Psychological Treatment of Refugee Trauma: what are symptoms the symptom of?

Thou know'st 'tis common:all that live must die,
Passing through nature to eternity.
Hamlet

Introduction

It is argued that the traumatic experiences of the refugees can sometimes be better understood as posttraumatic loss rather than posttraumatic stress. The advantages of this view become evident in treatment. The nature of refugee trauma is discussed with reference to the work carried out at The Migrant Health Service with a large number of refugees including the Kosovars in Safe Havens, Kurdish freedom fighters, Persian Ba Haiís, Sudanese men, Bosnian men from the Zepa camp in Serbia, the Shiite men from the Rapha camp in Saudi Arabia and many of the four hundred refugees and special humanitarian entrants seen by us every year.

1: Cultural variation in the role and significance of traumatic loss in the development of Posttraumatic Stress Disorder

Loss and separation are the most important experiences human beings have to learn to adapt to and deal with. The intensity of refugee trauma depends on the value and quantity of the lost objects and the circumstances under which they were lost. I believe we can make the assumption that the meaning attributed to what is lost varies across cultures. Losing property, family members, social status, identity,

familiar frames of reference, and systems of support has different meaning and different degree of life endangering threat for different cultures. The significance and danger of the loss varies considerably and so does its role in the development of Posttraumatic Stress Disorder. I can offer examples to illustrate this point.

A Kurdish youth who one would normally encourage to live independently as a solution to intergenerational conflict responds with the words; I would rather die than be further removed from my father. The loss of the relationship with the father has a very different meaning for this person. The loss of the relationship with the father is life threatening and if we don't recognise this we harm him with our mono-cultural therapy.

The death of a child or of a father represent different types of loss across different cultural groups. Fifty or more years ago, in the western society, the death of a child was felt as a natural event because families had so many children and attachments were not as strong. Today, the loss of a child, born or unborn, is experienced as a trauma one never fully recovers from. The death of a father in some culture is a threat of economic as well as personal loss from which the family may not survive. Death in war can generate heroes, death in a car crash is a senseless and complete loss.

Strong attachments to people and lifestyles bring a traumatic sense of loss when those people are lost and the system that allowed the lifestyle has disintegrated. People who cannot grieve their losses because of the traumatic nature of the loss or the absence of cultural processes to

regulate the grief, are unable to re-establish normality and risk developing Posttraumatic Stress Disorder.

2. The capacity of psychological therapy to be culturally and therapeutically responsive.

The psychological care of refugees is in many ways mined with potentially explosive professional, ethical, and social issues. It can single out, isolate, uproot, and displace health professionals who confuse projective identification with empathy, rehabilitation with compensation, and political conflict with trauma.

Psychological therapy like medication can help to reduce symptoms of autonomic system hyper-arousal, intrusive thoughts, avoidance, emotional numbing, and helplessness but it may not be what the traumatised client wants. Sometimes the symptoms of PTSD are the only means by which the individual and his or her family can get a service or assistance with health, housing, employment, and even the courts in an attempt to recover from the traumatic loss.

The aim of therapy should not be to only behaviourally reduce anxiety but to help to replace the lost objects with healthy internal objects (ie. good memories/experiences) and to improve the client's ability to think about, talk about, and cope with reality rather than defend against it. The war-traumatised refugee needs to adapt to changes in any of a number of mental structures relating to his or her sense of self, justice, belonging, stability, security, and predictability of the world. The failure to adapt or re-organize one psychological system to incorporate the

losses will result in a pathological inability to adjust to reality and to the development of Posttraumatic Stress Disorder.

In traumatic loss the individual experiences anxiety quite similar to posttraumatic stress. The individual:

1. Feels the self has been devalued and damaged
I am not the same person
I was destroyed by the way I was treated
I am nothing with out the lost object
I can't solve problems = I can't recover the lost object

2. Is unable to invest in new objects
I don't belong
I have no future and can offer no future to my family
I have nothing
has recurrent and intrusive memories of past

3. Seeks reparation
tries to forget the past and the loss
is angry and aggressive when reminded of past and its losses
wants compensation e.g. house, pension,
wants total control of family and own environment
strives for some kind of success ie. hero, boss, greatest compensation

4. Feels destructive
attempts to recover losses aggressively and becomes demanding
expresses problems controlling anger to demonstrates powerfulness

feels tense, irritable, nervous in relation to inability to control circumstances
has violent and frightening dreams
is hyper vigilant to danger
is on edge (feels persecuted)

These symptoms can serve a survival function and can be seen as partially adaptive. Sometimes their symptoms are all they have left of their past and their former identity in a host cultural quite different from their own.

I think the extent to which mono-cultural psychological models are responsive to the needs of culturally and linguistically diverse clients depends on the extent to which we willing to accept as valid different ways of knowing and experiencing the world. Effectiveness depends on the extent to which the therapist is willing to accept and explore the mental and cultural explanatory model of the client and to commence the therapeutic work with the significance attributed to the loss by the client's personal and cultural explanatory model. The client's belief system offers the therapist avenues for therapy.

3. The therapist:

needs to understand the client's mental, personal and social organization as well as the client's previous lifestyle. The client needs to feel understood and not judged. The client shouldn't have to defend his or her views and values.

needs to explore the significance of the loss and not attempt to give premature answers or make interpretations that don't come from the words and thoughts of the client.

Avoid questions which could give rise to the persecutory anxieties that authority figures might create.

needs to understand the difference between empathy and projective identification. The therapist can't feel the same way the client feels. Instead, the therapist has to understand how and what the client feels.

focus on rehabilitation not compensation

has to counter the belief that any loss is insuperable

has to distinguish between victims and perpetrators. The perpetrator is usually feels less safe and more destructive. Victims can find hope to reorganize their lives, while perpetrators have to cope with their sense of guilty for what they destroyed. They feel unable to repair what they had destroyed. Destroying himself or his family could be a dangerous expiatory need.

Like Macbeth, who cannot clean his hands.
" It will have blood, they say: blood will have blood" Macbeth.

Refugees have a very low recovery from trauma rate. Those who have success with employment and housing are also those who recover most. Are they the ones who cope better in the first place? What happens

when there are subsequent losses such as workplace injury? There is often a re-emergence in the symptoms of trauma. It is often misdiagnosed and it confounds the rehabilitation process.

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