Tiziana de Rogatis, Alberica Bazzoni,
Andreina Sgaglione

Wellbeing Languages Migration

Integrated methods between narrative medicine and storytelling in a linguistic protocol

(bilingual edition Italian-English)

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Consulenza editoriale: Valeria Cavalloro
Consulenza iconografica: Sara Belolli
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Dedication
To the individuals with whom we shared these materials in the classrooms of the reception centres and in the workshops

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Credits

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TIZIANA DE ROGATIS

NARRATIVE MEDICINE, MIGRATION TRAUMA AND IMAGES/METAPHORS. AN INTRODUCTION TO THE A2 AND B1 MATERIALS

1. Preface

This essay ties in with the discussion I began in the general introduction (*The story of an adventure. Linguistic wellbeing and narrative medicine in applied research in the context of migration*) and is divided into three sections: 1) *Stories, narrative medicine, and Princess Alexandra*; 2) *Stories, traumas, and microtraumas associated with migration*; 3) *Images, metaphors, and linguistic autobiography*.

The first section (*Stories, narrative medicine and Princess Alexandra*) should be considered in relation to the concept of linguistic wellbeing, as outlined in the *Introduction* (§4), and to the overall form. of our materials for levels A2 and B1. As Andreina Sgaglione explains in more detail, they were designed both as a way of monitoring the wellbeing and/or ill-being of immigrants and as an immersive experience that immigrants can have in their own migration stories, in the linguistic ways in which their bodies tell or silence this story of migration. This monitoring/experience can be very usefully conceived, for example, as a tool for initial contact and for strengthening the relationship with immigrants in classrooms, reception centres, and hospitals. The term "protocol" used in the subtitle of this book is meant to evoke a linguistic procedure for wellbeing. The reactions of the participants in

the classes where we tested the materials (*Introduction*, §2) show that enthusiasm for these materials has its own specific quality. These reactions show that the materials we propose do not simply monitor wellbeing; they generate it. In the context of the class, the materials activate the neurocognitive mechanisms of awareness and empathy, which are the brightest stars in the interconnected universe of wellbeing (Davidson/Schuyler 2015: 95).

We conceived this monitoring as a story divided into three parts: the three different parts of each level of the materials. The narrative quality of the materials is enhanced by the titles of the three parts, which are shared by both levels. The titles describe both the content of each individual part and the connection between one part and another of the three-part timeline: 1) *Imagine yourself, draw yourself, tell your story*; 2) *Seeds of rebirth*; 3) *Walking towards wellbeing*.

In constructing these two parts or stories in three stages, we were inspired by the methods of narrative medicine, which is based precisely on the ability to «recognize, absorb, interpret and be moved by the stories of illness» (Charon 2006: VII). The ability to describe people's state of wellbeing and/or ill-being applies to patient awareness, the relationship between patients and healthcare staff, and a number of practical aspects of medical procedures. The first section therefore explains the types of stories and practical applications of narrative medicine that have inspired us most. The section concludes with an application of the narrative techniques taken from narrative medicine to a story we created and included in the materials: the story of Princess Alexandra (activity 7a, part two, levels A2/B2). As I will also demonstrate in the second and third sections, the stories are therefore both the macro-structural principle on which the materials are based and the micro-structural principle of the activities included in the materials.

The second section (*Stories, traumas, and microtraumas associated with migration*) is again linked to the general introduction (§4), where I explained that the concept of wellbeing also needs to be understood through the complementary definition of ill-being. From the perspective of migration, one type of ill-being that has greatly helped and inspired us has been the extreme case of migration traumas and microtraumas, which we have also used extensively in the Activity Guide. Traumas and microtraumas of migration are therefore at the heart of this section, with reference to their connection with narrative medicine and some practical applications within our A2 and B1 materials.

The third section (*Images, metaphors, and linguistic autobiography*) is also linked to the concept of linguistic wellbeing at the heart of the general introduction (§4) and intersects with the categories of narrative medicine. In this third section, I focus in particular on our use of images, the interweaving of iconography and narrative metaphor, and another variant of stories: linguistic autobiography.

2. Stories, narrative medicine and Princess Alexandra

Thanks to a set of methods and practices defined by narrative medicine (Charon 2006), the transformative power of stories now crosses the boundaries of literature and manifests itself in the realms of wellbeing and care.

From the point of view of those who are ill or experiencing ill-being and from the point of view of those who treat that illness or ill-being, stories are a paradigm that is both ancient and hyper-contemporary. The wound inflicted by illness can produce a new vision, as taught by the mythical figure par excellence of the «wounded storyteller»: Tiresias, who is a seer because he is blind (Frank 1997: XI). What matters is not the choice between true or false but that there is a «narrative that provides coherence to the whole», a «narrative that can provide [...] meaning» by restoring the authenticity of a life story (Réal/Moro 2004: 225). On the one hand, on a cognitive level, the story is a structure capable of reconnecting the logical-causal fractures produced by trauma or microtrauma, putting back in order the broken analytical sequences of time and memory (Calabrese 2023: 82-85). On the other hand, on an emotional level, stories are the tool that allows the self to expand beyond fear and isolation, transforming it into a «communicative body» (Frank 1997: 48). From both perspectives, «self-stories» and «illness stories» (Frank 1997: XII, 18) – terms to be used in the broadest possible sense – have great restorative and cathartic power.

Thanks to stories and their embodiment in change, which is both the starting point and the driving force of every plot, those who are ill or experiencing ill-being can also offer themselves and others decisive interpretations of their symptoms and their lives. Stories encourage people to find their own voice, beyond the voice that everyone must use over and over in routine reports in hospitals, shelters, and schools. These are all places where, for various reasons, this voice may go unheard, or may be interrupted, distorted, or corrected.

Stories have also transformed medical records in several hospitals around the world. By making the narrative of medical records more understandable, medical histories in these hospitals have improved along with recovery rates. Thanks to narrative medicine, stories have also taken shape in hospitals through parallel charts, in which doctors can recount the memories and emotions triggered in them by the patient's medical history. Through these two applications, stories strengthen the relationship between those who care and those who are cared for, mobilizing in particular the ability of healthcare personnel to maintain empathy while keeping the right distance. By creating an emotional and cognitive connection between part and whole, between the medical chart and the parallel chart, the story of the illness or ill-being restores the vision of the whole and the points of view within each whole (Charon 2006: 4). This vision has been weakened, if not eliminated, by medical specializations and technologies. Stories therefore save lives and offer new possibilities for healthcare, education, and intercultural sustainability.

The storytelling practices described above are generated by the «clinical imagination» (Charon 2006: 5-6; 107) of narrative medicine, which is the ability to translate the «narrative imagination» into the field of healthcare. With this formula, philosopher Martha Nussbaum defines «the ability to think what it might be like to be in the shoes of a person different from oneself, to be an intelligent reader of that person's story, and to understand the emotions and wishes and desires that someone so placed might have» (Nussbaum 2010: 95). From the perspective of healthcare, narrative imagination is a multifaceted tool. On the one hand, narrative imagination is the *inventio*, i.e., the research through which writers have identified themes and suggestions in a wide variety of fields. On the other hand, it is storytelling, or the set of techniques and practices through which writers use that same research to generate narrative universes of extraordinary intensity and complexity: true «storyworlds» that are autonomous and parallel to the real world (Herman 2009: 105). On the other hand, narrative imagination is also the way in which readers have experienced immersion in a particular instance of storytelling. From the point of view of narrative medicine, commenting on a story in the freest and most diverse and ways (a form of «close reading»; Charon 2006: 107) means, for example, recounting one's own entry into the point of view of positive, negative, or ambivalent characters; it means processing all the fluctuations of empathy towards these characters and towards the world of the story they are part of.

The narrative imagination and its ability to fuel the connection between stories, care, and wellbeing also include certain core themes: the pain of life's limitations together with the complementary dimension of joy; stories of illness and healing together with the fluctuations between wellbeing and ill-being; and finally – more generally – extreme events, shaped by trauma. Far from being a catalogue of the inauspicious, these core themes help to explore the connection that exists between stories of bodily pathos and their dilemmas, namely «narrative ethics» (Frank 1997: 154; Charon 2006: 209). Those who experience and/or treat and/or support the «wreckage» (Frank 1997: 53) of ill-being or illness need to develop a system of values drawn from the mosaic of narrative perspectives, from the moral dilemma contained in the stories, from their openness to choice.

As I explained in the *Preface*, we designed all the materials for language levels A2 and B1 based precisely on this idea and practice of stories that come to us from narrative medicine. In their tripartite structure, the materials construct a story while at the same time envisaging wellbeing, as indicated by their titles (cfr. *Preface*). In terms of the structural construction of the materials, we have tried «thinking with stories»: «a process in which we as thinkers do not so much work on narrative as take the radical step back, almost a return to childhood experience, of allowing narratives to work on us» (Morris 2002: 196). Precisely in order to inhabit this childlike, and therefore essential and authentic, way of experiencing stories and their transformative power, we chose to create, among other activities, a fairy tale: the

short story of Princess Alexandra (activity 7a, part two, level A2/B1). Having lost her kingdom, Princess Alexandra is forced into exile, during which she falls into a deep depression (symbolized by the frozen heart/forest), which prompts her to seek help from a female doctor with the support of «a local woman». I will detail some aspects of our *inventio* here, while others can be found in the following two sections and in Andreina Sgaglione's essay. For example, we first chose women as protagonists in order to highlight the special attention our project has given to immigrant women (particularly in the storytelling workshops at the centre of the last part of this volume). We then gave these two characters symbolic names in order to intensify their fairy-tale quality. The name Alexandra has a regal and courageous aura (we thought, for example, of Alexander the Great). The name of the doctor, Florence, on the other hand, represents for us a tribute to Florence Nightingale, the inventor of the modern science of nursing, but in a broader sense it evokes the idea of blossoming flowers and thus also alludes to Florence: a splendid Renaissance city (with a reference to the seeds of rebirth that give the third part of the materials its title), where we have also tested our method with many learners.

From the point of view of storytelling, through the enchanted style of the fairy tale we have distilled a story of migration and loss that affects all immigrants in different ways. We have also constructed the plot in such a way as to leave the way open for change, which is a fundamental feature of migratory experiences already illustrated in relation to the concept of linguistic wellbeing (see *Introduction*, §4). Again, to emphasize the possibility of change, through the activities that follow, we encouraged each learner to imagine and retell Alexandra's story from the perspective of different characters (activity 7b, part two, levels A2/B2). Through repetition and reworking – a narrative technique borrowed from oral storytelling – narrative medicine hears «different nuances of potential meaning» (Frank 1997: 24). According to the narrative imagination, recreating the story from other points of view generates a process of increased empathy and interactive relationship. In the guide to this activity – which is aimed at teachers, intercultural mediators, and healthcare professionals – we also pointed out an important practice of narrative ethics. We have asked that that teachers not insist on an ending that results in healing, so that the way is left open for all the fluctuations of wellbeing and ill-being, up to the most extreme traumas and microtraumas associated with migration, which I will discuss now in the second section.

3. Stories, traumas, and microtraumas associated with migration

The word trauma is etymologically derived from the Greek term meaning 'wound' or 'injury', and its first use in a psychological and psychosomatic context dates back to 1878 (van der Hart/Brown 1990: 1691). Late 19th-century neurologists discovered

that experiencing extreme and intense emotions can cause damage, even if it is not visible (Moskowitz *et al.* 2019: 15).

Psychological trauma occurs only when an event of significant negative intensity cannot be processed or integrated into a person's memory and linguistic and social life. Therefore, an event of significant negative intensity does not necessarily generate trauma. The development of trauma always depends on the individual and family variables of each person, as well as on the culture within which the traumatic event occurs. Where trauma occurs, the failure to integrate the memory initially generates removal and/or dissociation, and subsequently a more or less severe and widespread series of symptoms (e.g., anxiety, insomnia, panic attacks, depression…), which are grouped around three broad areas: «hyperarousal, intrusion, and constriction» (Herman 1992: 35). Coined by the American Psychiatric Association in 1980, Post Traumatic Stress Disorder (PTSD) definitively highlights this core of delayed and displaced temporality that characterizes trauma.

While trauma is triggered by extreme events, microtrauma originates in events of less extreme negative intensity. Psychoanalytic, psychiatric, and neurocognitive research converges on the fact that «emotional losses» such as «the ending of an important relationship or the loss of one's home» (Moskowitz *et al.* 2019: 17) can have, for example, considerable traumatic potential depending on the social and intrapsychic context. More generally, «events that are not literally life-threatening but which include attachment loss and betrayal by an important attachment person also increase the risk of traumatization» (ibid.: 15). Microtrauma is amplified in a cumulative dynamic, i.e., in those repeated and scattered ruptures that, manifesting themselves «over the course of time and through the developmental process […] gradually get embedded in the specific traits of a given character structure […] [and] achieve the value of trauma only cumulatively and in retrospect» (Kahn 1974: 47).

The potential link between migration and trauma and microtrauma is unfortunately confirmed by an extensive bibliography (Bhugra *et al.* 2014; Losi 2010), which illustrates the traumatic nature, not only contemporary, of the three stages of migration: before (life in the country of origin and the causes of migration), the journey, and after (life in the host country). This triad immediately reveals the particular characteristic of trauma and microtrauma in contexts of migration. It relates to diverse cultural frameworks, because it involves the culture of the country of origin, that of the host country, and the «culture shock» generated in the immigrant by the more or less significant distance between the first and the second stage (Frigessi Castelnuovo/ Risso 1982: 162-163).

In this hybrid dimension, a continuous metamorphosis of core values, psychoanalytic categories are not sufficient in themselves, because they are based on a monological idea of culture. The very possibility of recognizing trauma depends on the cultural categories that define it (Alexander 2012: 6, 31). This process of recognition becomes impossible when our images of trauma are «narrow and constructed within

the experiences and realities of dominant groups» (Brown 1995: 102). In today's multicultural context, the problem is even more acute for immigrants, who may often suffer, because of their difference, from a form of «epistemic injustice»: «a wrong done to someone specifically in their capacity as a knower». Epistemic injustice is not only «a credibility deficit owning to identity prejudice» but also, more specifically, «a gap in collective interpretive resources» that results in placing someone «at an unfair disadvantage when it comes to making sense of their social experiences» (Fricker 2007: 28, 1).

Translating the category of «epistemic injustice» into the language of narrative medicine, an awareness emerges that the idea of narration must be expanded and forms of storytelling must be appropriate to diverse migrant and diasporic cultures. Otherwise, if the ideas and forms of storytelling are based solely on Western paradigms of body, narrativity, illness/health, ill-being/wellbeing, trauma and microtrauma, then those people who come from worlds of migration might not have the tools to name and narrate their experience.

Faced with the peremptory statements that the world continually demands of her through equally peremptory questions («who are you?», «where are you from?»), Igiaba Scego, an African-Italian writer, daughter and narrator of the Somali diaspora, reacts by recalling the words of the character of a Cardinal invented by the Anglo-Danish translingual writer Isak Dinesen/Karen Blixen (Dinesen 1957: 5): «I will answer in the classic manner: I will tell you a story» (Scego 2010: 160). Precisely because it is a mosaic of voices and destinies, stories lend themselves particularly well to the recognition of plural identities such as those of people in contexts of migration.

It is therefore crucial to nurture and leave room for the narrative imagination of learners, as we have done with various activities (on this subject, see also the second contribution by Alberica Bazzoni; part two of this volume). Among these, I return once again to those related to the story of Princess Alexandra (see §1). On the one hand, we chose to recount Princess Alexandra's trauma through the register of «enchantment» (Bettelheim 1976) typical of fairy tales. The fairy tale allowed us to respect a fundamental rule of our narrative ethics: the indirect and metaphorical evocation of migratory trauma or microtrauma. Narrative ethics always require us to avoid the immediate and direct use of the repertoire of trauma or microtrauma, so as not to trigger overly intense emotions and invade the realm of psychoanalysis and psychotherapy. On the other hand, we asked the learners to tell Alexandra's story from different points of view. In this way, we brought the stories of others into the picture, and they became our stories. With this technique, both the narrator and the listener, both the learner and the teacher, enter into the narrative for the other, creating a «Third Space» (Bhabha 1994: 36): an intermediate zone that, thanks to a method of clinical/narrative imagination with a focus on migration, brings together and transforms people who come from different worlds and who play different roles.

In the context of migratory trauma and microtrauma, reference to ethno-psychology, ethno-psychiatry, anthropology, intercultural mediation, and narrative imaginaries related to migrations is therefore fundamental. These fields of knowledge, in fact, interpret the encounter with the other and bring into the discussion other paradigms of care, language, wellbeing and ill-being, which differ in whole or in part from those of the West. Through the legacy of Michele Risso, the Italian founder of ethno-psychiatry, Virginia De Micco has, for example, very convincingly defined the concept of migratory microtrauma, describing it as an «daily microtrauma». This is a trauma «hidden» in everyday life that takes on an intrinsically uncanny quality (De Micco 2019: 55). The psychological distress of migration is widespread and pervasive, since it originates from a profound change in everyday life and in everyday life's obviousness: both of which are more or less radically contradicted by the experience in the host country. In this context, immigrants may experience an «unthought pain» and an «unrepresentable loss» (ibid.).

Precisely because of its scattered and cumulative nature, «daily microtrauma» takes on the characteristics of «insidious trauma» (Root in Brown 1995: 107). The camouflaged and hidden aspect of «insidious trauma» stems from the fact that migratory microtraumas take shape within the «epistemic injustice» I mentioned earlier.

The medical records compiled by Michele Risso during his experience as a psychiatrist in Bern, Switzerland between 1954 and 1963, clearly show the link between microtrauma and trauma in contexts of migration. Separated from their rural world, worn down by hard manual labour, exposed to the cultural shock of a foreign and often prejudicially hostile world (microtrauma), the Italian immigrants treated by Risso had romantic relationships with Swiss women. When the relationship entered into crisis (microtrauma), they began to suffer from psychosomatic symptoms so severe (trauma) that they required psychiatric hospitalization. We have chosen to include one of these medical records in the activities (activity 5, part three, level B1), because we consider the type of story proposed by Risso, the recognition expressed by this story, and the high recovery rates associated with this method to be very important. Risso recounts this and other stories also from the perspective of the suffering of these immigrants, inasmuch as he includes in the medical record the hypothesis suggested by his patients. According to each of them, the mysterious illness had actually come from an evil eye or a spell cast on them by their ex-partner (Risso/Böker 2000: 93-126). The medical records also included, along with the protocol of medical treatment, references to the magical rituals of exorcism that these patients practiced, thus providing an important translation of the magical world into the clinical/rationalistic world (Risso/Böker 2000: 136-137). Risso's medical records are an important example of that ethno-clinical narrative imagination that is capable of creating an intense doctor/patient relationship by recognising the cultural and cultic significance of certain types of migratory suffering that would otherwise be doomed to silence, censorship and therefore further pathologies (Nathan 1993: 40-41).

4. Images, metaphors, and linguistic autobiography

The narrative imagination is intrinsically interdisciplinary. It is open not only to verbalized linguistic storytelling but to all creative dimensions (Calabrese 2022: 71-96; Conti 2022: 97-116). In this sense, those arts that do not employ words are still of central importance inasmuch as they are still capable of narrativizing the meaning of an event, for example through figurative or abstract images.

This interdisciplinary openness to images becomes important in the field of migration, where the ability to verbalize may be more or less prohibited by trauma or microtrauma and where one is confronted with different cultural paradigms and the related «epistemic injustice». In this context, images play a key role because they are shared preverbal traces of a possible meaning (de Rogatis 2025: 2-3). For this reason, we have devoted a great deal of attention to the repertoire of images that accompanies the activities and which was created by Andreina Sgaglione (with the support of Sara Belolli, image consultant for the project). In the next essay, Andreina Sgaglione focuses at length on the image of the seed (activities 5b, 6a, 6b, second part levels A2/B1), which is an excellent, evocative example of the history of the oscillation between wellbeing and ill-being.

Yet we have also given great importance to the narrativized variant of images, namely metaphors, which can be defined as «a process of symbolic transposition of images» (Treccani 2025), and to the potential of figurative or abstract images to comment on narrative metaphors. True synthetic stories of emotional translation, of cognitive displacement and disorientation, and of dynamic synthesis between one cultural context and another (de Rogatis 2023: 173), metaphors are an important tool for the application of the narrative imagination in a migratory context. Returning once again to the story of Princess Alexandra, the metaphor of depression as a sort of frozenness is introduced by a figurative image of the princess in hibernation, which is extremely evocative and appropriate. Another example comes from activities 10a and 10b (part one, level B1), in which daily microtrauma is presented through a metaphor from ethno-psychiatrist Michele Risso. According to Risso, immigrants may find themselves – at certain stages or in certain circumstances of their lives – like mountaineers "halfway up the cliff": in a precarious, suspended state between their country of origin and their host country (conveyed in activity 10a along with a very appropriate image). To underscore the interdisciplinary, eclectic character of our method, which is rooted in narrative medicine, it is important to emphasise that metaphors drawn from ethno-clinical essays (such as Risso's) are repurposed within a mosaic of materials that also incorporates metaphors from literary contexts. To cite one example, the metaphor of the suitcase (activity 6a, 6b, part three, level A2/activity 8a, 8b, part three, level B1) was freely reimagined from *Dismatria*, a splendid short story by Igiaba Scego based precisely on this ethno-anthropological object of nomadism (2005: 8-9).

Another important repertoire of literary metaphors comes from linguistic autobiographies (Busch 2016, de Rogatis 2023, Thüne/Luppi 2022). With this formulation, I define the stories of those who recount their migration by evoking every aspect of their life in progress through the filter of the languages at the forefront of this nomadism and disorientation. In the materials, we have proposed some activities based on the linguistic autobiographies of Jhumpa Lahiri, Elvira Mujčić, and Agota Kristof (activity 10, part one, level A2; activity 11, part one, level B1). The linguistic experience – this complex mixture of cohabitation, nostalgia, and conflict between the language or languages of the country of origin and the language or languages of the host country – is in fact a key instrument for monitoring the stories of wellbeing or ill-being of immigrants and for stimulating, through this monitoring, an immersive experience in them.

We have used metaphors derived from linguistic autobiographies for various activities: for example, the metaphor of the mountain to climb (activity 10b, part one, level B1), the metaphor of the door (activity 4, part one, level A2/B1) and the metaphor of grafting (activity 9a, part one, level B1) were freely taken from the narrative imagination used by the Italian-Anglo-Bengali writer Jhumpa Lahiri to recount her own migration and her own journey between languages (2022: 19-22). At the heart of our method lies also an important application of linguistic autobiography, or the linguistic silhouette. This application is discussed below by Andreina Sgaglione, who has also enriched our material with a new silhouette hypothesis (activity 6, part one, levels A2/B1), which is in line with the narrative world of the child postulated by narrative medicine. I would like to thank her for this, and for everything.

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BIOGRAFIE DELLE AUTRICI / ABOUT THE AUTHORS

Tiziana de Rogatis è saggista, professoressa associata di Letterature Comparate, prorettrice presso l'Università per Stranieri di Siena e IAS Honorary Fellow (Università di Durham/ Inghilterra). La sua ricerca si concentra sul nesso tra medicina narrativa, traumi e translinguismi nella letteratura globale e, in particolare, nelle scrittrici. Ha co-curato *Trauma Narratives in Italian and Transnational Women Writers*. È autrice di *Elena Ferrante. Parole chiave*, un volume da lei presentato in Italia, Europa, Stati Uniti e Cina. Ha pubblicato monografie, saggi e commenti al testo sul canone modernista transnazionale (T.S. Eliot, Paul Valéry e Eugenio Montale).

Tiziana de Rogatis is an essayist, associate professor of comparative literature, vice dean at the University for Foreigners of Siena and an IAS Fellow (Durham University, England). Her research focuses on the connection between narrative medicine, trauma, and translingualism in global literature, particularly among women writers. She co-edited *Trauma Narratives in Italian and Transnational Women Writers*. She is the author of *Elena Ferrante. Parole chiave*, a volume she presented in Italy, Europe, the United States, and China. She has published monographs, essays, and commentaries on the transnational modernist canon (T.S. Eliot, Paul Valéry and Eugenio Montale).

Alberica Bazzoni è ricercatrice in Critica letteraria e letterature comparate all'Università per Stranieri di Siena. Ha conseguito il dottorato all'Università di Oxford e ha poi svolto progetti di ricerca all'Università di Warwick (British Academy) e all'ICI Berlin Institute for Cultural Inquiry. È autrice di *Il presente vivo. Temporalità del divenire e del trauma in Lispector, Ortese e Philip* (Mimesis 2025) e di *Writing for Freedom. Body, Identity and Power in Goliarda Sapienza's Narrative* (Peter Lang 2018) e di numerose pubblicazioni su riviste internazionali. La sua ricerca più recente verte sulla performatività testuale e sugli immaginari letterari del trauma e della resistenza.

Alberica Bazzoni is a Researcher in Comparative Literature at the University for Foreigners of Siena. She completed her PhD at the University of Oxford, and then held Postdoctoral Fellowships at the University of Warwick (British Academy) and at the ICI Berlin Institute for Cultural Inquiry. She is the author of *Il presente vivo. Temporalità del divenire e del trauma in Lispector, Ortese e Philip* (Mimesis 2025) and of *Writing for Freedom. Body, Identity and Power in Goliarda Sapienza's Narrative* (Peter Lang 2018), as well as of several publications on international journals. Her most recent research is concerned with textual performativity and literary imaginaries of trauma and resistance.

Andreina Sgaglione è dottoressa di ricerca in Linguistica e specialista in Didattica dell'italiano a stranieri. Dal 2000 insegna come esperta linguistica al Centro Linguistico dell'Università per Stranieri di Siena. Ha insegnato italiano negli USA e in Italia ad apprendenti immigrati. I suoi interessi di ricerca riguardano insegnamento del lessico, health literacy e medicina narrativa legata ai traumi migratori. Si è formata sul benessere nei contesti educativi presso l'Oxford University Department for Continuing Education e ha seguito il Trauma Research Foundation's – Boston Certificate Program in Traumatic Stress Studies. È autrice di numerose pubblicazioni nel settore.

Andreina Sgaglione holds a PhD in Linguistics and is a specialist in Teaching Italian as a Foreign Language. Since 2000, she has worked as a language expert at the Language Center of the University for Foreigners of Siena. She has taught Italian in the USA and in Italy to immigrant learners. Her main research interests include vocabulary teaching, health literacy, and narrative medicine related to migration-related trauma. She has received training on wellbeing at the Oxford University Department for Continuing Education and completed the Trauma Research Foundation's – Boston Certificate Program in Traumatic Stress Studies. She is the author of numerous publications in the field.

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