Refugee Children and Their Families: Theoretical and Clinical Perspective

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Many refugee children endure extreme events as a result of violent warfare and human rights violations (Zwi and Ugalde 1989, UNICEF 1996, Loretti 1997) This chapter demonstrates how the clinician works with the multidimensional effects of trauma on refugee children and their families that are compounded by forced uprooting, massive losses and the myriad changes brought about by migration.

Debate in the arena of refugee mental health has polarised into two camps. There are those who eschew the medicalisation of distress and the use of psychological models of trauma, including post-traumatic stress disorder (PTSD). Then there are those who find the medical and psychological models extremely helpful in formulating interventions in this complex area of work. This chapter attempts to chart the middle ground. It draws on the critique of western models of mental health; it reflects on some indigenous healing practices and it also makes use of thinking about trauma from western psychological medicine.

The chapter shows how an approach that is integrative, which draws on systemic and psychoanalytic practice and makes use of narrative ideas and clinical thinking drawn from attachment theory; is uniquely well placed to attend to the 'broken social world' of survivors. It maps out how the clinician can work collaboratively with the child and family to make it possible to work simultaneously with intrapsychic material, family dynamics and socio-political factors.

Warfare and western models of mental health

The circumstances of political violence and the culture and ethnicity of survivors raise profound questions about the application of western models of mental health and family life. Some proponents are deeply sceptical that refugees can benefit from western psychological models (Bracken et al. 1995). Others presuppose that trauma is a culturally neutral event that only requires the application of technically valid and value-free models of psychological intervention in order to make amends.

Bracken argues that people mediate their experience through culturally syntonic ways of living in which western explanations are redundant. Bracken’s chapter in Rethinking the Trauma of War (1998) sharpens the understanding of this redundancy. Western thought is characterised as dualistic and its scientific method is validated by virtue of its ability to be objective. As a result, medicine is based on a model that individualises illness experience. However, people in other societies do not prioritise or even live through individual experience and the nascent western trauma discourse does not make sense of extreme experiences that are mediated through communal ways of living. Therefore, if western methods are used imperialistically and
unthinkingly in other societies, the likelihood is that the communal bonds, which provide resilience in situations of adversity, may be undermined. On these grounds, Bracken argues that the application of western psychological medicine, psychiatry and psychotherapy to other societies is both ethically dubious and clinically unsound.

This thinking is no less relevant to refugees settling in western societies. However, in the west the social context of survival is complicated by the experience of displacement. Refugees have to contend with the loss, or at the very least the weakening, of familiar ways of life and forms of support. Furthermore, they may find that the host society is explicitly hostile to their ways of living. In addition, despite being very resourceful, for some refugees lack of adaptation may be a form of protest against the world they have lost.

Extreme events or trauma?

Despite these reservations, it would seem that experiences inflicted on refugee children and families are accurately captured by the symptoms described in the DSM-IV definition of PTSD. Axis ‘A’ of DSM-III-R (APA 1987) describes that:

The person has been exposed to a traumatic event in which both [writer's emphasis] of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror.

It is noted that, 'In children, this may be expressed instead by disorganised or agitated behaviour'. However, the term traumatic event is not defined. It is a tautology. Through the lens of western medical practice there may be broad agreement as to its meaning but in other contexts what may be regarded as traumatic (that is causative of trauma) may be experienced as a integral to a way of life at a particular time. For instance, during the intifada, the Palestinian struggle for self-determination, Palestinian children maintained good mental health despite the almost daily infliction of extreme events (Punamaki 1990, 1993). Evidence from children exposed to similar levels of hardship in the political climate of South Africa before the ending of apartheid makes the same point that when extreme events have a context that makes their endurance understandable and worthwhile, trauma tends not to emerge (Dawes et al.1992).

For these reasons extreme events is a preferable term to trauma. Used in this context the term extreme events is similarly self-referential but not tautologous. There is room for negotiation as to the meaning of what may be an extreme event in different contexts. Furthermore, to experience an extreme event does not imply that one will suffer trauma although, as with all life events, it often profoundly affects and reshapes life.

The self-referential nature of PTSD can reach absurd limits in particular clinical situations. For instance, on making a diagnosis of the disorder the clinician may reassure the patient that their symptoms are to be expected. This normalisation may relieve their secondary anxiety but what then? How does one advance from this tautology to primary symptom relief?
In the two sections that follow we first consider how indigenous healers in south-east Asia and Zimbabwe respond to extreme events. Then an example is taken from South Africa of how western and indigenous healing practice can be integrated. The chapter then moves on to look at how narrative can be used to integrate therapeutic practice with refugee children and families.

**Indigenous responses to war and atrocity**

Among young Cambodian refugees who were survivors of atrocity, Eisenbruch (1991) found that the intrusive phenomena of PTSD were considerably relieved in those who had access to indigenous priests and healers who were able to interpret their symptoms in terms that were syntonic with their culture. This led Eisenbruch to debate whether PTSD is an adequate diagnosis, or whether the concept of cultural bereavement is more appropriate.

Similar corollaries can be drawn from Reynold's (1996) study among Zimbabwean children affected by the Chimerenga, the native term for the armed struggle for independence. There was a belief that war upset the natural order. This explained how children were affected. When nyangas, that is native healers, were sought for consultation, negotiations ensured between the family and the nyanga in order to rest their skill at forecasting what was wrong. First, less critical symptoms would be offered to see if an accurate forecast could be made. If this was satisfactory to the family they would open up to the nyanga and give them the full picture. The nyanga’s forecasts often revealed that the sufferer had transgressed the given order in some way which then had to be propitiated. The striking thing about Reynold's study was that the nyangas represented a benign authority. They sanctioned parents to treat affected children with care rather than discipline.

**Integrating indigenous and western healing practices**

Similarities between indigenous and western healing practices have encouraged some clinicians to attempt the integration of these practices. Characteristic of these attempts is that the therapist uses a reflexive cultural stance to interpret the culture of the patient or family through the lens of their own culture. Therapeutic curiosity is used as a means of accessing the patient's own understanding of their affliction. Ultimately the patient's own meaning systems and ways of healing are considered as ways of restoring their well-being, but the therapist uses their own principles of interpretation to guide them through the process. Straker (1994) offers a striking example of this approach with three teenage daughters of a chief murdered in the violence of the South African civil war. Within a conventional western framework they would have been considered to have been suffering from PTSD. However, Straker read their symptoms within the more holistic framework of traditional African beliefs. These encompassed the social significance of their father's death, which led to the need to ritualise his untimely passing. They also derived meanings from the supernatural realm which led the young women to interpret their dreams and other intrusive phenomena as messages from the ancestors who sought propitiation for his death through ritual means.
Narrative and psychotherapy

The following sections extend the integrative thinking demonstrated by Eisenbruch and Straker with an outline of how therapy can make use of narrative ideas. Narrative is used as a theme to integrate thinking from anthropology, systemic practice and psychoanalytic psychotherapy: Narrative as an idea has come to be owned within the systemic tradition by a form of psychotherapy developed by the Australian family therapist Michael White. His elegant therapy makes use of ideas from linguistics. He notes how people essentialise experience so that characteristics which they develop appear to be an immutable part of themselves. These characteristics can tyrannise when they are symptoms of illness. White uses notions of deconstruction to enable people to detach and externalise those tyrannical parts of themselves and thereby to 're-author' their experience (White and Epston 1990). These are helpful ideas when working with settled children and families. However, they need to be extended when working with refugees who inhabit a world that has been torn apart. Thus the task of therapy is more one of sorting and locating themes of identity, resilience, tradition and the story of one's life against a backdrop of persecution and dislocation.

Narratives of resilience and endurance

Survivors' use of their own resources is a notion which Eastmond, an anthropologist, emphasises in reference to the communal nature of the refugee experience. Exile is liminal, ambiguous, open-ended, complex and non-linear. It is disruptive of the social order itself and as such creates ontological insecurity. However, she notes from her work with exiled Chileans in the United States (1989, 1993) and Bosnian refugees in Sweden (1998) that refugees are not passive victims but interact and negotiate with the host society. Furthermore, referring to Myerhoff (1986), she writes 'one of the most persistent ways that people make sense of themselves is to show themselves to themselves, through multiple forms: by telling themselves stories ... recreating themselves in an historical narrative' (Eastmond 1989).

Stories recognise that life is radically discontinuous. At the same time stories provide an experience of endurance and wholeness. This may be an illusion but it is an illusion that is not a trick. Rather it communicates something very powerful and psychologically true about the resilience and continuity of life itself (Gersie 1997).

Narrative as a transitional space

Narrative ideas can be linked to important thinking by Winnicott about how the growing child develops a coherent grasp of internal and external realities. He believed that 'the child has a primary wish to be understood' (Phillips 1988); that the developing child and its mother are a unity; and that the child collaborates with the mother in gaining self and identity. The role of the parent is to enable this through 'appreciative understanding' (Phillips 1988) and by relating external and internal experience. As child and mother interact they create a 'transitional space' through literal and symbolic communication out of which language and play emerge (Winnicott 1971). Similarly; through attunement to the patient's inner world the therapist provides a similar transitional space in which conflicts can be contained and worked through so that a more coherent identity emerges. Stories and narratives can enable attunement and coherence to develop. Furthermore, what needs special
emphasis is that, more than in any other psychotherapy setting, often what makes the real difference when working with refugee parents and children is just the actual therapeutic attachment itself. This provides a regular reliable appointment and the presence of a form of parental care and adaptation - very often without the need of interpretation - just being there: listening, understanding, bearing witness and validating experience.

**Narrative and continuity**

Many different approaches can be used to create narratives that provide a safe transitional space in which to engage and transform life experiences and difficulties. Linking psychotherapy to seasonal and religious festivals is a way of creating a transitional space that encompasses both the therapeutic setting and the external world of a refugee family's culture and traditions that is also affirmative of cultural identity. Aspects of the rituals can also be taken up within the psychotherapy to transform and carry away stuck and difficult feelings (Woodcock 1995a). Genograms, or kinship diagrams, are enormously helpful in mapping out families whose members may be scattered across the world. With children, the use of life story books, which embody both reality and fantasy and which enable them to sort out muddles of what is real and fantasy (Cattanach 1992), are very effective and powerful ways of creating healing narratives. These ways described should make effective use of protective factors: explaining and making sense of experience; providing continuity; providing opportunities for mastery; and finally rendering experience syntonic with a world view, which will need to expand to encompass extreme events. Naomi Richman's work with war-affected children and refugees exemplifies the need to make not only symbolic but real connections with the communities of children and families; to practically track interactions and issues between generations; and to work to support refugee children's identities through practical methods. Good work with refugee children who have survived extreme events will only be effective when the practical groundwork is given proper attention and work is done to literally find the child's place in the world (Richman 1998).

**Narrative and reflexivity**

Reflexive questions are a good starting point for a process that sets out to make sense of what has happened in the external world and to link that to thoughts and filings in the internal world of both refugee and psychotherapist. Unconscious feelings can be made more accessible as the inner story of what has happened is externalised. Children externalise readily through drawings and play: Adults externalise through narratives that situate inner experience 'out there'. For instance, a man who found it hard to face the anguish of his family often recounted the complex and anguished politics with which he had been involved. These were reflections of his inner world. As we talked and made links he was gradually able to make sense of the fact that the connection went back and forth between his internal and external world. We reached a point where talk of politics and human rights was enriched by this understanding metaphors for interpretations of psychological processes we made use of the rich fund of political stories to make our points.
The obvious truth is that refugees are persecuted by outside forces. However obvious, it is nevertheless actually helpful to make the point that the persecution they feel inside (and may act out in the family) comes from persecution inflicted on them by an external force or person or regime. That truism, strategically offered, can enable them to modulate feelings and sort out the muddle of emotions that come about as a result of human rights abuse. This is particularly important for young children who may muddle enraged fantasies that they feel towards their parents with actual events.

**Narrative and self-determination**

It is singularly important for psychotherapists to maximise refugees’ capacity for self-determination. This is because one of the defining aspects of refugee experience is that they suffer massive and multiple losses, terror and coercion by authorities that intentionally persecute as well as coercion by agencies who try to help. As a consequence of lack of civil rights and loss of external trappings of identity they are often dazed and confused. As Parkes (1997) remarks in relation to extraordinary events, the whole assumptive framework is challenged by the psychosocial transitions that are forced on survivors. For refugees the tremendous disruption in assumptive framework is amplified by the sensation that ultimately they are expendable. Their experiences are actually embodiments of terrifying psychic fears: nightmares that have become

Psychotherapy with refugee survivors can help to overcome the sensation of complete loss of personal autonomy by situating the work within a reflexive historical narrative. In other words, psychotherapy that prefaces work with her question, 'What brings us together to work on these issues at this point in time?' directs curiosity not only at refugee children and their families’ dilemmas, but also at the therapist’s place in the world. That is, our culture, history and social and political relationship to the human rights violations that have caused the upheavals that caused the family to flee. This process of reflection does not yield easy answers, but it needs to be done if effective psychotherapy is to be achieved with refugee survivors. This is because, as noted above, work with refugees is a form of globalisation and questions of therapy cannot be limited to the intrapsychic and interpersonal domain but also have to yield to questions about what produces and sustains identity within the tensions and disruptions of this new and increasingly complex world order.

**Racism and xenophobia: resistance to refugees**

Whenever refugees seek asylum in a country there is resistance from the host community, which may manifest as outright rejection and xenophobia or may take more subtle forms. In health and social care agencies there may be resistance to engaging with refugees’ needs because they seem overwhelming and do not easily fit in with prescribed care packages. Institutions may also unconsciously resist engagement with the disturbing and atavistic nature of the refugee experience. These responses tend to displace the responsibility for direct help on to voluntary organisations, which has the effect of marginalising refugee health care. Clinical experience suggests that this discrimination contributes to poorer social integration and ultimately to inferior health care. Lack of referral to specialist secondary services
is borne out by health care studies among ethnic minorities (Nazroo 1997). Racism places refugees in double jeopardy because of its inherently damaging effects that echo the experience of persecution. This requires that issues of racism and discrimination and its effect on the internal and external world must be brought reflexively into the therapeutic work so both therapist and child or family are freed to make a positive exploration of identity rather than one that is suppressed and essentialised by racism (Fernando 1991, Thomas 1992, Krause 1998).

**Social constructionist therapy**

The following sections illustrate how social constructionism can be used in order to harmonise systemic and psychoanalytic practice. The assumptions of social constructionism may be summarised as being that we do not live in a world in which the facts of our existence are stable scientific realities but one in which reality is mutable, socially constructed and constantly under negotiation (Anderson and Goolishian 1988). As a consequence, how one views and responds to reality will change, for example according to one's position as an insider or outsider to a culture (Merton 1973), or one's position in the life cycle, or one's gender (Gorel-Barnes 1998). Accordingly, this opens up the possibility that therapy can enable families to elaborate narratives, as detailed in the sections of the chapter above, which are ultimately freeing and healing.

The important feature of social constructionist therapeutic work with survivors of extreme events is its efficacy when combined with thinking from attachment theory: What the therapist sets out to do is to enable the child or family to understand and re-internalise what has been inflicted on them in a narrative that is congruent with their experience and valid in relation to their beliefs about themselves and the world around them. This may mean having to extend their beliefs about themselves and also having to accept that not everything is explicable. However, these narratives are effective, not when they are simplistically palatable, but when they struggle to make sense of the grittiness of experience. Furthermore, the child or families' clinical experience of having a therapist working alongside them, thoughtfully providing safety (Dolan 1991) while unpacking and making bizarre and troubling experiences coherent, offers not only a cognitive map of what has happened, but a relationship that can begin to overcome the intense psychological and existential loneliness of extreme experiences. This is an absolutely vital part of the healing experience. It may be thought of as akin to Winnicott's model of psychotherapy and parenting described earlier. The thinking of Byng-Hall (1995) is also very pertinent here. As is common in most forms of psychotherapy, the therapist sets out to provide a secure base from which the child and family can explore new scripts that transcend patterns of interaction inculcated by extreme experience, loss and the savage disappointment of exile.

**Systemic therapy**

Because of the co-development of later systemic approaches to psychotherapy with constructionism, the two are somewhat conflated nowadays. Constructionism can be used to deconstruct and relativise any psychotherapy; however, the strength of systemic therapy is that it inherently lends itself to constructionism because its
underlying epistemology is based on an open systems approach. This presupposes that causality is circular and that all living systems are open-ended and mutually influence each other (Jones 1993). The notion of punctuation is used to denote the idea that nothing can be described as essential, that is absolutely having to be in a particular way, because any description is dependent on the view one takes and therefore from which it is punctuated. For instance, if two boys are climbing and one falls out of the tree and breaks his neck, trauma in the boy who witnessed the event is not an absolute entity; It will depend on how the event is punctuated factually, cognitively and emotionally. Was the broken neck fatal or disabling? Were they brothers? Were they forbidden to climb trees or were their adventures encouraged? Was non-judgemental help easily on hand? - and so forth.

The strength of this open, negotiable, narrative approach when applied to refugees and extreme events is that it can be used to bring into view all the mutually influencing factors in their life story which shape their response to what has been inflicted on them. The family may view; or punctuate, what has been inflicted on them through the lens of their affiliation to a resistance culture. Another family may view what has happened through the lens of being helpless victims of political events outside their control. Naturally, different views may compete for attention in one family and very often within the individual parent or child. Here the notion of intertextuality is useful (Papadopoulos and Hildebrand 1997). This emerges from ideas current in narrative therapy; which as we have seen has made use of concepts drawn from Foucault (1972) and other social theorists that individuals, societies and by extension families construct reality through competing discourses. This produces discourses which are either marginal or dominant. For instance, in some families the experiences of children may be marginalised in favour of the dominant experience of the adult males in the family: Or the adaptive responses of women may be seen as a challenge rather than an opportunity for the family as a whole. Work with refugee families can make use of these narrative ideas in order to unpack, reframe or re-punctuate family interactions so as to illuminate the perspectives of family members that have been overlooked. The therapist attunes themselves to family scripts and attachment patterns and draws forth scripts and patterns that may be more inclusive, adaptive and resilient.

**Psychoanalytic approaches**

Because the psychoanalytic approach is included in this analysis of working with refugee children and families, the implication may be drawn that ultimately trauma is an intrapsychic event. However, the approach to psychoanalytic knowledge taken here is to regard its under-lying precepts as guiding metaphors, that are socially constructed, rather than regarding them as immutable and universalisable scientific facts. Nevertheless, this observation does not set out in any way to diminish the hard-won experience of psychoanalysis, awakening people to the instinctual drives and the unconscious and how we mediate these - ways of thinking that have reshaped western consciousness and permeated all forms of psychological thinking.

It is important that both external and internal experiences are validated and that unconscious processes are understood. With this in mind it is apparent that the most affected clinic population is helped by understanding the intrapsychic corollaries of
extreme events. For instance, children internalise relationship schemas that include observed and felt reactions of peers and adults to fear, repression and extreme violence. Thus we know if adults model robust coping, children are more likely to respond in a similar fashion (Freud 1965, Rutter 1985, van der Kolk 1987). At a deeper level responses to extreme events may resonate negatively with the child's or adult's internal working model of relationship with self and others. These may be complicated by the developmental stage and needs of the child. The young child's innate difficulty in distinguishing reality and fantasy may interfere with their ability to meaningfully process extreme events that in any case overwhelm their cognitive and emotional schemas. For example, a 5 year old boy who witnesses the violent rape of his mother in front of his arrested and helpless father may confuse this with the acting out of his own oedipal desires.

Because extreme events may overwhelm the individual's psychological defences, that is their ability to modulate incoming stimuli, the psyche responds by attempting to repress memories of the event. This leads to a phenomenon by which the event is both known and not known (Laub and Auerhahn 1993). Aspects of an event may be completely repressed. For example, an aid worker saw me after a break- down, which followed a terrifying ambush on a convoy in which he had been travelling. He had a serious but medically unexplained weakness of his ankle. Our shared anxiety had deterred us from some of the central aspects of his narrative. However, in one session I intuited that one of the guards had stood on his ankle while returning fire and suggested this to him. That was indeed true. The realisation was co-constructed from our conversation in which I attuned to his emotional state and listened very carefully to how the emotional tone and the facts hung together, while looking for key psychological experiences such as overwhelming fear, loss of control and shame (indicated by their absence in the narrative as much as their presence). This sensitivity to cues of what may have happened enabled us to unpack the story that when their truck was ambushed he was thrown out and into a roadside ditch by one of the guards who courageously fought off the attack. He had been in a state of acute fear and had soiled and wet himself. At the same time the guard had pinned him to the ground out of harm's way by standing on his ankle. As he recovered the memory his ankle recovered spontaneously. This illustrates that powerful associations to extreme events are sometimes 'stored' in the body (Scarry 1985). This can be particularly true of survivors of violence (Callaghan 1998): unbearable things that cannot be faced are very often somatised.

The particular attunement to his inner state described above is counter-transference. What occurs is that the unbearable things, which the sufferer cannot face, put the therapist in touch with their own experiences of pain and desperation. Unlike the sufferer, the therapist can make use of that experience on the sufferer's behalf and thereby offers a way of transforming their unbearable experiences. Counter-transference is often intuitive but as the therapist develops experience there comes an understanding that it is a form of knowing that can also be developed and trusted and put at the service of the sufferer. Systemic therapists would identify this process as making use of experience of the self.

In children, memories which are either repressed or more consciously forbidden can often be enacted and externalised through play: For example, I worked with a boy
and his father in conjoint play sessions. The father had been severely tortured and continued to be terrified. The 6 year old son had become anxious, bedwetting, defiant and unruly: My understanding was that despite the father's attempts to hide his experiences from his boy the son had both consciously and unconsciously experienced his father's terrorisation by the secret police. In the play work the boy symbolised the hated leader of their homeland with a caricatured Plasticine figure. He also modelled snakes with flames coming from their mouths. Towards the end of a session we entered a process of naming each of the more recognisable figures. When the boy named the dictator his father went into a paroxysm of fear. The boy then took one of the snakes and curled it around the dictator in a motion of entrapment. With this the father visibly relaxed. Later he recounted how at that moment he had realised how the son had been living with his terror, but they had no shared language with which to process their sensations of that experience. The son's play provided them with a repertoire of symbolic language with which to communicate about their experiences.

**Defences**

Defences need to be respected because they constitute effective ways of coping. They should only be challenged if the therapist has the skill and time to work things through to a resolution. For instance, a family with whom a colleague and myself worked had a very rigid set of defences based on their religious beliefs that allowed them to cope, but at some cost to their overall well-being. They were under threat of deportation by the immigration service and we did not believe it ethical to challenge and dismantle their defences, which enabled them to cope with this very difficult situation. This point leads to a further observation that refugees often have strong religious beliefs. These comfort and rationalise an often cruel world. These beliefs must be worked with and respected. Sometimes direct parallels can be drawn between religious beliefs and attitudes and psychological understandings. For instance, a child who witnessed violence against his father and mother later became very delinquent and was taken into care. When he eventually returned home his older sibling resented the care and attention he attracted. We talked with the parents about the return of the prodigal son. This biblical story with its cogent metaphor of rivalry in family life helped them to communicate about family relationships and to mediate the conflicts that had emerged.

By contrast, to regard psychological conceptions as rigorous and scientific and the religious beliefs as forms of reification will almost certainly confound therapy: Differences in world view become creative when brought into the open and discussed and negotiated. Furthermore, when a social constructionist position and therapeutic knowledge are taken as being a set of guiding metaphors that enables us to negotiate realities, to arrive at insight and to enable change, then the insights of Cox and Theilgard (1981) that 'metaphor is our means of effecting instantaneous fusion of two separated realms of experience' become very pertinent.

**Attachment theory**
The following sections consider how attachment theory can help in our understanding of reactions to extreme events and how interventions may be modelled that make use of this approach. This understanding of attachment theory also integrates thinking from psychoanalytic and systemic practice.

Attachment theory explains how parents transmit their attachment patterns from childhood to their own offspring. It is suggested that children with difficult attachments have parents who have internalised attachment patterns that are coercive, neglectful, ambivalent or unpredictable (de Zulueta 1993). Attachments between parents and children who have endured extreme events are often very strained. This can be because parents are distracted, preoccupied, depressed or traumatised (Melzak 1993). Equally, children who have endured the same events may be irritable, distracted, preoccupied or demanding and less rewarding to parents' and this can also strain attachments (Woodcock 1995b).

**Attachment schemas and extreme events**

However, attachment theory explains more than the interpersonal schemas of attachment behaviour, in fact it goes to the heart of how extreme events are internalised and how traumatogenic symptoms are set in motion.

Main (1991) suggests that before the age of 3 children are unable to be metacognitive. In other words, they are unable to think about their own thinking or, by corollary, their own feelings. To use her language, they are unable to 'dual code' events. Therefore, people, things and events are understood concretely as being a particular way. For instance, a grandfather cannot be simultaneously 'grandad' and 'mummy's father'. Between 3 and 4 children do begin to dual code. However, before this the child's development is helped if they experience relationships that are both emotionally congruent and cognitively coherent. This may explain why the cognitive and emotional development of children who suffer abuse is affected because children cannot dual code relationships and this leads to incoherence and confusion when, for instance a 'daddy' who loves them is also abusive. Similar confusion can occur for refugee children who experience figures of authority in their society abusing and terrorising their parents and even themselves.

During extreme events people report being 'lost' in the moment and being unable to process what is happening to them cognitively and emotionally. This may be because the event is so bizarre, or threatening or sudden that it overwhelms their ability to internalise it in a meaningful way. There is a loss of the ability to dual code the event. It is internalised as a set of very concrete gestalts -sometimes re-experienced as intrusive iconic images and possibly physical sensations of the original experience. Furthermore, what is felt as particularly devastating is the sense that they are alone with the experience: that no one can attune themselves to what has happened to them. This is experienced as a terrifying existential loneliness. This is made worse because they feel unable to maintain relationships with others. Their attachment nexus is disturbed and in its place are highly charged indigestible fragments of experience. This disturbed attachment to one's own internal representations of self and others suggests why many individuals find it hard to
socialise in the aftermath of extreme events and how previously gregarious, pro-
social people become withdrawn and socially anxious.

Intrusive phenomena, such as nightmares and flashbacks, represent successive
attempts to recreate and metabolise extreme events. However, extreme events are
likely to be too far beyond the scope of a person's cognitive or emotional range to be
accommodated. Simultaneously, avoidance emerges because the person does not
wish to recall the event either consciously or unconsciously, both because it is too
ghastly and also because it challenges the basis of their earlier psychic development
and a such represents an unsurpassable problem of assimilation.

Parents with coherent explanations of their childhood attachment (gained through
direct experience or through therapy) are more likely to attune to their children's
needs for proximity and thereby provide an experience of attachment that is
emotionally congruent and cognitively coherent. The process of attunement between
parent and child creates a zone described as a third area in which symbolic
interaction such as play springs forth. This is exactly the same as the transitional
space discussed above in relation to Winnicott's work. It is surmised that this forms
the crux of the creative nexus. This third area can also be described as the epistemic
space of the person. It is the cognitive and emotional space in which thoughts and
feelings are processed and brought into consciousness through metacognitive action.
In fact, the term 'metacognitive' does not go far enough because feelings are also
modulated in this space. One could say that feelings recognise each other and meta-
emotional processing also occurs.

The concretisation of extreme events is the opposite of the creative symbolising
experience that arises in the transitional space or third area. This contrast throws into
focus the central task of therapy which is to provide a basis on which the extreme
event can be symbolised cognitively and emotionally and thereby assimilated. This is
inherently a creative process. As such, it makes sense of why practices which enable
people to participate and witness performances from theatre through to political
protest and religious ritual, which promote symbolic realisation and so enable
alternative views to arise, are likely to enable healing. Furthermore, it explains why
indigenous healing practices are effective because they bring into play similar
creative and symbolising functions (Englund 1998). It also speaks to the efficacy of
play and play therapy as media for enabling both children and adults to process
extreme events.

**Working with children and parents**

Extreme events unsettle, disturb and displace parents' own internal representations of
their own parental attachments laid down during their own development. In brief, it
is as if the parent has 'lost' their own internalised parent. They in turn are
incapacitated in the parenting of their own children. However, the child's healthy
impulses towards development mean that the parent is challenged to respond.
Sometimes they are unable to do so and the child complains of a father or mother
who looks and smells the same as their original parent but is just a shell or shadow of
their former self. When the parent is unable to take up the child's challenge for
attachment, therapy can be helpful.
The therapist should hold in mind that through the process of projective
identification they can enable the parent to assimilate parts of themselves that they
find repugnant or otherwise indigestible. Projective identification is the process by
which the parent (or child) unconsciously projects parts of themselves which they
cannot assimilate into the therapist who then identifies with or acts out the
projection. The therapeutic task is to accept the projections, metabolise them and
symbolically represent them back to the parent (or child) in a way they can then
assimilate. As the therapist works with the interpersonal relationship between parent
and child through the process of projective identification, the parent can experience
the supportive parenting of the therapist. Simultaneously; through the relations
between themself and the child, supported within the therapeutic experience, the
parent may be able to re-internalise at a real and symbolic level a healing version of
their previously shattered attachment schema and thereby re-experience a recovery of
their own 'internal parent' through the responsive and attuned attention to the needs
of their own child. Very often this involves a great deal of supportive work - sorting
and validating experience through quite robust observations and interventions.

When parents are very disturbed the therapist can act as a container of the family's
experiences and interactions and as 'digester' for the family working with both parent
and child's projections until such time as healthier family patterns can emerge. This
is demanding work but understanding how these levels of experience interact and
mapping the child's, parents' or family's experience into a constructed narrative of
their real world experience can enable the therapist to cope with the demands of the
projections.

Clinical descriptions

There follow two case descriptions. The first exemplifies work with a family; which
illustrates the process described above of working with a parent's damaged inner self
through family work that is focused on parent and child dynamics. The second
illustrates direct work with a refugee child who has survived an enormous personal
atrocity.

Work with a family

The first case to be discussed is that of a Sudanese Catholic family. They were
referred by the father David's psychotherapist, who continued to work with him. This
proved to be very fruitful.

David had received a very harsh upbringing. His wife, Elizabeth, was warm, capable
and strong, although overwhelmed by her husband's periodic violence towards
herself and children. She was also haunted by a sense of isolation which, at times
bordered on despair. They had four children. Zeph, the 2 year old, had been born in
exile. The others were Hannah aged 9, Benjamin, 8 and Maria, 6. David had been the
organiser for an aid organisation. The organisation had been set up to provide
succour to Christian refugees fleeing from the war in the south. His work led him to
believe that the regime wished to destroy Christians moving into the north.
Differences of outlook and policy conflicts led him into being imprisoned and
severely tortured by the regime. After he was released his life remained under threat and the family fled into exile.

Clinical issues

The immediate clinical issues that emerged were David's violence towards his wife and children. He seemed to be mentally and emotionally rigid and emotionally disconnected from the children. He had very high academic expectations of the children and they were all fearful of him, particularly Benjamin. The children had various somatic symptoms - Hannah and Benjamin were bedwetting. Benjamin also had very sore and poorly managed eczema. We noticed the particularly conflictual nature of the relationship between David and Benjamin and the fact that Hannah, of all the children, seemed to be able to get away with a lot more. We saw Elizabeth's dilemma as being how to position herself in relation to the children's needs and David's behaviour.

I worked with this family with a colleague who is a child psychotherapist. Work in a partnership that represented the genders was pertinent to this family: David's brittle and rigid set of mind caused a gulf in the gender roles which he imposed on himself and his wife Elizabeth. She had a freshness of mind and the adaptability and opportunities in exile to study; develop and work, which apparently were not available in their homeland. Unsurprisingly these qualities were experienced as threatening by the rigid David. It can be hypothesised that his rigidity of mind came about because his inner representations of relationships and attachments had been engulfed by extreme events. It seems that he retained a cognitive map of intimate relationships but lacked the epistemic space and empathy to mediate the emotional information that came his way within relationships. Thus his relationships were mapped out on to a moral and cultural framework, but without the empathy to mediate cultural norms, his position was experienced as very rigid. For men accustomed by former cultural norms to fulfil authoritative roles, the rigidity that emerges when authority is asserted without empathy; backed by anxiety and fear because they can no longer 'read' the emotional map of the family; can lead to terrifying violence.

David was understandably in a very poor mental state after torture, because of the many losses inflicted on the family and the dilemmas of exile. He was anxious about the family's future. He was jumpy about just about everything that came his way; He ground his teeth at night and had frequent epileptiform fits in his sleep, which seemed to be triggered by tension. He also had terrible, frightening dreams filled with horror and violence. During the day he had intense flashbacks that often developed into fugues. He got into rages with the children's playfulness and noise. He attacked them for jeopardising their future by not doing their homework. Elizabeth tried to soften him towards the children but she was cowed into silence.
**Interventions**

We set out to understand the family attachments. They can be described as the 'royal road' for understanding family dynamics after extreme events. Our way of achieving this was to seek out the family's stories about itself. In doing this we were interested in both their declared or overt stories and their undeclared stories. We also listened out for whatever narratives were suppressed or repressed. For instance, the extent of David's violence was initially denied and also the pain of Elizabeth and the children's suffering. We had to choose the moments carefully to challenge this denial. The family system as a whole, which included them, ourselves and the community of support around them had to be able to cope with the potential for discomfort and change this would invoke.

**Building trust and the therapeutic alliance**

Understandably, the undeclared narratives emerged more readily as the family began to trust us and as we attuned ourselves to their style of relating to themselves and others. We discovered that David had always been a tense man. His childhood had been fraught with neglect and violence. The intense loneliness and physical and mental pain of the torture concatenated with his experiences as a growing child. It seemed that he had only the most brittle emotional template against which to rebuild relationships with his family. However, Elizabeth was a great therapeutic ally. We wondered what had led this warm, generous woman to marry this evilly ill-tempered and violent man who terrorised her and their lovely children. We discovered she had responded to a man who was singular, intelligent, idealistic and thoughtful: qualities which only seemed to appear during this period of their life in brief flashes. In their exhausted relationship we had to appeal to those aspects of his character: for instance, his belief in fairness which, for the reasons described above, manifested itself rather rigidly. We were also able to map the family's experiences on to their wider social and political circumstances. These aspects provided sufficient frame of reference to hold together a workable therapeutic alliance. Simultaneously, we also had to be mindful of David's possible fury at the gratifying role that Elizabeth had hewn for herself as the thoughtful carer, which so conveniently split the good and bad between them.

As described earlier it was a reasonable hypothesis to assume that extreme events had caused a breakdown in David's ability to make and maintain attachments. Because his internal representations had been overwhelmed with violence all attachments were fraught with the potential for being triggers to the extreme experiences of torture or an earlier layer of childhood neglect and violence. Furthermore, as he tried to participate in the interplay of intimate relationships they seemed to mock this proud man's inability to connect emotionally: As psychotherapists we had to see if it was possible for attachments to be made more coherent and therefore more safe.

One of the positive benefits of working with survivors where there had previously been workable relationships in the family is that once small bits of progress are made these are often amplified by positive feedback from the family to the survivor.
Restored aspects of relationships are refracted through family relationships in general and a sense of hope is generated. Throughout the work of this depth it was important that we identified strengths and the normality of how difficult it was to cope with “extreme events” while simultaneously working with the difficulties thrown up by their experiences.

Making use of attachment

At the same time we offered ourselves as attachment figures to the family, becoming as it were ‘good enough parents’ to both parents and children. Thus we were as if parents to a pre-logical child, to the confused and emotionally incoherent aspects of David. Simultaneously, we were the same to the rumbustious 2 year old Zeph, whom Elizabeth had to keep physically separate from David because he aroused his father dangerously. At the same time we were parental to the older children, seeing their need for warm, involved and contained parental experience. The firmness this required also suited the setting down of certain rules of conduct for David; for instance, the explicit requirement that he should not be violent to the family. Work on insight was required to arrive at an understanding of this injunction. It fitted David’s sense of duty and moral responsibility but his violence was not experienced by either himself or Elizabeth as rational and this made it more frightening. The lack of emotional connection between himself and the family when he was violent was terrifying for them. It felt as if they could not appeal to the inner person of David; he was beyond reach, emotionally cut off.

The detail of this work involved unpacking interactions within the family sessions of family therapy. We examined current themes and linked those with patterns of family life before exile. One of the family memories was of the older children playing in the Land-Rover and starting it up. The vehicle lurched forward and stalled. Luckily no harm came of it but David was incandescent with rage out of proportion to the incident. He read the situation as children being intentionally naughty. By degrees he was able to compare their behaviour back then with little Zeph’s behaviour in the present. Zeph was a responsive child, full of curiosity and play. This gave the impression to David of a child who was knowing and deliberately annoying in an adult sense. But this was the behaviour of a bright, imitative child seeking attachment to his father. After a series of interventions which worked on elaborating an understanding of Zeph’s play as seeking a relationship with his world (in which his father played an enormously significant part) David was able to read it as that, rather than having a more paranoid vision of a child deliberately setting out to naughtily provoke him. To begin with his acknowledgement was rather rueful, a sort of, ‘So I have to put up with the brat because this is good for both of us! But this was a significant breakthrough that enabled him to appreciate his child at play; and gradually he was able to engage playfully and with enjoyment himself.

The ability to play is an important marker in understanding the inner world of survivors of extreme events. The space between people at play or people and objects at play is composed of epistemic space. It is a space of possibility and imagination. To be able to make use of it is a sign of an intact attachment nexus. As David engaged in Zeph’s play he began to internalise through his son an internal working...
model of attachment that offered reparation for the damage done to him during torture and his own deprived childhood.

*Enabling resilience and coherence*

This work was enriched by being anchored within the matrix of the beliefs and myths passed down through past generations of the family. We looked for strengths in their families of origin that could be adapted to their situation in exile as well as ways of being that were redundant in their new circumstances. We also understood the family's experiences within the political and social context of what had been inflicted on them and their experiences, good and bad, within Britain as a host society. The purpose of all this work was to create coherent narratives for the family that made sense of life and their interactions at different levels of context. This created a scaffolding through which the therapeutic work was systemically linked. From the broadest, that is most socio-cultural to the most intimate, that is intrafamilial and intrapsychic, this conceptualisation of the work is isomorphic with the model parent-child coherence that has been noted in experimental work about attachment outlined earlier in the chapter. The notion of projective identification also came into play. This enabled us as therapists to internalise the unbearable parts of David's experience and behaviour that he projected into us, to absorb, dwell on it in consultation with each other and re-present it back in less toxic forms. For instance, we took the frightening violence that he projected at Elizabeth and the children. We struggled to absorb its impact and bring into our consciousness an understanding of the emotional currents that ran through it. Elizabeth also participated in this struggle on a daily basis during the early part of treatment as she sought to lessen the impact of David's violent internal world on the children. She was grateful for our partnership in the emotional enterprise and they were a delightful couple with their children as David came back to life.

*Work with a child*

When Simon was 6 his father, a political activist in an opposition party, went into hiding because of threats against his life. Police and army units raided the farmstead to search for him. They brutally interrogated Simon's mother, his paternal grandmother, a paternal aunt and Simon himself. They got no information from the family (sensibly, Simon had been told nothing of his father's whereabouts). In revenge - perhaps also in the desire to get information through terror and also to provide an exemplary case of what is inflicted on dissident families - the family was brutally terrorised. His grandmother and aunt were burned to death in a wing of the farmstead. His mother was raped. In a state of terror and agitation Simon hit out at the police. He was dragged into an adjoining room and anally raped by three police. At the age of 12 he was referred for psychotherapy by a paediatrician who had seen him because he was regularly soiling. This had been thoroughly investigated but had not been resolved with prophylactic care. Simon was a well-presented, bright boy; precocious in his attitudes and very articulate. In the first assessment meeting he and his mother wept silently as we went through the terror they had both endured. Apparently; he had no sensation of being 'full'. He did not have any other sensations that signalled when he needed to empty his bowel. Nor did he have any sensation when he soiled himself. To combat what amounted to a lack of feeling control over
his bowels he had developed an elaborate routine of regularly visually checking himself to see if he had soiled. This was done anxiously every hour in the school lavatories. At home he was more relaxed but nevertheless still anxious enough to check himself frequently. He was academically able and did well in school but was a little remote from his peers. Throughout the work I was able to draw on his many strengths and to foster his self-esteem while simultaneously working with his difficulties.

**Interventions**

Simon was a charming and articulate child, who described flashbacks that regularly occurred in school. One occurred during a history lesson on mediaeval warfare. Some of my work consisted of helping him to manage his flashbacks. We set out to understand them as 'memories of the past that had not been fully digested'. This relieved him of the worry that they were signs of a sinister and permanent mental disorder. However, this sort of reassurance, which reframes a mental phenomenon, is of small value unless the phenomenon can be brought under control. This was more slowly achieved over the course of the therapy by bringing into consciousness the associations that triggered the intrusive phenomena and teaching relaxation. Unsurprisingly, in as complex an experience as anal rape and murder these associations existed at many different levels and emerged 'over time as Simon gained confidence that I listened and absorbed his experience. Furthermore, they emerged as his own tolerance and consciousness of the associations developed. Forcing the pace would not have been helpful. Thus the initial work was largely successful in diminishing their occurrence but I remained alert to other associations that emerged as our work progressed.

**Work with anger**

Other work focused on Simon's feelings of anger. He modelled Plasticine figures of police and ran them down with a Lego-built truck, but he remained muted in his verbal expression of anger. He had no return of sensation or control in his bowel. I wondered if when wishing to open his bowel he could imagine 'shitting on the police who had raped him'. This worked a little and Simon was gleeful when reporting back to me, but the lasting benefits were marginal. Meanwhile he had run away from home over the evening several times and had become angry towards his mother and father. This seemed like progress, although the parents had to be helped through consultation to see the benefit of their mild-mannered son expressing such obvious aggression. The father was more able to cope with this than the mother who remained symbiotically attached to Simon and the extreme events both had endured. In fact both Simon and his parents found it very difficult to deal with their guilt at Simon's exposure to such terror and the fact that initially they had to flee without him leaving him in the company of trusted family friend. Sessions were spent tracking Simon's feeling about these matters and gradually enabling him to verbalise his experience.

**Work with autonomy and identity**

Despite his parent's affection and attention, Simon was a psychologically lonely child. This loneliness, in the theory outlined above, was a consequence of the
disturbance of his own internal attachments during the extreme events. This was complicated because he also had to contend with the impact on his psychological development of the simultaneous rape of his mother and his own sexual assault. This was evidenced by his continued struggle to separate what had happened to himself and his mother literally and symbolically. This 12 yearold, entering puberty, felt a huge degree of fusion with his mother. Within a safely conducted therapeutic relationship he was able to construct a strong narrative of the events, but there was often an elision of the facts and his psychological state: he had difficulty in holding the reality of who was inside whom.

Work was conducted on several fronts: to enable the oedipal 6 year old part of Simon to symbolically work through an attachment to his mother that was confounded by their extreme experience, to tackle his sense of psychological loneliness, and to improve his sense of autonomy.

**Issues of sexual identity**

Simon's oedipal confusion was taken up simultaneously with thinking with him about his current sexual identity. We spoke frankly about sex and relationships in a manner appropriate to his age and development. He was very eager to demonstrate interest in girls. He said they often importuned him for romantic friendships, although the stories were very unlikely. At the same time he evidenced worry that he had somehow been made homosexual by the rapes. He veered between bravado and self-doubt, seeking reassurance from me. He was eventually able to verbalise his worry that because the policemen had been inside him this had forcibly altered his sexual identity. We then spent some time considering the meaning of coercion and consent. He understood that at different levels of his being he had to consent to his sexuality. It was about what he was drawn to, not what was forced on him.

**Boredom, distraction, defensiveness and play**

Cognitively Simon had a fairly clear narrative, although his dreams, flashbacks and anxieties revealed a more confused and less assured picture. The extreme events had seriously interfered with his sense of autonomy: His symbiotic attachment to his mother revealed itself in his transference relationship to me as the therapeutic work deepened. For instance, he was enormously sensitive to my moods to the extent that I felt he had an uncanny ability to detect my underlying feelings. Sometimes, he spoke of my moods as if they were his own. His observations were often spiced with mildly deprecating comments about his feelings about himself. For instance, while struggling against my own sleepiness (a sure sign of avoidance of the intense feelings evoked by Simon's experiences) Simon noted that he was sleepy and bored. It was too threatening for him to be boring, which would add up to me being bored by him. Putting this directly into words resulted in a flat denial that this was the case. However, putting my own feeling state forward for examination was more productive. For example, 'You know, I'm feeling rather sleepy now. Sometimes I think it's so hard to think about what happened to you and your mum that it's easier just to sleep, then the pain, and everything, fades away'. This offer of my own
feelings legitimised his own sensations of wanting the horror to go. But then I wondered, 'How can we be more thoughtful about what has happened without being sleepy?'. 'Well', said. Simon, 'we could play with my yo-yo'. This was an attempt at distraction of which I could approve if it is being used creatively. I wondered to myself, does he focus on his beliefs and feelings and then shift into distraction or does the need for distraction come on him (like the sleepiness) too defensively; before the issue from which he is seeking distraction emerges into consciousness? Gradually, by judicious offerings of my own reactions to him and noticing and interpreting his feelings and sensations he gained a greater sense of insight and autonomy. Together with the work on his sexuality this enabled him to get free of the oedipal hold of the extreme events on his inner world.

The work here presented is very contracted into a fluency often missing from the spikiness of the sessions. There were sessions when he deterred me with charming defensive strategies and we got little further than playing with his latest toy. It felt initially as if here was a boy who had to please. The index of success was the gradual resolution of his soiling.

My guiding hypothesis was that Simon's lack of sensation in his bowel was a psychological blocking off of the physical and psychic pain of the rape. My hunch was that when he could feel and work through that, full bowel control and sensation would return. Gradually this was so. He was able to accept his feelings; he was able to conceptualise his beliefs and re-order them positively; and as time passed he was able to experience what had happened to him in the past, rather than as a continuous present.

**Conclusion**

*Work* of this nature is often horrifying. With David and Elizabeth's family and with Simon it was important to delineate the external world because it provided a structure which made sense of what had happened. This was as equally important as a container for my sense and emotions as it was for them. This was done by understanding the political story, the story of the family in its homeland with all the connotations of culture and differing family patterns and also the story of exile. Understanding their strengths, defences and coping mechanisms provided a structure that enabled their vulnerabilities and the effects of the horror they had endured to be explored. Recognition of their resilience also helped in the establishment of a workable therapeutic alliance.

Finally, it is the complexity of the experience of extreme events that requires a multidimensional model. Therapeutic notions were helpful constructs that enabled me to engage in the work. They are guiding metaphors. The ultimate task was to attune to the experience of David and Elizabeth and their children and to Simon: to close the gap between sensation, experience, language and understanding and enable a more coherent version of the self in the world to come forth. Ultimately, the challenge of this chapter and this work is for us to find ways of clinical thinking that contribute to social and political justice.
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