Supervision of Therapeutic Work With Refugees and Asylum Seekers

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Providing a supervision service to psychotherapists who are treating recent refugees and asylum seekers presents many challenges to our received knowledge of psychoanalytic therapy as well as the growing knowledge of psychological trauma. Psychotherapists are not only working with people who have been traumatised by the events preceding their departure from their country but they are also dealing with the trauma of their arrival in a country often with very different systems of values and beliefs. Treatment is therefore a mixture of the recent stressors, issues of their life in a different context and possibly problems, which pre-dated the issues leading to their flight to safety. Some people would have experienced years of persecution, which might have led to psychiatric presentation in their homeland. In many cases therapy would not be possible without some adaptation in technique. Therapy in the initial stages can be a form of debriefing, listening to the story and dealing with the many emotions that this throws up. This aspect of the work can lead to very powerful transferences in therapists who find it difficult, listening, bearing witness to what has happened to the patient and seemingly not being able to do anything. Often the therapist might be the first person to hear the uncensored version of the story, which might have been sanitised to protect others as well as preserving the dignity of the patient. Certain cultural taboos prevent some stories from being told and it might be some time before some aspects of the patient's materiel will be told.

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Working psychoanalytically with people from non-western cultures has been documented by Jafar Kareem (Kareem 1992). Kareem began his professional career in a children's home in Vienna with orphans and children dispersed from concentration camps after the Second World War. At close quarters he was able to observe the effects of trauma and privation in young people and the physiological effects of abuse and neglect. Kareem said that in order for western therapy to be effective with those who are not from western cultures, the method of the therapy and all that it is based on has to pay attention to the meeting place of the cultures. To that extent many cultures are intercultural, the difference being a matter of degree. To be more thoughtful about the therapy the therapist might need to prepare themselves for surprises, the way that the patient sees you as much as the way that the therapist sees the patient. Given our histories of colonisation and the religious and racial stereotyping that came out of that, assumptions need to be checked out and taken with thoughtfulness (Thomas 1995). It would be fair to say that western cultures' appropriation of everyday psychoanalytic metaphor and ideas might not be the same in African or Eastern cultures. The concept of psychological pain might not be entirely understood by patients who could more easily relate to the presentation of bodily pain. Recent writing in psychodynamic therapy have drawn our attention to the ways in which the memory of trauma can remain in the body and this also is important when working with refugees and asylum seekers. Working with new ideas in psychoanalytically informed therapy can provoke anxiety in therapists who worry that their work might stray too far from the psychoanalytic frame. Fearing that one might go beyond the pale of psychoanalytic orthodoxy can provoke intense anxiety in therapists who are new to working with the asylum seeker population.

The role of supervision whilst being many and varied needs to able to support therapists in new ways of helping their patients. Working with traumatised patients and sometimes stepping out of familiar ways of working can be a difficult experience. Valerie Sinason has written about the stress that therapists can be under whilst working with patients who have been seriously traumatised (Sinason 1997).

Supervising new areas of practice

One of the early functions of psychoanalytic supervision was to help therapists to be aware of their countertransference feelings and reactions to their patients. It was recognised that the therapist might become affected by strong feelings from the patient's past relationships that might in turn affect the therapeutic relationship. The supervisor needs to also pay attention to the present transference and what the therapist represents to the patient. On recounting their stories asylum seekers who have experienced violence and persecution will have some impact on their therapist. It is often the case that therapists feel overwhelmed by the emotions brought by the patient or sometimes frozen by the terror of their story. It is very difficult to remain neutral and to observe the accepted tradition of the blank screen traditionally adopted in psychoanalytic therapy. For those people who are in the process of reclaiming their lives as a result of fleeing for their safety, blank screen therapy will be of little help. The commitment of the therapist is to be present and emotionally available. In doing this the therapist is committing to their own personal exploration without guarantees of where it might lead them.

The other aspect of supervision, which has an important role, is that of support for the therapist and aiding their personal development.

Technical help can be helping the therapist to use the skills that they already possess. Because of the unfamiliarity of the client group and the changed context, therapists can at first feel de-skilled. Particularly affected are those who have not previously worked in the public sector where the scope of psychological presentation is broader. As well as these concerns some therapists are worried about straying too far away from the psychoanalytic frame, going native, and no longer paying homage to the principles of their psychoanalytic trainings. If beaten, tortured or raped women and men can feel that they need some form of ritual cleansing or healing as an adjunct to their therapy in accordance to some religious beliefs or cultural practices the wish for this can sometimes catch the therapist off guard. Even the showing of wounds or scars from torture is sometimes done quicker than the therapist is able to decline the offer. This degree of sharing is unfamiliar to most forms of psychotherapy but recent writings in psychotherapy indicate the memory of trauma that remains in the body, as if the body has a memory of past pain and trauma.

Many of the clients do not have a good understanding of the counselling or therapeutic process; they often do not have an understanding of public health or social service because these services were not provided in their country of origin. The role of the therapy and the therapist can be explained through an interpreter and if necessary this might need to happen more than once. For many people who are unaccustomed to the full attention of a listening ear such close proximity can feel uncomfortable after the initial telling of the story and expression of feelings. Patients have been able to express their fear that the therapy service is connected to the government immigration and asylum service and have been suspicious of the therapy.

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For those who came from totalitarian states with efficient networks of information gathering this caution is most wise. Patients are sometimes in various states of psychological trauma, many live alone in hostels having very little human contact. Sometimes the only opportunity to speak in their mother tongue would be with the interpreter at the centre. Casual meetings with fellow nationals are treated with suspicion, fearing that this person might be from a rival political group or a spy for their country.

Witnessing Symptoms of Persecution and Torture

The therapist is likely to encounter pockets of psychosis sometimes present in people who have been on the run or in exile for many years and receiving little or no mental health support. It is sometimes difficult to supervise therapists who are not familiar with symptoms and presentation of mentally ill patients. Those who have worked with serious mental health issues have been surprised to see the type of symptomology that were prevalent before modern post 1960's medication. In the

early eighties I had worked with a young man escaping persecution from Ethiopia. He described to me how he would spend a great deal of his time reliving the things that had happened to him or that he had witnessed. Re-sitting exams in aviation science in the UK, he found it very difficult to concentrate and remembered that he had spent an hour, the duration of a lecture staring at the large glass window in the lecture theatre watching his arrest and torture as if it were a film projected on to the glass. He was awoken

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from this state by one of his fellow students at the end of the class. Supervisees have talked of similar experiences in the consulting rooms with patients who have escaped persecution and torture. Therapists who are new to this work are often surprised at the number of patients who experience dissociated states. What we have learned is that like the very early studies in war neurosis in the 1920's post war Europe is that trauma has played its part in pushing people to the limits of their mental endurance and that escape is the only mechanism of survival. What is interesting to note is that disturbance is in certain areas of the patient's life and ability to function and is often not pervasive enough to usher in total breakdown states. Sometimes the florid or culturally determined expression of grief in those who have lost country and kin can at times take on the appearance of psychosis. Demonstrating grief, whilst common in many Mediterranean Middle Eastern and African cultures, is not considered the norm for British cultures.

Elif, a fabric designer, frequently falls silent with her therapist who has learned not to panic but to be silent and witness what is happening. Elif has been able to talk about the silences that she falls into and tells her therapist that she is always goes back to the cell where she was kept watchful and waiting for when it would be her turn to be asked the same questions over and over again, and beaten on her legs with canes for giving the same answers. These fugue like states are not unusual in this population of patients, nor is it unusual to witness regressions and out breaks of paranoia. Patients are sometimes convinced that they are being followed and become too panicked to leave the centre without being contained or calmed. The problem for therapists is that they are not entirely sure that their patient is not being followed and they can find themselves sometimes fired up with anxiety.

Transferential Issues

Often patients are very isolated and the therapist is the only person with whom they have a meaningful conversation. Consequently, the therapist can become a very significant figure in the patient's life. Whilst some of this is transferential and requires a great deal of tact in supervision, some fall within the realm of the real relationship

(Clarkson 1995). People who are going through one of the most frightening experiences in their lives with little support will use the therapist in a variety of ways. It is the job of the therapist and the supervisor to stay attuned to the patient's needs. Marie-Solange, eighteen, has been seeing her therapist for seven months. After the slaughter of her family in the Congo she is now the oldest member. With the help of the catholic church, for whom her father worked, she was brought to the United Kingdom with her ten year old brother and her female cousin of fifteen. After the adults in the village were robbed and shot, Marie-Solange and other teenage girls were raped and vaginally mutilated. In terror she prayed throughout her ordeal and one of the rebel soldiers stabbed her between her legs but another soldier persuaded him to leave her and not harm her any further. This patient tells her therapist that she sees her as her mother and that the therapist must have been sent by God to help her. Her French speaking African therapist feels very connected to this young woman, who is responsible for her two younger relatives. The therapist was taken by surprise when after the client had spoken of pain she lifted her skirt to show the dressing on her year and a half old wound, which is slow to heal. The therapist was not only shocked by the familiarity with which Marie-Solange lifted her skirts but by the painful image that remained with her. Having daughters who are older than her client, the therapist felt concern and guilt as someone who had escaped a similar tyranny some years earlier. The experience of children will always provoke a powerful reaction in the therapist, who variously feel that they need to take them home to protect them and nurture them along with their own children, to doubting that it was possible for a child to have such horrendous experiences. Some therapists experience a sense of unworthiness in relation to such children who on the face of it are made of better stuff than the therapist was at a comparable age.

Seven months of working with Mussa, an eleven-year-old boy who had been referred by the school for being bullied by other boys, his therapist was at a loss for words. Mussa would sit zipping up his anorak and unzipping it. Whilst he liked coming to see his therapist who was helping him to deal more effectively with his situation at school he sometimes wondered why he had to come. Mussa ventured to put this question to his mother who told him that he had problems and needed to be able to talk to someone about them. He had given his therapist a brief account of leaving West Africa claiming not to remember. Mussa turned up for his session and after settling in his seat asked his therapist if he could say something to him, but he was not sure if the therapist could tell anyone because not even his mother knew. Again fidgeting with the zip opening and concealing himself in his jacket, he said that the rebels came to his village and made them all stand in class groups. He said that everyone was frightened and the little children were crying. Teachers who tried to take children away to safety in the forest were shot for everyone to see. Mussa said that some of them, the older children, were told to choose someone that they had to shoot. He was told that if he did not shoot someone that they would shoot him. He shot a girl from his class. He asked his shocked therapist for a drink of squash and a biscuit. In possession of his refreshment he said that he had not told anyone about this incident and he proceeded to play with the box of toys. Mussa did not return to this material in his two following sessions. Information from their own therapy indicates that Mussa's teenage sister and mother were taken away to undergo their own ordeal the day that their village was raided. Many people were killed and Mussa and his family were lucky to

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escape. The work with this boy is at its beginning stage now that he has chosen who will hear his story. It is not unusual for children and young people to hold on to their painful stories to tell the person of their choosing at a time of their choice. Sometimes the story is told because it becomes too difficult for them to hold on to it. I think that Mussa was able to talk to his therapist because he realised that the therapist was not going to let him go after his many attempts to seem bored, play the innocent game of having no idea why he was coming every week and hiding his rage so much that he was a bully's target. Some children seem to incubate disturbing information until they feel able to be unburdened of it. It is a matter of concern that there are many young people who like time bombs are walking around with toxic information unable to express this in a constructive way. It is not surprising that our referrals from schools are increasing and that the children referred have erupted in violence sometimes after taunts or put-downs. It is my view that the violence that they have witnessed or their own outrage at their victimisation leads to enactment or a form of protest at being picked on yet again. Not all of their action is impulsive because their dreams and nightmares have been filled with motifs of retribution or epic escapes from sometimes-unknown assailants.

Not familiar with the close attention of females outside of the family the female therapist has occasionally been seen as a possible romantic suitor. Getting the therapist to clarify the situation can lead to a loss of face on the patient's part. The fact that our work is intercultural is very evident both to our patients and ourselves. For most people it is an unfamiliar experience to live outside the confines of a family, and being among strangers in another country is quite alien. Many things are new, the relationship with authority, the opposite sex, as well as changed roles and relationships. Some parents have found it difficult to cope with the new found independence of children and wives. The shift of cultural attitudes to a freer more tolerant one might not be welcomed and the asylum seeker might feel a distinct sense of discomfort and in some cases disempowerment. These differences in culture will inevitably become apparent in the consulting room. If an interpreter is working with the therapist some of the issues of misunderstanding can be explored. With a faltering grasp of English and without the mediating services of an interpreter it would be much more difficult for therapists to engage in a discussion with the patient particularly if transference issues are being talked about.

Helping the therapist to manage the countertransference and its related phenomena is not always easy as a supervisor who is also moved by the plight of the patients. As a supervisor of therapy with refugees and asylum seekers I am myself a work in progress, I have a great deal to learn. Patrick Casement (1985) discussing

the supervision of others said that the supervisor could sometimes find themselves entering a further phase of growth. Supervising therapists in small groups of three or so has proved to be an invaluable experience and has provided learning opportunities for myself and the other supervisors in the centre. The practice of group supervision has been used for many years and has been particularly useful for its sharing supportive function but also as a learning tool. In an area of practice where our footsteps are relatively new, the group helps with the direction that new ideas might take as well as for contributing practice experiences. It has been documented (Sinason 1997) that psychotherapists tend to report stress as a result of working with patients who have had distressing experiences. She cited the witnessing of torture and disasters as well as the experience of sexual abuse. Psychotherapists have to some extent agreed to work with asylum seekers partly knowing that they will be exposed to many distressing cases but they can also leave the centre at times with a sense of being battered emotionally. Having more than one supervisee in the room acts as a mediating presence to reduce the degree of distress that can be dealt with in the room. Inevitably, the tyranny of the powerful supervisor is also modified. The supervisor's view is not the only one and the point of view of the third or the fourth person can be voiced. In a practical way others can develop their own skill as supervisors.

Conclusion

There are many rewards for therapists and supervisors who work with asylum seekers and refugees. As well as coming to their place of refuge with many problems to overcome, many also arrive with hope and enthusiasm for a new life. The therapeutic team and others who support the centre to make the work possible are always pleased with successes, however there are many who we support who do not get through the asylum application process and are returned to the country that they tried to escape from. Whilst not all asylum seekers and refugees need therapy to help them to deal with psychological damage, a minority of people do present with significant problems. From the position of supervisor it has been possible to see the benefits of therapeutic help to this group. With a mind to the future I can see that both statutory and voluntary services might need to respond to the difficulties that will face the child refugees and asylum seekers as they settle and come of age in the United Kingdom. Like everyone else they will be visited with memories and information that had been buried in more dormant areas of their minds. Like the children of the 1940's holocaust survivors they will develop curiosity about their family history particularly if this information is kept from them in order to protect them from the pain of knowing, and their parents from the pain of telling. In what lies ahead psychotherapists and their supervisors have much to contribute.

Further Reading

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