

# MISUNDERSTANDING SITUATIONS IN CULTURE AND CULTURAL CARE

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## *Abstract*

This article focuses on cultural misunderstanding in care relations, starting from the analysis of the effects misunderstanding causes in the relation between doctor and migrant patient.

The Western medical model tends to be based on objective data, which can be diagnosed through more and more precise and detailed techniques, but it excludes human and cultural aspects of subjectivity and relation from care. This exclusion creates distance, which increases when doctor and patient do not share a cultural homogeneity but differ for their language and the way they conceive their body, health, disease.

By showing some clinical examples, this contribution points out how specialized competence can cause dark areas of obscurity, disagreement and misunderstanding, although being successful in many distressing situations.

The interpretation of misunderstanding in the field of healthcare delimits our observation to disease, treatment, the relation between doctor and patient, but the identification and comprehension of misunderstanding are possible also focusing our attention on the organizational and institutional environment where misunderstanding takes place.

*Keywords:* cultural misunderstanding, healthcare relations, cultural models

## *1. Introduction*

Much has been written on migration, its causes and the effects it generates or which produce it: causes, effects, results and forms are largely visible and understandable in history and everyday life.

Meeting or coming across a “migrant object” is however enough to transform an understandable viewpoint into a rough, dangerous terrain, extremely difficult to handle.

In its complex social, political, community-related implications, migration is characterized for its tendency to disorganize all attempts of systematic analysis, showing reluctance about being even temporarily led or attributed to a univocal and commonly shared interpretation of the subjects and cultural objects it introduces in the domain of observation and action.

The picture resulting from this is thus heterogeneous and unstable, and only partly reveals its implications, drifts, developments and potentialities.

Our research focused on the themes of ethnopsychanalytical clinical practice, psychopathology of migration and settings built and devoted to the treatment of afflictive situations shown by migrant subjects.

From time to time, our mindset and action plan has dealt with the irreducible dimension of cultural and human diversity. Clinical lived experiences have more and more moved our attention on the analysis of misunderstandings, rejects, reciprocal incomprehension. The need to consult places, notions, theories and words which build and originate the operations to understand clinical reality has become always more crucial.

When two subjectivities meet, understanding what happens undergoes an operation of reduction and signification within an order of speech and thought. If, on one hand, this operation allows making work objects emerging and visible, on the other it produces shadows, invisibilities or blindness spaces. It is therefore important to consult the method we use to observe and deal with facts and reality. In this article we aim at analyzing the cultural misunderstanding as result of composition and breakdown operations caused by treatment systems, starting from clinical examples.

## *2. About the Concept of Misunderstanding*

A misunderstanding takes place when, in good faith, two people or groups, with different culture, conceptions and casts of mind, social and institutional position, find it hard to understand each other on one or more themes, which are particularly delicate for one or the other. More in detail, gender, age, (religious, political, educational, etc.) and cultural differences start the inclination to misunderstand each other. "Cultural misunderstanding" originates from the diversity of languages and cultures, but also from differences of gender and age. It is the case of the interaction with migrants or the contact among different socio-cultural classes (Profita, 2013).

All relationships between individuals or groups goes through some misunderstandings. Their acknowledgement and management allows improving the strengthening of relationships. Being obliged to cope with incomprehension allows each one of us to reflect on what does not work, get closer to other people's positions, build or negotiate the meaning of controversial or conflicting aspects of living together.

The misunderstanding is part of the relational, social and cultural order of each living being, and crosses all social groups playing the role of stimulating to deal with difficult situations. For this reason, Baré (1985) defined the misunderstanding as "productive", that is able to produce a new event. The difficulty lies in recognizing the misunderstanding and, at least in part, being able to manage it not to become unaware victims and end up with forms of explicit conflicts. The misunderstanding has in fact a long incubation period, does not show and remains hidden before becoming visible in choices and behaviors.

## 2.1. Cultural Misunderstanding and Relationship between Doctor and Patient

The interpretation of misunderstanding in the clinical domain limits the observation to health, care, relation between doctor and patient, keeping well in mind that all this is developed both within an organizational and institutional environment, and in relation to the cultural models proposed by the subjects.

The focus is on the relationship between doctor and patient, what they tell each other, the stories and the observation of behaviors which take place in different phases or moments of the relationship. In all cases, keeping in mind the various vectors conditioning the meeting between doctor and patient is not only good observational practice, but also hermeneutic element necessary to understand what really takes place.

The care relationship is meant as the interaction of all involved actors which can be described as confrontation between cultures. In a clinic with migrant patients the following elements can be found: the doctor and caring staff's approach to patients, their reactions and answers to the relational and professional system, collaboration or resistance to the care treatment. As a result, it is important to describe how communication processes develop and identify hidden and not immediately visible aspects of the communication between actors. These elements are often ignored and generate misunderstandings.

The plans or apparatuses which compose and define care relationships can be summarized as follows:

- A general cultural system;
- The social reality ruled by laws, conventions, various ways to carry out, in terms of local cultures, what has generally been prescribed;
- The specific realities which determine and help form organizational climate and operational procedures;

- The relational networks and single individualities which retroact with the various organizational systems.

These two short statements are enough to realize how, in care relationships, times and spaces preceding, containing and organizing the two main actors' actions become visible and present.

Medical anthropology (Kleinman, 1978; Quaranta, *et al.*, 2012) and ethnopsychiatry (Devereux, 1973; Nathan, 1993) well highlighted how the concepts of health and disease are specific cultural constructions, authentic explanatory models provided with notions, techniques, primary meanings which can only be reduced per approximation or superposition.

These cultural models are mainly embodied by subjects, doctors and patients, who become their mostly unaware vectors and representatives..

A treatment always takes place through a choice and a decision, and the place where a decision or therapeutic action takes place remains implicit or not asked.

Our hypothesis is that misunderstanding originates from this implicit facet, germinating until it produces evident forms of resistance to the treatment, therapy interruptions, compliance, or, conversely, explicit opposition to the treatment.

A superficial interpretation of the phenomena connected to misunderstanding leads us to think they are due to a mistake, an incompetence or a distraction and this is mainly the cause of the tendency to treat misunderstanding as a problem arising from the sole diversity of language, which can therefore be erased through a precise translation.

As a matter of fact, the phenomena related to misunderstanding reveal and show, in vivo, the work the cultural system carries out in organizing the apparatuses it uses to give meaning and shape to human dimension, physiology and pathology.

Culture works through three apparatuses:

- The cultural system (cosmovision, language, body techniques, health models, disease forms, treatment modalities);
- The institution, meant as complex and culturally specific social and cultural training, rules the relations among subjects, exists before them and is inscribed in permanence (Kaës, *et al.*, 1988). What is more, each institution has identifying and distinguishing purposes, and different (religious, juridical, defensive, therapeutic) functions;
- The specific clinical apparatus meant as the organized place, with a contingent and concrete character, where means are prepared to achieve the purposes of the institutions which legitimate its efficiency.

Each of these three apparatuses rules, analyzes and helps the interaction with cultural otherness and disease. Each of them produces meanings, by explaining, understanding and solving actions. All three apparatuses show a portion of the object they are called to work on.

The meaning of the term 'apparatus' in this context is the one given by philosophy, starting from Foucault, who constantly uses it without precisely defining it, from *Discipline and Punish* (1975) to *Dits et Écrits* [Said and Written] (1978): "*What I'm trying to pick out with this term is, firstly, a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions—in short, the said as much as the unsaid. Such are the elements of the apparatus. The apparatus itself is the system of relations that can be established between these elements*" (Foucault, 2001: 229).

According to Foucault, the apparatus is a container which can generate a content and responds to the need to create a rational order.

Deleuze (1989), too, takes part to the debate on the apparatus, saying that the purpose of apparatuses is to create speech and visibility. According to the Author, visibility and enunciation are the two specific dimensions through which the action of an apparatus takes place. Visibility must not be meant, though, as a light which lets us see preexisting objects, but it is rather created by the light system each apparatus uses, i.e. the way the light falls or spreads out and distributes visible and non visible, showing or hiding the object which does not exist without it. The same process dynamics occurs for words and enunciations an apparatus allows formulating as variables of a science, a literary genre, a speech (Deleuze, 1989).

Our research experience<sup>1</sup> allowed us to observe how these levels create visibility areas, while they are taking place, and at the same time produce blind zones, where portions of the other remain quiet and invisible. The dialectics and interaction among the various apparatuses are, according to us, the origin of the majority of misunderstandings.

### 3. *Biomedical Model and Healthcare Service Organizational Model*

What we have explained so far allows us to go back to care relationships and a more thorough analysis of the plans composing and defining them.

A first evidence is just about the analysis of the organizational apparatus.

The organization of services is based on the biomedical model of treatment, corresponding to the training of healthcare staff. Treatment systems, service organizations, volunteering structures follow the same organizational criterion, which transforms effectiveness and financial compatibility into the rule which guides actions (Byron, Good, 1994), starting from the precise description of how the doctor's training takes place, and gives us a complete picture of how 'medicine builds its own objects'. In laboratories, the human body is disassembled in such a way that it becomes the place of medical knowledge. It is no more the body we have experience of, live and experiment, but, in laboratories and anatomy rooms, it becomes a number of muscular bundles, arteries, nerves, etc. "*the human body is given a new meaning and interacts with it in a new way*" (Good, 1994: 112-113).

In universities, though, a new language is taught, which is much richer in details, more precise and thorough, and does not correspond to what common people are used to anymore. As we improve ourselves, our sight becomes sharper, we detach ourselves from the common sense and the ordinary way to feel and perceive things. Ours is no more the phenomenal body we all perceive, but something which was built differently and involves medical disciplines. A doctor's education requires a number of specific skills and a specialized language: diagnosing as quickly as possible, pertinently and thoroughly describing and discussing cases, precisely and efficiently finding out the most suitable therapy. In a nutshell, doctors are asked to be performing, accurate in their diagnosis and efficient in their therapeutic action. Besides a technical and epistemological model, a way of being is created concerning the way they have to practice, in a hospital or a clinic, or in any other occasion they need to serve as doctors.

The biomedical model has its origins in the scientific reductionism which granted relevant performances. We should unquestionably recognize and appreciate the progress achieved in the treatment of organic diseases and the study of methods and procedures when dealing with health problems which otherwise would have no solution. Common, endemic and even rare diseases have found, or hopefully will soon find a solution thanks to constant research and the construction of technological apparatuses which allow coping with, and sometimes resolving, otherwise incurable problems.

The system built from the biomedical model tends to be based on objective data which can be diagnosed, but it is inclined to neglect the aspects of a relationship. All patients who find in their doctor

a greater attention to the aspects of human subjectivity generally express an appreciation and tend to become attached to the doctor who paid such attention to them, as if it was an undue extra.

With patients who do not show a cultural homogeneity, the problems may become even more complex. Linguistic differences, different ways to interpret relationships, distinct life philosophies, dissimilar religious confessions set a gap which can hardly be filled just with good will, or relying on the pretended universality of biological treatment. We had the chance to study various situations where the biomedical model and a more thorough overview of the person do not always find a complete synthesis.

An example of the way this model intervenes in the organization of a service and the practices of taking charge is represented by the patient's medical history card. All the Services where our research took place use a medical history card which is filled out during the first visit and will follow the patient during all his therapeutic process.

The medical history card contains two important data survey and collection areas: the first is devoted to personal information – age, gender, birthplace, language, residence, employment, family, etc. – the other to medical history – family history of cardiac or metabolic pathologies, previous illnesses and their outcomes, allergies to medicines, etc.

In our opinion, it should be pointed out that the two areas of the card are filled out in two different moments and by two different people, respectively the doctor and the cultural mediator, and remain two separate information spaces, throughout all medical visits and in the majority of cases.

This discontinuity can be clearly seen in each of the observations we carried out and involves all the Services we observed. Our attention focused on the history of the disease, the evolution and resolution of the symptom, the treatment plan to be followed as well as its effects, the indicators and indexes pointed out by prescribed clinical analyses, because when a person enters a doctor's office, his or her consistence takes the shape of pressure values, glycemie index, treatable abdomen, etc.

The medical part of the card contains the patient's clinical history, and becomes the memory of all consultations, treatment requests and followed therapies, and also files all diagnostic medical reports. This is also the part of the card which receives, during the visit, the doctor's exclusive attention, and the patient's identity and personal history remain on the background.

The two parts of each patient's card work in discontinuity, even though they remain active for the most part of the medical visit or the disease in general, in a reciprocal dimension but the one being quiet and invisible with respect to the other.

The case of fully correct medical visits which do not consider the patient's other qualities and characteristics often take place and risk to make the treatment work less successful.

We report below two cases observed in this regard.

#### *M.'s Case (a Bangladeshi patient suffering from diabetes)*

The patient speaks to the doctor who has already been treating him for months, and says he needs a prescription for some medicines. The doctor ascertains that the patient did not carry out the blood exams he had been prescribed during the last visit, did not fill out his dietary log, did not follow the regime he had been suggested and never checked his glycemia. None of these behaviors is further analyzed, but just "admonished" as negligence to correct. The doctor, in fact, continues his visit through a therapeutic education intervention where he points out the importance of following a varied and rich regime and fill out a daily log of the meals he consumes. The patient says he has understood his mistake and reassures the doctor promising he is going to follow the advice received, but his look and expression are visibly absent and mortified. This evidence, which remains totally dis-

regarded by the doctor, who is engaged in the prescription, does not escape the mediator, who, entered accidentally in the room, recognizes the patient as regular visitor of the clinic. The mediator breaks the ritual of the medical visit and asks him the reason of such a mortified expression. Only at this point, the patient says he has lost his job and almost lives of charity, eating just what his compatriots offer him; following a varied diet rich in fruits and vegetables is impossible for him.

The space of the clinical consultation becomes the background of two complementary situations which are declined according to two different outlines: a bio-medical one, and the other involves human lived experience.

The interview finishes with the doctor's prescription and the mediator's intervention aimed at activating a connection with *Caritas [Religious Charity]* Services in order for the patient to be able to use shopping vouchers.

#### *D.'s Case (5-Month Pregnant Rumanian Patient)*

The patient addresses Emergency's Health Center for Migrants for her first gynecological visit, and is already five-month pregnant. The gynecologist prescribes her some routine clinical exams. As the employees who deal with patients' enrollment in the health center archive have ascertained that she has her residency permit, is regularly registered in the National Health Service and already has her GP, they send her to him for the request and prescription of the clinical analyses indicated by the gynecologist<sup>2</sup>.

The GP, who had not been informed by the patient, at least until that moment, that she was pregnant, does not give her any prescription, and, in a huff, calls the Health Center claiming his role and complaining about the lack of respect of the structural order regulating treatment guidelines (GP, specialized services, hospitals, etc.).

At the formal level of service organization and treatment guidelines, the patient should first of all address her GP and then carry out the following specialized passages. Unfortunately, this was not the case, and not much is asked about the reasons which led the patient's choices, a greater priority is given to fixing the order of the organized and articulated healthcare machine.

These situations are not certainly an exception. We have often observed communication problems among professionals and troubles encountered by services to create a network. Their origin perhaps lies in the separation of tasks and duties, resulting from the scientific organization of work. Patients are neither seen nor considered in their totality of body, mind and culture, but assumed by each employee for their specific part.

Starting from these examples, we can build the backdrop where the organizational outline takes place combining the healthcare services we observed.

The scene is the following: we are in a hospital, or a health center, where migrant patients go, sometimes alone, other times with their families or some compatriots. There is a doctor, the staff in charge of the treatment and, sometimes, the interpreter, necessary figure to be able to perform the job. Together with these people, whose action is immediately visible, the scene contains another supporting actor: the institution which welcomes and allows the therapeutic relationship, within certain limits.

As a matter of fact, for this latter, too, institutions are at least two: the visible one of the hospital, health center, or private clinic, that is the apparatus dictating norms and rules of the real operating modality, and the more invisible but decisive one, represented by the cultural scientific model of medicine. A third institution is the one patients belong to, outlining their viewpoint, their introjected

or embodied cultural dimension, which prepares, orientates and establishes conceiving models of what happens in the concrete relationships with doctors and treatment apparatuses.

In order to clearly exemplify what we have just said, we propose a scheme where it is possible to visualize the vectors by means of which the overall structure works. The specific therapeutic action occurs within an institutionalized apparatus where the various protagonists move according to defined procedures, but in a system of relations which varies from time to time.

This scene can be summarized in the following scheme<sup>3</sup>:

Please, insert scheme no.1 here

The thesis we propose is that: *the greater the protagonists' awareness of what they can be influenced by (even the influence of structural elements) the smaller the risk of misunderstandings.*

In other words, the more the protagonists are aware of the vectors influencing the therapeutic action (not only those pertaining to their role and duties, but also the ones influencing their behaviors as well as their peers') the smaller the inclinations to misunderstanding. The ability to read and understand the forces at stake, their direction and traps, can partly avoid the mechanic and repetitive action suggested by habits and a consolidated operating modality, and help that action of approaching the other which opens new meeting perspectives, even at the level of treatment. Of course, the main responsibility falls on the doctor, whom we do not consider as warden of the clinical apparatus, but as its interpreter, careful and available to introduce the necessary changes in order to be more successful in his therapeutic action and more responding to the users' needs, rather than simply devoted to the organization's requests.

Patients, in turn, show apparently available and obedient, but observe everything and are ready to either complain or sluggishly go home, according to their convenience, if they perceive or just vaguely feel that something does not coincide with their personal opinion or sensed as dissonant in the relationship. Even though their attitude can be sometimes complaisant, patients can autonomously perceive and act, creating situations of communication barrier with their doctor, disguised as an apparent comprehension and compliance to what they have been recommended.

Scott (2009) speaks of a hidden language which inferiority produces and indicates in noise and rumors. For what we could see, complaints and feeling neglected, feeling they are not taken seriously will result in the rejection of diagnosis or therapy, without telling or showing it to the doctor, etc. Hidden questions can be found in interstices, according to Roussillon's (1988) successful locution.

#### 4. *Interstices and the Disclosure of Misunderstandings*

Interstices are described by Roussillon (1988) as the spaces containing what cannot be ascribed elsewhere, or also the spaces in establishments holding what remains unimagined or still to be imagined, conflictive or unintelligible through the logics of one of the apparatuses working in the institution.

Interstitial spaces are the places shared by all the professionals working in a service (corridors, waiting rooms, yards, etc.), that is all those meeting places where people stop between two activities and spend the time between two defined and structured institutional activities (or experienced as such). The interstice can also be defined in terms of time, in this case the interstitial space is the time separating the duration of work considered in juridical-economical terms from the time effectively spent to carry out an experienced job (Roussillon, 1988).



What is more, the interstice enjoys a special status: it is inside the institution but experienced as “extra-territorial”, belongs to everyone and guarantees them free time and space with respect to the limits established by one’s own institutional role.

Described as such, interstitial spaces play a crucial role for institutions. They are actually the places where the tiles messed up by the various apparatuses are put in order. While the healthcare institution orientates opinions and prescribes actions, it arranges within itself the space where the invisibility produced by its various apparatuses can be newly treated and put back in order. The role played by interstices is organized in three main dynamics: the *recovery*, through which what is said or done in the interstice is later resumed and integrated in all working activities; the *deposit*, which describes the process during which everything is said or done in the interstice is set aside, in order to be stored, frozen or locked-up according to the emotional significance of the facts considered; the *crypt*, where what is said or done is doomed to reside in the interstice through scission or foreclosure processes with no chance of being resumed and developed.

When Roussillon describes these dynamics, he points out both the regulating value of interstices and the profound ambiguity of the processes occurring in these spaces. These processes can actually result in mechanisms of protection and defense from anguish as well as operations of transformation and elaboration.

The transitional function through which the interstice allows revealing, thinking and transforming operations is only one of its possible destinies. Its transforming potentiality is possible when the organizational structure can support and consider the interstitial phenomena as evolutionary and not as threat to the stability of the connection and the continuity of the institutional mandate.

During the interviews with healthcare workers, we could detect how each activity is carried out in spaces and decision margins limited by the role covered and the function performed by each person. We thoroughly described how, within the medical consultation, the question is dealt with according to biomedical logics, so as it happens for the other professional figures (social workers, interpreters, mediators, nurses), whose action is carried out within the limits put by their role and institutional mandate.

Although with very different characteristics and modalities, within the services which took part to the research, we could observe and find out how the interstitial space allows each employee a greater freedom to rework what has remained hidden or silent during medical consultations, social welfare interventions or health and social service orientations.

It is worthy pointing out that, not always and not in all services, cultural mediators – or the other professionals who work on the same clinical situation – are permanently present in the clinical consultation room. This occurs both for reasons to be tracked down in the definition of each worker’s operational spaces and for the characteristics peculiar to healthcare institutions, always more organized on criteria of efficiency and time and resource economy. This is why interstitial spaces become more important in their role of containers than what remains not treated by each employee, and in their intermediate function of reconnection and visualization of the misunderstandings generated by each defined space.

It is the case of a woman affected by AIDS, whose clinical story is fragmented, disordered and stored in various treatment places, each of which keeps only one part that remains invisible and hidden to the other for a long time.

M. woman, 36, from Ghana, is a patient known by Palermo’s Health Center for Migrants, where in the past years she had requested various general medical consultations due to minor symptoms (flues or joint inflammations), as well as pediatric ones in favor of her children.

We meet M. several times, struggling with various medical consultations.

The clinical diagnostic process follows the steps described below:

- Doctor 1: due to asthenia and a sense of tiredness which has already been lasting for some weeks, the patient contacts the health center. The doctor who takes the patient and her treatment request in charge starts a diagnostic in-depth examination through the prescription of clinical analyses, and especially blood count.
- Doctor 2: the patient shows the results of the blood count prescribed during the previous visit. The blood count highlights a normochromic anemia, with very low HGB values. This datum leads the doctor to prescribe further examinations. The patient is asked her informed consent to carry out tests on viral markers (HIV, hepatitis, etc.) before going on with clinical exams of her spinal cord and a hematologic visit. The patient grants her consent, with no further questions.
- Doctor 3: the result of the tests prescribed during the previous consultation is positive for HIV, and this is why mediators have scheduled an appointment with the ID specialist. The doctor begins the counseling for a HIV infection. The interview shows that the patient already knew about her infection, and none of the doctors did. The patient says she first knew about her HIV infection three years before, for the birth of her last son, occurred in one of Palermo's hospitals. The child's case had already been taken in charge by the pediatricians who work at the health center, but only during this visit the mother refers that at his birth and for the following three months, the child had undergone diagnostic screenings according to which he had resulted HIV-negative. The doctor starts the anamnesis of the patient's life history, whose answers are fragmented and evasive. The doctor does not insist and accepts the monosyllabic answers he receives. Only at the end of the interview the patient, until then apparently unemotional, says she is scared and would like to understand what is going to happen. The doctor calms her saying there are further exams to do and she will be looked after in a specific health center.
- The patient is sent to the Infectious Disease Department of the University Health Center for the follow up of her diagnostic and therapeutic process (confirmation, staging notation and therapy tests).

Only at the end of the interview and when the patient has already left, the ID specialist, who was so reassuring during the interview, will address the cultural mediator in order to have more information on the patient's clinical history and what she revealed and hid about her condition.

Even though the reconstruction of this clinical story still remains open and incomplete, it seems to well exemplify the typical organization of healthcare institutions, as well as the multiple dynamic functions of the interstice.

As far as the organizational structure of healthcare services is concerned, this story shows a follow up which, however punctual in answering to the treatment request, is parceled in many therapeutic spaces which are separate and not communicating with each other. The medical record reports and shows the continuity of the follow up, but only guarantees the passage of medical information and adds nothing about the patient's life history; in other terms, it hides in the same moment it produces the report of performed clinical actions and prescribed therapeutic indications. Therefore, any other doctor can act in continuity and succession with what has been previously carried out, with no further interrogation space except for the one emerging from clinical evidence. It is also true that this organization allows patients to keep their stories and clinical conditions secret, guaranteeing them from the mournful anxiety the HIV-positive status diagnosis recalls and shows.

The case shows how, with respect to anxiety, the interstice worked as place of the secret, where patient and healthcare workers are connected. All the protagonists of this clinical story are at the same

time guaranteeing a tile and guaranteed, and for this reason protected, from knowing the final structure of the story which, though, contains its result from the beginning.

The disclosure of the secret, and therefore the possibility to recover what had remained slotted in the organizational folds is carried out when, beyond the actions led by role and time of a clinical consultation, the doctor asks the workers of the health center. ‘What do you know about this woman?’ is much more than a curious question, it activates the circulation of a word of recognition, connection, but also trust in the possibility to develop a story, and therefore a commonly shared and participated treatment.

## 5. Conclusions

If misunderstanding originates from ignorance (*méconnaissance*), recognition has, first of all, an identification value of its own *méconnaissance*, contrasting the effects it produces. There are hidden elements, or, more simply, as Proust said, linked to the “anesthetizing action of our routine” or the ‘compelling’ procedure of the rule.

As far as our research is concerned, taking on an institutionalized role with its practices and rules means that all the procedures acquired and interiorized as specific and characterizing one’s own institutional position are a sort of cognitive screen, a guide, which impedes a direct assumption. The implicit but mandatory request is that the patient enters the doctor’s (biomedical) ‘project’ as well as the clinical apparatus. One could say that this makes clinical activity even more efficient and successful, which is true, but from the patient’s viewpoint, it becomes a *reductio [reduction]*, in a sort of invisibility and a gap he/she cannot fill anymore. By definition, the person who knows is the doctor, who holds the truth, prescribes treatments and generally respects the protocol, paying less attention to what the patient could say with his/her “request”. Within this framework of meanings and organization of healthcare practices, we run the risk of falling in a reified mindset (Honneth, 2007), where knowledge is separated from recognition, with the consequence that the patient becomes invisible and his/her disease the main focus. The feeling of not being perceived, of being transformed into medical reports or unintelligible prescriptions creates impasse positions and polite contrasts which find no points in common.

This is the problem to pay attention to: how much do patients feel perceived and recognized in the progression of ordinary clinical practices?

Confirming their trust in their doctor, some patients declared they always feel well understood, however they preferred to follow other prescriptions and suggestions. In our research we ascertained that there are patients who either quite explicitly refuse to follow what they have been prescribed as therapy, or show as model patients and then follow a totally different process or habit: traditional therapies, or other remedies often coming from advice given by people they rely upon.

A second critical point can be recognized in the fact that healthcare workers can hardly get involved in a relationship they feel as ‘dangerous’ or ‘worrying’. It can depend on a special education to the clinical interview, on defenses connected with their personality, in other terms countertransferral elements and cultural countertransfert. Having stiff attitudes and postures, proceeding through coded schemes, shows their trouble to recognize and control their responses and reactions with respect to what leads the patient. In this way, unconscious defenses are activated with respect to aroused emotional tensions and anxieties. Wearing a mask, hiding behind procedures, abstractly following the protocol reduces the tensions, or, as Devereux (2012) says: « *la protection fournie par la position scientifique est seulement temporaire [the protection given by the scientific position is only temporary]* »... « *l’activité scientifique en tant que telle peut, par elle même, atténuer davantage l’épreuve*

*consciente de l'angoisse par une abréaction partielle des tensions à travers l'activité [the scientific activity as such can, by itself, further reduce the conscious evidence of anxiety by means of a partial abreaction of tensions through the activity] » (Devereux, 2012: 131).*

An integrated training, which includes both biomedical and relational concepts, is the necessary condition to contrast the drift of misunderstanding and avoid countertransferral traps. Without the attention an integrated training deserves, all healthcare workers are subject to the frustrations which do not only depend on their personal technical knowledge, but also on the other person's recognition. The result can thus become a recital, apparently satisfactory for each of them, but hardly successful despite all technically rigid architectures.

The misunderstanding seems to become the element on which every relationship between different people, more or less based on therapy, is found and developed. The analysis and disclosure of the cover holding misunderstandings represent the specialist's main job, even before the patient's analysis and defense removal. This cover does not only involve the relationship between therapist and patient, but extends itself until it covers the technical, institutional and cultural apparatus embracing the whole efficiency. What is more, if the doctor is surrounded by his/her scientific, institutional and cultural structures, the patient, in his/her turn, is bearer of the same complexity. Organizing such a work cannot simply be a matter of languages, but involves the architecture of the relationship between the notions and powers (Foucault, 1975), which influence the level of relationships.

## Misunderstanding Situations in Culture and Cultural Care

Scheme no.1

Relational spaces/ General cultural systems    ⇒    social system

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↓

Specific cultural domains    local cultures    institutional organisms

↓

Concrete realities

↓

Places (ward, office, waiting room, corridors)

↓

Clinical apparatuses (interview, visit, prescription)

↓

Relational exchanges (transfert multiplicity)

↓

Patient – doctor – interpreter - family – social workers

<sup>1</sup> Our research work took place in Hospitals and Services devoted to migrants, in Sicily and Alsace. More in detail, the involved structures were: Palermo's Center for Migrants of *Ospedale Aiuto Materno* and Emergency's Clinic for Migrants; the Transcultural Psychiatry Service of Catania's City Health Assistance Authority [ASP 6], *Le Nouvel Hopital de Strasbourg* and Strasbourg's Hospital Psychiatry Ward, in Alsace.

Our research activity was based on the participating observation method and the use of interviews to doctors, patients, mediators, interpreters. The choice to proceed through the participating observation method allowed us to become directly acquainted with the organization of health services, and the procedures workers adopt and follow. The observation is at the same time dynamic of meeting and knowledge which, step by step, allows orientating in the service space and times, finding out how it specifically functions, understanding its movements and modalities starting from the meeting with the professionals who animate and build it by using their medical, organizational, managerial skills, as well as their humanity. In addition to participating observation, the use of narrative interviews to doctors, nurses, healthcare workers, mediators and interpreters allowed us to explore the following thematic areas: role, function, education, adopted working modality, experience lived within their own workplace and in their relation with patients. Narrative interviews addressed to patients thoroughly analyzed the following areas: disease history, received care perception, followed therapeutic guidelines. Collected data were analyzed with content analysis procedures.

A further work specifically devoted to the description of the services involved by our research will fully report the results of data analysis and cultural themes emerged during the activity.

<sup>2</sup> We think it is not inappropriate to remind that the Health Center offers medical assistance to migrants with or without their residency permit and migrants coming from EC nations who, when lacking a regular work contract, cannot be enrolled in the National Health Service.

<sup>3</sup> The content of the box represents the *set*, i.e. the space-time-relationship occupied by protagonists during a consultation with the typical managing/accomplishing modalities of the treatment relationship. What is outside the box in the grey area we put in the upper part is the least visible portion, not immediately perceivable, but which strongly influences what happens in the direct meeting, not only in the sense of influencing the practical rules of the therapeutic action, but also affecting the protagonists' emotions and conducts.

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