Family Therapy and Human Rights: Working with Refugees

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War, political violence, atrocity and forcible uprooting have a potentially massive impact on the mental health of refugees. In the first instance, war and political terror threaten life itself and basic material survival. The physical destruction of home and forcible uprooting tears communities and families apart and drives them from their basic means of support and identity. Furthermore, the psychological integrity of individual survivors is threatened by the impact of atrocity and massive emotional, social and material losses on the inner world.

Refugees appear to manifest the greatest mental resilience when they can account for what has been inflicted on them within the context of their beliefs and traditions. However, the ability of beliefs and traditions to act as mediating factors to prevent breakdown in mental health can be overwhelmed by the cumulative effects of loss and atrocity on the individual or family’s depleted sense of identity.

Thus rootedness in belief, tradition and ways of being is not by itself a protective factor. It is the ability of traditions and beliefs to adapt and facilitate transformations of meaning which is helpful. When culture is used as a resource, the therapist needs to fit an understanding of tradition and belief with mainstream therapeutic work. The following case study offers an illustration of how this can be achieved, and highlights some of the central themes in work with refugees.

Loss and Grief

Sara and her husband Farouk were referred to the Foundation by their GP because of his concern about Sara’s mental health. Two months previously her beloved father and brother had been executed for plotting against the regime of their home country. Sara had supported her father politically, and was forced to flee the country with her eldest son, leaving her husband and younger son to follow. Farouk managed to escape into southern Europe, but was unable to obtain a visa for his son, Parviz, to fly onto Britain. At the airport, time ticking away, Farouk was forced to choose either to return with his son or to send Parviz back with the agent who had brought them, while he flew on to join Sara in Britain. He chose the latter.

Sara was in a suicidal state of grief, and Farouk complained of massive, cramping pains in his chest, which he believed were symptoms of heart disease. Sara blamed him furiously but silently for abandoning their son; Farouk was similarly unable to voice his anger at Sara for throwing the family into this turmoil by her political involvement, because he feared that she was too close to total despair and suicide to hear criticism. Despite his silence, however, Sara did blame herself for their predicament, and was agonised by the loss of her father whom she felt had led her into danger and then abandoned her. At the same time she idealised her father, and was unable to allow herself to feel anger toward him. Instead she displaced her anger onto Farouk, whom she made out to be a weak-minded shadow, although in reality he was an impressive, thoughtful man.
Containing

Using a modified cognitive approach to trace the beliefs and existential choices which had shaped this couple’s experience was one possible pathway into the heart of their predicament. Such an approach might have opened up and enriched their suppressed communication. However, they had lost so much and were in a state of such acute anxiety about having abandoned their son that a more overtly supportive approach was indicated. People who are overwhelmed by situations may not have the emotional and cognitive structures in their inner world to process events meaningfully.

I therefore spent time enabling them to feel safe and contained, and in unpacking and empathising with their feelings, before shifting into a more searching mode of therapy. I began by searching with them for equivalent states of mind they may previously have experienced in other situations of loss and anxiety, and exploring with them how they had coped. By this means I began a process of scaling and normalising their experience.

Sara was in a state of disbelief and denial about the death of her father and brother. She had not seen either of them dead or buried, and this contributed to her sense of unreality about their deaths: at a certain level, she did not believe that they were really dead. Part of the work was therefore to get her to visualise her father and brother dead, and mentally to bury them. This entailed evoking the physical aspects of death by asking the couple about death rites and burial customs in their country; how customs are physically carried out; how the body would be washed and laid out; who would do these things; who would attend the funeral; what were the different roles taken by men and women. It also required taking Sara through the unique circumstances which made her grief so difficult to process.

I therefore asked Sara how many of the rituals of death would have applied to her father, who was executed in prison. This shifted the emotional tone into the domain of her shame and outrage about what had happened to her family. The sessions were deeply moving and Sara cried a lot. I took time both before and after the sessions to think through the issues raised, and to measure the impact on my own and the interpreter’s reactions. This was important if we were to continue to offer a safe, containing space for Sara and Farouk.

After about four sessions of this intense work, Sara began to let go of her preoccupation with suicide. This had taken the form of an impulsive longing to follow her father into death. She shifted into an acute longing to see her youngest son, Parviz, again. At this point Farouk’s chest pains were at their most acute. He was investigated by the cardiac team at a teaching hospital, and found to have no evident cardiac abnormality. We created a metaphor for the pain: it was like a hand gripping his heart; the hand was compressing his heart with grief; the hand wished to tear out this heart which had abandoned his son and weigh it up for what it was worth; the heart was pressed with a heavy stone of guilt. These externalisations of his inner feelings gave the couple access to some of the emotions he was carrying.

We discussed together how the grip on the heart could be loosed, or the stone of guilt lightened, and as this language of the heart became incorporated into their conversation so Farouk’s symptoms eased away. Sara understood that her anger against him was partly displaced from the complex feelings of outrage she felt about her father’s death. As we unpacked their feelings, they began to see that it was possible to express the massive extent of their rage and hate so that it would not annihilate the other, nor displace their fundamental attachment. In a later session Sara, who was always more forthcoming, said that she had lost everything, but understood as never before how deeply she loved Farouk.
Tradition

The anniversary of her father’s death was a difficult time for Sara. I discovered that it was customary at such anniversaries to bake halva, a sweet cake, to offer to family and friends who would call, and to give to the poor. Sara felt that she could not follow this custom because they had no obvious community to which to offer the halva, and because people in Britain would not understand the significance of the food, or say the appropriate blessing which in the Islamic tradition accompanies receiving the halva. However, Sara was persuaded to adapt this tradition. She baked the halva and, with Farouk, said the appropriate blessings over the food. The plates were then left in the clinic waiting room and on the reception desk. This fulfilled some of the ritual’s purpose in its original setting: it gave Sara some public acknowledgement of her grief, and provided a symbol of solidarity with other patients of the Medical Foundation.

The separation from Parviz was almost unbearable to the couple. I searched for equivalent experiences of separation, but they had been a close family. When practicable, telephone contact was made. This lifeline often brought difficult news, particularly when Parviz was sick. But each contact created a sense of real life between the parents and Parviz and his grandmother, Farouk’s mother, who was caring for him. As time passed, a leap was made in which Sara and Farouk were able to envisage that they had not totally abandoned Parviz, and sessions were spent discussing how to advise Farouk’s mother on her care of him.

All this work was coloured by uncertainty. The couple were asylum seekers, with no absolute certainty that the UK immigration department would deal favourably with their case. This is an uncertainty which I, the therapist, also had to manage. To ground their expectations in reality, I encouraged them to keep contact with their asylum lawyer, to keep advised on the progress on their claim and the likelihood of being re-united with Parviz. At the lawyer’s request, I also wrote a report on my work with couple, which added a human dimension to his legal representation.

Discussion

Refugees’ experiences of atrocity, massive loss and displacement are beyond the experience of most Western health professionals. The horror of what these people have endured can be difficult to contemplate, and may make us wish to recoil and close off to them. This is not a shameful response; rather, a natural protective reaction to exposure to terrible and unthinkable experiences. If we can understand why we may react in this way, we are better placed to work with compassion and skill.

For this reason, time should be taken before starting work with refugee families to think through the issues and emotions they may bring. This mental preparation should include finding support oneself, and allowing sufficient time to prepare for the session and the tasks that will follow.

Issues of cultural difference will also have to be considered, and this may lead the therapist to question Western notions of health, the sick role, and appropriate ways of helping. Cultural difference should not prevent us working effectively with such clients, if we remain open, questioning of our own assumptions and practices, and willing to explore new challenges. That said, some preparatory information should be sought before the first session about such issues as gender, childhood, work, the life cycle and so forth within the family’s home country. Over time, the family will become the best source of information about these issues. However, it helps to gain their confidence if some groundwork has been
done. Time should be spent researching their beliefs and traditions, and the human rights situation in their country of origin, and understanding the background reasons why the family have fled into exile.

It is unusual to be in a position to work with a refugee family without having to use an interpreter. Acquiring skills in communication through interpreters is essential. The interpreter is not a colourless conduit of the therapist’s words; rather, he or she is a colleague and a potential therapeutic ally, who will enrich communication with the family and who may be a helpful source of information about the family’s beliefs and traditions. Therapy is essentially about communication, and this should be borne in mind by the therapist. It is therefore important to take time to find a congenial interpreter, and to involve them as a co-worker in the enterprise of helping the family.

A primary rule when working with refugee families is to set the aims of the first session no further than establishing a relationship with them, introducing the notion of therapeutic talk, and gaining their confidence by attempting to resolve any difficulties in communication between the therapist and family members. It is important to respect their patterns of communication. For example, forming a therapeutic relationship with a Shia family can be facilitated by initially directing conversation through the father, and then seeking his permission to talk directly with his wife and children.

Facilitating communication is critical to the therapeutic process. The aim of war and atrocity is to overwhelm and silence those who refuse to conform to a dominant ideology. Establishing as unique the voice of those whom others have tried to silence is a central therapeutic task.

Conclusion

Work with refugees requires a respectful curiosity which seeks to enable them to use and adapt their beliefs and traditions in order to cope with new ways of life. Much of the work requires an understanding of processes of bereavement, which have similarities and differences across cultures. It is vitally important for the therapist to take time to understand the impact of a patient’s experience on ourselves. We also need to reflect a belief in the human rights values embedded in medical practice, and have confidence that mainstream skills developed out of experience and training can make a difference that is helpful to refugees who are survivors of war and atrocity.