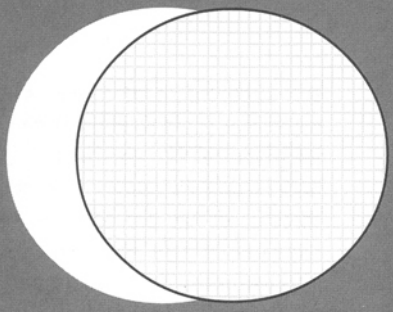
Loss and Recovery



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Introduction

For the past two years I have been involved in psychotherapy at The Refugee Therapy Centre in Manor Gardens, in north London. The account that follows describes one of my cases there. It is based on my thoughts, feelings and observations in spending one hour a week with a young refugee couple. They came at first with their five month old baby. During the time I have known them they have had a second baby; the elder child is now two and a half. For reasons of confidentiality I am not describing details of their identity and backgrounds.

I have been working at the Refugee Therapy Centre for three years, as a therapist. My training was at the London Centre for Psychotherapy, where I qualified in 1981. Since then, my work has been mainly in private practice.

The opportunity to work as part of a multi disciplinary team at the Refugee Therapy Centre is something I greatly value. The contact with clients from other parts of the world who have been forced to leave their own countries is a moving experience. It requires the therapist to challenge many of their own assumptions

I am fortunate to have been able to work with a young woman interpreter from the same culture as the clients. It has been immensely rewarding sharing the experience with her, as will appear later.

When I am describing work at the Refugee Therapy Centre I shall refer to clients: for work in private practice I shall refer to patients. This corresponds to what is usual in both situations, and helps clarification. It is also usual to describe people who are yet without permission to stay here as 'asylum seekers'. Those who have been granted status are known as 'refugees'. The family I have been working with are asylum seekers; but I use the term refugees throughout to cover the wider picture.

Choosing to work with refugees opens a door onto a world which is vast and unknown. The differences of race, culture, language and experience which they bring meet all the cross-currents of projection and expectation. The impact of difference is great. As a white, middle-class Englishwoman, what right or qualification do I have to attempt to work with refugees?

Somewhere from my personal history I have a sense of finding a place on the edge of different worlds — looking both ways. The Refugee Therapy Centre is creating its own tradition of training, supervision and practice built on psychodynamic principles, and I am proud to be part of this endeavour. It has a particular purpose and perspective, and a global view of the need for therapy thrown up by the political conflicts and destructiveness of the late twentieth century. I guess that some of my personal involvement in the work comes from guilt at having a secure and comfortable place in a world full of external danger and deprivation. There is also shame at the withdrawal of compassion and humanity in our own society towards refugees, and the massive projection of denigration through misinformation commonly expressed. I feel a need to identify with the outsider; but also to guard against over-identification, which would lead me into a denial of my own privileged position. The work with refugees draws me to a place within myself between the known and the unknown — between the established tradition of psychoanalytic psychotherapy and its development into work with a particular client-need among refugees.

In work with refugees I have found three features of the landscape: confusion, dissociation and the will to survive. The tools of traditional psychoanalytic psychotherapy - transference, countertransference, reliance on the boundaries of the setting, and the attempt to hear the unconscious communication — are to be found in the work: but their use may require adaptation.

CONFUSION

The couple were originally referred for help with bereavement. They had lost a first baby in tragic circumstances in this country, when the wife was already into her second pregnancy. This would have been hard enough in any event, but for them the pain of loss was made worse by confusion in not understanding what the hospital, the police and the coroner were requiring of them. At the time, they had only a few words of English. The wife became withdrawn and depressed, tearful much of the time: her husband took on the role of looking after her and their second baby, when it was born, in a calm and caring way which was genuinely moving. He brought his wife and baby to therapy for her needs, and it was clear he could not begin to think about his own needs. I learned over time that in their culture it is expected that men do not show vulnerability or have emotional need. Before I met them they had had some sessions with a therapist very experienced in this work. She had picked up their bereavement issues confidently, and given them practical suggestions to help them through the grieving process. I was aware that I needed to continue her work. I also assumed that the task was to think about the wider background of trauma which they had experienced in their country of origin, and the hardship they suffered in leaving it.

In fact, the therapeutic time and space, and the therapist's presence, at first seemed to offer little more than some recognisable continuity. My assumption that they would need to talk about the depth of their experience as refugees seemed to conflict with their need to hold on to some sense of present stability, however tenuous. My impression from being with them for a few months was that the massive upheaval and physical and psychical uprooting they had been through created a mental overload, barely containable. Any approach from my side to talk about the bad times seemed to produce a fear of becoming destabilized and unable to function. They seemed to be telling me that they needed to forget, not to remember. I felt grossly inadequate, and turned to any writers I could find who might

be helpful. I put my dilemma of the need to talk about the bad times versus the need to forget to their previous, experienced, therapist, who is also Clinical Director of the Centre. She said, 'Perhaps they can talk about life in their village before the trauma.' (Alayarian, A. (2002). This simple suggestion became an approach to which they could respond, and for me a first bit of new technique which was appropriate to their needs. They gave me many vivid pictures of the village life they had known, before gradually saying a little about how it had been destroyed. When the husband said, 'All is now ruined,' it was an accurate description of what had happened in their external world. It was also a description of their internal state in which the known ordering of experience had been overwhelmed: confusion had replaced it. The therapist's experience in this work is that the memory of external trauma can only be approached gradually and in small amounts along with continual holding of present reality. As my supervisor put it, 'You take a teaspoon to remove a glacier!' (Thomas, L. (2003). The need for containment is paramount.

The breaking of contact between the generations is devastating in a culture where family constellates identity

Freud lays down some principles for thinking about trauma. He says in many parts of his writing that trauma is created by any stimulus which overwhelms the mind's ability to deal with it. In *Beyond the Pleasure Principle* he described the mind as having a protective layer to filter excessive stimuli from external sources.

> We describe as 'traumatic' any excitations from outside which are powerful enough to break through the protective shield. ... Such an event as an external trauma is bound to provoke a disturbance on a large scale in the functioning of the organism's energy and to set in motion every possible defensive measure.
>
> (Freud, *SE 18* p.29).

He distinguishes clearly between external and internal danger. 'A real danger is a danger which threatens a person from an external object, and a neurotic danger is one which threatens him from an instinctual demand.' (Freud, *SE 20* p.167)

The relationship between the massive external danger to which refugees have been exposed and the impact on their internal state of mind is the crucial question for the therapist attempting to be attuned to them. Freud continues, '... the external (real) danger must also have managed to become internalized if it is to be significant for the ego.' (*SE 20* p.168)

The refugees I have been with experienced being part of a whole community that was subjected to terror, and overwhelmed by external force. They were, like many of the younger generation, driven to flight. The breaking of contact between the generations is devastating in a culture where family constellates identity. Guilt at having left many close friends and relatives behind, and shame induced by helplessness, are powerful pressures on the ability to maintain a sense of acceptable personal identity. It appears that the woman was able to maintain a

functioning self until the loss of her baby precipitated her fall into depression. The husband when I first met them was maintaining himself as her carer, with a cheerful, courteous demeanour. I was well aware of the cost to him in containing his own anger, pain and loss. In addition, before flight, this gentle man had temporarily been part of resistance fighting. The ability to go on functioning in the way he is doing at present suggests that his ego is dealing with internalized trauma 'with every possible defence' in a remarkable way. There is a sense, however, that his life as a man, vital to his own purposes and identity, is 'on hold'.

Countertransference

A deeper understanding of psychic reality in the work with the refugee clients came from my countertransference. For a long time there was no transference experience which I could discern apart from the need for me to be a non-intrusive, reliable, containing presence, part of the institutional framework, which was a kind of matrix. Sessions were continuing each week; the wife was becoming less depressed and able to speak a little; the husband as ever was cooperative and caring of his wife. My countertransference was a feeling of complete impotence and irrelevance, almost futility: also that there was something different or extra that I should be doing. When I was able to understand, quite suddenly one day, that this was exactly what the husband felt, it was the beginning of some foothold in the work at a psychic level. I was relieved to be able to pick this up as projective identification, and to be reassured that there was a real engagement in therapy. I was experiencing the husband's sense of impotence and guilt at his flight from his country leaving his parents unprotected. This had been an impossible situation for him, since he was also attracting danger to them. Then he had been unable to avert the personal bereavement which he and his wife had suffered in this country. His only sense of personal validation came from his protective concern for his wife: but this prevented him from speaking about his own pain, and particularly his own sense of guilt and impotence. When I was able to use my countertransference it was possible to find ways to speak to his underlying feeling state in an empathic way. I also found that this helped me to stay with my own sense of confusion and uncertainty. Confusion and disruption of the kind that I have been describing does not easily translate into words.

With hindsight, I think I began by disguising from myself how great and unfamiliar a challenge this work presented. I assumed a kind of pretend normality, as if, being an experienced therapist, I should be familiar with the situation. Yet in many ways it was totally unlike what I had experienced before. For the first time I needed to use an interpreter, and this was an unfamiliar situation for me. She was also new to the work. She was sensitive, helpful and enthusiastic. The husband, the interpreter and I tried to cooperate to establish a working alliance. The wife remained withdrawn for some months, rarely speaking. In retrospect, it would have been better if I had spent time at the beginning talking about the strangeness of the situation for us all, and perhaps the anxiety we were all feeling.

My response to anxiety was to become much more active than I would usually be in work with patients. Partly this was also realistic and necessary in order to maintain contact across a great divide of cultural difference. On one occasion I commented, 'I seem to be asking an awful lot of questions.' The husband replied, 'It's better that way. My head is so confused I don't know what to talk about. There is so much, and as if there

is nothing.' When I was able to use my countertransference I could find an empathic comment like, 'It's very hard to have to deal with so many uncertainties,' and he could reply, 'Yes, you're right. What can you do?'

Whereas in private practice I would rely on the patient being able to free-associate in some way, even to confusion, here it was much harder. It was difficult to leave silences, in case we lost each other. In some way, not having a shared language appeared to create anxiety that we would not be able to maintain shared thinking across silence. Also I felt, perhaps mistakenly, that my interpreter would find silences difficult to understand.

I have been forced to reconsider many issues of technique in this work and to consider where it requires traditional psychoanalytic technique to be adapted. There is always the possibility that my adaptation may be defensive, in which case I would need to find some other way of meeting the difficulty.

Here I am concerned with the differences involved in work with refugees, where their internal disturbance is the result of massive external traumatic input, threatening physical survival. In these circumstances primitive levels of brain-function come into play, needed in primitive situations of physical need for survival by all mammals.

In my observation of work with some refugee clients I think that all their basic emotional systems would have been stimulated to an unmanageable level, leading to a loss of normal self-regulatory confidence. Three years after their flight from external threat they still experience an underlying state of mental confusion with a primitive quality, as if experience cannot be sorted out.

The need is for therapy to provide some reflective opportunity within a secure framework of time and space to allow normal processes to resume.

DISSOCIATION

In my short experience with refugee clients, I have observed in them states of confusion and helplessness. As Freud says, the mind responds to threat of trauma 'with every possible defence.' In such circumstances the most typical defence would seem to be some kind of dissociation.

In *Fetishism* (1927), Freud describes a form of dissociation whereby the ego splits itself in order to be able to hold at the same time two beliefs which are incompatible. This would be designed to avoid pain, grief or anxiety at facing a truth. He gives the example of two young men who had each lost a father in boyhood. They had avoided reality by managing to both know and disavow their father's death.

It was only one current in their mental life that had not recognised their father's death; there was another current which took full account of that fact. The attitude which fitted in with the wish and the attitude which fitted in with reality existed side by side.

Freud, [1927] SE 21, pp.156)

This type of dissociation to avoid a truth which feels unbearable also prevents the ego from coming to terms with some part of reality. In the work which I have been describing, facts of the more recent past often seem hazy. I feel hesitant to pursue major questions with the clients: for example, whether their parents are alive or dead. It appears as if the reality is either unknowable or unbearable. Sometimes the wife will talk about her mother as if she is present in her life; sometimes any questions meet a blank response. It may be that, as in Freud's example, my clients are holding beliefs, both that their parents are alive, and that they are dead. Certainly there is little evident attempt to find out what the reality might be.

A different and opposite problem exists for them in dealing with the future. In reality, in the near future two contrary possibilities exist, namely that they may, or may not, be allowed to stay here. In this case, the terrible pain of uncertainty about the future is dealt with by holding on to one or other possibility as a reality. Either there is a conviction that they will have to go, or a bland optimism that they will be able to stay. It has been hard for me as a therapist to help my clients hold together the reality of two future possibilities, and an unknown outcome.

Attempts to make links between past, present and future, or between the external and internal reality, often founder. Dissociated pain, fear and anger take on somatic forms which move around the body and defy medical diagnosis

A variation of technique.

The dread of being 'removed' or 'returned' is always present just below the surface, but rarely spoken about. Instead there is often a strange shallow reality which has neither the depth of the past nor projection into the future. When the clients' removal seemed very likely, I felt that I had to approach it with them in some way. Taking this to supervision, I was advised, 'Help them think practically. If they have to go, what would they need to take?' (Thomas, L. 2003). This approach enabled us to touch the feelings involved, as it were, incidentally. This illustrates a particular quality of the work. Where external reality has been so destructive and disrupting, internal states can sometimes be approached by focusing on external issues. This may facilitate containment. Anything which supports these clients' capability and confidence to manage in practical terms, whatever the external situation they have to face, can be therapeutic. Some clients' internal states are so terrifying that they have to be mediated by the holding of external practical reality.

This is an important difference of technique. In the tradition of psychoanalytic psychotherapy we are likely to focus on an understanding of internal states and unconscious phantasy, closely related to work in the transference. The particular quality of transference in the work with refugees will be taken up again later.

Somatization

Attempts to make links between past, present and future, or between the external and internal reality, often founder. Dissociated pain, fear and anger take on somatic forms which move around the body and defy medical diagnosis. The bodily pain carries dissociated psychic pain which it has been impossible to process in the mind. This is not unfamiliar with patients in traditional practice. The somatic communication, however, is a very frequent form of expression for refugee clients. The body speaks directly; it is our earliest experience of ourselves before language. Regression to the somatic seems particularly likely in situations where primitive fears of non-survival have been aroused.

In traditional psychotherapy we may interpret the symptom, or attempt to place

it in some meaningful context of experience. In working with clients from a different cultural background and tradition, it often seems as if interpretation has little to offer. Concepts of unconscious communication, which are now widely accepted in the society we belong to, may be far outside the conceptual world of our clients in the Refugee Therapy Centre. It is hard to pick up the message from bodily pain in a way which conveys appreciation of both physical and psychical reality.

This again sounds like 'what every therapist knows': but the task of addressing somatic symptoms in therapy with clients from a different cultural tradition means that the therapist has to be aware of many different assumptions about the body-mind relationship within the clients' culture.

Impact of trauma on the ability to symbolize

The need to survive narrows the horizon of the mind. Where there is fear of annihilation, the mind focuses on whatever concrete reality seems most immediately relevant. Thus trauma destroys the ability to symbolize, and make connections of meaning. Trauma interrupts the ability to put experience into language, and to link it to other mental content.

Over time, the wife of the couple with whom I have been working recovered a good deal of vitality in her daytime life, but continued to complain of very bad nights. She would wake up in states of terror, but could describe no images or specific fears. For a long time she could report nothing like a dream, only a vague sense of threatening darkness or evil presence. We returned to the night-time fears many times, and eventually she brought some bizarre and horrifying dream fragments. This seemed to me an exciting indication of progress; but, strangely, neither she nor I could associate to, or elaborate on, the fragments in any way. They appeared dissociated from symbolic meaning, and no connections could be made. When we paid close attention to any dream fragments that she could bring, gradually they became less bizarre and some narrative began to appear. With her, however, my ability to associate seemed disrupted, compared to my usual experience in working with dreams.

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In attempting to enter into the dreams or daytime experiences of clients who have suffered traumatic impairment of their mental functioning I experience my own functioning to be impaired. It is often only after a session that I can think about a somatic symptom or associate to a dream fragment with any conviction. I would see this phenomenon as a form of dissociation, where meaning and language are disconnected through trauma.

Impact of trauma on memory

Current research by cognitive psychologists amplifies our understanding of memory systems. Chris R. Brewin (2003) describes the existence of two memory systems: one more primitive and activated under extreme fear, one more complex and allowing greater subtlety of processing: there are more primitive direct routes which activate defence responses very quickly but at a simplified perceptual level. 'These subcortical pathways mainly process information at the level of individual perceptual features such as color, shape or direction of movement' (p.117). By contrast there are alternative routes involving more brain areas. All of these pathways allow more complex and integrative processing in the context of space and time. 'In evolutionary terms these parts of the brain are more recent. The pathways involve more synapses and are slower but they permit a much more complex analysis of what is in the environment that is most closely associated with the fearful event' (p.117).

In the work with the couple which I have been describing, I have seen their great difficulty in accessing any coherent memory of trauma. Apart from natural resistance to revisiting intense fear and panic, it appears that stretches of narrative are missing. The couple could only access isolated sensory details, particularly of sight and touch. They could say, 'When everyone fled from the village one night it was very dark ... we held hands not to lose each other ... in the forest we couldn't see each other until the moon came out.' These intense moments burned in through the senses stand out indelibly.

Many of the symptoms affecting refugees would match the description of Post Traumatic Stress Disorder given in *DSM* IV, 1994, where an objective description is given of stressors and responses. Witnessing actual or threatened death or serious injury is a typical stressor; helplessness, trauma in flashback, avoidance, confusion of past and present are typical responses. Brewin links current research with the work of Janet in 'L'amnesie et la dissociation de souvenir par l'emotion' (1904).

Janet proposed that extremely frightening experiences might be unable to be assimilated into a person's ordinary beliefs, assumptions and meaning structures; in which case they would be stored in a different form, 'dissociated' from conscious awareness and involuntary control. Traumatic memory was inflexible and fixed, in contrast to narrative memory which was adaptable to current circumstances. (p.108)

Very possibly in private practice we meet patients suffering PTSD as a result, for example, of accident or bereavement. We work with them to process and link the experience with all the mental resources which may have been disrupted. In work with refugees, however, there is a difference in scale. The impact of the external threat is not just upon an individual but upon a whole community or ethnic group. Terror may have lasted for years; a whole environment may have been devastated. Their experience may leave the therapist feeling helpless and disorientated, unable to be in any way effective.

Renos Papadopoulos (2002) cautions against generalizing or pathologising refugees. He writes:

> *Although refugees do not constitute any one coherent diagnostic category of psychological or psychopathological characteristics, the fact that they have all lost their homes makes them share a deep sense of nostalgic yearning for restoring that very specific type of loss. (p.15)*

He elaborates the various meanings of 'home' in terms of origin and future, physical and imaginary, external and internal, and speaks of the 'mosaic substratum of identity'.

It is important to appreciate that disturbance of the mosaic substratum creates a kind of loss that could be characterized as primary, as opposed to all the secondary losses which are of a tangible nature and of which the person is aware (p. 18).

This description enables me better to orientate myself in my work with refugees. The Refugee Therapy Centre is a place that approaches being some kind of a home and point of reorientation for people suffering 'nostalgic disorientation — this uniqueness of the refugee predicament' (Papadopoulos, p.15). I have learned that in my clients' culture, 'relationship' in terms of the community is the key to personal identity. Each member of the village is recognised as part of an extended family. To lose contact with this cultural matrix disrupts the whole security of personal identity. Importantly, each person was needed and able to contribute to the communal life, at home.

This work challenges me to think about a different kind of transference, related to a fear of social annihilation. The meaning of relationship within the therapy has to be seen in a social context.

TRANSFERENCE AND SURVIVAL

Thinking about the transference in this context is complicated when the need for survival in the external world has been an urgent concern and preoccupation. The therapist is first of all representative of the host society. To begin with the clients are probably careful not to complain. They fear rejection, and recognise dependence for life-support through benefits, since they are not allowed to work. The therapist has the huge advantage of belonging in this society, holding a passport, privileged in every way. There is ambivalence, inevitably. The therapist is 'someone who knows how things are done here', and should be able to help. Such a situation can raise feelings of humiliation at the inequality, and envy of the therapist's secure belonging.

The transference is powerfully cultural as well as personal and it is necessary to keep both in mind. One outcome of the therapy I am describing is that both clients are now able at times to express anger and grievance at experiences here. It has been important for the therapist to be able to receive these negative projections and hold them.

The transference is also to the Refugee Therapy Centre as a substitute for 'home'. For the clients, the building is an environment designed to welcome them, and it fulfils this purpose very well. Much thought has been given to creating rooms where clients can have some sense of being at home. There are harmonious colours and comfortable furnishings, and lots of toys for children. Above all, there are many pictures of people from all over the world, giving clients a chance to find some identification in the space. It is an environment full of vitality and interest. For the refugee clients, it provides continuity, support for their identity and a place where they are known. It has become a community with its own structures and relationships, where refugees and members of a host society belong together.

Transference to the therapist is many-layered; the therapist is representative of the host society and also of the Refugee Therapy Centre, and also carrier of more personal projections. I have been aware of the wife's powerful need of a maternal figure, and her isolation from feminine support.

During the first year of therapy, when she was beginning to speak more freely, she brought photos and documents relating to the baby they had lost. The sense that the couple needed a person to witness personal loss was powerful and immediate. The wife also needed maternal support during the third pregnancy. In this situation, as in more traditional settings, the therapist has to survive in order to be available. To survive effectively requires finding a difficult balance between the external and internal world. The pull towards the clients' tangible needs is strong. I have often felt envy of those with legal or medical expertise. It is not uncommon for therapists to fantasize about offering refugees a home or financial support. It is a constant effort to translate experience into words that can link up different levels of experience and meaning. It also depends greatly on the skill of the interpreter — which could be the subject of a chapter in itself. Transference to the interpreter can be much simpler than to the therapist. There is direct contact through language. In my case the interpreter was of a similar age to the clients and they had shared similar experiences. I detected no ambivalence in their relationship to her.

The link between myself and the interpreter has been crucial. Together we are part of a holding professional environment. We talk briefly together before and after every session. We have different roles, but share the experience of bearing witness to the clients' lives. At times when fears of non-survival recede, we think with our clients about future plans. Whether they have to leave, or whether they can stay, there are avenues and possibilities to explore. There is great loss, but a beginning of recovery.

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