HEALTH LITERACY AND NARRATIVE MEDICINE IN THE TEACHING OF ITALIAN AS A SECOND LANGUAGE: PROMOTING WELLBEING TO ADDRESS MIGRATORY AND VICARIOUS TRAUMA

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1. INTRODUCTION

Teaching Italian as a second language (L2) in migratory contexts increasingly constitutes a complex space, in which the linguistic dimension cannot be separated from the learners' life experiences. Migration carries with it a series of individual and collective traumas, ranging from the loss of family and community ties to often violent travel conditions and the existential precariousness experienced in host countries. Added to this is the phenomenon of vicarious trauma, which affects teachers, mediators, and social workers who are exposed on a daily basis to accounts of suffering that are difficult to process. In this scenario, the language classroom risks being reduced to a mere site of skill transmission if the centrality of personal experiences and narratives is not acknowledged.

This article aims to develop a structured reflection on several key issues emerging in the teaching and learning of adult immigrants. In section 2, a brief analysis is presented of the learners' profiles, with particular attention to their educational and personal needs situated within the complex experience of migratory trauma and its multiple dimensions. Within the same section, a specific focus is dedicated to the affective dimension, which concerns both the learners, who often bring painful lived experiences, and the teachers, who are called upon to manage intense emotional dynamics. This perspective highlights the importance of an educational approach capable of integrating cognitive and emotional aspects. Furthermore, a reflection on teaching materials is offered, aiming to examine the image of the migrant learner they convey and to assess the extent to which these representations either facilitate or hinder truly inclusive learning pathways. Section 3 is dedicated to the concept of vicarious trauma, a category still scarcely explored in pedagogical and educational contexts, particularly in the teaching of Italian as an L2. This perspective allows for a reversal of the traditional focus, shifting attention from the learners' experiences alone to those of teachers, who may be exposed directly or indirectly to the effects of their students' traumatic narratives. The aim is to highlight the psychological and professional risks associated with these dynamics, as well as the specific support and protection needs of educators. In section 4, several possible responses are proposed, aimed at strengthening the resilience and overall wellbeing of both learners and teachers. In this regard, tools such as health literacy and narrative medicine are integrated within an educational approach capable of combining knowledge and practice, in order to prioritize health and wellbeing as fundamental prerequisites for learning and for the educational relationship. Health literacy (HL), originally defined in the US in the 1970s as the ability to understand health-related information, has evolved from addressing

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communication barriers in clinical settings to a key factor in supporting patient autonomy and self-care. With the rise of chronic illnesses, HL has been seen as essential for empowerment and reducing reliance on hospital services (Lorini, Bonaccorsi, 2022). The concept now includes interventions targeting individuals, vulnerable groups, the general population, and healthcare organizations. Today, HL is recognized as a determinant of health, and low HL levels are linked to greater health inequalities (Rowlands *et al.*, 2017). On the other hand, narrative medicine, which promotes a clinical care approach grounded in communication skills, can offer valuable insights for teaching, especially with migrant learners who may have experienced trauma. The teacher-learner relationship in such contexts often goes beyond typical educational interaction and takes on aspects similar to a care relationship. Drawing on narrative medicine, alongside strong cultural competence, can therefore help educators develop effective, empathetic communication strategies suited to learners shaped by migratory trauma.

2. THE NARRATIVES OF MIGRANTS: BODIES AT WORK AND DENIED EMOTIONS

Teaching Italian as an L2 in migratory contexts currently involves significant challenges that characterize a complex space, often inhabited by silences and shadows yet to be illuminated. The obstacles to overcome are numerous and have long been the subject of extensive debate among experts in the field. The complexities to be addressed are closely linked to the multifaceted and heterogeneous scenarios of our time:

> Si tratta delle sfide del mondo globale, che ha messo in movimento come forse mai nella storia del genere umano masse di popolazione partite dai propri luoghi di origine per andare là dove si pensa esista lavoro, e perciò la possibilità di una vita migliore, o che hanno fuggito guerre e persecuzioni […]. Il mondo globale e post-globale, della illimitata mobilità delle merci e delle persone, è perciò anche il mondo dell'illimitato contatto e miscuglio delle forme simboliche, dei linguaggi e delle lingue che danno forma al modo di essere, alle identità, alle forme di vita delle persone e dei loro prodotti: forme di vita che sono le culture, le identità, che si vedono rimesse globalmente in gioco dalle nuove forme dei contatti fra le persone (Vedovelli, 2013: 420-421).

The profiles of adult foreign migrants have radically transformed the typological landscape of Italian L2 learners since they began to arrive (Vedovelli, 2002: 148) and have been a subject of analysis, particularly in relation to the communicative exchange networks and social contexts in which they are embedded. The needs related to the development and practical applicability of linguistic-communicative competence, as well as the broader requirements of this segment of the population, have also been examined with the aim of calibrating potential educational interventions (see Demetrio, Favaro, 1992; Massara, 2001; Vedovelli, 2001). However, when discussing adult migrants, generalizations must be avoided, as they represent an extremely heterogeneous group encompassing individuals with highly diverse needs.

Recent investigations from 2024, proposed by the *Dossier Statistico Immigrazione* and the reports of Caritas Italiana and Fondazione Migrantes, provide increasingly precise data regarding diatopic variables in terms of both the language/culture of origin and the language/culture of the host area; diastratic variables, such as age, gender, cultural background, motivations, and needs; and diaphasic variables related to learning contexts (see Balboni, 2014; Diadori, 2022). The debate is further enriched by the positive repercussions of recent research trends that open the way to new approaches to personal

and educational relationships with students from migrant backgrounds in schools. These include the need to recognize and value their linguistic and cultural repertoires, the careful analysis of the processes involved in developing linguistic-communicative competence in Italian L2, the role of the first language in the maturation of semiotic and linguistic abilities, the use of multilingual teaching as a daily educational practice, and issues related to assessment and evaluation of competences (see Villarini, 1995; Barni, 2021; Gallina, 2021).

Essentially, for migrant learners, more so than for other types of students, it is necessary, as Chini (2004: 18) states, to move away from «una visione piuttosto rigida e compartimentizzata della questione: da un lato la lingua d'origine, L1, e la sua conservazione o perdita; dall'altro la L2 da acquisire e il suo insegnamento», toward a stance that promotes the development of a plurilingual identity. There are also studies that critically reflect on the heterogeneity of the linguistic training offered, on teacher profiles, on teaching situations, and more generally on the quality of instruction, depicting a landscape characterized by a play of light and shadow that resists an unambiguous synthesis (see De Marco, 2000; Vedovelli, 2002; Diadori *et al.*, 2015; Minuz *et al.*, 2016; Troncarelli, La Grassa, 2018; Diadori, 2022). The issues surrounding adult migrants, including linguistic, social, and educational dimensions, just to name a few, have thus become topics whose development, nourished by substantial research in the field, has contributed significantly not only to the improvement of teaching and learning pathways for this demographic, but also to a profound collective awareness of the subject.

The solutions to the numerous issues that have emerged over time have never been obvious or straightforward, but they have created channels for productive dialogue that have generated significant centripetal momentum from a wide range of contexts. From these dynamic movements, often accompanied by acts of generosity and courage, commendable initiatives have emerged. Offering a constructive reflection here means not only acknowledging what has already been achieved, both theoretically and in practice, but also highlighting, on the basis of this solid foundation, aspects that represent missing pieces of a mosaic still in the process of being assembled. Among these aspects, it is essential to include a perspective that takes migratory trauma into account, with the aim of adding interpretative elements that can complement existing knowledge about the characteristics of migrant learners. First, it must be noted that the history of migration in modernity has been burdened by profound prejudices, which have led it to coincide with a psychiatric narrative, in which the inevitable traumatic symptoms had been pathologized by the medical science of host countries, ultimately resulting in the theorization of an equivalence between mental illness and migration:

> Tra Ottocento e Novecento, il disadattamento degli emigrati viene infatti ricondotto da una certa psichiatria eugenetica, di area europea e statunitense, ad una affinità elettiva con la malattia mentale. Un'eredità degenerata e/o una tara etnica sarebbero quindi la causa dell'emigrazione, arrivando a spingere gli individui con squilibri più o meno conclamati a lasciare il proprio Paese e a incarnarsi nella figura del «migrante alienato» […] Tra Europa e Stati Uniti, il pregiudizio psichiatrico ha costituito un vero e proprio paradigma, che «negli emigrati indicava i portatori degenerati e pericolosi del disordine mentale, della follia, della trasgressione alla norma della salute e della produttività» [….]. Un immenso travaso di popolazione, l'esodo più grande che la storia moderna abbia conosciuto, lo sfruttamento dell'esercito industriale di riserva che nasce dall'abbandono delle campagne europee e dal dislivello mondiale tra paesi sottosviluppati e paesi industrializzati, vengono spiegati con bella semplicità quale risultato di personalità costituzionalmente malate (Frigessi Castelnuovo, Risso, 1982: 71-102).

This profound distortion of historical reality demonstrates that, in order to truly understand the trauma experienced by migrants and to avoid rigid interpretations or racist stereotypes, it is essential to adopt a multicultural perspective. First, it should be clarified that migratory trauma is not the same for everyone but is closely related to the dramatic contexts of migration. Such contexts can involve various forms of violence, persecution, and discrimination depending on socio-economic, communicative, and linguistic resources, which are intertwined with factors related to gender, possible LGBT orientation, age, ethnic, religious, and racial affiliations, as well as the type of migration (individual, group, family, or part of a migratory chain), individual resources, psychic structure, and the social and cultural conditions of each person (de Rogatis, 2023: 31).

The initial acquisition of the host country's language is strongly linked to the individual processes of uprooting and re-rooting undertaken for various reasons. These processes may be solitary or occur within networks of friends and family, composed of co-nationals, Italians, or other foreigners, and may develop through the interaction between individual biographies and reception contexts, between migration motivations and the conditions or opportunities that arise with the start of life in a new country. Integral to these trajectories are the quantity and quality of interactions in Italian with natives or other immigrants, the actual uses of the language in an increasingly multilingual society, and the attitudes of Italian society, which may respond in different ways: being receptive, indifferent, or hostile to coexistence (Minuz, 2016: 7). The link between trauma and health has been recognized and statistically documented, particularly regarding mental health risk factors observable during the phases of the migratory process or of escape, as well as during settlement in the host country.

Post-traumatic stress disorder, mood disorders, depression, and, more broadly, mental health disorders are the conditions most frequently reported among international migrants (WHO, 2023), with prevalence rates often higher than those observed in host societies. In any case, one crucial element must be kept in mind when engaging with migrant learners: the experience of exile, diaspora, and leaving one's homeland is destabilizing and often accompanied by feelings of suffering and psychic fragmentation. The actual conditions experienced by migrating individuals are rarely explored, particularly with respect to internal wounds that are seldom fully able to be healed (Moll, 2022: 60). The prevailing tendency is to adopt a deficit model that emphasizes the learners' problems and shortcomings (see Cefai, 2008; Nilsson, Bunar, 2016). More than twenty years ago, Barni and Villarini anticipated this issue by linking the topic of language to identity, highlighting both the effort and the complexity involved:

> Per quanto riguarda gli immigrati, la lingua esalta la sua funzione di principio d'identità innescando processi su varie dimensioni: nella lingua si catalizzano i problemi di identità perduta (quando si lascia il proprio paese e si perde il contatto quotidiano con la propria lingua), cercata (nel tentativo di essere nel paese ospite, di esistere secondo una qualche identità capace di dare senso), scissa (quando le due identità culturali non si ricompongono e l'apprendimento linguistico si blocca e non consente l'integrazione), equilibrata (quando il migrante segnala nella adeguata competenza linguistica il successo migratorio che non rinnega le radici d'origine). In tutti questi processi, che riguardano sia gli adulti che i bambini, la lingua è strumento dei processi di identità e segnale dello stato del processo (Barni,Villarini, 2001: 35).

In educational contexts where migrant learners are present, it becomes necessary to consider the potential impact that traumatic components may have on the learning process in order to integrate the notion of trauma into didactic practices. Trauma presents insidious features in the form of invisible and often overlooked symptoms that exert a direct influence on both the adaptation process and the overall quality of life of migrants. This condition constitutes a constantly present traumatic entanglement, a veritable «daily micro-traumatism» (De Micco, 2017), which manifests itself in unique processes. Everyday experience loses its self-evident quality and becomes ambiguous, requiring a continuous effort to decode and interpret. At the same time, the rupture of the bond with one's origins generates inner conflict, doubt, and anxiety, leading to a relentless questioning devoid of definitive answers. To this must be added the permanent and pressing necessity of undertaking a process of identity re-foundation, made indispensable by the absence of solid psychic and social reference points.

Migratory trauma emerges as a transgenerational process, capable of extending across time from one generation to another and expanding across space, involving not only individual subjects but also the communities of both origin and arrival. This phenomenon requires attentive listening and deep sensitivity in order to be perceived and acknowledged in its more subtle dimensions, often concealed beneath the appearance of successful integration which, in reality, proves to be solid only on the surface (*ibidem*). In the autobiographical narratives of migrant learners, traumatic elements frequently surface, which teachers sometimes collect (Sgaglione, 2024a: 89). Yet, although teachers largely acknowledge that trauma hinders language learning (*ibidem*), trauma still appears as a repressed presence regarding which they remain uncertain about whether and how to intervene. The initiatives implemented are affected by a lack of deep awareness of the problem or, alternatively, rely on the individual and creative resources of single teachers (*ibidem*). This perception is shared by many educators in different contexts worldwide, who report feeling unprepared to adequately address the needs of students with traumatic experiences (Caringi *et al.*, 2015).

In light of these considerations, it is useful to propose a redefinition of the needs of adult immigrant learners: language training courses designed for this type of learner acquire an important instrumental function that can generate positive effects on our country's productive system (Vedovelli, 2013). Therefore, the planning of possible educational pathways carries a greater ethical weight compared to programs designed for audiences with more generic motivations and less direct links to professional integration (La Grassa, 2014: 226). The profile outlined by Vedovelli (2010) identifies both the linguistic-communicative needs and the macro-areas in which competencies acquired in either formal or informal contexts are most likely to be used, namely, regularization, employment, housing, health and social care, education and training, socialization, and leisure. The data that has emerged from studies that have evaluated both teaching materials and spoken corpora (see Villarini, 2008a, 2008b, 2011, 2012, 2013; La Grassa, 2014, 2015) explicitly call for an emphasis on work-related vocabulary. Taking these indications into account is of vital importance in order to promote teaching and learning pathways that are firmly rooted in the social, economic, and productive realities into which people from migratory contexts aspire to integrate. However, it seems necessary to acknowledge that, although professional needs must retain a primary role, equal importance should be given to restoring centrality to the

inner dimension of migrant subjects, not only in terms of physical and psychological wellbeing but, above all, with regard to their affective life.

The figure of the immigrant learner has been explored from multiple perspectives, and although generalizations must be carefully avoided, the prevailing idea that emerges, especially in recent textbooks dedicated to this target group, is that of individuals who are expected primarily to produce and work efficiently (Sgaglione, forthcoming). In the dedicated sections, e. g., the theme of health is primarily linked to the personal domain: the scenarios presented tend to depict immigrants as sick individuals in need of care, thereby rigidly defining roles in predetermined situations. Illness is represented, with few exceptions, mainly at the physical level, scarcely at the psychophysical level, and insufficient space is given to the emotional and affective dimensions of health. The public domain receives little attention: consequently, there are no texts on information related to immediate public risks, safety procedures, prevention, or the connection between environmental damage and health. The same applies to the occupational domain in relation to health: basic regulations, warnings, and instructions on workplace health and safety are missing. The underlying idea conveyed is that of bodies expected to function in an idealized environment where accidents do not occur and any fears or concerns are dismissed and denied. The intimate life of the individual seems to remain a taboo, as if delving into psychological aspects might undermine the performative dynamic of the migrant learner, who appears to be confined within a relational universe where all possibilities of redemption and recognition are tightly linked to work (De Micco, 2002: 38). The migrant is often imprisoned within the metaphor of an effective and efficient body, while the soul, that is, everything concerning a deeper dimension of inner wellbeing, remains confined to a suspended time, in an elsewhere difficult to locate, where nostalgia, the past, and the unlived reside. The dynamics connected to migratory trauma establish the educational sphere as one of the privileged contexts for the promotion of health, based on the assumption that personal wellbeing is an essential condition for any form of learning. From this perspective, it is not sufficient to speak of socialization and leisure as the only elements more closely related to the individual human sphere. The affective dimension of life emerges as a priority area to be explored and further analysed, together with a deeper inquiry into the theme of psycho-physical health, in order to grasp its pedagogical, social, and cultural implications for promoting a new and different approach to learning (Sgaglione, 2024b).

Before addressing the beneficial practices that allow the analyses carried out so far to be transformed into concrete actions, it is essential to acknowledge that the affective dimension of the immigrant learner is closely intertwined with that of the teacher. These two nuclei cannot be conceived separately, and their synergy produces a variety of outcomes in the learning process. The teacher, often considered marginal from the emotional point of view in relation to the learner, ends up shouldering an invisible burden that can carry significant costs: this affects both the learners' wellbeing and the dynamics of their motivation and achievement (Balboni, 2013). This intertwining between the affective lives of the learner and the teacher furthermore allows for a reflection on vicarious (or secondary) trauma: the intense emotional involvement and the constant exposure to the traumatic experiences lived by students can themselves expose teachers to a form of secondary stress or indirect traumatization, with important effects on both personal wellbeing and the quality of teaching. Acknowledging this possibility is essential to promoting practices of care and protection directed not only toward those who learn but also toward those who teach.

3. THE OTHER SIDE OF THE COIN: VICARIOUS TRAUMA

Vicarious trauma is a category usually associated with healthcare workers, psychologists, and first responders, and its impact has often been underestimated and/or overlooked within the field of teaching. Yet, this perspective requires renewed critical attention: teacher wellbeing[2] has never been as crucial as it is in the current context. Rooted in positive psychology, research on teacher wellbeing has recently undergone significant expansion. Several studies (Moskowitz, 1978; Hochschild, 1983; Seligman, 2011; Fiorilli *et al*., 2015; Oxford, 2016) have shown that language teaching, although intrinsically rewarding, also entails high levels of anxiety and exposes teachers to constant pressures and negative emotions that accompany their professional careers. Teacher wellbeing is closely linked to student outcomes, motivation, and level of engagement. Nevertheless, research conducted in this area remains unfortunately limited and fragmented (Gabryś-Barker, 2021: 143). It becomes a priority to acquire competencies that not only allow teachers to regulate their own emotions but also to support students in enhancing positive emotions, managing anxiety, and consequently achieving greater wellbeing and a more effective learning experience (Mercer, Gregersen, 2020). For teachers to feel satisfied and, by extension, more effective, they must be able to rely on equitable working conditions: manageable workloads, adequate remuneration, opportunities for continuous professional development, autonomy in curricular and pedagogical choices, as well as structured support from school, regional, and national institutions (Gabryś-Barker, 2021: 144). However, this alone is not sufficient: in contexts marked by migratory trauma, a relationship with the learner based on empathy, authenticity, and mutuality (Walker, Rosen, 2004) forms the foundation of any educational initiative. There are professional boundaries that must never be crossed; nevertheless, it becomes difficult for teachers to metaphorically close the classroom door and forget the stories, faces, and gazes of those they encounter. Educators must be prepared to confront traumatic narratives, silences, and also to view the world from the perspective of someone who is weary and struggling with economic hardships, broken roots, stressful work, and yet chooses to attend a language course, bringing their world into the learning experience.

Exposure to trauma carries specific risks: secondary traumatic stress, the emotional tension experienced when an individual becomes aware of another person's direct traumatic experiences (Figley, 1995); vicarious traumatization, which manifests as a profound sense of discouragement, resulting in a loss of certainty, safety, and control over the world (Pearlman, Saakvitne, 1995); and burnout, a syndrome of emotional exhaustion potentially accompanied by a high level of cynicism (Maslach, Jackson, 1981). In addition, there is a series of consequences that teachers may experience at various levels: feelings of loneliness, a perception of never doing enough, hypervigilance, decreased creativity, a sense of inadequacy regarding tasks perceived as insurmountable, a tendency to minimize, and in extreme cases, chronic fatigue, fear, and guilt (van Dernoot Lipsky, 2009). Another phenomenon to consider, one that has only recently become a subject of reflection and for which studies remain limited, is presenteeism (see Uslukaya *et al.* 2022; Garcia, Juliani 2024; Serya, El-Gilany 2025). This term refers to the behavior of individuals who, driven by job insecurity or anxiety, go to or remain in the workplace beyond their obligations or regardless of their health conditions. The consequence is an increased risk of illness and workplace accidents and, according to certain production logics, reduced efficiency. For

[2] Although the discussion primarily focuses on teachers, it should be understood that, implicitly, the phenomenon of vicarious trauma actually involves the entire category of educational professionals, including mediators, language facilitators, and all those who work in school contexts with immigrant populations.

teachers, this phenomenon is influenced by both internal and external factors shaping their relationship with work. Presenteeism involves personal, financial, and sociocultural aspects, as well as organizational factors that lead teachers to feel compelled to work even when ill in order to fulfill their duties (Garcia, Juliani, 2024: 2). The issues mentioned so far generate feelings and states of mind that can be amplified by today's external contexts, which often present obstacles such as bureaucratic errors, widespread insensitivity, rudeness, delays, and slowness (Conte, 2009: XI). An epistemic shift is necessary: the use of practices that promote wellbeing becomes a method of care that must not be neglected (Saakvitne *et al.*, 2000). Informing oneself about the topic and finding time to attend to one's own wellbeing must responsibly accompany the work of those operating in the field.

4. GIVING BODIES BACK THEIR VOICES: WELLBEING BETWEEN HEALTH LITERACY AND NARRATIVE MEDICINE

Traumatic events do not exist solely outside the school and teaching environment; rather, they arrive with those who have experienced them (Dutro, Bien, 2014), creating complex forms of distress. As Judith Herman, a scholar with profound expertise on the subject, explains: «Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life» (Herman, 1997: 33). For a long time, solutions were envisioned that appealed to a vague promotion of strategies intended to activate individual resilience. Resilience has long been interpreted as a strictly individual capacity, useful for combating stress and fostering determination, perseverance, grit, and endurance. The concept typically implied a presumed invulnerability that the individual was expected to acquire in the face of life's challenges. However, recent studies emphasize that resilience, although varying according to the biological and psychological characteristics of individuals and the social processes in which they are involved, must be framed as an interaction between the person and their environment (Ungar, 2012). One cannot simply ask individuals who have experienced severe trauma and, through no choice of their own, have been subjected to wars, violence, and grave injustices, to develop adaptive strategies for new situations while ignoring the structural factors that caused their harrowing lived experiences:

> Resilience suggests that an individual can negotiate survival and success in spite of adversity, and in the aftermath of adversity. Of course, some aspects of resilience depend on you, and other aspects depend on your environment. In some situations, resilience may be easy; in others, more difficult. Even more simply, resilience is the ability to successfully adapt in the face of adversity. It does not mean immunity to stress and trauma. It does not mean that stress and trauma will not affect you or leave negative impacts. It means that you have solid defenses to confront it and stand your ground, as best as you can, in the face of what may come. In other words, resilience describes your ability to adapt to adverse circumstances in order to maintain your access and ability to navigate survival resources (Niconchuk, 2020: 258).

From this perspective, resilience is useful for developing a reasonable degree of control over the body's responses to traumatic stressors that come from outside and over how we relate to others in the environment in which we live, while maintaining the ability to act in contexts of prolonged uncertainty. An ecological perspective in which resilience is understood as a state of well-being closely connected to a context that offers the support, resources and services needed for positive development. This capacity can be greatly

enhanced by educational interventions that foster a safe, equitable and stimulating learning environment in which strong social connections are established (Cefai, 2021: 222). The way forward is to propose initiatives that fall within new categories, including that of "scalability", a quality relating to the ability of an intervention, project or service to be expanded and reach more people, territories or contexts without compromising its effectiveness or sustainability. In other words, an intervention is "scalable" if it has the following characteristics: it does not overly depend on rare or expensive resources; it can be standardised, i.e. it can be replicated following clear and adaptable procedures; it is economically sustainable, even when developed on a large scale; it is flexible (see Milat *et al.*, 2013, 2020), i.e. it can be adapted to different contexts without losing effectiveness:

> Scalability is not an all-or-nothing concept. Some interventions have features that make them more scalable than others. Interventions become more scalable when they rely less on specialist human resources. To make interventions potentially scalable […] interventions are changed so they become feasible in communities that do not have adequate access to specialists. Such modifications can create more accessible care that reaches a larger number of people. These modifications could include using non-specialist to deliver the intervention, or innovative delivery strategies such as self-help books or using mobile devices. Some of these interventions, implemented ats scale, may prove to be somewhat less effective than conventional models of psychological treatment. This, however, may be acceptable in exchange for the increased coverage and accessibility gained in return (WHO, 2017). The principles of understanding trauma and stress, cultural humility and equity, resilience and social emotional learning, safety and predictability, compassion and dependability, and empowerment and collaboration (Dorado *et al.*, 2016).

Efforts aimed at strengthening self-efficacy and wellbeing through daily self-care and community support help identify distress at an early stage and represent an effective preventative strategy, a form of primary prevention that avoids the development of forms of suffering that would require complex specialist treatment, the cost of which would have an impact on public health (WHO, 2003). From this perspective, the introduction of an educational approach that is aware of the impact of trauma in classrooms with immigrant learners is a fundamental step towards creating safer, more inclusive and learner-friendly educational environments, potentially helping reduce future pressures on specialist services. But how do these skills translate into the classroom? What teaching practices can promote successful learning and increase the active involvement of learners? The preferred teaching practices are those that aim to create a collaborative classroom environment, paying particular attention to relationships with students (Bashant, 2020) and their emotions, integrating concepts of health literacy (Sørensen *et al.*, 2012), a specific form of cultural competence (Kickbusch, 2001) essential for wellbeing in the contemporary world.

Health literacy encompasses cognitive and social skills that determine individuals' motivation and ability to access, understand and use information in order to promote and maintain health. The importance of health literacy is growing, as it is a fundamental component of ensuring optimal social, economic and health development. To paraphrase a frequently quoted statement by Nutbeam (2000), health literacy goes beyond the simple ability to read brochures or book medical appointments but provides the tools to positively promote behavioural choices and health-related decisions.

Health literacy represents one of the many skills necessary for contemporary adults to operate effectively in any society (Marks, Higgins, 2012: 63). In learning/teaching

programmes, especially those aimed at migrant learners, it is essential to provide the linguistic, social, personal and cognitive skills necessary to interact with the healthcare system, not only to communicate successfully with doctors, but also to cope with the stress inevitably associated with situations that present difficult challenges (Troncarelli, La Grassa, 2018). In the classroom, HL can be addressed in many ways, not only through activities focused on body-related vocabulary, common illnesses, or informational health aspects, but also by emphasizing psychophysical well-being and the ability to make decisions and act in health-related situations. A notable example is provided by communicative mediation activities that facilitate the creation of an intercultural space, comparing the healthcare system of one's country of origin with that of the host country, or examining the different ways symptoms are described and treated across cultures. Such mediation activities can engage learners in 'bridging' situations of need, prompting questions like: 'How can I help others feel better? How can I convey this information to those who need it?' This approach is grounded in the assumption that health is closely intertwined with community membership and a sense of responsibility toward others. In addition, on the teachers' side, integrating concepts of health literacy means that new competencies should include abilities such as recognizing trauma-related behaviours in learning contexts, creating an emotionally safe environment for learners to prevent negative consequences, identifying and promptly defusing situations of tension that may arise from the involuntary reactivation of trauma, and supporting students in acquiring skills that gradually facilitate cerebral adaptation toward new forms of self-regulation (Bashant, 2020). Such training should cover:

> the principles of understanding trauma and stress, cultural humility and equity, resilience and social emotional learning, safety and predictability, compassion and dependability, and empowerment and collaboration (Dorado *et al.*, 2016).

These practices, policies, and procedures support the learning needs of individuals affected by trauma, while also addressing the vicarious traumatic stress experienced by educators. The complex and delicate relationship established between the teacher and the migrant learner who has suffered any migratory trauma cannot be pigeonholed into ordinary didactic interactions. Instead, it must take on the characteristics of a more intense bond closer to a relationship of care understood in the broadest sense of the term (Sgaglione, 2024b: 259). The guiding principle is that of narrative medicine: to care in order to be cared for, to help others heal in order to heal oneself:

> The theme of care commonly refers to the doctor-patient relationship, the core of narrative medicine. […] Often teachers find themselves in the position of being the only available remedy when facing educational emergencies. They are frequently the only more-than-casual point of contact between the host society and the migrant learner […] Naturally the process of teaching and learning a language is never in any way comparable to a pathology, but the sense of discouragement and inadequacy that often assails teachers with respect to bureaucracy and the thousand other difficulties they face associated with the lack of adequate spaces, conditions, and tools, can generate negative side effects that impact everyone involved in the process. […] Continuing analogically, the teacher-learner relationship also uniquely characterizes the dynamics that are embedded into the act of teaching. Both participate in the creation of a bond that is realized in an educational agreement, shaped by osmosis-like exchanges from which unique, unrepeatable experiences derive. Teachers bring all their knowledge, the teaching experience from their

> professional life; learners bring into play their subjective experience, their individual and family history, the languages they know, the signs of their experience of migration left in their body and mind, the expectations, and the fears and desires that arise from the investment of their resources in a language course (ivi: 260-262).

This virtuous intertwining is based primarily on listening and mutual recognition:

> Narrative medicine is committed to developing deep and accurate attention to the accounts of self are told and heard in the context of healthcare. Whether in settings of individual clinic care, health promotion, or global health activism, our deepest mission is to improve healthcare by recognizing the persons who seek health with their health. Along with the accuracy of recognition come the powerful consequences for the person- of having been heard, of having achieved an unimpeded and free voicing of the matter at hand. […] the idea that one person can understand what another person says or means is the deepest part of science and the deepest part of art. This idea is the groundspring of language, of beauty, of knowledge, of government, of culture, and of love. In the shadow of that meta-perspective of human experience, we place our work in narrative medicine at a series of boundaries, realizing that the effort is always to bridge the divides, to seek the permeability, to unlock the channels that might provide unexpected benefit to both sides (Charon, 157-177).

Preferred working tools become linguistic autobiographies, understood as a method for narrating one's inner world and as a way to create a connection between language and emotions. Applying the principles of narrative medicine in the educational context primarily entails valuing active listening and recognizing in the student not merely a name destined to be forgotten, but the bearer of a story to be honoured and respected. This perspective implies an awareness of the privileged role assumed by the teacher in the instruction of Italian, a language that for centuries has been intertwined with wellbeing, philosophy, art, beauty, and emotion. Italian as a foreign language is not only a communicative tool but also a potential vehicle of therapeutic value, capable of generating transformative processes for both the learner and the teacher. The educator can integrate the repertoire of stories acquired through their studies and readings directly into classroom practice. In this way, stories are not limited to individual experiences but can be projected into the bodies and experiences of students, generating new forms of expression and imagination. This approach is one of «thinking with stories rather than thinking about stories» (Frank, 1995: 58). In this sense, the pedagogical act also becomes a narrative and performative act in which words become embodied and generate creative resonances. The use of a reflective diary (Sgaglione, 2024b: 264) represents a methodological tool useful for recording thoughts and sensations that emerge within the educational relationship: doubts, unresolved questions, and spaces of uncertainty that, far from being obstacles, become constitutive elements of the processes of learning and mutual growth. Writing serves to remember, to materialize thoughts, and to attempt to give space to what cannot be known or fully understood.

A poignant example of narrative medicine, once again drawn from the medical field, is offered by the testimony of Dr. Sarah Abedi, an emergency physician in Los Angeles. She shares her own sense of grief in confronting the critical condition of a Hispanic woman before her. At the centre of her account lies doubt, the manifestation of a profoundly human struggle to accept the unacceptable:

> I don't think she knew when she was walking into Harbor that it would be the last thing she ever did. I don't know if she knew she would never see her husband again. I don't think she ever thought she would not be going home again or see her children again. I don't know if she knew that morning that it would be the last time she woke up in her own bed. I don't know if I'm safe. I don't know if I will be one of the younger ones who ends up on a ventilator if I get sick. I don't know why it's the worst pain I have ever felt when I see my health care colleagues around the world dying in staggering numbers. I don't feel that many of the people who are supposed to keep me safe will actually keep me safe. […] I don't feel like a hero. […] I don't know if she feels as bad as her numbers look. I don't know how scared she is. I don't know how to explain a breathing tube in Spanish with the detail I need. I don't have a pen to write down her husband's phone number on that paper towel. […] I don't have the ability to stop myself from bagging her after seeing that low pulse oximetry reading because I cannot let her die. I don't know why she was the hardest intubation of my entire residency. I don't want her to die like this. I don't wish this on any fellow human. […] I don't want to feel this heaviness anymore. I don't know where to put this. I just don't know (Abedi, 2020).

Even within the brevity of the narrative, a number of themes emerge, albeit fleetingly: sorrow, immense fatigue, the fear of making mistakes, the steadfast determination to persevere until the very end, the sense of inadequacy in the face of linguistic barriers, and the complexity of letting go. It is evident that the intention here is not to equate an extreme medical emergency with what occurs in educational contexts. This is not the perspective being proposed. Rather, the relevance of narrative medicine lies in the ways in which words are used, how stories transform the knot of anguish and emotions described above. The reflective articulation of uncertainties and difficulties constitutes a powerful instrument of narrative medicine, one that many educators, particularly those working with immigrant learners, may adopt to their advantage. Putting such experiences into words allows for the creation of a space of reflection in which alternative courses of action can be explored, thus preventing the risk of being overwhelmed by the complexities that certain situations inevitably entail. The passage from thought to word represents the first step in the process of helping oneself in order to help others. This is the lesson conveyed by Dr. Abedi's testimony. Finding a space to put words is narrative medicine. It's an act of promoting wellbeing that reminds us that difficult, moving, dramatic, or fascinating stories can be found even in educational relationships. Starting from these stories and working on the emotions and health literacy while keeping wellbeing at the forefront, the field of education can become the ideal terrain for promoting teaching practices capable of generating awareness, creativity and mutual transformation.

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