Translation of a chapter 8, pp. 119-129 in Dutch in: Handboek Culturele psychiatrie en psychotherapie, Prof. dr. Joop de Jong & dr. Sjoerd Colijn (red.) Utrecht: de Tijdstroom, 2010. (in Dutch)

RITUALS AND PROTECTIVE WRAPPING IN PSYCHIATRY

Re-wrapping Patients with Family- Bound Instruments and Co-Creating Transitional Spaces

Dirck van Bekkum (cultural and clinical anthropologist: moira@ctt.nl), Kitlyn Tjin A Djie (transcultural family therapist), Glenn Helberg (transcultural child/youth psychiatrist) and Irene Zwaan (developmental psychologist).

1. Introduction
2. Symptom patterning (syndromes) and migration
3. Accumulated liminal vulnerabilities in life-phase transitions
4. Migrants from 'We-driven' systems
5. 'Protective Wrappings' and 're-embedding' as therapeutic concepts
6. Transitional and liminal spaces
7. Construction of liminal spaces and prescribing rituals
8. Where are we, and how do we proceed?

1. Introduction

Anthropologist Bartels (2002) denotes adequate mental care as 'cultural production' and 'cultivating the request for help.' She states that a certain continuity and stability in the life of the patient is needed to facilitate change in therapy. Balancing change and continuity are both indispensable in daily lives of individual people and groups of people like families. In this chapter systemic conceptions are elaborated upon to translate the balancing of change and continuity to a mental health care setting.

Patients in psychiatry with a migration history frequently cope with syndromes like depression, anxiety disorder, psychosis and schizophrenia. In the emergence and progress of illness history, in most cases, unprocessed effects of flight and migration are hidden. In this chapter, supported by case vignettes, we demonstrate how the effects of migration, even years later and intergenerational, can be detected, approached and treated from an anthropological and systemic perspective.

Following Van Bekkum et al (1996) we define migration as a transition, a life-phase transition with specific 'accumulated liminal vulnerabilities'. Liminal means that they 'find themselves betwixt and between one or more realities (Turner 1969) Discontinuities and breaches in family continuity, originating in migration, re-emerge often in new life-phase-transitions. Unprocessed bereavement characterizes many requests by migrants for help in health care systems.

Many of those refugees and migrants seeking help also 'migrated' from more 'We-driven' systems into Dutch more, 'I-driven' and sometimes racist (mental) health care systems. They try to deal with both decimation of their original support systems and with disruption of ways in which they maintain and cherish their family- and social bonds and networks. With such instruments as 'mapping accumulated liminal vulnerabilities', 'protective wrapping' (genograms, lifelines) and (creating transitional spaces with client-systems), unprocessed effects of migration histories can be diagnosed and treated more effectively. This transitional (anthropological-systemic) model builds upon concepts like culture shock (Oberg, 1958), acculturative stress (Berry & Anis 1974), migration and family conflict (Slutzki 1979) and migration as third individuation (Akhtar, 1995).

Unbearable effects of migration and refuge can be made bearable with (co-creating family-culture-bound) rituals and with protective wrapping. 'Protective wrapping' is a new concept (Tjin A Djie & Zwaan, 2007), contains interventions which compensates, and makes bearable, loss of '*enveloppement*' of the client in his/her family system during and after migration. Attributing repeated meaning to losses and 're-embedding' the patient in a (temporary) supports system are core ingredients. To enter the new world (life-phase), old expectations and precious memories need to be released. What is also needed is re-arranging of loyalties, bonds, and emotions (transformations) of the patient's inner and outer world. 'Transitional spaces' (Winnicott, 1953) and 'liminal spaces'(Turner,1967) are developmental psychological, anthropological-systemic concepts with which mental health care workers can analyze the effects of migration and help their clients to process them. Three case vignettes are used to demonstrate applicability and usefulness of the concepts.

Fariba (1): decimation of support system and chronic instability

Fariba stranded in the Netherlands in 1984 as an eighteen year old refugee from Iran. Her passport was not valid and she had to resort to applying for political asylum. She was on her way to the United States, where part of her family had already arrived. Fariba fervently believed the political situation in Iran would change in the next two years so that she could return. Subsequent political events two years later made it abundantly clear she would not be able to return. Only then did she begin to psychologically process her migration and flight. Her pain became bearable when she decided to attend the College for Social Work, with which she could help her fellow countrymen in the Netherlands. Choice of study turned out to be I-driven in the Netherlands; personal motives dominate, which caused confusion yet again, because the interests of her family and friends in Iran and the United States were more important than her own. She then received the horrible news that her friends and comrades had been arrested in Iran. A good friend was hung to death and her thirteen year old brother was imprisoned for life in her place. Feelings of impotence, guilt and anger made her lose all hope.

Fariba's case is a matter of her 'liminal vulnerability' being continually extended to such a degree there was practically no stabilization of her situation after having migrated. New events re-opened old unprocessed psychic wounds. There was insufficient continuity to transform the consequences of migration.

2. Syndromes and migration

Knipscheer and Kleber (2005) partially account for health problems and symptom patterns of migrants receiving psychiatric care as being an interwoven blend of a socio-economic disadvantages with differences in culture. Patients receive psychiatric treatment when problems escalate. In Angelo's case the consequences of migration and exclusion can be considered contributing factors to his psychosis.

Angelo (1): sexual identity, coming of age and migration

Angelo is a nineteen year old man of Aruban origin. He had only been in the Netherlands for a couple of months when he was given psychiatric treatment for psychotic behaviour. In Aruba he had been living with his mother and there had been a number of important women in his life such as his grandmother and the mother of a friend. Ever since he was thirteen, Angelo had been sexually abused by women who also cared for him like a mother. He failed the final exams for his vocational training and decided to go to the Netherlands where his father was living, in order to try again and get his diploma.

Research continues to indicate there is a connection between migration or flight and the development of psychic syndromes (Kamperman et al, 2005). A clinical anthropological perspective on migration is: in a relative short period of time migration brings about drastic changes in a nuclear and extended family system which can be distorting and decimates the social support system available in their country of origin. Psychologically taken this 'major life event' causes highly stressful and traumatic experiences (Berry et al, 2006). Unprocessed effects of migration can lead to stagnated and delayed mourning, deep humiliation, neglected and chronic syndromes (Yakushko, 2008). Every child and adult reacts different to the dramatic changes and patterning of symptoms (syndromes) does not emerges solely from socio-economic or cultural factors. Distorted relations and communication can also be connected to the history of a family's migration. The effects of migration on first generation migrants are often manifested in a battered social and home environment and this has an influence on the somatic and psychic health of family members. With the second and third generation identity problems and intergenerational breaches can manifest themselves. Considering the family history of migration as one of the contributing factors for symptom patterns, with those seeking help with a migrant background, can therefore provide chances of avoiding making incorrect diagnoses and improving psychiatric treatment.

3. Accumulation of liminal vulnerabilities in life-phase transitions

Life-phase transitions are a part of everyone's life and occur during birth, adolescence, marriage, moving, divorce, coming of age, change of job, and the death of parents. Life-phase transitions are always accompanied by stress whereby intensive changes take place in family and social ties and in the roles that we fulfil. Sometimes multiple life-phase transitions take place simultaneously, like moving to another city for a new job. Or quitting work because of a birth of a child. In order to avoid confusion between diagnostics and treatment, we introduce the concept of accumulated life-phase transitions. Stress levels increase the more transitions accumulate. A characteristic feature of life-phase transitions is that unprocessed experiences from a previous transition can again manifest themselves in the next life-phase transition (Erikson, 1968) The pain of loss, or an old trauma comes back later when important events take place. The loss of a parent or absence of family will again be felt at a marriage or the birth of a child.
Migration too can be considered to be a life-phase transition (Sluzki, 1979); Akhtar, 1995; Van Bekkum e.a. 1996). After all, in the life of a migrant a number of changes take place at the same time: leaving behind a job, family, homeland, culture, habits, food, house. And simultaneously taking on a new everyday life environment, new work, new culture, new manners, rituals, norms and values. Migration is a special life-phase transition in the sense that with each life-phase transition the migrant experience can again manifest itself. Homesickness and loss can be repeatedly experienced when moving, at the birth of a child, divorce, or becoming a parent (Tjin A Djie & Zwaan, 2007). Fariba Rhmaty (2007), cultural system therapist, meticulously describes how her migration process took place in fits and starts after her flight from Iran. A traumatic event triggers previous feelings of loss as a result of migration, again and again. With a family of a Turkish girl these experiences of loss and strong (hidden) ambivalences in the system come painfully to the surface.

Nilgun (1): identity, adolescence, migration, and intergenerational conflicts

Nilgun is 18 years old and in the middle of her coming of age. When she was 10, she came to the Netherlands with her father, mother, brothers and sisters from Turkey. She exhibits psychotic behaviour with hallucinations. The symptoms resemble the onset of schizophrenia. Besides medication, research was conducted into her family situation. It turns out a long term conflict has been going on between her parents, accompanied by strong emotions and arguments. Her father wants to return to Turkey, her mother wants to stay in the Netherlands. Things escalate to such a degree, the mother threatens the father with a big knife. At first the mental health care workers try to get the parents to compromise, from a Western perspective of equality and democracy. In so doing they hope to tone down the emotions in the family in order to improve Nilgun's syndrome. However, the arguments and tensions do not disappear. Nilgun again has a brief psychotic episode.

Nilgun's development appears to be doubly hampered by the accumulation of adolescence and migration vulnerabilities. Adolescence is (through behaviour marked by experiment and pushing limits) a life-phase transition that causes breaks in the family system, hidden tension, unprocessed loss or which causes pain. Nilgun's symptoms represent from a daughter's perspective the conflict between her parents. For the time being, it causes insoluble, conflicting loyalties in her. Her life phase transition as an adolescent, in particular balancing her loyalties between Dutch and Turkish culture, is brought to a dramatic halt because of her psychoses. Her crisis can be redressed as 'accumulated liminal vulnerabilities' in different phase transitions in the family system: 1) adolescence, 2) migration and 3) older unprocessed distorted communicational patterns in the (extended) family system. Without sufficient embedding in secure spaces through her parents and family Nilgun appears incapable of (a) learning to switch between family and Dutch culture and (b) to successfully complete her transition into an adult personality.

Being able to find your way, being raised in a migrant family, in the host country causes tension. The degree of stress depends on many factors, such as age, religion, kinship and the moment and reasons for migration, such as war, trauma, and whether one expects to return to the country of origin (Van Bekkum e.a., 1996). Also the degree of openness and creation of space for migrants by the indigenous Dutch plays a role (Ghorashi, 2006). Successful migration means that during the liminal (vulnerable) phase emotional and social transformations (re-arrangements) where loss, trauma, hurts, and improvements take on newly accepted forms with the migrant and his or her system.

Angelo (2): decimation and disturbance support system, sexual identity, accumulation of liminal vulnerabilities

The support he expected to get from his father once in the Netherlands was very disappointing. That could not have been otherwise since he was not used to having a father around after sixteen years of being raised by women. Development of his sexual identity was seriously disrupted by sexual experiences with women who also acted like a mother to him. Nevertheless in the Netherlands there are substantially fewer family members who can stabilize him and those family members that are present, took no notice. He rented a room, but got into financial difficulties. School was also harder than he had expected.

By mapping all aspects of migration, before, during and after the fact, it turns out that Angelo finds himself dramatically embroiled in the liminal migration phase in which it appears he has become stuck. The disappointing support of his father and the absence of mothers, including the sexual experiences that caused his pathology, the culture shock of migration, and disappointments concerning his schooling impede him from successfully making the transition to adulthood. This accumulation of vulnerabilities halts his development and growth.

4 Migrants from We-driven systems

Migration from a collective system to a country in which the individual system dominates, can hinder successful re-integration. It is important to conduct research as to why this is the case. Which vulnerabilities play a role in this life-phase transition? Which sources of strength can be identified that can bring about stabilization?

Fariba (2): coping strategy is 'study and work hard to stabilize yourself'

Studying hard was Fariba's strategy to survive and a new identity slowly began to take shape. To keep from feeling pain, a great deal of and hard work is an option. After the war had ended and a number of family members had fled to safer places, she did not spend much time on stabilizing. The news that her father had died again greatly knocked her off-balance and made her yearn for her old familiar family system and accompanying rituals. Her new identity was not strong enough cope with this phase of vulnerability and mourning. She again felt uprooted, missed embedding her own group and suffered a bout of depression.

The ways in which families are organized and the functions that family members perform, different from culture to culture. Even though more and more hybrid forms have arisen, in the Dutch multicultural contexts, roughly two kinds of family systems are distinguishable. This distinction applies to migrant (allochthonous) and native (autochthonous) Dutch citizens. Many Dutch citizens from migrant families are we-driven in which the interests of the group prevail over individual interests. Group interest corresponds to family continuity which dominates more often in migrant families. Family continuity is the result of experiences that have built up over generations as to the manner in which the well being and success of future generations can be realized. Each family has developed its own wisdom.

Systems geared more towards individuals are more prevalent in the Western countries where the development of one's talents and personality and seeking personal happiness is of central importance. Not the extended family but the nuclear family (parents and children) play a role in the important choices and decisions of family members. In western health care systems, migrants are in danger of being pulled loose from the collective system that usually functions well. They become confused because the system in the Netherlands is not in keeping with nor offers the same support as the ones in their homeland. And that is quite often the case in terms of the health care. By taking up the patient's family continuity, their working relationship can be more easily become established and treatment more effective.

Migration interrupts the functioning of the original family system. In the country of origin the kinship networks are much more extensive than they are in the country of migration. Support systems are often decimated, whereby individual family members are increasingly left to their own devices in their kinship roles of (mother, father, son, daughter, grandpa and grandma). In collective systems decision-making structures function according to a certain pattern handed down from generation to

generation. This pattern is dependent, among other things, on whether or not the culture is more dominated by women or men.

Collective family systems have more figures of authority. In western society the happiness of the child is of paramount importance and the only authority figures are the child's parents. In collective systems the child has a more instrumental role and much of its identity is derived from the degree to which it contributes to family continuity. Often decisions taken concerning the child are not made by the parents, but by others who wield authority, such as the grandfather or oldest aunt. If parents with children migrate to countries without the extended family to a country where the nuclear family is prevalent, then they encounter difficulties because the system does not function like it used to function. Support and authority figures are absent.

5. 'Protective Wrappings and 're-embedding' as therapeutic concepts

French ethno-psychiatry refers to the need for protection and enveloping as *enveloppement* (Sterman 1996). Health care workers can temporarily fulfil such an enveloping role. The French cultural psychiatrist Moro (Sturm, Nadig & Moro 2010) creates an 'envelope' within the context of health care by reflecting upon expressions, dreams and complaints of migrant families with a multicultural team of student anthropologists and psychologists. These considerations are always made within the context of culture, the past, religion and family history. Diagnosis and treatment follow the patient's cultural codes which enable the patient to remain rooted and to regain his balance and recover.

Fariba (3): re-embedding and coming home

Fariba decided to follow postgraduate courses to become a system therapist. 'Protective wrapping' and 're-embedding' are put into practise in that type of cultural system approach. The students formed a closely-knit system as a group during their education. And the collective of therapists (www.ctt.nu) became a substitute support system for Fariba. She learned how to re-embed herself, took the time to re-integrate her personality and step by step 'come home' in the Netherlands.

Building on Sterman (1996) and Moro (Sturm 2006) Tjin A Djie (2007) developed the concept and metaphor 'Protective Wrappings' which she uses in her system therapy practise. The concept of protective wrappings is plural. It can be employed analytically to investigate and make an inventory of (unprocessed) consequences of migration. It can also be a therapeutic concept to be used with the patient to make the consequences of migration bearable. It can be a noun but also a verb. An object or a photograph of a loved one left behind can offer solace. You can also 'protectively wrap' yourself by recollecting or telling stories to others about old treasured and familiar moments; through smells, sounds, music, stories, photographs and images. You can also protectively wrap yourself by writing, sending e-mails, making phone calls, going on Skype with loved ones in the country of origin. But persons here in the host country can also make the loss of embedding after migration bearable or even replace it. That could be in one's working environment, a sport's club, a circle of friends who in terms of hierarchy and structure resemble the group in the country of origin. 'Protective Wrapping' can be anything that fits the patient and/or his or her system. They help to get through the vulnerable liminal phase unscathed.

'Protective wrapping' are anchors from the past, such as family, or that which reminds one of it, friends, customs, rituals, food, in short everything that is old, familiar and trusted when things were still safe. Protective wrapping enable people to 'regain' themselves, that means to say, to re-root themselves in their original culture, and to enter into the process of re-integration with greater strength. Meurs (1998) speaks of a 'desire for the acquisition of the culture of origin'. As we have seen, migrants with psychiatric syndromes are often involved with layers of life-phase transitions, in which the traumatic and unprocessed experience of migration manifests itself again. The patient needs 'protective wrapping' to regain strength.

Angelo (3): re-embedding and stabilising

The mental health care workers in Angelo's case decide, besides medication, to create protective wrapping to embed him. To start with, the support system he had in Aruba was mapped out, so equivalents could be created in his current situation. His grandfather on his mother's side was asked

to keep more in touch with Angelo. A personal coach was provided for Angelo to help him to connect with his family again and develop a new support system. During therapy Angelo talks about his confusing sexual experiences with mother figures. By reflecting upon this with his mental health care worker Angelo feels like he is understood, and these experiences are less of a burden to his personality development. His school is also engaged to help embed Angelo. His hobby in Aruba had been to give First Aid. He resumes this with his coach in the Netherlands. After a while the voices in his head disappear and Angelo can go off his medication. By 're-embedding' him, he feels much better.

'Re-embedding' in family and social ties has a healthy and stabilising effect on migrants and refugees (Walsh, 1998; Rousseau et al, 2004). Migration demands a re-arrangement of family continuity. If important support and authority figures are at a great distance, then the functioning of the 'nuclear family' is severely put to the test in crisis situations (Tjin A Djie & Zwaan), 2007). For mental health care it is important to investigate to what extent and in what manner the system is maintained. Drawing up a genogram covering three generations, in which the migration is covered and authority and support figures are indentified, is of great use.

On the other hand it is important for patients from a we-driven culture to involve family members present in the treatment. The loss of *enveloppement* and social embedding is characteristic of many requests for psychiatric help by migrants. Getting family involved, either physically, or on the telephone and internet can have a stabilising effect on patients with a migrant past. They are protective wrapping. And if there is no family, it works to map out the roles of the family in a genogram, and let the patient act out what grandma, uncle or aunt or father would have advised in this situation. In some cases it is not possible to communicate with family or to let support figures literally or figuratively play a part in treatment. If the loss is too great, it is sometimes too painful for a patient to relive family memories. In such cases it is important to work on building an alternative support system for the patient. In such a way, patients can be made aware of 'protective wrapping' function of, for instance, going on Skype with family, listening to Moluccan songs or a Javanese radio station in Surinam, or visiting their countries of birth, hometowns, or neighbourhoods via *Google Earth*.

6. Transitional and liminal spaces

Quite a few migrants leave their homeland with the agreement they will return to the extended family. By doing so they do *not* enter into the life-phase transition with the goal of working through to the next phase. They stay, as it were, in an 'intermediate space.' They do not go over to the other side, but halfway there they turn back. Holding on to the perspective of remigration while in practice it becomes increasingly unrealizable, leads to inner conflict and split personality. Sinking roots in different soil is a painful process and is often intangible (Meurs & Gailly, 1998). These aspects of migration form important points of contact for mental health care workers, on the one hand to analyze problems, and on the other to organise effective treatment (Tjin A Djie & Zwaan, 2007). Many migrants undergoing mental health care are bothered by having 'gotten stuck' in an 'intermediate space.'.

One concept to give structure to life-phase transitions and make use of rituals in therapy, can be found in the developmental psychology of Winnicott and anthropology of Turner. Winnicott refers to *transitional objects* when it comes to bridging painful periods of absence of the mother (Winnicott, 1953). [1] The child copes with this absence by holding on to a 'bridging object.' This for instance, could be a cuddly toy, through which the child can be sensorial reminded his secure environment and therefore feel safe. Winnicott observes that good parent-child relationships also foster a *transitional space* which the child needs to build its own relationship to reality outside his parents. Play, imagination and fantasy are indispensable aspects of that building process (Winnicott, 1953). Winnicott puts this space at the heart of his psychotherapy.

This explanatory framework is widely disseminated in child and youth psychiatry. It arose and is rooted in the western concept of individuality and the primacy of the (psychoanalytic) dyadic relationship of mother-child (Van Bekkum, 1998a). The concept of transitional space needs modification when applied to large extended families, which is the case with many migrants, in which there quite a few relatives are permanently present during the child's upbringing. Van Waning (1999, p. 21) writes about the development of the self in different cultures, and puts forward that western conceptual frameworks always proceed from one to one relations between mother and child. This is

unjust, she states, since in cultures with other socio-cultural patterns it is not so much a case of the child separating from its mother, as with Winnicott, but much more of the child being delegated to a group in subtle ways. In order to be better able to connect with family structures, we sought a more systemic equivalent of the (psychological) transitional space. (note 1)

In many cultures life-phase transitions are surrounded by rituals. Through a comparative culture analysis the anthropologist van Gennep (1908) separated the transition rituals (rites of passage) into three phases: separation phase, liminal phase, and re-integration phase. The liminal phase is a vulnerable phase, because what was known was left behind, and nothing new has taken its place. There is little continuity and a great deal of change. The final change (transformation) to the next life phase takes place in the liminal phase.

Victor Turner (1967; 1969b; 1974) worked out further the concept of the liminal phase in his research into the Ndembu in Africa. He distinguished a liminal space in both the healing and rites of passage rituals of the Ndembu. It is a constructed setting in which rationality and bounds temporarily disappear which allows a state of *communitas* to arise. In this space, those involved take an irreversible emotional step to the next (life)phase and situation. The concluding of a marriage, a funeral, and a birth that is surrounded by a working ritual, contain both moments of liminality (instability and insecurity) as *communitas* (continuity through deep connection). It is simultaneously a ‘destabilising and transformational space’ in which someone can experience both loss of the old as a desire for the new. There is a feeling of being lost, but also of a strong potential for renewal and creativity. From Turner’s analysis the function of rites of passages can be reduced to three components: (a) to keep risks of vulnerabilities during transition to a minimum, (b) to put a time limit on the period of instability and (c) to give structure to the liminal vulnerability to all those involved and irreversibly reorder it. After an initiation or marriage you cannot behave in the way you did previously.

Van Bekkum et. al. (1996) described the liminal phase during migration as the vulnerable psycho-social period of transition in the process of migration that is characterized by ambiguity and ambivalence in the social and cultural orientations of migrants. That ambiguity and ambivalence can be transformed into new continuity with the help of rites of passage rituals from one’s own culture.

7. Construction of liminal spaces and prescribing rituals

Van der Hart (1982; 1988) describes that rites of passage rituals, rituals of renewal and continuity, and rites of farewell offer a psycho-therapeutic framework in which changes and transformations can take place. De Jong (1986) builds a bridge between the active ingredients of the Ndöp-ritual and modern psychotherapy. Sterman (1996/2007) describes the importance of the usual rituals associated with funerals. In consultation with the family, therapists can construct rituals that are inspired by the original ones and the ‘new’ subculture of the patient (Imber-Black, 1988). With patients with a migrant history it is important to look for equivalents and possibilities of translating these rituals to the present context. Certainly when these patients come from cultures in which rituals are strongly anchored and life-phase transitions are marked in a ritualistic manner. Examples are rituals for leave-taking, cleansing, and rites of passage (van der Hart 1982; 1988).

Nilgun (2): connecting to sources of strength from one’s own culture and liminal spaces

At first the mental health care workers try to get the parents to compromise, from a Western perspective of equality and democracy. In so doing they hope to create peace and tone down the emotions in the family in order to help Nilgun to heal. However, the arguments and tensions do not disappear. Then the mental health care workers decide to connect to the anchors of the family. Both parents were born and raised Muslims, but because of the migration they no longer use religion as a source of strength and power. The shift from a Muslim context to a non-Muslim context makes it more difficult to continue using the original rituals. Going slightly against their own views, the mental heath care workers decide among themselves to employ religion as a source of strength. They call the family together in a family council and ask them to pray for Nilgun to be healed and for a solution to the marital conflict. The father receives a suitable passage from the Koran from the imam and the family recited this ‘*Sura*’ together several times a week. After a couple of months the father and mother tell the health care workers that praying has given them an insight. The family decides to

return to Turkey. Peace returns and Nilgun's symptoms are reduced. Once the family has returned to Turkey, where they have their own house, everyone turns out to be doing well. Nilgun can stop taking medication in Turkey.

8. Where are we, and how do we proceed?

Down the generations, people from all cultures have developed ways of coping with loss and trauma. For Dutch citizens with a migration background those voluntarily seeking psychiatric help, or those involuntarily submitted for treatment, that sometimes calls for a different approach. In this chapter the authors have tried to connect with everyday solutions to make life easier to bear. Few people can lead healthy lives without relatives. Therefore the implementation of a support system, if the patient agrees, is a good intervention. Furthermore connecting to religious, familial, and cultural practices is also a fine step. They may indeed be religious, family and cultural customs. They could also entail old rituals being given new forms. New concepts such as protective wrapping, developed through the migration experiences of one of the authors, can be implemented. New rituals can be constructed. The conceptual framework put forward in this chapter has proven useful to the authors and their colleagues and been applied for a number of years in a number of mental health care practices.
It calls for a great deal of courage on the part of individual mental health care workers, by supervisors and managers to consciously apply these insights into healthcare in these times of DBC's (note 2) and cost-per-item health care. Some healthcare workers who are interested, need additional 'intercultural' competences. It is important to put the one-sided western approach into perspective and be open to other paradigms.

In practice it turns out that strategies employed to offer solutions that work are close to the culture (of both the native as well as migrant patient). The following steps are essential: (1) acknowledge and recognize breaches and hidden losses in the family history and seek/tap resources in family continuity, (2) find and map accumulated and layered vulnerabilities in life-phase transitions, (3) facilitate storytelling of the, both painful and joyful, living in multiple worlds, (4) map loss of embedding and re-embedding of the patient where necessary, and (5) create liminal spaces: co-design and perform rituals from clientsystem's own culture. The central dynamic of this form of mental healthcare is a shifting between perspectives of patient's own system and western (Dutch) (mental) healthcare perspectives.

At the beginning of this chapter we claimed that a certain stability in the patient's (family) life is necessary in order to make a change in therapy possible. We hope that this chapter offers possibilities to mental healthcare workers to implement *protective wrapping* and *rituals* into their treatment of migrants and refugees. This supports clients and their families to restore family continuity with their relatives elsewhere and with previous generations from their country of origin. If continuity is restored, change and development again become possible.

Note 1: The concept 'protective wrapping' as a noun, as elaborated on here, overlaps the concept of transitional space. There is no unequivocal agreement as to the implementation of the concepts of 'transitional and liminal spaces' in therapy. Meurs (in Meurs & Gailly, 1998) for instance, puts the concept of 'transitional space' into operation a part of family treatment as a *meeting space* to build bridges between the two cultures in which migrants live. That entails the creation of meeting space in which the wishes, expectations and convictions of the parents and children are both entertained. This interpretation of 'transitional' strongly resembles what we, following Turner (1969), refer to here as liminal space.

Note 2: In the recent health care system in Netherlands a central the diagnostic tool is called a "DBC" (Dutch: *Diagnose Behandel Combinatie*) . It is a treatment protocol with a fixed price when a specific syndrome is diagnosed.

Literature

Akthar, S. (1995). The third individuation: Immigration, identity and the psychoanalytic process, *Journal of the American Psychoanalytic Association, 43,* 1051–1084.
Bartels, E. (2002). Intercultural Social Care: the Concept of Culture, *Social Interventie, 1,* 14-22. (in Dutch)
Berry, J. & Annis, R.C. (1974). Acculturative Stress: The Role of Ecology, Culture and Differentiation, *Journal of Cross-Cultural Psychology, 5*, 382-405.
Berry, J., J. Phinney, D. Sam & P. Vedder, (2006). Immigrant *Youth in Cultural Transition: Acculturation, Identity and Adaptation Across National Contexts*, Mawah: Lawrence Erlbaum Associates.
Chavers, R. E. (1984). *Transversional Psychology, A systematic study of psychtherapy,* Utrecht: DIES Cooperative Publishers.
Erikson, E. H. (1968). Youth Idenity & Crisis, New York: W.W. Norton & Co
Ghorashi, H. (2006). Hey Dutch,man, move over with your thick identity, *De Volkskrant* , 14 oktober 2006. (in Dutch)

Fiese, B. H., K. A. Hooker; Lisa Kotary; Janet Schwagler, (1993). Family Rituals in the Early Stages of Parenthood, *Journal of Marriage and the Family, 55,* 3, 633-642.
Imber-Black, E.; Roberts, J.; & Whiting, R. (1988). *Rituals in Families and Family Therapy.* New York: Norton.
Jong, J. de, (1986). Palmwine in new bags, or: some thoughts around a Ndöp -ritual, *Tijdschrift voor Psychiatrie, 28, 1,* 15-29. (in Dutch)
Kamperman, A.M., Komproe, I.H., & De Jong, J.T.V.M. (2005). Psychische gezondheidstoestand van migranten: discrepantie tussen psychiatrische stoornissen en ervaren klachten en beperkingen. *Tijdschrift voor Psychiatrie, 47,* 761-769. (in Dutch)
Kappen, T. & Dulmen, S. van (2008). General practitioners' responses to the initial presentation of medically unexplained symptoms: a quantitative analysis. *BioPsychoSocial Medicine, 2,* 22, pp. 1-8.
Medema, N., (2005) Chinese Earth: How Spring Became our Dauhghter, Amsterdam: Mets en Schilt. (in Dutch)
Meurs, P. (1998). Verlangen naar verwevenheid met cultuur van herkomst. De psychodynamiek van migratie in verschillende gedaanten, P. Meurs, & A. Gailly (Eds.), *Taking Root in Foreign Earth: Migrant Families & Mental Health Workers Meet Cultural Difference*. (pp. 93-112). Leuven: Acco. (in Dutch)
Mulder, N., L., G. T. Koopmans, and J.-P. Selten, (2006). Emergency psychiatry, compulsory admissions and clinical presentation among immigrants to The Netherlands, *British Journal of Psychiatry*, *188*, 4, 386 - 391.
Oberg, K. (1958). *Culture shock and the problem of adjustment to new cultural environments*. Washington, D.C.: Department of State (FSI).
Rhmaty, F. (2005). *How to survive my life as refugee*? Presentation seminar “Diversity in Mation”, april 2007, Amsterdam. www.ctt.nu [accessed: 20 maart 2009]. (in Dutch)
Rousseau, C., Marie-Claire, Rufagarib, Déogratias Bagilishya,Toby Measham, (2004). Remaking family life: strategies for reestablishing continuity among Congolese refugees during the family reunification process, *Social Science & Medicine, 5, 9* 1095–1108.
Selten, J., N., Veen, W. Feller, J. Blom en R. Kahn, (2001a). Incidence of psychotic disorders in immigrant groups to the Netherlands, *British Journal of Psychiatry, 178*, 4, 367-372.
Selten, J., N., N. Veen, W. Feller, J. Blom, H. Hoek en R. Kahn, (2001b). Incidence of schizophrenia with autochtonous & allochtonous Dutch in The Hague, *Nederlands Tijdschrift voor Geneeskunde, 145,* 34, 1647-1651. (in Dutch)
Slutzki, Carlos E. (1979). Migration and Family Conflict, *Family Process, 18*, 379-390.
Sterman, Django (1996/2007) Een olijfboom op de ijsberg, Utrecht: Pharos. (in Dutch)
Sturm, Gesine (2006) Listening to the "Other" in Transcultural Therapies. Worldviews, Idiomatic Expressions of Illness and the Use of Cultural Representations in Intercultural Communication, in: Gender, Health, and Cultures: Networking for a better Future for Women within an enlarged Europe Walburga Freitag, Vera Lasch, Ute Sonntag (Hrsg.), Kassel: Kassel University Press.
Sussman, Marvin B. (1954). Family Continuity: Selective Factors Which Affect Relationships between Families at Generational Levels, *Marriage and Family Living, 16,* 2, 112-120.
Tjin A Djie, K. (2001).The specific task of migrant children, C.J.A. Roosen, A. Savenije, R. Beunderman en A. Kolman (red.), Beyond Boundaries*: psychotherapy with adolescents*, (pp. 132-144), Assen: van Gorcum & Comp. (in Dutch)
Tjin A Djie, K. & Zwaan, I. (2007). *Protective Wrapping, transcultural help for families.* Assen: Koninklijke van Gorcum. (in Dutch)
Turner, V.W. (1967), Betwixt and Between: The Liminal Period in Rites de Passage, V.W. Turner, *The Forest of Symbols*, (pp. 93-111), Ithaca, NY: Cornell University Press,.
Turner, V.W. (1969). *The Ritual Process, Structure and Anti-Structure*, New York: Aldine.
Turner, V.W. (1974). *Dramas, Fields, and Metaphors: Symbolic Action in Human Society*, Cornell University Press.
Van Bekkum, D. (1998a). The Multiple Connection: on the Road to Intercultural Forms of Masculinities, in: The First Sex, Anja Meulenbelt (red), Van Gennep: Amsterdam. (translated from Dutch)
Van Bekkum, D. (1998b). Rite de Passage, Supporting Structures during Coming of Age, in: *Justitiële Verkenningen*, *24, 6,* 74-816. (translated from Dutch)
Van Bekkum, D. (1998c). Leisure, Play and Work in Urban Settings: Search for Liminal Experiences in Male Adolescents, *Leisure, Time and Space: Meanings and Values in people’s lives, Sheila Scraton (ed.), Special Issue Leisure Studies Association, 57*,
Van Bekkum, D. (1998d). Transitions and Inner Conflicts in Adolescents: a Clinical Anthropological Addition to Psychotherapeutic Praxis, in: *Tijdschrift voor Kinder en Jeugdpsychotherapie*, 28, 3, 79-92. (in Dutch and English) www.tegenwicht.org/32_man/adolescenten_tekst.htm (accessed 28 maart 2010)
Van Bekkum, D. (1999). To Belong and To Be Different: Balancing National and Ethnic Loyalties in Male Adolescents, in : *Dominant Culture as a Foreign Culture: Dominant Groups in the Eyes of Minorities*, J. Mucha (ed.) East European Mongraphs, Columbia University Press.
Van Bekkum, D. (2002). Demanded!: Transition Rituals for Civil Incorporation of Young Men, *Kwalon tijdschrift voor kwalitatief onderzoek*, *vol 7, nr 2.* (in Dutch and English)
Van Bekkum, D. & M. v.d. Ende, S. Heezen, A. Hijmans van den Bergh (1996) Migration as Transition: Liminal Vulnerabilities in Migrants and Implications for Mental Health Care, in: *Handboek Transculturele Psychiatrie en Psychotherapie*, J. de Jong en M. v. d. Berg, (red.). (summary translated from Dutch)
Van Bekkum, D. & F. Sevinç (2006). Cultural (Counter) Transference in Transcultural Encounters in Therapy, *Cultuur, Migratie & Gezondheid, 2,* 1, 2-11. (in Dutch)
Van der Hart**,** O. (1982) *Rituals in Psychotherapy: Transition and Continuity*, Utrecht University, Utrecht.
Van der Hart**,** O. (1988) *Coping with Loss: The Therapeutic Use of Leave-taking Rituals,* New York: Irvington Publishers.
Walsh, F. (2006) The resilience of the field of family therapy, *Journal of Marital and Family Therapy*, *24,* 3, 269-271. Froma Walsh (ed) Strengthening Family Resilience, Guilford Press, London.
Winnicott, Donald. (1953). Transitional objects and transitional phenomena. *Int. Journal of Psycho-Analysis*, *34*,89-97.
Yakushko, Oksana, Megan Watson & Sarah Thompson, (2008). Stress and Coping in the Lives of Recent Immigrants and Refugees: Considerations for Counseling, *International Journal for the Advancement of Counselling, 30, 3,* 167-178.