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IDENTITY FORMATION DIFFICULTIES IN IMMIGRANT ADOLESCENTS: THREE CASES FROM GERMANY

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Adolescence is a period of instability caused by biological changes and restructuring of the personality. An immigration background renders the process of identity formation even more difficult or fragile, with an additional burden coming from persecution and harassment. Three case studies of mentally disturbed adolescents with different immigration backgrounds illustrate the problems in diagnosis and psychotherapy. All three cases share a common feature—the particular influence of the native country on the psychic disorder of the adolescent, be it a suitable target of narcissistic self-aggrandizement, a reactivated metaphor of the past or a deposited conflict. I point out and discuss the danger of diagnostic colonization and activation of perpetrator-victim constellations—such as the Nazi past in the present. Offering a transcultural transitional space as a container yields a therapeutic approach to the different worlds of these borderland adolescents.

KEY WORDS: adolescence; identity formation; immigration; transcultural transference space

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Although 7.6 million people originating from other countries live in Germany and nearly 16.5 million of 80.5 million German inhabitants (20% of the population) have an immigrant background (according to the German Federal Statistical Office), psychoanalytic literature on the psychotherapeutic interaction with immigrants is scarce. This is an astonishing deficit especially in view of adolescents, for whom identity formation may become a great problem given their bicultural background.

As the second phase of individuation (Mahler *et al.*, 1975; Blos, 1962), adolescence is often a period replete with crisis and can be even more

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unstable in the event of an additional third phase of individuation (Akhtar, 1995), such as coping with one's immigrant status. Adolescents generally experience role confusion during their quest for identity (Erikson, 1950). Differences in cultural perspectives may often lead to further disorientation or even culturally determined identity confusion (Jensen *et al.*, 2011). Furthermore, forced migration creates the conditions under which the adolescent Ego may be traumatized more easily, resulting in the development of defense mechanisms, which may interfere with the natural process of identity formation (Anagnostopoulos *et al.*, 2006).

Every three years the OECD (Organization for Economic Co-Operation and Development), concerned with the economic and social well-being of people around the world, conducts a PISA (Program for International Student Assessment) (see: www.oecd.org). The 2004 OECD showed that children of immigrants in a socially weak environment are inadequately supported in Germany, and that most have either completed a low level of study or not completed their schooling at all (OECD, 2008). Adolescents with an immigrant background who lack academic and social integration in support of their quest for identity, become a sort of melting pot for dangerous developments—whether it be antisocial personality, militancy, or drug abuse.

In this paper I discuss the specific characteristics of adolescence, and the problem of identity formation in adolescents with an immigration background.

ADOLESCENCE AND IMMIGRATION

Adolescence is a time of profound bio-psychosocial restructuring. Epidemiological studies show this period to be characterized by considerable instabilities. The boundaries between normality and pathology are diffuse and it may be difficult to distinguish between healthy and pathological narcissism or between borderline disorder and borderline-like behavior (Streeck-Fischer, 2014). Adolescent behavior—often fraught with risk—should be understood in light of biological imbalance. Adolescents have limited control of their behavior and tend to seek quick success, variety and immediate satisfaction, instead of pursuing long-term goals (Casey *et al.*, 2008). Their capacities for self-regulation are not yet fully developed. The immature ventral prefrontal cortex cannot yet perform sufficient top-down control of affects and or the reward promising regions of the brain (i.e., the amygdala and the nucleus accumbens). These facts account for the many peculiarities of adolescence.

Identity concerns one's individual personality and results from relationships with important others that develop over the course of one's life (Seiffge-Krenke, 2012). Identity has also been described as the experience of coherence and continuity (Ermann, 2011). The formation of individual and ethnic identity is a complex process involving a combination of biological, social, cultural and environmental factors (Mann, 2006). Although identity formation is a lifelong process, the steps taken during adolescence lay the foundation for the future. The adolescent's identity is not merely the sum of his or her childhood identifications but a combination of early and new identifications (Erikson, 1950). This process is replete with crisis and danger. Not only do adolescents become able to think about themselves in more differentiated ways, but cognitive changes also affect how their relationship experiences are handled. Adolescents relate their own past to their present and future and in the best-case scenarios will develop identity-forming narratives and goals on this basis. Consequently, identity in adolescence is mainly concerned with the maturation of self-regulation and the complexity of social functioning.

Marcia (1966) describes different levels of identity formation. *Achievement of identity* is the highest level, namely the integration of identity, associated with pronounced self-esteem and mature interpersonal abilities. This level is generally attained only at the end of adolescence. This latter period is characterized by the *identity moratorium*, and is primarily determined by exploratory behavior not resulting in decisions. In contrast, *identity foreclosure* is characterized by non-exploratory, obedient and conformist behavior. *Identity diffusion* is associated with severe psychic and social problems. According to Kernberg (1975) and others, it is the result of a structural pathology. These different levels form a kind of pattern for identity processes, and potentially becoming a problem if a desirable *achievement of identity* is not attained at the end of adolescence.

Adolescents are very receptive to foreign cultural perspectives, values and forms of behavior. Not infrequently, the result will therefore be dissonant acculturation in adolescents generally, and particularly so in adolescents with an immigrant background, who adopt cultural values that conflict with those of the society in which they now live (Portes, 1997).

With the rapid global expansion of the Internet throughout the world, social networks have developed, responding to the common interests of adolescents everywhere, but these networks also convey conflicting orientations and values (Jensen *et al.*, 2011). Consequently, the quest for identity may involve rambling between different cultures, often associated with a feeling of in-betweenness.

The ethnic origin of an adolescent plays an important role in the transgenerational transfer of cultural ideals, especially if the immigrant adolescent feels rejected by the new society and its culture. Berry (1997) describes four different patterns of acculturation:

Assimilation is an adaption to the new culture with the development of a corresponding cultural identity. In this case the identity of the country of origin is abandoned. A gap in the family may result if parents do not follow the adaptation of the adolescent.

Integration is a combination of the original cultural identity with elements of the new culture. Such developments are desirable but hardly realizable if the values of the cultures are very different.

In the case of *separation*, people reject the new culture and keep their distance from it.

In the case of *marginalization* neither the culture of the country of origin nor that of the new country becomes important for identity formation. The resulting problems are usually related to severe conflicts and may lead to identity diffusion.

If the adolescent does not acquire a clear orientation from the parents, because the parents themselves have difficulties of their own with acculturation or with inadequate integration, the third phase of individuation becomes a real challenge. In Germany, particularly adolescents from Southern Europe or Turkey experience severe acculturation stress. Immigration as a stress factor is sometimes also regarded as a traumatic experience (Grinberg and Grinberg, 1990; Özkan and Hüther, 2012). On the one hand, immigration is then viewed as a sequential traumatization (Keilson, 1979) resulting from persecution and violence in the native country, as well as the conditions of the immigration process itself (e.g., sojourns in reception camps, placement in foreign social surrounding, and hindered occupational integration). On the other hand, the immigration process is described as a cumulative or tension trauma (Grinberg and Grinberg, 1990) because of its ongoing stress. During the immigration process, adolescents experience uprooting affecting both themselves and their parents. Feelings of non-belonging and "delocation" (Bhabha, 2000) then block identity development. The resulting encapsulation of adolescents serves to prevent a loss of self and identity.

The data on whether immigrants tend more often to exhibit psychic and psychosomatic problems are contradictory (Glaesmer *et al.*, 2009). While a German study found no difference in the rates of incidence, significantly higher rates of depression suicidality, anxiety, substance abuse and eating disorders were found in adolescents of first and second generation immigrants in the USA (Pumariega and Rothe, 2010; Pumariega and Cagande, 2013). Results from the German KIGGS study (2008), a longterm study on health of children and adolescents in Germany conducted at the Robert Koch

Institute, suggest that low socio-economic status, as well as an immigration background of the family, are risk factors for psychiatric disorders. For example, the percentage of borderline abnormal or clearly abnormal levels for immigrant children (21.3%) is almost as high as in families with a low socio-economic status (23.2%), and almost three times higher than in families with a high socio-economic status.

Patients with a bicultural background often seek psychiatric or psychotherapeutic treatment. The problems revealed in the psychoanalytic treatment of such patients, especially adolescents, have hardly been illuminated to date. In contrast to the treatment of adolescents of German origin, it is important also to offer a transcultural transference space when treating these bi-cultural patients, in order to better understand phenomena related to their native cultural background. Otherwise therapy may be reduced to a superficial and fragile adaptation to the given personal and social conditions (Sharabany and Israeli, 2008; Samuels, 2002). Adolescents falling back on infantile relationship experiences during adolescent development, especially, need bicultural containers.

Berenstein and Puget (1997) described three spaces of transference: (1) the intra-subjective space that the child creates between itself and the mother during its development; (2) the inter-subjective space that the individual finds in his environment, his family and society; and (3) the trans-subjective or transcultural space between different cultures. Berenstein and Puget refer to Winnicott's (1965) understanding of the transference space as an intermediate space of experience with contributions from both inner reality and outer life. Understanding the inner reality of the adolescent also means understanding and considering the significance of the deeper and unconscious impact of foreign rituals, symbols and practices (Nadig, 2006; Kohte-Meyer, 2006). The transcultural space of transference may then become a space of shelter and identity, where symbolic structures (Özbek and Wohlfahrt, 2006) can be newly developed.

THREE CASES

The special problems in the psychotherapy of adolescents with an immigrant background can be illustrated by three case studies. Two of the adolescents received short-term in-patient treatment, and within the therapeutic team activated particular conflicts related to their immigrant background. The therapists were confronted with helplessness, anxiety, irritation and challenges that were partly dramatized and partly denied. These conflicts could not always be incorporated and contained.

Three groups of problems generally arose during the therapeutic work with these adolescents: (1) descent into glorified militant ideologies of the

native country, (2) perpetrator/victim constellations with reactivation of elements of the Nazi past in the present and (3) dangers of diagnostic colonization. All three cases had a common feature, namely the importance of the country of origin, which had especially influenced the disorder of the particular adolescent, either as a target (Volkan, 1988) of narcissistic self-aggrandizement or as a reactivated metaphor or as a "deposited" conflict (Volkan *et al.*, 2001).

CASE 1: "*You Germans don't understand us"—nationalistic extreme right-wing ideologies of the country of origin as a target for self-support*

C., a 15-year-old male adolescent, was the son of a Polish-German mother and a Turkish father who both came to Germany as adolescents, met there, but did not marry. Besides one younger brother, C. supposedly has ten half-brothers, nine of them from his father's relationships. C. lived with his mother. The father had left her when C. was seven years old. C. had sporadic contact with his father, who frequently was away on construction jobs. C.'s outward appearance was a bit strange at first glance. He was dressed all in white. His hair was cut short, a bit like Mike Tyson's, and he gave the impression of being a violent macho or extremely right-wing youth who adhered to the rules of a gang milieu.

During the first session C. stated: "You Germans don't understand us. If someone is poor he just goes to the supermarket and takes what you have." His disorder exhibited multiple symptoms such as destructive behavior against himself and others, transgressing behavior, increased irritability and deficient impulse and affect control. C. was at risk of antisocial development. At the same time, he glamorized Turkish culture. He decorated his room with Turkish flags and other Turkish cultural markers. Identification with his father was extremely important to him. He idealized his father, with whom he associated the image of a "tough guy," and thought he was showing strength by identifying with his father. The mother remained colorless in his descriptions and she apparently did not offer him any attractive common ground. On the other hand, he did emphasize that his family was sacred to him.

C. lived in a trouble area, with frequent street battles between Turkish and Kurdish youth gangs. Integration in school and vocation as elements of our social expectations were not attractive for him; he felt compelled to obey the rules of the street, where might was right. Because of problems in speech, writing and reading, he was on the verge of failure at school. As a result, he searched for orientations in his native culture in support of his distressed self (Streeck-Fischer, 2014), and became drawn to the ideology of the Grey Wolves, a Turkish ultra-national (extreme right-wing) organization. As a Turkish nationalist he could feel he was someone special. This attitude gave him strength, orientation and narcissistic enhancement to counter and

survive the discriminations he experienced in his surroundings. Like his father, who based his conduct on the outmoded life styles of his country (e.g., by maintaining relationships with several women), C. reverted to forms of legitimization by permitting actions outside the law and order of the country in which he was living. For example, he would say that "If you are poor you can take what you need." His identity formation led him into a dangerous form of parareality.

CASE 2: *Perpetrator-victim constellations—the Nazi past becomes the present*

A 16-year old female adolescent, B., underwent in-patient treatment for only eight weeks. She evoked intense reactions and discussions in the therapeutic team that were not only attributable to her severe illness but also understandable as the expression of a complex process concerning her handling of the trans-generational past in the present. B. exhibited multiple boundary distortions. It was curiously unclear whose past was involved and what should be mastered—the fate of the adolescent who was at the center of treatment or the sense of guilt from the Nazi past that was stirred up during therapy by an encounter with the role of the perpetrator in a victim-perpetrator enactment. A traumatic process was restaged in the transference-countertransference between the adolescent and the therapeutic team (see also: Laub and Auerhahn, 1993).

B. was receiving in-patient treatment because of severe anorexia, with self-cutting, vomiting and laxative abuse. She was blond and had a pleasant, attractive face. She was emaciated, had a bedraggled look and evoked in others much pity and willingness to help her. At the same time, her body odor was repugnant, and she evoked disgust with her dirty clothes all covered with vomit. Associations with concentration camps were articulated, as often arise in the treatment of severe anorexia. However, on learning that B. came from Russia and was of Jewish origin, the staff of the adolescent ward suffered multiple anxieties, fearing responsibility for her possible death. Professional distance was no longer possible and it was not clear how much of this anxiety was associated with B. personally, and how much with the fact that she was Jewish, with the image of Germany's Nazi past evoked in the staff. The boundary between B.'s problems and knowledge of the German past was peculiarly blurred.

The family had lived in Moscow until B. was 11 years old. Without any preparation, B.'s parents, both academic professionals enjoying a good income in Moscow, confronted her with the prospect of emigration. Having experienced increasing anti-Semitism in Russia and feeling persecuted and excluded, the parents initially planned to emigrate to Israel after the sudden death of B.'s grandfather. This not being possible, they decided to emigrate to Germany instead. The family stayed for one year in a German transit camp. After a few months the father fell in love with another woman and the family

broke up. B. felt overwhelmed and a complete alien in Germany, a country she had not chosen. She wanted to emigrate to Canada to become a photography model.

B.'s presence raised many questions: Was she a young patient with ordinary anorexia and a typical family background (namely its break-up), with high demands on performance, or did there exist familial trauma related to National Socialism, revived by the family's immigration to Germany, which she, as a member of the third generation, expressed through action? Did she suffer from detachment and separation problems with the fixation on a dyadic level of object relations, provoked by the father's departure? Had she entered a severe identity crisis concerning her origin and sexuality in this foreign country? Or were there secrets left uncommunicated within this incommunicative family? For example, it remained unclear whether the grandfather had died of natural causes. Perhaps government security agents had persecuted him and this was the reason for the family's emigration. Another possibility was that B. had experienced traumatic violence in the transit camp, such as sexual trauma. She hinted at this, but ultimately the staff was left in the dark on this matter.

Some members of the therapeutic team felt as though they were torturers or concentration camp guards. They countered such feelings by trying to keep B. alive—with sadistic means; it seemed to them, while at the same time witnessing her slow decline. Fears were reported that B. might demonstrate with her death how evil and vicious we Germans are. The discussions in the therapeutic team were very intense. In particular, the establishment of a boundary or, in more abstract terms, a decentralized viewpoint with an exterritorial location, seemed to fail. Some staff members refused to tolerate further treatment of B. and urged her transfer. B. had exclusive relationships with certain therapists, who seemed to revive her by their supporting presence. For example, B. would loiter in front of certain doors, sometimes for long periods of time, and wait especially for one female therapist until she saw B. and invited her to enter. She evoked rescue fantasies in this therapist and the feelings of being selected. The therapist was convinced that it must be possible to show B. that she was not facing "evil Germans" and that her life in Germany could now be worthwhile. The attitudes of the team members became more and more polarized—some became full of fear and alarm, wondering (e.g., whether B. might die in their care), while others became angry about what B. was doing to them, and still others became willing to accompany her through a kind of torture chamber in order to find salvation at the end. The female therapist in particular was criticized for undertaking everything for the treatment of B. She finally had to recognize that her rescue fantasies were ignoring the reality of B.'s possible death, and even more that she was willing to become entangled in

a disastrous process of continued closeness and mutual destruction as in a malignant regression, in order to avoid separation, otherness, self-determination or evil, especially since B.'s fate and deep pain were affecting her so much.

While the therapist struggled for her standing with B., the team searched together with B. for tolerable conditions, debated about ingestion and about how she could do something good for herself and her body with our assistance. She finally had to be transferred for somatic treatment because her physical state had badly deteriorated. In the end, the team was relieved that B. had accepted somatic treatment with gavage, having become aware of her dangerous condition without feeling overwhelmed. It was this drawing of a boundary that she could accept as something not only evil and directed against her—with the members of the team hoping all the while that she would return after being nursed back to health.

Conditions had changed by the time B. came back three weeks later: B. was well-fed, albeit a bit bloated, and her clothes were clean. Now therapy could "really" begin. It seemed as though she had just arrived in Germany. But B. did not want to continue therapy. After the parents had begun to speak with her, she decided she wanted to go back to her mother. As a result, many things remained unclear and puzzling. Nevertheless, it seemed as if the team had together passed through traumatic events of her and the parents' past as well as the present situation of immigration—to the point where we had difficulty setting boundaries and became peculiarly loving perpetrators, wishing as it were that B. would "stay alive for us and our past—(and not for yourself)," while ignoring the possibility of her dying. It then became possible, however, to overcome this confusing victim-perpetrator constellation by not overwhelming B. with compulsory measures like force-feeding or commitment to an institution, but rather by supporting her internally and externally. Before that point we had evidently been caught up in the idea, which she had encountered in her family, that separation means death, as it had meant in the world of the concentration camp, and as had seemed to be the case between her and us. Perhaps this was the familial tragedy B. had to overcome: You must live for us and our ancestors.

During the first eight weeks B.'s family did not give us much insight into their familial conditions. On the contrary, the family became incommunicative, froze up, and tried to convince us that they would do everything necessary. They could not confide in us about how frightening and strange the Germans and this foreign culture perhaps were to them.

It can only be speculated whether apparitions of the familial past had also emerged here, a past of people who were used to being hunted and who had learned to be inconspicuous, and who were behaving in the same way in this new country—adaptively and inconspicuously, just like B., who nevertheless

protested against this life in a different country with a message embodied as a deadly illness.

Things were different in the therapeutic team, where the lack of a boundary between the past and the present became evident and where ghosts of the German past (Fraiberg *et al.*, 1975)—the past of Jewish persecution and of the Holocaust—were revived, which made professional distance almost impossible. While we obtained no information about B.'s further identity development, it seemed as if she had now accepted to be in Germany.

CASE 3: *The danger of diagnostic colonization*

15½ years old A., the daughter of a German mother and a black African father, entered in-patient care because of visual and auditory hallucinations. She heard voices from three 16-year-old aids—Caucasian adolescents—commenting on her own behavior and that of others. She also often felt depressed, had problems falling asleep, became apathetic and indifferent, exhibited mood fluctuations with hypomanic and depressive states. She was irritable and prone to outbursts of rage. She also had an obsessive-compulsive symptomatology with ablutomania. Because of her complex symptoms she had often been absent from school.

A. had been suffering from hallucinations for 3½ years. At age 12, she had joined her father on a visit to his native African country for three weeks. There she lived with her father in a separate apartment at the family residence and shared a bedroom with him. During this time she encountered impressive mystical rituals. After her return, and already suffering from hallucinations, she moved to a boarding school far away from home. At the same time, the mother's partner moved in (her parents had been separated for ten years). Three months later she was sexually abused (without penetration) by a black African adolescent, who had been a close friend. The hallucinations became more intense with a command character. She heard stern voices rebuking her or ordering her to misbehave.

Questions quickly arose about how to classify A.'s problems. She showed the symptoms of florid paranoid-hallucinatory psychosis; she, herself, was afraid that she was suffering from schizophrenia. However, she was very vital, adequately affective, creative, and possessing good cognitive skills and the capacity to symbolize. Did she suffer from a dissociative disorder? The sexual traumatization occurred after the hallucinations had already existed. Certainly, her experiences—being alone with the father in his native country, moving to the boarding school, loss of direct contact with the parents, sexual abuse—could be seen as cumulative traumatization. Because of her good aptitude, A. had no problems with integration in the peer group; on the contrary, she enjoyed a rather good standing. The therapeutic team engaged in lively discussion about the proper diagnosis of A.'s symptoms. Should she be

medicated, as soon as possible, given her psychotic symptoms? Were Western diagnostic criteria even appropriate in her case? There was an apparent danger that A. would be made more ill than she already was. Western diagnostic tools and behavioral models might colonize A. into a Procrustean system, without regard for her individual case (Pumariega and Cagande, 2013).

For the father and his native family, A. was the reincarnation of the paternal grand mother, being the first child to have been born after her death. As the matriarch of the family, A.'s grandmother had enjoyed a prominent position. The father accordingly referred to A. as his princess. While the mother worked, he had been the person to whom A. was most attached during her early childhood.

Because A.'s symptoms developed immediately following her visit to Africa, the family suspected that someone might have "cursed" her as an act of revenge. When A.'s symptoms worsened, one of the father's relatives, a Catholic priest, was charged with building a wooden cross and worshiping and blessing it for three days. During these three days A. claimed to see a wooden cross on her foot. She said she tried to remove it, but without success. After a quarter of an hour the cross disappeared by itself.

As the reincarnation of the grandmother—the matriarch—A. had been, since birth, a reservoir of highly significant object images representing that person and family traditions (Volkan, 2010). In this way, the dead grandmother and the traditions associated with her remained alive for the father. In a sense A. was a replacement child for the dead grandmother, a wholly different kind of replacement than is understood by this concept in Western culture, where the exact characteristics and personality traits of a previously deceased dead child are deposited in a later-born child. Volkan *et al.* (2001) regard this depositing as trans-generational transmission. The generational boundary is then dissolved. The blurring of the demarcation between reality and fantasy, past and present—a feature often found in traumatization—seems to have pre-existed here and have been permanently and intrusively maintained by the father's special attention to his princess. Perhaps A. had been "cursed" because of her role as the incipient matriarch—from envy or because she did not at all correspond to her grandmother, or perhaps even because, as the reincarnation of the grandmother, she presented an affront to the African relatives. Perhaps sexual desires had also developed during her quest for identity that were inconsistent with the African relatives' expectations. Perhaps she had experienced something traumatic, such as too much closeness with her father. Finally, it was also conceivable that A. internally resisted the familial intrusions and that the "curse" had been directed at the treacherous father and his foreign family.

African cultural beliefs (Maiello, 1999) associate mental illness with a disturbance in the relationships with ancestors. Their withdrawal can make

the individual and the family susceptible to deadly witchcraft spells. The essential issue concerns not the cause of the disorder but its bringer. In any case, there is a big difference between ancestors in African culture and internal objects according to Western psychodynamic thought. Ancestors concretely exist in the external world, whereas Western culture constructs the concept of an "internal object" as a metaphor for describing intra-psychic vicissitudes. As long as ancestors in the African culture are believed to give support and advice, they practically serve as good internalized objects.

In terms of A.'s African cultural environment, the ancestors—and the grandmother within her—have withdrawn from the young A. Disrupting the connection with the ancestors leads to severe dissociation, attacks on linking, or to psychotic phenomena (Maiello, 1999). The voices that appeared and bewildered A. would then have been an inevitable consequence, the externalizations of peers threatening A.'s existing self-perception as persecuting objects. The obviously traumatic sexual abuse most likely further dissolved the already blurred boundary between reality and fantasy. If the ancestors, especially the grandmother, as the good objects had withdrawn from A., and A. was instead being persecuted by dangerous objects, the aim of therapy should have been to provide a new space for the good objects and to re-anchor them at the boundary between the inner and outer worlds. In the therapeutic session, this could involve having the grandmother be present, virtually, and asking what she would think about A., and how she would stand by A. if she were actually present.

African culture, evidently, supports the blurring of boundaries between reality and fantasy. By construing this phenomenon as pathological, we fail to address the problems of these adolescents in their quest for identity. A. becomes confused as the result of different cultural worlds colliding within her. If we accept the Western assessment of A.'s situation as the only valid one, we risk forcing a superficial assimilation in the identity process instead of supporting the sort of integration to which both cultures are amenable.

CONCLUSION

All three adolescents were more or less proficient in German, so there were no ostensible communication difficulties. The two adolescents with African and Turkish roots grew up in Germany but experienced, through their parents, a world divided in half, as it were, between a "motherland" and a "fatherland." These different worlds became especially virulent during adolescence. For both patients, their origins became a threat as well as a temptation during identity formation.

The danger of forcing adolescent patients with bicultural background origins to lie in a Procrustean bed is especially great when applying our

customary diagnostic labels, particularly because the behavior of adolescents and young adults often appears quite strange to begin with. Therapy may then easily result in the patient's superficial adaptation to our expectations without the fundamental culturally and sub-culturally influenced conflicts actually becoming the focus of therapeutic work. Instead, misdiagnosis, deficient therapeutic alliances, non-adherence (Yilmaz *et al.*, 2013) or discontinuation of therapy may result.

Under these circumstances, judgmental and, at times, imperialistic attitudes may creep into the countertransference on the part of the therapist. Questions may then arise, such as, why the adolescent creates such a parallel world instead of choosing integration, or whether he, himself is responsible for his condition, especially if his family receives government financial aid and he is financially supported as well. Phenomena like those found in C.'s case—a young man without orientation fighting for survival, risking antisocial development, and succumbing to militant marginalization—are dangerous and must not be overlooked in view of Islamic promises of salvation.

All three adolescents showed symptoms that might be regarded as consequences of traumatic stress. In the case of the adolescent with African roots, the boundaries between reality and fantasy and between the mother's and the father's cultures were blurred, with psychotic intrusions, resulting in the confusion of values. Boundaries also became blurred in the complex transference–countertransference dynamics between the adolescent of Russian-Jewish origin and the therapeutic team. On arrival in a "hostile" country, a perpetrator-victim scenario developed on both sides that, ultimately, ran a beneficial course. The adolescent with the Turkish background ran the risk of drifting off into a world of fantasy and violence characterized by nationalistic and extreme right-wing ideologies.

To treat these borderland-adolescents appropriately, we must make a transcultural, transitional space available and, in it open ourselves to what is culturally foreign to us, register it and discern its meaning. This also means overcoming the temptation to fall back on ready-made, familiar categorizations and allow for ignorance and uncertainty. Finally, it also means having an eye for the impact of cultural factors on both the patient and the analyst. Since such adolescents are often themselves unable to recognize and articulate what is foreign, it is helpful to obtain as much information as possible about the foreign culture and its special features.

If we are able to abstain from attitudes that can easily assume an imperialistic and colonializing character or, in Winnicott's (1965) words, avoid using "strange gestures"[2] inducing adaptation, protest or destruction, then our handling of foreign cultures and their immediate consequences for the individual may lead to a fruitful and creative path for the adolescent's identity formation.

NOTES

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2. Winnicott (1965) does not say strange gesture as in German translation but describes the mother as "not good enough" or "deficient" (p. 145).

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