Child Refugees Who are Survivors of Repression and its Concomitants Including Torture

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This contribution is in two parts - the first written by Sheila Melzak and the second, in the form of a commentary, by Jeremy Woodcock. References covering both articles are given at the end.

Introduction

I am employed as principal child psychotherapist at a charity called the Medical Foundation for Care and Treatment of Victims of Torture. At this centre a multi-professional team of paid and volunteer workers offer practical, medical and psychotherapeutic support to refugees from repressive regimes who are survivors of torture, organised violence, or war.

The stresses in the lives of refugees can be overwhelming. The trauma of life in their home country combines with the traumata of life in exile. Refugees thus experience massive loss and accumulated and continuous traumata. They have to integrate experiences of change, torture, racism, loss of position, familiar context, bad housing, unemployment and, centrally, the loss of the thread of continuity.

I am joined today by Mr Jeremy Woodcock, a colleague from my centre who is a social worker and trainee family therapist, in order to illustrate the multi-professional co-operation essential in our work.

It is our experience that not all refugees come to our centre with serious psychological symptoms - even those with similar experiences of trauma, loss and change. Those who survive psychologically seem to have the capacity to manage the transition from one culture to another and to retain the central familiar solid emotional core of their roots. Such survivors also seem able to hold on to ideas, ideologies, beliefs or fantasies, and to use the support of family and community to help them to criticise and withstand various aspects of repression.

Other refugees are isolated from their communities or may come from communities that are divided and split, with individuals turned against each other and very mistrustful. This is a central characteristic of life in a repressive regime that is mirrored in some communities in exile. Children and young people who begin their childhood in one culture can cope with cultural transition if their parents, or other adults in their lives, are able to weather the changes. This process is well described by Freud and Burlingham (1973) in their work in the war nurseries. Other children may have been tortured, may have observed their parents being tortured, may have lost parents by death or disappearance, or may have had serious emotional difficulties that pre-dated their exile. Many children have to deal with change in their parents. They lose not only their real parent, who fails to keep them safe from trauma and change and emotional pain, but also the idealised, “perfect” parent. Some children and young people arrive alone.

Adolescents, in the process of separating from their childhood relationship with their parents and taking on an adult social, sexual and work role, have special
problems if they begin their adolescence in one culture and end it in another with changed, or lost, or dead parents. They have a serious problem of making identifications. It is difficult to think about what might be the central organiser of the identifications of the refugee adolescent. It is a fact that identifications with idealised or changed parents are important, but I wonder if identifications with the new culture, with idealised and distorted memories of the home country, are not of equal importance? I wonder how memories of parents’ values are internalised, especially when parents are lost or have radically changed?

The children and young people I see do not know if they will ever see their home and friends again. These are strange losses to be assimilated for a developing child and present a different task to mourning of loss by death. At the same time they have had to survive imprisonment, torture and immense change.

In the process of transition they may hold onto a variety of sometimes very flimsy transitional objects from their distant and more recent past in an effort to maintain mental continuity.

The relationship of children to a repressive regime is mediated in various ways via their parents (Barocas and Barocas, 1989; Davidson, 1980). Refugee parents who have experienced cumulative traumata, loss and change may be unable to recognise and meet their children’s developmental needs. Children developing within a repressive regime as they grow older will develop a certain relationship to repressive authority that slowly becomes independent of their parents’ relationship towards this authority. In my work with seriously disturbed adolescents I have found it useful to bear in mind five factors:

1. Developmental level, developmental history and cultural history
2. Secrecy and the character of the repressive regime
3. Trauma
4. Loss
5. Cultural transition

As therapists it is very hard to listen to the stories of children, young people and adults with whom we work. It is even harder to listen and be effective therapeutically as the tragedy and trauma of these stories makes it difficult to hold on to the skills we have as psychotherapists.

In this context it is useful to consider in depth these five factors and the ways in which they interact to over-determine emotional difficulties if we are going to carry out psychotherapeutic work that will aim to integrate all aspects of their experience, problematic and non-problematic, and help them to function independently and without severe emotional problems. These five factors are relevant in organising the experiences of the young people with whom we work.

The psychoanalytic model that divides the mind into a conscious and an unconscious part is essential to our work and especially the notion of defences, defences against experiencing emotional pain. This defence is at some cost to the assessment of reality and of having good relationships with themselves and with others, to being able to work and think. It is my job to make these unconscious defences conscious, and at the same time to support and contain their anxieties during the process of change.

The five factors we have found helpful to keep in mind are:-

1. Developmental Level, Developmental History and Cultural History
Here it is important to highlight the fact that children think and feel in different ways at different levels of development. They also have different ways of relating to adults, to peers and to themselves at different ages. Particularly in our work with children and young people who have observed and experienced immense violence, the regression to or persistence of magical thinking is important to consider and work with. Here the adult boundaries between feeling something, thinking something, wishing something and acting on these internal feelings, are not present.

We all know that for healthy development children need ideally at least one adult who is continuously present during the whole of their development. Children can weather some neglect and deprivation and some overwhelming in their development. Excessive amounts of neglect and overwhelming are called abuse. It is well known from the literature on child abuse that one of the most pathogenic factors in abusive situations is “secrecy”. Abused children will be able to work through the effects of their abuse more easily if there are adults or even peers who acknowledge the reality of their experience. Adults, abused as children, will tend to have persisting serious psychological symptoms if their experience of abuse was not acknowledged. They will tend to internalise “the secrecy” into their way of dealing with the world with limitations on their capacity to assess reality and have good relationships with themselves and with others (see the work of Finkelhor 1984). The literature on child abuse demonstrates that, paradoxically, abused children feel that they are to blame for the abuse rather than the perpetrator of the abuse.

It is a fact that some children and young people who have experienced or observed imprisonment and torture by adult authority figures outside their family, and who become refugees, demonstrate many of the symptoms and relate in psychotherapeutic treatment in similar ways to children abused within families. This relates to the second point.

2. Secrecy and the Character of the Repressive Regime

The families, children and young people with whom we work have lived for years in repressive regimes where the techniques of repression are dehumanising and divisive of the population. Techniques of repression include secrecy about the aims of repression, organised violence, the creation of refugees and horrific torture. These techniques are intended to make people repress, i.e. to literally forget, and certainly not to enact, any ideas in opposition to the government. In some societies repression is overt and in some it is covert, and there are well documented connections between the two types of repression, (see the work of Chomsky, 1991 and Martin Baros , 1990).

The remaining three essential factors to consider in therapeutic work with refugees are the following:

3. Trauma

If we use a psychoanalytic definition of trauma, being traumatised means being overwhelmed and the loss of certain faculties we rely on to make sense of the world - this overwhelming tends to repeat itself at irregular intervals after the trauma, with repeated memories of the shocking events. For young refugees torture, cultural transition, loss and exile can all be traumatic.

4. Loss

Refugees experience both concrete and abstract losses. Often refugees do not know if their losses are permanent or temporary. They are thus not easy to mourn. Losses for young refugees can include loss of parents, loss of peers, loss of culture, country, ideology and
loss of self. Loss is particularly hard to assimilate when a child is in transition between one developmental phase and the next.

5. Cultural Transition
Young refugees have to manage the changes of social expectation on them between one culture and another. Some may have or may develop effective ways of coping with these changes. Other will defend, at some cost, against the shock of change. Some will want to mix only with peers from their own country and at the opposite extreme others will reject contacts with their own culture and tradition and want to be assimilated. This dilemma is illustrated in the story of a girl who saw herself as a feminist in her own culture by rejecting the veil. In England this kind of protest was meaningless (Blackwell, 1989).

Discussion

From the discussion several interesting points were made to elaborate the relationships between secrecy, child abuse and repressive regimes, and the ways in which social secrets were transmitted through the generations, e.g. secrets of the Armenian massacre (not included in school curricula) or secrets of the Holocaust in World War II. We tried to tease out various clinical and developmental problems including the difference in effect between abuse by parents and by strangers, and the effect on adolescents of loss of their parents during this phase of development.

Some members of our group were very aware of the traumatic nature of our stories and the way in which the trauma was replayed in the way in which members of our group related to each other. We were both puzzled that the experience of our child and adolescent refugee clients, which is the experience of thousands of children in the world today, was so hard to listen to and have discussed this issue on several occasions since the meeting.

We also had some discussion about the way that the knowledge of child psychotherapists about child development could be used in communities overwhelmed and divided by trauma, war, and organised violence. In these situations children with emotional difficulties cannot be seen in a one to one situation, but their mental health needs must be acknowledged and met.

Sheila Melzak

Commentary by Jeremy Woodcock

It was a pleasure to hear Sandra Ramsden’s address this morning on The Role of a Non-Medical Psychotherapist in a Paediatric Setting. Mrs Ramsden struck me as being my sort of psychotherapist in so far as she was highly attuned to the skill of gently, although at times assertively, reframing a child’s or family’s difficulty, and thus giving the matter just sufficient attention to allow the patient to reorganise themselves on a healthier footing. Such a perspective is of particular importance to our work at the Medical Foundation where we often find ourselves working with children and families who are organised around experiences of torture and organised violence, yet who nevertheless have patterns of resilience which can be mobilised toward healthy ends by similarly minimal interventions.

Naturally, this should not distract us from paying appropriate attention to the difficulties of clients, as described by Sheila Melzak, who have developed serious
complexes by way of early childhood experiences which have concatenated with experiences of torture, exile and massive losses, and who require sustained ongoing work.

Sometimes it is difficult; when considering our cases which often have very complex backgrounds, to decide whether long term work is required, or if brief therapy will be sufficient. I believe that Michael Rutter’s thinking on resilience in the face of adversity (Rutter, 1985) is of significant help in making such decisions. He outlines patterns of resilience and their acquisition which in summary are: the ability to integrate the traumatic experience into one’s belief system; the presence of self esteem; the ability to be pro-active in the face of ongoing stress; the presence of secure affectional relationships; a measure of success and achievement; the interaction with others in securing these gains; parental modelling; the ability of the child to process events in a meaningful way; and lastly, the gaining of mastery over stressful events, which is in itself a protective factor. When the presence or absence of these factors are taken into account in a child or family who have been referred, it is easier to decide what form of help to offer.

The case presented here illustrates some of these themes, and links in with Sheila Melzak’s thinking on the interaction between secrecy, organised violence and repression, and how these factors become literally embodied in some families and acted out. The case described illustrates how the patterns of resilience in the children were stronger than those of the parents whose framework for living had broken down in exile. In this instance our thinking about resilience helped to decide to offer therapy to the parents rather than to the children.

Case History

This Kurdish family had been in exile for some ten years when referred by the parents themselves. They said they were concerned about their eleven-year-old son who had contracted polio while an infant in prison with his mother. He was being bullied at school and also on the run-down council estate on which they lived. As a result the father, who had been severely tortured (during which his legs had been broken many times), and who had been jobless all these years, was grateful to occupy himself accompanying his son to school. During the long summer vacation both the son and the daughter, close in age, were kept indoors. Meanwhile the son was presented to us as a shy, school phobic, cripple.

As we began to perturb the family’s view of itself, it emerged that the son, far from being bullied, had thrashed his tormentors and had been threatened with exclusion from school. Furthermore, his sister, far from being timid, was a sassy young girl with a broad South London accent and wit to match, well capable of holding her own.

During the session, despite our efforts to encourage them, there was little talk between family members. By contrast the infant son, obviously the focus of much shared pleasure, was handled with skill and affection by each of them in turn.

Here was a classically stuck family. The infant presented no threat and was a source of shared pleasure. By contrast the pubescent son and daughter presented the threat of being absorbed into the host culture and thus dividing the family, since the parents’ most cherished wish was to return to their homeland. The family were unable to declare these tensions openly, thus they were detoured through the son who was presented as the
problem. In fact the family was really organised around dad, who had a crippling, though undeclared, case of depression.

Attention to how family patterns of secrecy and repression were organising this family, along with each individual member’s patterns of resilience allowed us to alight on the parents as being the unit for treatment. Brief work was offered in which powerful reframing, along the lines aforementioned, enabled the couple to reorganise more appropriately around the developmental needs of the children. That in turn shifted the parents forward into new growth of their own as they got to grips with the personal and family demands of adaptation to exile. Such is the diversity of work with children and families at the Medical Foundation.

References
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