people we work with and our role as professionals, thus giving a "political" perspective, mainly on the "the application to political problematics of thinking that originates in the field of psychotherapy". Moreover, she underlines that "Challenging psychotherapy traditions and the authority that comes with them is political. The politics of collaborative practice rest partly in this challenge. This includes a call for shifts in our thinking including: critically analyzing dominant discourses, e.g., the social, the cultural, and the psychotherapeutic, and the universal truths they purport; and shifting from an individual discourse to a relational one that promotes local knowledge. Collaborative practice also calls for

shifts in our actions including: setting aside taking on the role of helper; moving our thinking and being away from "about" and towards "together"; maintaining coherence in our ways of being in our professional and personal worlds; and being visible as a person; all of which, in one way or another, contribute to the creation of an alternative view of language and meaning, in which one human being is in relationship with another human being.

Similarly, David Paré (2011) invites us to a collaborative ethic that is reflected in a group process and in certain core values of our work. At the same time, Renos Papadopoulos (2019) highlights the psychosocial implications of the refugee condition. Below are some important parameters relating to this ethic:

- People's lives are multi-layered, as is mine. Deconstructing generalized views and stereotypes is an essential step in reminding everyone that every person has a name, relatives, history, beliefs, hopes and desires.

  > *I get angry when I feel humiliated, when I talk and they don't listen to me as if they consider me incompetent. They don't understand what I'm saying. What can I do, I get angry and I express my anger... And I feel the same way when I speak to the authorities (...) I haven't talked to my wife about the rape... from member of parliament to refugee... they broke me completely.*

  A.

- It's more useful to build on what works, rather than trying to fix something that doesn't work. In my experience, this refers to a relationship-based therapeutic process, based on the relationship within an emotional climate that focuses on the positive:

  > *I hear many voices of unknown men telling me "Commit suicide!", as if they are telling me I have no value and that life is over for me (..) In order to cope, I walk a lot, I fool the mind with activities, I meet people, I watch movies. Sometimes I get disoriented and smoke some marijuana to sleep which has helped me a lot as it strengthens my inner voice, although it might also be destroying me (I also have a lung problem)*

L.

- What we find is in accordance with what we are looking for. I often look for symptoms. It is an agreement I have with the person before me. The asylum service will not be satisfied with just a narrative.

- Client preferences are the main compass for my work, and dialogue should include their interests, that is, it should include the people for whom the interventions are created, however difficult this may be.

  > *It is important to me that you helped me find a solution with the panic attacks, and to breathe better.*

F.

- One of the primary roles of researchers and professionals should be to deconstruct the idea of the "archetypal refugee", seeking ways of activation against their "silence".

This helps in an orientation towards every day and ordinary life, towards the quest for the "way" in which we move and "go on" with our lives.

- Awareness of cultural influence on concepts and power imbalances in the lives of individuals.

- The person is not the problem. The problem for the people I met was homelessness, police repression, the fragmentation and inability of services to interconnect, the termination of receiving benefits, and so on. The issue is the way human rights, the legal dimension, and the psychosocial dimension can be combined so that these people can regain their voice and be helped to support themselves in dealing with their problems:

> *"I don't feel safe anywhere. I don't have any documents and I'm worried about being caught. At nights I begin to ponder. At the same time, people avoid me because I am gay (...) My future seems like Calvary. There is nothing better for me… I don't feel safe anywhere. I don't have any documents and I'm worried I'm going to get caught."*

M.

- Focus on skill and knowledge rather than pathology, dysfunction, etc. This means that I may have to put aside the widespread notion that academics and mental health professionals "know best": the client is a specialist in himself and his world; the professional is an expert in creating a space and a process for collaborative relationships and dialogues.

> *I try to protect myself by doing the best I can: I avoid bad situations, I "fly away", I walk a lot, I talk to people I trust (e.g. to the psychologist), because many people have criticized me (e.g. they called me a sorcerer).*

D.

> *Sleep, alcohol, martial arts, these things help me. I have studied and worked as an electrician. What I have done in my life still offers me some meaning and value. It is important for me to discuss about that.*

X.

The aim is to move from a hierarchical-binary, qualified/non-qualified model to a more egalitarian encounter, in which people maintain their dignity and pride, history, language and culture without erasing the different positions of power and privileges. This entails clear positions on the limits of the relationship, the possibilities, the roles, etc. At times, I had to say, "I can't promise you that you'll sleep. I can't promise you that I can find you a home. I can promise you that what you say concerns me personally and I will be here to do the best I can."

Narratives, meaning, history, action

It is obvious that the people who come to talk to us are asking for something. For some, this is the first time they meet with a psychiatrist. Often this word is not even part of their vocabulary. The danger here is to tune in to the colonial logic of psychiatry.

What is a psychiatrist and what does he/she do? This question has on several occasions given rise to very interesting debates. How does the community of origin of the person we encounter respond to similar situations? Frequently the conversation is difficult as people often come with narratives, which Arthur Frank (1997) characterizes as chaotic. Sometimes there is need for a prompt response, for something that will soften the anxiety, something that will make communication and storytelling possible.

Frank, based in part on his own experience as a cancer patient, gives one of the most inspiring approaches in the field of narrative medicine and deals with issues related to problems arising from dualism, from questions of power, the validity of narratives and the ontological implications of disease narratives. He perceives disease but also, I would add, any other destabilizing event, as a call for a narrative on two levels. On one level, we narrate something about the disease to doctors, relatives and friends, and on another level, we try to reconstruct a life that illness or life events interrupted or broke. That is why it is different to take a patient's medical history (where, for example, the doctor interrupts, asks and tries to make some sense out of the story, and make a diagnosis) as opposed to listening to a story (where he/she basically listens without interrupting no matter how confusing, unconnected the story may be).

Following the thread of Frank's work, the types of the narratives I came across are mainly divided into two main categories: restorative narratives and chaos narratives. Phil Thomas (2018, 139-158), a psychiatrist in a clearly more multicultural Birmingham, helps us with this distinction:

Restitution narratives: This would be summed up in the phrase: "Yesterday I was fine, today I got sick, tomorrow I will be fine again". It is a direct narration of a story of illness, where the specialist, usually a doctor or other health professional, is called upon to give an answer, to solve the problem posed. Contemporary medicine and psychiatry cannot accept the existence of a puzzle that cannot be solved. Obviously, this particular narrative genre is directly related to a technological view of medicine and psychiatry that holds the keys to the mystery. It presupposes a devaluation of the past and a view of science as a constantly triumphant force over evils, constantly moving towards an increasingly brighter future, which makes the world ever more beautiful. But what happens when there is no answer? When there is no remedy and restoration is impossible?

It is worth mentioning that Frank does not refer to causes but to founding acts, acts that took place in the patient's past either non intentionally, such as an accident, or intentionally as is usually the case of a traumatic event (e.g., an abuse). This is an important distinction between intentional and non-intentional causality. The first is inextricably linked to agency, while the second rises above our powers and our sphere of influence. But even in the latter case, when things are not in our hands, there is at least some measure of choice. This act marks the quest for a moral basis of illness and suffering experienced by a person in order for him/her to be understood. Thus, when the disease becomes incurable and rehabilitation impossible, then the founding act becomes central and moral questions prevail: Should I blame the voices I hear? If not, who is to blame? Why did this happen to me? (Frank, 1996: 75-96)

Chaos narratives: This would be summed up in the phrase "…and then... and then... and then..." These are the narratives that are often found in crisis situations in the form of piecemeal storytelling and fragmented stories, which often have no coherence, where the individual is transferred from one place to another and from era to era, and, at first, they often seem to the listener as pointless, meaningless. Such narratives appear where there is intense trauma that often does not find a way to be expressed. The story remains unspoken and ineffable and we must not push people through our interventions. There is no diagnosis or diagnostic category for "a life unlivable" (Frank, 1996: 97-114)

Following the above, one could say that in some cases we may discern yet another kind of narrative, what Frank (1996: 115-136) calls **quest narratives:** the disease as a quest that is usually recognized retrospectively. It concerns people who have begun to feel/sense their experience as a process. The metaphor of "journey" creates moral implications: it implies a struggle against disfavor, against adversity such as, for example, is the case for people who are fighting against the stigma of mental illness, people who have participated in political struggles in which case adversity is perceived as part of this (common) struggle. Here Frank distinguishes three sub-categories:

- **Memoirs**: tender, gentle, nonlinear narratives, reminiscences of past illnesses in the present, such as the narrative of torture and gender-based violence as a narrative of struggle. Such narratives take us even further away from a pathologizing look and invite us to see the fighter, the man who stood up to an injustice and for this he was punished.
- **Automythology:** concerns the emergence of a new self from the ashes of the old (the phoenix that is reborn). These seem quite rare within the refugee condition. But I have heard people talking about the need for rebirth.
- **Manifesto:** These are narratives with a political dimension, the discourse of activists. For F. there is no doubt that talking to a psychiatrist is the result of political persecution.

Phil Thomas (2018, 139-158) mentions two fundamental features of existence namely **temporality** and **historicity.** Our lives have a beginning, middle and end – we can evaluate them as processes that continue, as stories that are not yet complete and that, in essence, only by reaching their end may the narrative end, not forgetting that the stories continue. They are also characterized by **contingency**, **randomness, reflectiveness,** and **pre-reflection**. We live and often reflect on our lives, what we did, what brought us here; we keep a distance from things and situations, and we see ourselves by zooming out of the context that contains us. But we also live a large part of our lives pre-reflectively without consciousness of what exactly we are living, we simply exist in the world. These two ways of being are both valid and complementary. We often struggle to bring order to experiences, and according to the narrative theory a very powerful way to do this is by storytelling. This is what will give meaning to the vague or confusing experience. Thus, it becomes clear that meaning, **story** and **(human) action** are intertwined. At the same time, storytelling and **agency** are important for understanding the meaning and signification of human suffering.

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Constructing a narrative: The triptych of threat-power-meaning

Often a conversation can start from what connects us. Football may be one of these things. Galeano (2016) asks "what do football and God have in common?" He replies: "Their believers are totally devoted to them, and intellectuals question them". Galeano speaks from the point of view of the man who loves football, who bloodied his knees as a small boy in the neighborhood terrains and is willing to travel to the other the side of the world to watch a good game. "A good game, for God's sake." Some of the people I met are looking to watch a good game, somewhere... for the Congolese so long as, of course, the colonial Belgians do not win.

Speaking of football, I am already talking about promoting social action, a way in which man copes with life, while co-constructing a validated narrative. Moreover, only when you understand the importance that football had in a person's life can you realize what his leg injury meant to him. You don't only lose people. You may also lose your ability to kick the ball. What threats does the inability to play football represent?

Power has many ways to strike and threaten. The Power Threat Meaning Framework (PTMF, 2018) is a radical alternative to the taxonomy models of discomfort. As a five-year co-production of a group of top clinical psychologists and well-known survivors it was published by the British Psychological Association as an alternative to the psychiatric approach to understanding and treating mental distress.

This context is based on survivors' dictum "instead of asking what's wrong with me, ask what has happened to me". It perceives what psychiatry calls a "symptom" as an understandable response to life events and as a creative way of survival. It summarizes a huge amount of data on the role of the various forms of power in people's lives, sees people as beings who act and make meanings, within their living conditions, and highlights the connections between subjective dysphoria and social inequality and injustice of all kinds. It highlights how we can create recovery narratives as an alternative to diagnoses, whether in contact with services or not. The goals it sets include:

- recognizing that emotional stress and "problematic" behavior are understandable reactions to human history and circumstances
- restoring the link between discomfort and social injustice
- increasing people’s access to power and resources
- the creation of validated narratives
- the promotion of social actions

It is very helpful to think in terms of Power, Threat, Meaning and Response to the Threat, but in reality, these elements are not independent but co-evolving. "Power" implies "Threat" and "Response to Threat" and they are all shaped by their "Meanings". Power is everywhere in our lives, sometimes in obvious ways and sometimes in less obvious ways:

> *Medication no longer helps. Before it was helping. Now, after the rejection, it doesn't help. From the moment I heard the decision I'm not well."*

M.

I have only talked about all this here. No one else knows (...) But memories come at any moment… along with the daily fear of the police.
C.

When I am alone, I think about all the adversities of my life. I might sit in bed and stay awake all night. If I sleep, I jump screaming and panting, and as a result my roommates see me as a sorcerer or as mentally ill.
R.

Power can act in many ways: legal power (the decision rejecting the asylum claim), economic power (discontinuation of benefits for refugees in June 2021), material power (homelessness, starvation), interpersonal power, coercive poweŕ or power by force, social/cultural (racism, sexism, etc.), ideological power (control of language, meaning and perception). There is not only one form of violence. There is no such thing as a single traumatic event that triggers, although accounts of a "defining moment" or a "critical event" may come up.

Herman (1992), speaks of the "healing power of telling the truth", making recovery a process of "re-appropriation of experience in order to take back authorship of our own stories" (Dillon and May, 2002). Is this not a form of agency?

Thus, recovery becomes a deep, unique, personal, political process of changing attitudes, values, emotions, goals and roles of a person. It becomes a way of living a satisfying, hopeful, cooperative life even when there are limitations due to an illness - adversity. It involves the development of a new meaning and purpose in life, as one grows beyond the devastating effects of a mental illness.

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Fragmented services – fragmented people

Again, the aforementioned may seem useful, but they are in danger of remaining beautiful words if they are not linked to political action. What can a man do with "alternative diagnoses" if his stomach is empty and at night he sleeps in the cold?

The medication helped and I feel better, I can sleep and rest. But the fact that I'm wandering homeless doesn't help."
D.
I sleep anywhere I can. I drink all day. They bring me tsipouro. When I'm drunk I am not hungry.
G.

It has been said that "soup kitchens, however humane, do not change the number of the hungry" (Albee, 1995: 347). According to Natisha Patel (2011), we need to examine our professional codes and ethical frameworks, recognize their political and philosophical foundations, their individualism, the implicit 'individual - society' dualism that governs them (e.g.

individual responsibility versus social responsibility, individual 'good' versus 'social good'), as well as their tendency to decontextualize 'ethical' assessments and practices.

Does anyone think there is any elementary humanity in the policies around the "refugee issue"? What to remember first? The spurious "first reception"? The military control in increasingly controlled and closed, 'hospitality' camps across the country? Turning people into objects for refoulement? Skype interviews? The "construction" of Turkey as a "safe third country"? And all this already put in place by the "left-wing" agents, even before we get to the present day and the apotheosis of far-right politics and rhetoric.

The policy of pushbacks, the "deterrent" policy is reminiscent of the policies/culture of the large all-encompassing psychiatric institutions, which although supposedly made for treatment, their operation is clearly repressive. On the one hand, the aim is to maintain internal cohesion and, on the other, to adapt to external requirements, to the pressures created by the so-called "migrant flows". The vulgarity of the term alone constitutes an ideological power aimed at controlling language and meaning.

Within such a condition, recovery becomes difficult. Turkey is considered a safe country, concentration camps are christened reception centers, pushbacks in the Aegean are concealed and the thousands of drownings are the fault of some smugglers. Once you manage to set foot on European soil, if you refuse the "services" provided to you, you will be punished, since you will find yourself in the uncertainty of a life "without documents". If you accept them, you will still be punished, since receiving a service means aligning with the dominant policy. It is sufficient to take a look at the criteria for granting asylum, to understand that the majority of the persecuted "do not fit anywhere".

Even when I didn't have therapy I used to talk with the physiotherapist and now I don't have this anymore. When I was there, under the care of MSF, I knew where to go. Now I feel alone. Pressure… I'm not sure why things got complicated again lately. I feel frustrated. It's like it used to be when I was thinking too much. Now I am trying but I can't help it. I feel under pressure: I feel a weight on my heart. This is what I feel. I believe that thoughts are connected to such a feeling. Now that I'm not thinking too much, this pressure is still there. I feel blocked. I need to feel free and calm. I want to feel something. I don't understand who I am. I was hoping to walk again but I don't see it happening. I wanted to be like everyone else. My doctors said there is nothing else they can do. I try to stand on it but it hurts. I can't seem to forget the pain. I feel the pressure piling up from the inside. I have so many questions about this.

What is going to happen now that it started?

Why does it come so often?

Why doesn't it go away?

Why doesn't it stop?

G.

I try to give an answer to the questions, but I can't: *"When G. started to have objections and oppose the regime, the arrests and physical abuse began. During this period, he broke his leg after an incident of physical abuse. He went to Turkey and during his stay, he was arrested without any previous incident, despite having legal documents. The police, he says, detained him, and after a long drive they reached an apartment. He couldn't leave. He suffered systematic sexual and physical abuse for days. He was unable to calculate the number of abusers or go into more detail. He managed to escape by jumping through an open balcony door. Due to the height of the drop, his already injured leg was severely damaged. A few years later, while he has begun to get stronger, to walk somewhat, to hurt less and to live in a house waiting for the interview with the asylum service, the discontinuation of the cooperation of almost the entire group that supported him at MSF was another slap in his face that forced him to return to a position without alternatives and was soon forced to live again "with no alternatives" and* to "*consent" to the order, without the possibility of escape*, imprisoned in the *psychiatric field, just as he was imprisoned in the external world the contradictions of which he was unable to deal with dialectically. How is the question "why doesn't it stop? to be answered then?"*

One could cite for hours on end incidents that confirm this double bond in which all parties involved are trapped. The employee is in a situation that creates a constant ambivalence. It is no coincidence that the majority of employees soon declare themselves exhausted. The same ambivalence is maintained by the people we meet. If they arrive in Europe, they will be told at some point "well, didn't you know where you were going?", while if they find themselves unemployed, they will be told "well didn't you know where you were going to look for a job?" Obviously not all parties involved have the same power or the same privileges and in any case being left without a job as a Greek, cis straight male psychiatrist does not have the same weight as living on the streets as an Afghan, gay survivor of gender-based violence. Even these lines are written from a privileged position.

If one looks at the landscape of the "services" provided, one will see how fragmented and precarious they are. One could say that from its creation the third sector was to be fragmented. In a similarly reflective process, Fanis Dedes and Giouli Tsirtoglou (2008) point out that the lack of resources and of a clear framework result in the fragmentation and unstable operation of the services provided. Circumstantial collaborations depend on the culture of the organization and the mood of the employee, who, however, also works in a condition of constant precariousness. If the social currency is one aspect of the isomorphic condition between a professional and a survivor of gender-based violence, the other is precariousness. The one is safe if, for example, the asylum service allows, and the other as long as the donor allows. This mutual "bond of insecurity" may also be a key condition for making sense of the need for common struggles. As early as 2008, Stavros Psaroudakis (in Triliva & Marvakis, 2019) talks about the "symbiosis of precarities" and comments on the psychosocial practice of NGOs in Greece, observing:

> "NGO psychosocial praxis in Greece: disperse, yet systematic encounters between 'native' young psycho-social scientists, working under severely devalued terms of employment on the one side, and people from 'vulnerable social groups', themselves dealing with extremely harsh terms of living on the other..."

Triliva & Marvakis (2019) comment on the NGO-zation of psychological work in Greece as a result of a neoliberal transformation aimed at overcoming the real crisis of capital accumulation. It is a

> "political imperative in order to avoid the transition to a new historically strong level of social organization and, at the same time, avoid the restrictions of the previous level of social organization. At the same time, this political project attempts in every way to exploit as much as it is possible people's creative potential and production. Nevertheless, this historic compromise is a complicated enterprise which simultaneously unfolds in each and every social field and sphere of people's lives, transforming meanings and relationships"

To the extent that the game is determined by the search for a donor, by the submission of "smart" and attractive proposals for funding, the abuse will continue. It is precisely this dimension, that the donor is projected as the necessary condition for responding to the problem, or rather for managing the problem that constitutes part of the "double bond". The search for a donor and ultimately the donors themselves are part of the problem in itself.

Ewen Speed (2011) speaking about the funding of healthcare by third-sector organizations and the entry of NGOs into the "game", gave form to a process that marks the slow but steady intrusion of the state into areas of civil society that until recently were out of reach, and a fundamental redefinition of the boundaries between the civil society and the state, resulting in a real shrinking of the opportunities that activists have in order to resist the hegemonic discourse of medicine. Gradually the responsibility for the services provided is placed in the market instead of the state, which according to Speed (2011:137) results in "The dominant mode of organization in the government sector is a market competition model, as such, the rise of the need for strong regulation of non- statutory providers (...) must be read as marking an expansion of the principles of neoliberalism into the third sector (...). The introduction of the capability to provide statutory services is inherently bound to the processes aimed at promoting competition (choice) between providers, such that the local purchasers can secure the best price. The inclusion of civil society organizations in this context is simply an opportunity to introduce more providers in order to increase competition".

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Closure

Vicky Reynolds (2021) speaking about resistance to fragmentation and burnout points out that I am not at risk from the transmission of traumatic stress, from vicarious trauma, from secondary traumatic stress, from burnout, from compassion fatigue or empathic stress disorder but from the lack of justice. This statement probably resonates with the slogan that movements have at times adopted: "there is no health without freedom and justice."

It is not easy to look at the world of terror, the world of violence, the world of exclusion. But if we do not recognize that this world is us – since we are the institutions, the rules, the principles, the norms, the regulations and the organizations – if we do not recognize that we are part of the world of threat and abuse, in which the ill feel oppressed, we will not be able to

understand that the crisis of the ill is our own crisis. My goal when I started writing was to speak out and put together everything that is spinning around inside my body. If I started writing today, I would write differently. This does not change the fact that somewhere out there is a reality, one that we are constructing each and every minute as human beings mutually, through our constant interdependence and interaction. My job may be to experience, as dialectically as I can, the contradictions of this reality and to maintain an open attitude in favor of justice: to challenge the status quo and highlight political problems, like the Martinican psychiatrist Franz Fanon (1963, 1967), who dispelled the myth of neutrality in psychiatry and spoke of the widespread use of torture by the French government in the Algerian war of independence.

Solidarity extends beyond simply naming oppressions and oppressors, and "means the transformation of the self, institutions and the world", because only by working in accordance with my moral stance does sustainability become possible (Reynolds, 2021). I need to maintain my critique of the concepts of neutrality, objectivism and detached professionalism that normalize frameworks that are unacceptable. My work, says Reynolds, is particular and difficult, but not special and matters as far as "unquantifiable" results are concerned. At the same time, I learn to defy cynicism. After all, as Freire (1970, pp. 71-73) put it, "The dehumanization resulting from an unjust order is not a cause for despair, but for hope, leading to the incessant pursuit of the humanity denied by injustice' (...) Revolutionary love, by definition, "is emancipatory, and generative in terms of fostering further acts of love: It cannot co-exist with abuses of power". Wherever the oppressed are, the act of love is a commitment to their purpose—the purpose of liberation.

Acknowledgments

I would also like to say a special thank to the collaborators I had during this two-year project: the psychologist Giorgos Tsantirakis, the social worker Eleftheria Sintrou and the interpreter Lina Sipitanou, who was, with her knowledge and experience, an essential cultural mediator. Lina also translated the article into English. The group carried a heavy burden and, to some extent, emerging polarisations, conflicts and difficulties echo wider impasses. I would also like Maria Liapi who was open to criticism and discussion and contributed with her own criticism of the article, as well as the comrades from Solidarity with migrants for their own substantive criticism from another direction. All of the above individuals contributed substantially to keeping the dialogue open.

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