

CLINICAL CASE STUDY

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A MOROCCAN WOMAN SUFFERING FROM DEPRESSION: MIGRATION AS AN ATTEMPT TO ESCAPE *SORCELLERIE* *

CLINICAL HISTORY

Patient identification. B. is a 46 year-old single Moroccan woman who migrated to Eastern Canada in 1993. She lives alone and has received social welfare payments for four years, but she is now involved in a job development program financed by the Government.

History of present illness. B. presented to a psychiatric outpatient clinic in her new neighborhood after being in psychotherapy for 18 months. This treatment had started in 1993, soon after she suffered a depressive crisis five months after her arrival in Canada. Her crisis developed in the following way: B. had been unable to find work and had been forced to end a relationship with a fellow countryman, so she wanted to return to Morocco. By chance, she met a Lebanese social worker at the YWCA where she had hoped to find an inexpensive place to stay before leaving. During the interview with the social worker, the patient started to cry and was unable to stop. The social worker referred her to a half-way house, where, for about two weeks, B. remained in a state of near total muteness and slept "all day." Given her withdrawal and her crying spells, she was asked to consult a general practitioner, who referred her to a psychiatrist. The psychiatrist, in turn, sent her to a community health center where she attended short-term group therapy (20 weeks). This treatment being insufficient, it was followed by individual psychotherapy for about one year. The interruption of that treatment, due to the departure of her therapist, coincided with B.'s move from the half-way house. The patient was told to seek further help at the psychiatric outpatient clinic of the neighborhood to which she had moved.

* The term *sorcellerie* as used by the patient is difficult to translate, but its meaning may be approximated by the following: possession by *jnun* and use of magical methods, such as poisoning, curses, and charms.



At her evaluation interview in this clinic, B.'s main complaints were the following: poor concentration, decreased sleep, and problems in interpersonal relationships. The patient also reported feeling chronically sad since a trip to Morocco four months previously, during which she had found it difficult to relate to her family. The following symptoms were also present: loss of interests, lack of appetite, fluctuating weight, suicidal ideation without a precise plan, guilt feelings, lowered self-esteem, and symptoms of anxiety, such as difficulty breathing, tachycardia, and diaphoresis. These symptoms had been present most of the time for the past year and a half, although with milder intensity during the last 12 months. The history revealed also that she had been treated for hyperthyroidism for the past year. Her thyroid status was currently well-controlled. Neither the thyroid condition nor the medication used, Propylthiouracil, was judged to affect the patient's psychiatric symptomatology.

Psychiatric history and previous treatment. Before her migration to Canada, B. never sought psychiatric help despite having suffered depressive episodes during adolescence and into her thirties. She also suffered from acute anxiety attacks during her affective decompensations, associated with the fear of losing her mind. For a brief moment during an attack, "she had to try very hard to concentrate in order for her soul not to leave her body."

Social and developmental history. The patient's mother was married at age nine to a man who suffered from tuberculosis. Two years later, a few months before his death, marriage was consummated. After her husband's death, B.'s mother returned home. At thirteen she was married to the patient's father, and two years later B. was born. B. was born in a small town in Morocco, where her father worked as a mechanic on a fishing boat. She was the second child of her mother's second marriage. Her older sister and younger brother died while still infants. The patient recalled witnessing physical abuse of her mother by her father. However, he was not abusive towards B., even though at times he would punish her for bad behavior by hitting her with a belt. This is a customary way of punishing children in many North African countries and was not considered abusive by the patient. Her parents split up several times and finally got divorced when the patient was about 4 years old. B. was sent to live with her aunt, her mother's oldest sister.

B. was very unhappy during the years spent in her aunt's home after her parents' divorce. For many years she was the only child, as her cousin was

born when B. was 8 years old. She was treated like a servant, especially by her aunt, who abused her physically and emotionally. Starting at age four, B. often followed strangers when she was sent on errands, hoping they would take her in and rescue her. She would often get in trouble for her delays coming home. The only positive aspect B. mentioned about this time was her relationship with her aunt's husband, an *Imam* (a scholar of the holy texts and leader of the mosque) who often took her side when her aunt criticized her. He taught B. to read the Koran. After she turned ten, B. stayed mainly with her mother who lived in the *Medina* (the old town); very often she was left alone at home. In early adolescence, B. learned that her mother had acquired a bad reputation as a prostitute who earned her livelihood by taking money for sex.

When B. was about 14 years old, her father decided she should marry one of his nephews. Her mother did not agree with this plan and arranged an engagement with her oldest sister's son. About two years later, her aunt put an end to this engagement and B. was told that her engagement simply was a ruse to counter her father's plan. This decision hurt B. badly, since she had fallen in love with her cousin.

B. was a grade A student since primary school and one of the few girls to attend high school. However, she was not able to perform well academically during her last two years. B. said that difficulties in her relationship with her future mother-in-law (her aunt) and her mother's deteriorating mental health made it very hard for her to concentrate on her studies. Her mother was not able to take care of the household. She became more and more distant, was often in a bad mood, and occasionally became violent. The first depressive and anxiety episode in which B. became afraid she would lose her mind occurred during this period.

B. was unable to graduate from high school. A second attempt, one year later, was again unsuccessful. By chance, she discovered an announcement in a local newspaper advertising employment opportunities for flight attendants. To undergo the necessary training, B. moved to Casablanca, where she stayed at a maternal cousin's house. However, she felt betrayed because nobody in her mother's family was helping her. Since her engagement to her cousin had been broken off, B.'s relationship with most members of her mother's family had become strained. Gradually, she broke contact with her mother's family and developed a closer relationship with her father and his second wife. B. had always kept contact with her father, even though she had been told he was a bad influence, and despite her parents' frequent fights over child support.

B. never married, but, while working as a flight attendant, she had a romantic relationship for nine years with a man who came from a

rich family. Given the difference in social status, marriage was out of reach for her. While living with him, B. had two abortions. Although this relationship was disappointing, she was not able to put an end to it.

As a child, B. had always dreamed of having a family “like everybody else,” and even in her adult life the idea that her parents would get back together remained an important goal. She planned to buy adjacent houses for her parents, each house containing two apartments. One house was meant to be occupied by her mother and herself, the other by her father and his second wife. In 1983, she agreed to work in a neighboring country in order to earn more money through a supplement for working abroad. She finally put together the money to buy the house she had dreamed of. However, a few months later, her father revealed his plan to be married for the third time. The third wife was several years younger than B. Her father had also decided to take possession of the house.

B. felt unable to defend her property and became very depressed. She came to feel that her life had lost all purpose. Although details of this episode were difficult to obtain, the patient’s symptoms at this time seem to be consistent with a major depressive episode. B. was still working in a neighboring country, and she then began a short but intense relationship with a high ranking army officer. One day she did not show up for work and lost her job. Her influential friend tried to arrange things but the situation deteriorated. Rumors about B. being a spy made him end the relationship. She felt her entire life was shattered by this incident. It put an end to her career, and because she was questioned and kept under surveillance by the Moroccan police when she returned home, she also lost most of her friends.

Given her conflicts with her father and with her mother’s family, she was very isolated for several months. The second time she felt afraid of losing her mind occurred during this lonesome period, while still suffering from major depression. Her maternal uncle encouraged her to attempt a reconciliation with her aunt’s family. Despite the bad memories regarding her aunt, these relatives had always represented her only family and, for B., her cousin was her “sister.” B. finally found work in a tourism office and later in a company doing business with Canada. This company sent her to Eastern Canada for 18 months. B. wished to stay, but in order to be eligible as an immigrant, she was forced to return to Morocco. In 1993, B. again migrated to the eastern part of Canada, where she fell ill a few months later.

Family history. Her mother has been mentally ill for thirty years, but only about two years ago, when B. was in Morocco for a short visit, did her

mother accept to consult a psychiatrist, who diagnosed a Bipolar Disorder with psychotic features. Since then, she takes medication and her health seems to have slightly improved.

The patient's father is a member of the *Gnawiyya* brotherhood (a mystical order originally founded by slaves from sub-Saharan Africa in the 18th century). B. does not know her father's reasons for joining this brotherhood. Although he had had no formal diagnosis, it seems plausible that he suffered from a mental or physical illness, since members of this kind of brotherhood are often former patients.

Course and outcome. The patient's vague answers during the first evaluation interview made it very difficult to obtain the psychiatric as well as the social and developmental history. Given the limited success of her previous treatment, and the patient's spontaneous statement that she did not believe in "traditional" explanations – psychoanalytic theory would argue that this unprompted denial suggests that this kind of explanation could be part of B.'s deeper explanatory models – it seemed advantageous to further explore B.'s problem using a special approach. This approach was ethnopsychanalytic therapy, in which the patient can use his/her mother tongue if (s)he wishes, and the therapists are familiar with traditional explanatory models. Subsequent evaluation sessions revealed more clearly the severity of B.'s depressive symptoms, and the treating psychiatrist started the patient on antidepressant medication, paroxetine 20 mg daily.

The patient responded well to medication, reporting improvement of her symptoms. However, she also mentioned suffering from side effects that were difficult to distinguish from her original depressive illness, including anxiety, poor concentration, and feeling estranged. After the dose was nearly cut in half, this form of treatment was well-accepted and gradually her symptoms decreased.

Ethnopsychanalytic therapy, in the form of two-hour group sessions twice a month, was started at the same time as pharmacotherapy, initially also in order to obtain further information on the patient. This form of therapy, pioneered by Tobie Nathan, is characterized by the use of a multicultural group of therapists, assembled among professionals from various disciplines, trained in Western universities and who are familiar with the logic of culturally traditional therapeutic interventions. In this multitheoretical approach comprising psychoanalytic theory as well as traditional explanatory models, specific references to the patient's culture of origin (sayings, explanatory models, etc.) help to reconstitute, at least partially, his/her cultural universe.

In the first sessions, B. mainly reported difficulties in her present social interactions which she explained as due to cultural differences. However, her descriptions of her relationships prior to migration and associations to dreams in which family members and former friends played an important role, revealed similar difficulties in B.'s understanding of social and family interactions in her own culture. Several of the patient's personality characteristics suggested some Axis II pathology: her criticism of others' irrational and aggressive behavior and the denial of her own aggressiveness; her tendency never to be able to come to the point, always insisting on details and peripheral events; her perfectionism, such that she procrastinated and had difficulty completing tasks; and the frequent attempts to cancel thoughts just verbalized. These characteristics suggested the presence in the patient of obsessive-compulsive personality traits. B.'s enduring difficulty organizing events chronologically might also represent a form of doubt related to OCP traits.

During the first six months of therapy, the patient also attended several lectures on the causes and treatment of depression. On the one hand, seeking different forms of treatment is in line with help-seeking behavior in her home country. On the other hand, since receiving explanations about her illness was a part of her pharmacological treatment, B.'s use of several resources also illustrates her need for control and her difficulties with trust.

Once a key aim of ethnopschoanalytic group therapy was attained by reestablishing continuity with the patient's past through the integration of traditional views into current therapeutic work, individual sessions gradually became the predominant form of treatment. In ethnopschoanalytic practice, individual therapy with one of the group therapists can be added to the ongoing group sessions. With the patient's consent, a brief summary of the work done in the individual sessions is presented to the group. B. herself requested this treatment approach, as she felt unable to talk about her mother's prostitution in front of the group.

Individual therapy also began the process of working through B.'s basic psychological conflicts, such as her need to defend against dependence yearnings, mainly illustrated by her long history of "independence," and her fear of trust that made it so difficult for her to ask for help. Her experiences as a student revealed her lack of self-esteem more clearly and led to the recall of very painful memories of emotional abuse by her aunt and of neglect by her mother. Her need to be perfect in order to be accepted and loved could be addressed in therapy while approaching her difficulties writing papers. Although B. still has significant trouble accepting her anger and recognizing her need for control, she is starting to understand interpersonal relationships better. In the last year, B. has reported two marriage

proposals from fellow Moroccans, although she does not feel ready to get involved.

During the first year following her stay at the half-way house, B. kept in close contact with that institution. She started out as a volunteer, and then began to work part-time in a shop owned by the half-way house. Given her difficulty finding a regular job, B. decided to attend a six-month course in international business administration offered by the Government to the unemployed. Although she was forced to work very hard, she was able to complete this training with great success. With the help of a program for small businesses financed by the Government, she is now trying to put together a small export-import business with Morocco. Last summer, she became a Canadian citizen, and hopes to be able to live in both countries.

Diagnostic formulation

Axis I	296.32	Major depressive disorder, recurrent, moderate
Axis II		Obsessive-compulsive personality traits
Axis III		Hyperthyroidism, controlled
Axis IV		Problems with primary support group: In past: parents' divorce, physical and emotional abuse by an aunt, mother's illness Current: conflict with her father, mother's illness Problems related to the social environment (discrimination in last employment) Occupational problems (unemployment)
Axis V	At evaluation:	GAF: 45
	Current:	GAF: 75

CULTURAL FORMULATION

A. Cultural identity

1. *Cultural reference group(s)*. B. is a first generation Moroccan immigrant to Canada, who spent her childhood and adolescence in the small town in Morocco where she was born, and then moved to Casablanca to train and work as a flight attendant. During her life in Morocco, only Moroccans and other North Africans were part of her social network, although her work let her interact with people from various cultural origins.

B. is a member of the first generation of her family to attend the public school system, where she was able to learn French. School was the only place where she got any kind of recognition, and she seems to have been attracted to French culture, including classical music and French literature.

She continued to value the particular local culture of the Medina and still seems to devalue her aunt's social environment. Despite her own difficulties, B.'s mother appears to have been a role model of an independent woman for B., since she was able to earn her own livelihood and had "friends" in high-ranking positions who helped her in her "battles" with her ex-husband regarding child-support. B.'s professional ambitions allowed her to be financially independent and to provide for her parents. Her financial means also gave her a certain status, which helped to compensate for the somewhat negative reputation of her profession as a flight attendant. Her interest in the feminist movement seems to have been a way of protecting herself, as she is aware that, especially in the small town where her mother's family lives, a woman who is not married and has no children has a low status.

B. is a modern Moroccan woman in the sense that she is well acquainted with Western ideas. However, as will be described below, she also has extensive knowledge of the traditional aspects of Moroccan culture, especially regarding notions of health, illness, and misfortune. Furthermore, she is interested in spiritual life.

Now that she is well adapted to her host country, she could be regarded as bicultural. The differences between the following two dreams, both of which relate to the same setting in Morocco, seem to illustrate a more complete integration of both cultural identities. In the first dream, experienced as a nightmare and reported early in the treatment, the patient lost her Moroccan passport when her mother's house, built on the edge of a mountain, fell into a river in the valley below. In the second dream, B. guided a group of foreigners trying to climb the steep side of this mountain, and brought them safely to a refuge, a small house that belonged to a pious Moroccan, who offered to share his meal with them.

2. *Language.* B. speaks fluent French and has some command of English. She learned French at school; French classes started in the third grade of primary school. The language spoken at home has always been dialectal Arabic. B.'s parents are illiterate because public education only became compulsory in Morocco in the late fifties to early sixties.

3. *Cultural factors in development.* Given the fact that in the fifties and sixties divorce was still rare in B.'s hometown, to be a child of divorced parents carried significant stigma. B. reported that her mother's bad reputation influenced her life mainly in adolescence. Compared to her friends at school and to her cousins, the daughters of her mother's oldest sister, B. was much more closely watched. The patient still has great difficulty

talking about the impact on her life of her mother having become a prostitute after the divorce. In Morocco, as elsewhere, to call somebody "*fille ou fils de pute*" (son or daughter of a prostitute) constitutes a frequently used and very forceful insult. Her mother's reputation must therefore have had significant negative consequences. Since the family is of utmost importance in Moroccan society, not to know who one's father is means not to have a family and, thus, almost not to exist, or to be at the margins of society. Her plan to reunite her parents, which dominated her adult life for fifteen years, illustrates the importance of her need to restore her situation.

It was only after one year of treatment that B. mentioned the fact that her engagement to her maternal cousin was a "pseudo-engagement" which made it possible for her mother to oppose her father's plans. Previously, B. had presented the problems in her relationship with her future mother-in-law as being the main reason for the breakup of the engagement. Given the importance of marriage for women, the fake engagement probably meant that B., once again, did not succeed in being "like everybody else," and this must have had significant negative impact on her self-esteem.

To be a single, middle-aged woman is more socially acceptable in Canada than it is in Morocco, so the pressure on B. to get married has lessened since her migration. On the other hand, whereas her formal education was somewhat exceptional in her home country, in Canada her credentials are ordinary. In view of her current difficulty finding a job, she is trying to develop her own small business.

4. *Involvement with culture of origin.* During her first stay in Canada, B. lived with a Moroccan girlfriend. While living at the half-way house, she had little contact with other Moroccans living in the same Canadian town. However, she kept in touch with her mother and other members of her family. B. still owns an apartment in Casablanca which she sublets to a friend. It is important to her to have a place to stay in case she needs to go back because of her mother's illness. Since her arrival in Canada, she has made two trips back home.

B. continues to celebrate important Moroccan and Muslim holidays and, encouraged by her therapists, she occasionally attends the mosque and reads the Koran quite regularly. Furthermore, the two marriage proposals she received were made by Moroccans.

5. *Involvement with host culture.* Instrumental adaptation to her host country was facilitated by her having traveled all over the world as a flight attendant; for several years she came to Canada once a month.

In the half-way house where B. spent over a year, she was mainly in contact with women from the host culture but also with immigrants from various countries. She learned about financial aid programs and programs designed to facilitate the integration into the work force of people living on welfare. She has developed some close ties with women from the host culture.

B. Cultural explanation of the illness

1. *Predominant idioms of distress and local illness categories.* B.'s recent psychiatric problems beginning in 1993 (the crisis involving crying spells, muteness, and hypersomnia), occurred a few months after her immigration to Canada. Since B. had almost no contact with members of her community and nobody back home knew about her problem, her symptoms were explained according to Western theories. The psychiatrist she was referred to told her she was suffering from depression.

B. insisted that poor concentration was her key symptom. She was able to convince her general practitioner that she might be suffering from a brain lesion and requested x-rays. He obtained a Head CT-Scan, but the results were negative. The patient's request suggests that she entertained a physiological explanation for her problem, which constitutes a frequently used explanatory model in the traditional Moroccan medical system. The patient mentioned that she felt insulted when she was referred to a psychiatrist, as this conveyed the impression that she was crazy. In general, it appears that, for B., a physiological explanation carried fewer adverse consequences than explanations involving mental illness. These explanations suggest instead that the patient might no longer be able to fulfill his/her social roles.

In the patient's Moroccan community, B.'s symptoms – and in general, symptoms that Western clinicians ascribe to depression, such as tiredness, loss of interests, decreased libido, lack of appetite, muteness, isolation, apathy, and sadness – can be interpreted as *Makhtuf* (lit. “to be captured by a *jinn*”). Different kinds of pathology correspond to different kinds of contact with the *jinn*. *Jinn* or *jnun* (plural), whose existence is mentioned in the Koran, are spirits different in nature from the objects of the phenomenal world. According to popular Islam, the invisible world of *jnun* is a sort of double of the human world. Like human beings, *jnun* have to eat, they get married and have children. A parallel exists between human beings and *jnun*, but beyond the similarities in terms of social and political structures, the world of *jnun* is “upside down” in terms of the space inhabited and the time of activity. Their world is inaccessible to humans (except for some extraordinary persons, such as prophets, saints,

and exorcists), whereas *jnun* live in the real world. Given this ambiguity, these supernatural beings are in-between the concrete and its abstract shadow, between objective reality (*dahir*) and hidden reality (*ghayib*). This ambiguity means that it is impossible to impose a dichotomy between two states of reality which are complementary.

2. *Meaning and severity of symptoms in relation to cultural norms.* For most Moroccans, illness is a social and not an individual event. The patient is involved in a process of negotiation with members of his/her group (family members, neighbors, friends) which aims at naming and explaining the disorder on a consensual basis after having discussed several hypotheses. Thus, diagnosis takes place long before the encounter with the healer starts. However, the latter will confirm or reject the family's diagnosis before (s)he begins the healing procedures or reorients the patient's help-seeking behavior.

The loss of B.'s job in 1986 and her health problems prior to and after this event (symptoms similar to the ones experienced in 1993), were seen as significant disorders by her community. One of her friends wanted her to consult a well known *fqih* (a specialist who uses various therapeutic means, such as objects, symbols, sacred texts, etc., and who can remove or make a pact with a pathogenic *jinn*). Her neighbor and members of her family asked her to consult diviners and seers. In B.'s community, as in many non-Western societies, there is often no clear distinction between illness and general misfortune, such as the loss of work or money, sudden death, crop failure, etc. All of these problems may be explained by similar causes. Thus, the loss of her job and her health problems, both signs of disorder, were seen as consequences of common causes which, according to the standards of B.'s community, would be due to social conflicts and/or stem from the supernatural world.

B. reported her friends' and family's views of her problems in the third month of intercultural psychotherapy, but stressed immediately that she did not follow their advice on whom to consult. Given the fact that in the previous therapy sessions she had referred to traditional explanations only in relation to her mother's illness, to mention later how her own problems were understood back home was seen as an important step.

3. *Perceived causes and explanatory models.* In Moroccan culture, it is often difficult to distinguish clearly between the naming of distress and the causes referred to, as naming often already alludes to the cause. In other words, in B.'s culture, descriptive categories are usually less important than

etiologic ones. For instance, to diagnose a given disorder as possession points to the intervention of a *jinn*.

Many theories of causation are to be found in Moroccan society. These theories of causation can be seen as an amalgamation of various folk beliefs and beliefs derived from traditional Arab medicine, as well as from modern Western medicine. In the latter two theories, naturalistic explanations are predominant. However, supernatural elements seem to play a certain role in all Moroccan explanations of disease. In his anthropological writings on Morocco, Crapanzano outlines two main categories of popular explanations of illness. One involves the *jnun*, as in being struck or possessed by a *jinn*. The other includes magical poisonings, magical curses, witchcraft, and the evil eye. Theoretically, healers are chosen according to the cause of an illness.

In light of the consensual nature of the diagnosis presented by the family and the social group, often several causes are considered. Furthermore, despite the importance of the specific symptomatology, several types of therapy may be seen as efficacious for a given complaint. As mentioned above, B. was asked to consult various healers.

During the evaluation sessions, the patient explained her depression as mainly due to the difficulties she experienced over a period of years, especially since her father had taken her property and since she had lost her job as a flight attendant. According to her former therapist, she was depressed because she had turned inward against herself anger that was originally directed at her father. In addition, she felt she was having difficulty improving because of the stresses linked to the process of adaptation to her new country.

In the second evaluation session, when her own and her families' histories were investigated, we learned that her mother's illness was interpreted by the members of her mother's family as due to her father's *sorcellerie*. B. claimed not to believe in this explanation and illustrated her point of view by reporting a test she had made: she brought her mother to a *lila* (a ritual therapeutic session) organized by the *Gnawiyya* brotherhood to which her father belonged. The fact that her mother did not enter a trance was interpreted by B. as proof that her mother was not possessed by a *jinn*.

Later in treatment, in a key turning point for the patient during the twelfth session of psychotherapy, B. revealed another experience with Moroccan traditional therapy. A paternal cousin had introduced her to the leader of the regional *Gnawiyya* lodge, and B. learned that this man had once put a curse on her mother on her father's behalf. After discovering how to force this man to annul his curse, she brought her mother to a *lila* chaired by him. B. told her therapists during the psychotherapy session that

her request to remove the curse was successful and that, from then on, her mother felt better, particularly because her terrible headaches diminished greatly.

Following this turning point in psychotherapy, B.'s extensive knowledge of traditional explanations and practices became increasingly evident. It became clear that her knowledge dated back to her childhood and adolescence; for instance, already as a child she had learned how to read cards. In light of the fact that she had lived most of her life in Morocco, her small town familial background, and her mother's residence in the more traditional environment of the Medina, B.'s knowledge is not surprising. It is well known that many Moroccans, and especially women, are acquainted with traditional healing practices and their corresponding explanatory models, although to various degrees, because these practices are usually part of general enculturation. Particularly in urbanized areas, tradition and modernism are two inclusive and interactive components of the Moroccan way of life. Therefore, to be a "modern" Moroccan does not preclude being deeply embedded in tradition.

However, B.'s knowledge is also the result of a special interest in traditional practices which developed after she lost the job she had in a neighboring country. B. felt that she had nothing more to lose and decided to find out how *sorcellerie* works, despite the risks involved. In Casablanca, one of her neighbors seems to have been a good informant on magical charms and witchcraft techniques. B.'s investigations led her to conclude that marriage was out of reach for her because of her father's *sorcellerie*. She also developed the idea that she would not be able to have children because her aunt, in whom she confided when she had her abortions, had used a special technique to make her barren.

In Moroccan society, there are a great variety of healers and therapies besides Western practitioners. These include *fuqaha* (Koranic teachers), herbalists, exorcists, and various brotherhoods (*Gnawiyya*, *Isawiyya*, *Rahaliyya*, *Hamudshiyya*, among others). Visits to several sacred places are also considered helpful, such as visiting saints' tombs, sacred grottos, springs, pits, trees or baths. Although early in her treatment B. had denied following up on her families' and friends' advice to consult various traditional healers, she reported later on that she did consult some of them. However, she still maintains that she did not comply with the treatments prescribed.

B.'s situation must have been judged to be very serious, since finally her mother's family told her to leave the country. Their hope may have been that by living abroad B. would be safe from her father's supernatural activity described by the patient as *sorcellerie* or *s'hur*. The patient used

the Arabic term when talking to the Moroccan co-therapist. B. defines *sorcellerie* or *s'hur* as the use of magical curses and magical poisoning; her definition of *sorcellerie*, which might be translated as "witchcraft," also includes the intervention of *jnun*. B. told us that *Sha'ban*, the month before *Ramadan*, is a period during which the *Gnawiyya* brotherhood is very active, using *jnun* to do harm. Therefore, she decided to make an offering each week at the mosque during this dangerous month. As noted by Nathan, some *taleb*s or sorcerers (*sa'har*) may use *jnun* as "auxiliary spirits." Thus someone can become "possessed" because an enemy has "sent" spirits by means of *s'hur*.

4. *Help-seeking experiences and plans.* B. only sought help from Western medicine when she had a crisis in 1993, a few months after her arrival in Canada. The general practitioner initially recommended by the half-way house referred her to a psychiatrist. B. reported having great difficulty understanding the rationale for the treatment prescribed by the psychiatrist, group psychotherapy; she did not know what she was supposed to do in group. B.'s reaction does not appear surprising, since in her culture of origin Western psychotherapy is only used by a small segment of the population. In contrast, B. had had personal consultations with different healers in Morocco and had participated in therapeutic sessions of the *Gnawiyya* brotherhood while accompanying her mother. In addition, she had witnessed, and even sometimes financed, *lilas* organized by her father on a regular basis in her own home. Given these experiences, she was probably struck by the difference between psychotherapy and traditional treatments. In the latter, the patient is not expected to talk about his/her inner world. The healer usually asks only a few questions and mainly interrogates the invisible. In these treatments, one tries to reestablish order through the use of different forms of protection, such as praying, attending the mosque, sacrifices, making a pilgrimage, wearing amulets, and exorcism.

During her upcoming trip home, B. intends to make a special sacrifice for her mother. She also hopes to find someone who can help her to protect herself through the use of prayers. According to B., a curse has made it difficult for her to use prayers as a form of protection.

C. Cultural factors related to psychosocial environment and levels of functioning

1. *Social stressors.* For the last six months, B. has received a salary from the Government for participating in a program aimed at developing small businesses. But she still remains very insecure about her future, since

she has no guarantee that her plan will work out. Her duty to take care of her mother is difficult for B. to accept. After completing the plans for her business, she will finally be able to visit her mother, who has long expected her to return home. The pressure on B. from her mother's family to confront her father and retrieve her property constitutes a significant stressor. B. reports feeling resentful over having to fight for her property so as to be better able to care for her mother. In addition, B. would like to live part-time in both Morocco and Canada, but she is aware of the sizeable obstacles in the way of her wish, especially if her business project should fail.

2. *Social supports.* For over two years, B.'s social network was limited to persons related to the half-way house. For the last year, however, she has also kept contact with members of the Moroccan community living in Canada. Her business studies made it possible to develop relationships with several colleagues who are now helping each other in their business ventures. After a period of silence during the first six months of her treatment – while dealing with her anger at her mother and at members of her mother's family – B. reestablished regular contact with them. Her relationship with her maternal uncle has become more important; B. is now aware that he could help her deal with her father.

3. *Levels of functioning and disability.* At present, B.'s level of functioning is considerably higher than two years ago. She is now able to work full-time. Also, she seems to have learned how to ask for help, if necessary. Social interactions have become less stressful. Nevertheless, her trip back home will be an important test of her ability to relate to others.

D. Cultural elements in the clinician-patient relationship

As previously described, B.'s culture mostly views illness as a social, not an individual, event, and members of the community are involved in naming and explaining the disorder; they also assist in choosing the therapeutic itinerary. This important help in the search for meaning was lacking for B. during her early stay in Canada, because B. had very little contact with members of the Moroccan community and also did not reveal her problems to her mother's family. Thus, the approach chosen by her therapists for further evaluation and treatment, ethnopschoanalytic therapy, fulfilled a function usually held by members of the community. This clinical approach was also used because the previous psychotherapeutic treatment had not been successful.

In ethnopschoanalytic therapy, the therapists' questions convey their interest in understanding how the patient's problems would be explained by his/her family and friends, as a way of approximating the patient's cultural group. For instance, when B. mentioned that her mother had been ill for a long time, we asked her how this illness was explained by the members of her family. This kind of intervention stems from one of the premises of ethnopschoanalytic therapy. In a situation of illness and misfortune, explanations coherent with basic concepts of the patient's culture of origin may be more helpful in giving meaning to suffering than borrowed concepts from another culture. When a patient seems hesitant to refer to explanations specific to his/her own culture, one of the co-therapists may mention how a similar problem could be interpreted in his/her own culture. For example, one of the co-therapists in B.'s group, who is Kongo, suggested that one might say "something was done to the family" when a mother has been ill for a long time and her daughter has suffered many misfortunes. B. immediately associated to this statement by revealing that she had been told that the wife of her father's brother had used a magical curse to destroy her family. This aunt was jealous because she was unable to have children. B.'s reaction suggested that, as suspected by the therapists, she was familiar with traditional explanatory models. Nevertheless, during the first six months of treatment, B. manifested strong ambivalence regarding these traditional explanations.

B.'s revelation of the main reason for her migration, reported in the twelfth session, helped to understand this ambivalence better. B. had left Morocco in order to protect herself from further misfortune caused by her father's *sorcellerie*. Since her mother is the only member of her family who keeps contact with her father, B. had tried to hide her whereabouts from him by letting her mother believe she was living in France with her maternal uncle's family. Despite these precautions, the fact that she became ill a few months after her arrival in Canada suggested to B. that her strategy for self-protection had not been successful. It is less surprising, then, that in 1993, in order to deny the possibility of supernatural activity reaching her even on the other side of the Atlantic, B. insisted on a physiologic explanation for her condition, and asked for x-rays to test this hypothesis. Although she spontaneously referred to traditional explanations during her second psychiatric evaluation in 1995, she tried to deny their accuracy. She was probably afraid that supernatural explanations might again apply to her present problem. It seems that the development of a trusting therapeutic relationship helped B. face the possibility of supernatural involvement. The revelation of the main reason for her migration represented a turning point in her treatment. From then on B. seemed to be more genuine in

therapy, and used her mother tongue more spontaneously, even in individual sessions with her therapist, who has no knowledge of Arabic.

The use of traditional explanatory models in therapy goes along with the idea that it may be important to use traditional therapeutic interventions coherent with the patient's explanatory models. The value of coherence between the culturally specific ways of expressing distress, their explanations, and treatments is well established. Thus, after using a traditional explanation for B.'s situation – that her mother's illness and B.'s misfortunes meant that something supernatural had been done to B.'s family – it was necessary to offer the patient a means of intervention coherent with this kind of explanation.

In light of the key role of the family and the social group in traditional explanations and treatments, the reliance on cultural coherence by the ethnopschoanalytic approach means that the use of traditional explanatory models is usually accompanied by involvement of the patient's family in treatment. In this way, this approach helps to reestablish or enhance contact with the patient's family. For instance, the patient may be told to ask his/her family back home to perform an offering or a ritual sacrifice as a way of seeking protection. In order to understand this request, the family will usually discuss the patient's problem and possibly seek outside help. Thus the patient is no longer isolated since his/her problem is taken up by the group. In view of B.'s conflictual relationship with her mother's family and the fact that her own father is identified as the aggressor, it was not possible to use this approach in B.'s case. However, it was possible to encourage B. to use in a more regular fashion protective strategies offered by her religion that she had practiced in the past, such as praying, reading or listening to specific Koranic verses and making offerings on Holy days. The Koran acknowledges the existence of supernatural forces and, therefore, offers several means of protection.

B.'s resistance to follow up on these prescriptions even after accepting them verbally, diminished somewhat after the turning point during the twelfth session of ethnopschoanalysis. However, her difficulties doing what she was advised to do in therapy are also related to her personality traits.

Her need for control became manifest early on in treatment, for instance, in her inability to respect the end of the session, and her attitude of superiority showed in her description of most members of her family as aggressive, vulgar people, bent on exploiting her. These behaviors and her obsessional rambling provoked quite strong negative countertransference reactions in her therapists.

Given B.'s character traits, it seems to have been important for her to have had the experience that, despite her indirect expression of aggressiveness, the therapeutic relationship survived. This experience, in turn, may have helped her to develop a trusting therapeutic relationship.

Despite B.'s initial ambivalence regarding traditional explanations, after about one year of treatment she did say how helpful it had been for her to be able to talk about *sorcellerie*, as this subject had come up in various conversations with Moroccan friends. She would have liked to refer a Moroccan friend to our group, but for administrative reasons, it was not possible for us to see her.

B.'s initial negative attitude regarding many aspects of Moroccan culture might also have been influenced in part by her need to please those she needs, especially her therapist. Using traditional explanatory models and encouraging recourse to traditional protective strategies in the context of an official institution of the host country means also that their value is recognized. This might help the patient to integrate better the past and the present of her migration experience.

E. Overall cultural assessment

B.'s bicultural identity was a challenge for her caregivers. Her apparent Western identity, expressed by her fluency in French, her dress, and her professional identity prior to migration, made it difficult to detect the importance of her traditional Moroccan identity within the realm of health and illness. Consonant with this identity, while living in Morocco, B. only sought help from traditional sources.

When B. fell ill in 1993 a few months after her arrival in Canada, accurate assessment and treatment were hindered because the patient had not revealed the severity and duration of similar problems prior to migration and because key subtle elements of her bicultural identity were missed. Nearly two years later, when the patient presented for a second psychiatric evaluation in another outpatient clinic, the availability of a culturally sensitive approach helped to establish a more accurate diagnosis: major depressive disorder. Pharmacotherapy was started early in treatment and helped reduce B.'s symptoms related to her recurrent major depression.

Psychotherapeutic treatment, in the form of ethnopschoanalytic therapy, was also offered. This clinical approach, which was also used in the evaluation process, is coherent with B.'s bicultural identity. Cultural explanations of the patient's problem and psychodynamic explanations were seen as equally important. In therapy, the patient was able to discuss the contribution of traditional explanatory models to her understanding of her situation. In particular, she revealed that a key reason for her migration

to Canada was to use this as a strategy to protect herself from *sorcellerie* organized against her by her own father. After she disclosed her view that this strategy had been unsuccessful in improving her situation, the integration of traditional explanations into her therapy became much easier. From there, it was possible to talk about various past experiences with traditional treatments. In addition, the extent of B.'s obsessive compulsive personality traits became more evident, once the patient's doubts were no longer aimed mainly at questioning and resisting her traditional explanatory models.

Ethnopschoanalytic therapy also helped the patient to understand better her difficulties in past and present relationships. This process was very painful at times, involving discussing memories of abuse, shame, and rejection, but it helped her to understand, among other conflicts, why her dream to reunite her parents had dominated her adult life. Recognizing that this plan represented her own dream made it possible for her to see her father's refusal to go along with it in a different way, and therefore may facilitate future interactions with her father.

This case suggests that even for patients who appear highly Westernized, once they are confronted with illness, references by therapists to traditional views may be necessary in order to help give meaning to their disorder. In light of the value of coherence between the expression of a disorder, its explanation, and its treatment, use of traditional explanatory models in therapy – especially if they point to supernatural causes – may require access to knowledge of religious practices, or even, when locally available, to the expert help of traditional therapists.

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