Chapter in McGoldrick, M. ed.: Re-Visioning Family Therapy: Race, Culture and Gender in Clinical Practice. New York, Guilford Press, 1998.

MIGRATION AND THE DISRUPTION OF THE SOCIAL NETWORK

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Our personal social network--that rather stable but continually evolving interpersonal fabric constituted by close and distant family members, friends, work and study connections, and relationships that result from informal and formal participation in community organizations (religious, social, political, health-related, etc.)--constitutes a key depository of our identity, our history and our well being (Sluzki, 1996). Countless research projects have evidenced the tight correlation between quality of the personal social support system and the individual's health and chances of survival (Berkman, 1984, House et al., 1982; Schoenbach et al., 1986), including such a varied array of factors such as frequency of myocardial infarctions (Orth-Gomer et al, 1993) and recovery from that disorder (Medalie et al., 1973), tuberculosis (Holmes, 1954), accidents (Tillman and Homes, 1949), likelihood of rehospitalization after being discharged from a psychiatric hospital (Dozier et al., 1987), et cetera, et cetera.

The personal social network is a dynamic, evolving system. It affects, and is affected by, each of the normative stages in a person's life. In fact, most of the rituals that recognize life passages, from birth to marriage to death, include active network participation. It is also extremely sensitive to cultural and

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gender variables: different cultures have different norms and expectations in terms of network involvement into people's every day's life, and females and males show markedly differences in network development and network maintenance skills and in network utilization.

In the increasingly mobile society that characterizes our industrial and post-industrial eras, relocation (within countries) and migration (between countries) constitute a frequent, almost normative, phenomenon that unavoidably entails a major disruption in the social niche of the individual. (Sluzki 1979, 1992). Normativity notwithstanding, there is little explicit recognition of this disruption, and of its effects, in either the public or the professional eye. As a result, little is done by people who migrate to manage those processes (and when they suffer the consequences of that disruption, they experience it as <u>their</u> failure), little is done by public policies and public practices and, alas, not enough is done by therapists unless they are sensitized to those issues.

The purpose of this chapter is to illustrate the severe effects of the disruption of the personal social network during migration with a poignant clinical case[2], and to use this case to underline some therapeutic stances that may contribute to ameliorate their effect.

A family of Philippine origin came to a family-oriented family medicine clinic to seek treatment for the unusual behaviors of a 14 year-old boy who,

[2]The clinical example used in this chapter has been previously discussed in C.E.Sluzki (1996): <u>Social Networks: Frontier of the Systemic Practice</u>. (in Spanish) Barcelona: Gedisa, (in Portuguese) Sao Paulo: Casa do Psicologo (in English, in preparation, under the title: <u>The Creation of Therapeutic Alternatives: Social Network in Systemic Practice</u>.

starting two months before, began to exhibit striking body tics, such as moving his arms as if to shoo flies away and intermittently producing explosive clicking sounds with his mouth, uttered in the course of conversations or out of the blue, alternating with an otherwise pleasant and appropriate behavior and speaking mode. The youngster acted oblivious to that behavior, and, when confronted, could not explain it. That disruptive interference with the young man's daily social behavior had grown in intensity in the past few weeks, to the point that the principal of the junior high school he was attending informed his parents that those movements and explosive insults had become so disruptive that their son had to be removed from his classroom and, eventually, suspended from school until the problem was solved. These behaviors had acquired such predominance that the boy could no longer use public transportation, as fellow passengers took personally the insults he was muttering and had occasionally confronted him.

The clinically astute reader will have already recognized in this description the traits of the Gill de la Tourette syndrome, a diagnostic category to which some specialists attribute a neurological base, others add it to the larger set of schizophrenias and yet others define it as an independent diagnostic category.

During the interview, this slender, properly dressed, shy and very pleasant youngster participated moderately, his utterances as well as his silence tinted by occasional noises, insults and abrupt movements which occurred, so to speak, on another channel, parallel to that of the conversation while criss-crossing it rather frequently. In fact, the boy expressed worry about his symptoms but he seemed almost indifferent to their effect -- they took place not only in parallel channels but also in parallel worlds. When I would ask him

"What was that?" he would either deny those enactments or define them as puzzling for himself: His typical answers would be "Nothing" or "I don't know." The content of his contribution to the conversation was, otherwise, totally appropriate for his age, without any hint of additional "pathology" (by that I mean that the boy did not show any behavior or participatory style that could orient me in the direction of a configuration such as schizophrenia or any other diagnostic category, beyond the already mentioned Gill de la Tourette Syndrome). Until he was suspended from the school, his academic performance had been satisfactory.

His parents, a young, educated, elegant and socially gracious couple, fluent in English, expressed their preoccupation and puzzlement about their son. A younger daughter 10 years old participated appropriately in the interview and added little additional information. Her brother's unusual behavior had been already normalized by her except in public situations, where it made her laugh and feel ashamed.

As the interview progressed, I explored everybody's theories about the boy's symptoms. The parents informed me that their family physician had made a provisional diagnosis of schizophrenia, but they did not understand well what it meant. Neither the youngster himself nor his sister offered any theory or insight into the matter. In turn, I also confided to them that I had not yet been able to produce myself any cogent explanation for the youngster's behavior, but that I supposed that, as frequently is the case with tics, it had to do with tensions and stress -- a vague tension-reducing statement that seemed to satisfy the parents, at least at that moment in the session. I informed them that I would recommend temporarily a medication for the boy (more specifically,

haloperidol, a psychotropic medication recommended specifically for this syndrome in the psychopharmacological literature) and proposed to follow this meeting with one with the parents alone to explore with them additional elements of their life history in order to allow me to further familiarize myself with their predicament.

The decision to medicate (and in general terms my wish to keep myself up to date in terms of clinical psychopharmacology) represented my commitment toward maintaining a balanced bio-psycho-social perspective in clinical practice, and to avoid the risk of depriving patients under my care of the possible benefit of psychotropic medications because of my own ideological bias in favor of the psycho-social interventions. All and all, this eclectic position contains an unavoidable drawback: once I have added the medication, I lose the possibility to discriminate the relative contribution of the psycho-social variables (and interventions) and the neuro-biological variables (and interventions) to any improvement. In turn, the decision to interview the parental couple alone derived from my impression that, during the first interview, they kept at all times a stance of "model parents" in front of their children--and, indeed, in front of me if not of each other--, which fits with my knowledge of the dominant value of "saving face at all expense" in people heavily influenced by Asian-Oriental cultures.

In the course of the second and third interview that followed, only with the couple, the family history unfolded. They both belonged to upper-middle class traditional Philippine families. He was a lawyer and his father had been a senator representing an opposition party. She, in turn, had a general college education and belonged to a family with connections to the establishment of the

same political party. They knew each other since childhood, as their parents shared social circles and clubs. Almost predictably they started courtship while adolescents, married rather young with everybody's blessing, and had their two children within the large welcoming web of their two extended families. Their family and social life evolved in a sheltered and stable fashion, following class and culture-outlined social pathways. However, after a military coup d'etat which unleashed a political persecution of opponents to the new de facto regime, his family was seriously threatened and the couple, in an effort to protect themselves and their children, had migrated to the United States about 5 years ago, receiving some economic support from both families, but not enough to live comfortably. Thus, the husband, and soon also the wife, started to work full time and part-time respectively. Since his credentials as an attorney did not have validity in the US (laws and judicial processes are fundamentally different from country to country), he could at the most obtain a job as coordinator of a social center for the Philippine community, where he could use some of his prior training as a lawyer. In turn, she completed training as a dental hygienist at a community college and started working part-time during the hours when the children were in school. Both mentioned with a smile that the adaptation to the new circumstances hadn't been easy, but in what I understood as an effort to keep the appearances, both agreed that it had been a positive experience for them. I introduced progressively the other side of the coin, resonating to their descriptions with occasional comments about my own and my family's experience of immigration, about situations of cross-cultural misunderstanding and experiences of cultural dissonance, about the family difficulties triggered by the unavoidable interpersonal overload of migration, generating in that fashion an empathetic echo about the most difficult aspects of their recent history. This had the progressive effect of normalizing their

difficulties and legitimizing their experiences: their shortcomings ceased to be signs of weakness or incompetence to become a common if not unavoidable effect of difficult circumstances. It also modeled for them a stance of openness about one's own pain that contributed to define the context of therapy as a safe one.

Progressively, they became more expressive and less defensive with me. And, what is even more important, they opened to each other. Once and over again, when one of them would describe--almost confess-- some specific area of difficulties, the other would respond with surprised comments like "You never even leaked that to us", or "I did not realize that you were having such a bad time." This I responded: "Each one of you seems to have taken care of the other through minimizing comments about your own difficulties. But that may have the unavoidable after-effect of reducing your alertness to the other's signals." They found this comment very helpful. At one moment the wife began to sob while expressing her isolation and feelings of loneliness, and the husband exclaimed with astonishment and tenderness that those they were the first tears he had seen in her since they arrived to the United States.

This rich unfolding of their individual and joint history also allowed me to glance at the vicissitudes of their social network in the course of this difficult transition: in the Philippines, each of them grew up in an extended family, with a rich and rather dense net of relatives and friends, including many stable, long-lasting friendships with classmates and playmates from childhood, adolescent friends and teammates, and young adulthood workmates-turned-friends and conjoint (couple) friends. Even after being married, and despite getting along very well and loving each other, in addition to the shared friends with whom the

couple would socialize, each one kept his/her own personal network of close friends. The wife could confide her emotional problems to her female cousins and friends, ask for and provide advice, and count on them for a range of functions. She could also rely upon, and be relied upon, by her siblings and her parents, and so could the husband. In addition, he was a junior partner in his father's law firm. The couple did not need to develop a broad range of areas of intimacy, nor had they acquired the skills to do so, since many of these functions were consistently and non-conflictually covered by other members of their network. Such intimacy was not prescribed by their culture (including their class culture), within which men and women kept many separate social relations, activities and encounters.

Once they migrated, their interpersonal net collapsed dramatically. They now lived surrounded by people with whom they had little in common. They were not skilled in developing quick new relationships (skill that is frequently developed, for instance, in military families, who have to move frequently from base to base). There was also a class differential with many people of their own community, and their own class bias made it harder for them to reach out to them. This substantial social vacuum was, of course, within their awareness, but the extent of its effect on them was not. One of these effects was that each one of them began to expect that the other would fulfill interpersonal roles and functions lost through their migration, as well as newly needed reciprocal support functions.

Each of them expected that the other become an unconditional supporter, lover, confidant, companion, and resonance board, roles some of which were totally new for each toward the other. And this happened precisely

in a period when each was overloaded and needy and therefore less open and accessible to the needs of the other. Besides, both were trapped by certain added constraints inherent to their culture in regard to behaviors that are considered acceptable and expected or not within the couple, which conspired against their ability to fulfill some of those functions--previously covered by other members of their extended network, and unfulfilled since the move. It was, in fact, difficult for them to lower the drawbridge of intimacy when some of the potential exchanges would risk reducing the face-saving refuge of merely formal exchanges.

These difficulties, overloads, and pains of loneliness were explored and gently discussed with and by them. An added step was reached when I introduced an idea that was rather novel for them: perhaps the children are experiencing these same types of emotions and difficulties. Moreover, I pointed out, perhaps their son's strange behavior was a way to demand attention -- independently of the inconveniences brought about by such a methodology. The couple stated that a good part of their effort had been dedicated to making the transition more viable for their children, but they acknowledged that their efforts have focused more on practical matters than on providing emotional support. The husband commented that he had noticed that he had distanced himself a lot from the youngsters, particularly from the son, and the wife added that, since the move, she had noticed that her husband has been less expressive of his affection in general, gently implying that she also experienced that deprivation, while she quickly justified it on the basis of his work overload and other family responsibilities he had assumed. The husband accepted her recrimination at face value, and reassured her that he would do his best to express all his affection for the three of them. In general terms, both

acknowledged self-critically that they have been stingy in their support of the other, and vowed to increase their sensitivity toward the other's need as well as to be more open about their own needs, following relational pathways explored and experienced as safe in the course of both sessions.

Despite my curiosity, and not wishing to sidetrack our focus of attention from the interpersonal processes, I explored only minimally how the son's symptoms were evolving; when I did, they mentioned that he was improving markedly and, in the course of the second session with the couple, they let me know that he had returned to school and no longer had difficulties in social situations or on public transportation. Also, at the end of that session and as if an afterthought, the father mentioned that there were signals of a drastic improvement in the political climate of their country that might open up the possibility of the family's return to the Philippines. He confessed that the only thing that kept him in this country was a sense that to return without having "conquered America" was tantamount to failure. His wife told him that she had already feared that that sense of failure would trouble him, and that she didn't mention the issue before out of fear of offending him, knowing how important success was for him. She showered him with praises for his success, especially considering the many difficulties entailed by their abrupt migration. The couple also took advantage of this atmosphere of openness and intimacy to reveal to each other that they had kept private contact through mail with friends and relatives in their country. The conversation became even richer with the recognition that this secret desire had conspired against the possibility of developing a fulfilling social network in the United States: "Why should we make the effort to establish social contacts if we were thinking of returning to our country soon" (a mythical 'soon', since they had not spoken about this and

had not defined their migratory experience as time-and-context-limited or permanent). Both laughed, relieved that this topic could be discussed. I suggested to them that, once they felt totally comfortable with this topic, they discuss it openly with their children, who might also bear some secret hopes, similar or even different to theirs. This last comment worried the parents: What would happen if they wanted to return but their children did not? The couple's sessions closed with their expressions of gratitude, which I reciprocated by stating that I had also learned a lot from their openness.

I scheduled one follow-up interview with the whole family, in which the parents described changes in the family climate toward more closeness and warmth. They also mentioned that they were considering a return to the Philippines, and that the first one to leave would be the son in order to prepare for the examinations to enter as sophomore at the bilingual (Tagalong-English) Secondary School that he would attend. He would live temporarily at his grandparents' house until the return of the rest of the family. I commented that it is always wise to begin any moves by sending in advance a scout to explore the territory and prepare the locals for the family re-entry. Smiling at what they understood as a wise joke, they praised their son for his new potential role. The boy -- who continued taking the prescribed medication and kept functioning well in school -- did not present any symptomatic behavior during the session.

At the closure of that consultation I suggested that we meet for a couple of follow-up appointments, at three months intervals, which they accepted. However, I saw them only once, after some four months, in an interview in which they commented that the young man's symptoms had vanished. They also informed me that the change in the political situation was making it

possible for them to plan to return soon to their country without major risks to any of them. Some eight months after that session, at the end of the year, I received a postcard from them, sending me Season Greetings from the Philippines.

From the rich tapestry of processes that characterized this therapy I would like to highlight the following points:

- the vicissitudes of the experience of migration constitutes a narrative that is readily accepted by all the participants--family and therapist alike--as a legitimate and meaningful theme of the therapeutic conversation; it allows for all the characters of the story to be placed in dignifying loci; it permits to define areas of conflict that do not hinge negatively on the intentions of the participants and areas of competence in all the characters; it generates a background against which actions acquire a positive meaning, difficulties are legitimated under a new light, problems are redefined and alternative solutions are developed; from that perspective, the theme of migration, when legitimated by the experience of the family, constitutes a powerful attractor that expands and reorganizes the description of the problems and the range of the potential solutions[3];

[3] Even though the network disruption that follows a relocation is more readily explicit and salient as a theme for families belonging to cultures that favor close-knit, extended, family ties and are characterized by low geographic mobility, the active exploration of those variables--based on the assumption on the part of the consultant that such a disruption has taken place regardless of the culture of origin of the family--will show that these vicissitudes constitute a theme of almost universal appeal, one of those "strong attractors" that will organize the collective conversation in a meaningful way, with powerful transformative potentials of the collective experience.

- already within the content of the narrative, migration unavoidably overloads any family, and even more parental couples; many functions previously fulfilled by the members of the extended network --relatives as well as friends-- remain unfulfilled; each member of the family or couple, experiencing that void, expects the other to fill in, regardless of the fact that the other might have never done so before; as those needs go unsatisfied, complaints and resentment often ensue, which only contributes to escalate both needs and unavailability;
- this increase in needs and reciprocal expectations takes place precisely while the partner is in turn most overloaded and less able to fulfill the other's need;
- the dedication to fulfill the children's needs is frequently a smoke-screen to hide the needs of the adults; and, at the same time, the need to concentrate on everyday survival on the part of the parents may make them miss clues of pains and difficulties in their children, especially if those mimic that of their parents;
- a key component of the therapist's function as both cultural broker and legitimizer of the experiences of dissonance requires that the therapist maintains an empathetic, contextualizing and normalizing stance, with assumptions of competence and good intent about the participants' behaviors;
- the explicit focus of the therapist on the vicissitudes of the process of migration is readily understood by the consulting families, and has the powerful effect of both demystifying and de-pathologizing the therapeutic process: symptoms and conflicts are thus not an expression of pathology or of incompetence, but the by-product of an intrinsically and unavoidably

complex and painful process for which we are seldom prepared, and for which we have to develop new skills and new awareness.

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