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International Master of Science in Social Work

Talking Through or Working Practically?

What Do Traumatized Refugees Need?



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ABSTRACT

The large number of refugees fleeing their native countries from war and related terror is a world-wide concern. Many of these refugees have experienced traumatic events, in some cases leading to the diagnosis of posttraumatic stress disorder. As a result of observations of contact with and treatment of traumatized refugees by both medical staff and volunteers during a field placement in a Liberian refugee settlement in Gomoa Buduburam, Ghana, a number of questions with regard to the treatment of traumatized refugees and the importance and influence of factors other than therapy on the healing of trauma and a general feeling of wellbeing were raised.

In an attempt to get clarity about these questions, an extensive exploration of previous research and theoretical models was executed. The results of this literature search were combined with information gathered through interviews with professionals working in different settings in the field of traumatized refugees in Sweden, in order to gain deeper insight into the two main perspectives on what traumatized refugees need, namely 1) talking through as a form of trauma therapy; or 2) working practically, which entails for the refugees to live a normal life. A third, ecological, perspective on traumatized refugees was added in order to be able to combine the two previously mentioned approaches. The result is an interpretation of the content and the strengths of the different views.

Keywords: REFUGEE, TRAUMA, THERAPY, 'NORMALITY', ECOLOGICAL PERSPECTIVE



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1 INTRODUCTION

Despite the ending of several violent conflicts and the return of large groups of refugees to their homes, millions of refugees worldwide still struggle to find a safe haven, either in more secure regions in their country of origin, in neighboring countries, or further away from their homeland. Many of these refugees left their countries as a result of war, political unrest, suppression and human rights violations (UNHCR, 2007). On January 1st 2005, in total 19,195,350 people were considered to be people of concern to the United Nations High Commissioner for Refugees, 4,430,000 of whom sought refuge in Europe (UNHCR, 2007: 10). The challenges these people need to face up to are numerous.

“Most refugees are likely to need food, shelter; be physically and emotionally exhausted on arrival; be wary of strangers; have private sorrows; experience fluctuation of mood; feel helpless and sometimes dehumanised and incompetent; and be in some sense “bereaved” and need to go through the process of mourning” (Rack, in: Loughry and Eyber, 2003: 4).

1.1 Gomoa Buduburam, Ghana

Gomoa Buduburam in Ghana forms a haven of refuge for approximately 42,000 Liberians who fled their country to escape the war and its aftermath. The settlement was established by the Ghanaian government in 1990 and the refugees were taken care of in cooperation with local families (Dick, 2002), non-governmental organizations and community-based organizations (Hampshire and Porter, 2006). When the flood of refugees became too large to cope with however, UNHCR was called upon for help. Apart from the period of 2000-2002 when the support was withdrawn, UNHCR has assisted the Liberian refugees throughout (Hampshire and Porter, 2006). According to UNHCR statistics, 35,653 Liberians who are officially registered as refugees were living in Ghana in the end of 2006 (UNHCR, 2007: 179). The majority of them are living in Buduburam.

In the settlement, resources are scarce and professionals limited. Care of the most traumatized among these refugees—who are all considered to be psychiatric patients, with illnesses which sometimes seem to be wrongfully blamed on war trauma—is the responsibility of R., a Liberian volunteer with no education or experience in (social) work with traumatized people. During a five week field practice I spend several days with R., accompanying him during his visits and met some of the suffering clients he works with.

We visit an old lady. She lives in a small room, where she is taken care of by her daughter. The room is dark, but relatively clean, with a narrow porch connecting it to two similar adjacent rooms. Wire and torn mosquito gauze cover the window frames. The wire and gauze door is hanging crooked in its hinges.

We are offered broken plastic chairs by the woman’s daughter, who stands. The old lady takes place on a small stool. If I suggest that I should trade places with the lady, so she can sit in my chair, I am shushed with a remark that it is not my place as a visitor to be worried about things like that.

During our visit the old lady doesn’t say a word. She sits on her stool, holding a comb in her hand, which she does not use for combing her long grey hair, seemingly unaware of what is happening around her. Her eyes are empty one moment, bewildered another. R. tells me that the lady is traumatized by the war and is not capable of taking care of herself. If any of us address her, she smiles, but does not speak. When we are ready to leave, the old lady retreats back into her room.

Later the same day we pass a woman in her late thirties, with a slight intellectual disability. She runs a tiny business from a small table, on a sandy square,

selling peeled oranges. We sit down with her on a bench next to her house nearby, while she leaves her oranges unattended. To R. the main interest seems to be if the woman takes her medication as prescribed. She tells that she is feeling alright and that she is happy with her small trade because it gives her some means of supporting herself and pastime during the day. Although R. approaches her in a friendly but authoritarian way, the contact seems to do the woman good and to give her confidence. A promise from R. that from that day on I will be her friend and greet her as I pass, appears to be a valuable present.

An old lady and her son join us on one of the visits to the psychiatric hospital in Accra. During the buss ride the woman does not speak a word, neither with her son, nor with R. or me and she keeps plucking at her clothes. She seems distracted, confused and unaware of the world around her. After arriving in the psychiatric hospital she and her son wait for a long time. While waiting, the woman wanders off several times, not recognizing the person who brings her back to the bench where she was sitting. She tells stories about the past with no beginning and no end. When the nurse calls her name, her son takes her hand and guides her to the consultation room. We leave and she is left behind.

A man in his forties meets us in one of the small streets of the settlement, when we are on our way to the camp clinic. The man looks nervous and restless, walking quickly and holding his leather shoulder bag very tight. He is one of R.'s traumatized clients and when he recognizes R, I am introduced to him. While R. walks on, the man opens his bag to show me what is in there. He takes out several Christian magazines and wants to talk with me about religion. When I tell him that I do not believe in any god, his eyes become even larger and he gets more restless. He tries to convince of the importance of believing in god and going to church while jumping from one leg to the other. After some time R. comes back and sends the man home.

With B., a woman in her thirties, and R., I visit the physician in the camp clinic. B. does not have to wait in the waiting room, but is led straight into the treatment room, past the other patients. She sits opposite of the doctor, who asks her to explain why she came. B. is experiencing problems, voices tell her that she should eat raw cassava and she is clearly not feeling well. While she tells her story, R. interrupts several times, telling the story for her, but he is silenced with a short glance from the physician.

When the doctor leaves the room for a moment, B. takes my hand and asks me with tears in her eyes to please help her. R., the volunteer, thinks that B. needs to be referred to the psychiatric hospital in Accra. B. gets the desired referral. B. is admitted to the psychiatric hospital and is two weeks later released, when she is crying and begging to come home and both the nurses and the psychiatrist judge that there is nothing wrong with her.

The care and treatment given to the traumatized people, as well as people with other psychiatric problems, in the refugee settlement in Gomoa Buduburam, Ghana, mainly focuses on medication and leading as normal a life as possible. Further care is limited to a visit from R. every now and then and a relatively regular monitoring by a psychiatrist in the psychiatric hospital in Accra. Although some of the severely traumatized refugees are taken care of by family, while others are committed to the psychiatric hospital in Accra, most of them participate in everyday life, work or try to accumulate an income in other ways and take care of themselves.

1.2 Questions

My experiences in Gomoa Buduburam in Ghana raised many questions about traumatized refugees and their treatment. Could the approach in the refugee settlement in Buduburam be called treatment? What are the underlying ideas and the effectiveness of that treatment? Which other approaches exist? What additional factors contribute to the healing of traumatized refugees? Ideally, which elements should care and treatment of traumatized refugees contain? Which factors, other than treatment components, should one take into consideration when working with this group of clients?

In the treatment of traumatized refugees one can roughly distinguish between three interventions—medication, “talking through” and “working practically”. As the use of medication in trauma treatment can be seen as a way of surviving and coping with symptoms, rather than treating them, this intervention will not be my focus. In earlier research pharmacotherapy for PTSD was found to be effective for the treatment of symptoms, though only when used in combination with psychotherapy. It is regarded as “a useful adjunct to psychotherapy, for which it may serve a facilitative effect”, though not a treatment in its own right (Gerrity and Solomon, 1996: 91). In the DSM-IV TR the use of medication is considered to be an intervention which “targets the underlying neurobiological alterations found in PTSD and attempts to control symptoms so that the [...] treatment goals can be more effectively accomplished” (First and Tasman, 2004: 933). The treatment aims mentioned however, are of psychological and psychosocial nature, centered on reducing symptoms and strengthening the patient’s ability to function in daily life.

Much of the existing literature and research done in the field of trauma treatment originates from the disciplines of psychology and psychiatry and focuses on “talking through” as a form of trauma therapy (e.g. Agger and Jensen, 1990; Derges and Henderson, 2003; Neuner et al., 2004; Ghorashi, 2008). Social work however, as a holistic and eclectic practice, entails a much wider range of interventions and approaches than merely talking through. The International Federation of Social Workers describes that “[s]ocial work [...] addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction” (IFSW, 2000). According to the federation’s International Policy on Refugees, social work with refugees should evolve around stabilizing and optimizing both their social and psychological wellbeing (IFSW, 1998).

Studies into the effect and importance of socio-economic factors in relation to the wellbeing of refugees can give insight in this other side, which is just as essential to the practice of social work (e.g. Ager et al., 2002; Guay et al., 2006, Johansson Blight et al., 2006; Miller et al., 2002). In this thesis I aim to answer the following research questions.

- Which are the underlying ideas and the effectiveness of the “talking through” approach in working with traumatized refugees?
- Which are other possible approaches in working with traumatized refugees?
- What other factors are of influence in helping refugees to cope with and process their traumas?
- Which combination of approaches and influential factors seems appropriate in helping refugees to cope with and process their traumas?

2 METHODOLOGY

In an attempt to find answers to the research questions stated in the previous chapter, this thesis is the result of combining the information and research results from several literature sources with insights and thoughts gathered through interviews with four professionals working with the treatment of traumatized refugees for both communal and international organizations.

2.1 Literature Study

The literature used for this study was found through an extensive search in several databases, subject specific journals, books and book chapters. A large part of the search was executed in the databases *Sociological Abstracts* and *PsycARTICLES*, using any combination of the terms *refugee*, *migrant*, or *immigrant* with *trauma*, *traumatized*, *posttraumatic stress*, *PTSD*, *wellbeing*, *well-being*, *socio-economic factors*, *treatment*, *therapy*, *talking*, *narrative* as words anywhere in the text, keywords or descriptors. Found articles were screened for usefulness based on their abstract. A search in medical databases did not give any helpful results.

All issues of the *Journal of Refugee Studies*, *Refugee Survey Quarterly*, the *Journal of Traumatic Stress* and *Social Science and Medicine* were searched through for possibly relevant articles, based on titles and abstracts, including all volumes up till 1990 if available. These journals were chosen based on their publication of a number of articles found in the database search. The *Journal of Refugee Studies* is a multidisciplinary journal in which articles from both academics and professionals are published in association with the Refugee Studies Centre at the University of Oxford. *Refugee Survey Quarterly* is a publication on behalf of the United Nations High Commissioner for Refugees, of which each issue reviews articles and documents on a specific subject within the area of forced migration. A publication of the International Society for Traumatic Stress Studies, the *Journal of Traumatic Stress* discusses theory, research, treatment, prevention, education and legal and policy issues concerning traumatic stress. *Social Science and Medicine* is an international and multidisciplinary journal which publishes articles, research and reviews on all subjects of interest to social scientists, health practitioners and policy makers. The journal is published by Elsevier Ltd. in the United Kingdom.

A social work student from the University in Stellenbosch, South Africa, was kind enough to search all issues of the journal *Social Work, Maatskaplike Werk: 'n Vaktydskrif vir die Maatskaplike Werker, A Professional Journal for the Social Worker*, published by the Social Work Department at that university. Intention of the search was to broaden the mainly European and North-American literature base of this thesis with sources from this journal, which is, to the best knowledge of the author and her supervisor, the only social work journal published in sub-Saharan Africa. Unfortunately, no articles on the treatment of traumatized refugees were found, which is remarkable, given the fact that Africa is a continent that produces and accommodates large numbers of refugees.

The university library database was searched several times for both books and e-books, using the same keywords as for the database search, though not necessarily combining them. The content of potentially interesting books and e-books was browsed through, resulting in the selection of one or more chapters or the decision to dismiss the source, based on irrelevance. Both my supervisor and one of my interviewees drew my attention to a number of books, chapters, authors and articles. During and after working through most of the collected literature, authors, articles, journals and books that were of possible interest we noted down and investigated. Reference lists of read literature proved valuable, both in confirming the validity of the authors and sources already found and used and in pointing to new options.

Despite the quite large amount of sources these queries resulted in, much of the literature turned out to focus on either trauma or refugees or wellbeing, but not a combination of them. At least half of the sources were found to be too little specific for use in this thesis. Although literature

on both trauma and on refugees is plentiful, literature about the treatment of traumatized refugees, with specific attention for the subjects raised in the research questions, rather than their general wellbeing, is not as readily available.

2.2 Interviews

For the interviews, four professionals working with traumatized refugees in different professions and settings were approached, who all agreed to participate and share their knowledge and ideas. The interviewees were selected through purposive snowball or network sampling, in this way that the first interviewee, Elisabeth Sandén at the Crisis- and Trauma Unit in Gothenburg, was recommended to me by my thesis supervisor, and suggested other settings and organizations where professionals from various educational backgrounds working with traumatized refugees might be willing to be interviewed. I was introduced to Tina Tyrchan, a general practitioner at the Healthcare Center in Frölunda, Gothenburg through personal contacts.

The interviews were conducted in the working environment of the interviewees, with exception of the interview with Tina Tyrchan, which took place in my home. Before starting the actual interview, I asked each interviewee if I could use their full name, function and a specific description of their workplace, which all interviewees agreed to without hesitation. In addition, the interviewees were asked permission to record the interview. First, all interviewees were explained the purpose of the interview and the intention of the thesis, fulfilling the informational requirement. It was clarified that the information given during the interview would only be used for the purpose of this thesis and that any private information, concerning clients or the interviewee herself would be excluded. Having freely and willingly agreed to be interviewed and having understood the requirements of information, restricted use and confidentiality, the requirement of informed consent was considered to be accomplished.

The interviews were conducted using an interview guide which contained a general outline of the topics and a few possible follow-up questions. The purpose of not designing very detailed questions was for the interviewee to be able to talk freely and the interviewer to be aware of the topics that should at least be covered, but not to be restricted to these topics. For each interview the interview guide was slightly adapted, both based on the experiences of the previous interviews and on the profession and work setting of the interviewee. The topics that were discussed during the interviews are 1) a description the interviewee's function, the workplace and the way of working with traumatized refugees; 2) thoughts and insights with regard to talking through trauma; 3) perspective on "working practically", which included not talking about traumatic events, but moving on with life; 4) point of view on the influence and importance of factors in the refugee's environment in relation to dealing with trauma; 5) points of special interest to take into account when working with traumatized refugees; and 6) to describe which elements should ideally be part of "treatment" for traumatized refugees? The length of the interviews varied, between 35 and 100 minutes. The interview with Catherina Karlsson was unfortunately the shortest, due to her having very limited time, and is as a result restricted to her tasks as a social worker and the ideology on which her work is founded. All interviews were transcribed verbatim.

2.3 Interviewees

A short description of the organizations and professions in which the experts interviewed for this thesis are active will hopefully make it possible to get a clearer picture of their professional background and the basis for their ideas and opinions.

Elisabeth Sandén, family therapist, 'Kris- och Traumaenheten'¹

At the Crisis and Trauma Unit in Gothenburg, Elisabeth Sandén, who was educated as a social worker before specializing as a family therapist, provides therapy to traumatized refugees. In the unit two family therapists, psychologists, two part-time psychiatrists and a physiotherapist work managed by a team leader with a nursing background. The trauma treatment is regarded to be teamwork, where all contribute with their specific discipline. In addition to talking through their trauma with one of the psychotherapists or psychologists, traumatized refugees who are treated the unit can be helped through physiotherapy in groups and swimming, on separated occasions for both sexes, under supervision of the physiotherapist.

Tina Tyrchan, general practitioner, 'Frölunda Vårdcentral'²

In the healthcare center in Frölunda, Gothenburg, Tina Tyrchan, general practitioner, mainly meets traumatized refugees as a consequence of physical complaints, which often turn out to be psychosomatic problems, resulting in a first psychological evaluation. In addition to her experience as a general practitioner, she worked for Médecins Sans Frontières, Doctors without Borders, in a management function, training local staff and supervising activities in a first care center in Burundi.

In the health care center, besides the physical care, a curator helps refugees with organizing their new lives. Moreover, a nurse trains patients in bodily awareness, breathing and relaxing techniques, combined with 'little talk therapy', as it is referred to in the healthcare center.

Elisabeth Axelsson, director and psychotherapist, 'Svenska Röda Korsets behandlingscenter för krigsskadade och torterade'³

The Red Cross Centre for Victims of War and Torture in Skövde welcomes all refugees from the western regions of Sweden, who suffer from trauma related to war and torture and their family members, irrespective of their legal status. Elisabeth Axelsson is director and part-time psychotherapist at the center. *"The idea to begin with in the Red Cross was to take care of the entire person in one place, so they wouldn't have to go running off to all sorts of other places for the care they needed"* (interview E. A., 2008-09-19). To be predictable and trustworthy are key concepts.

Psychotherapy is the main treatment given at the center, complemented with physiotherapy, social work, recently set-up art therapy and individual and family support from volunteers. Not all patients are assisted by all disciplines; the treatment of each individual is complied according to what someone needs at a certain point in time. Five psychotherapists are responsible for the therapeutic treatment of the patients, each one of them using his or her distinct techniques. The physiotherapist mainly focuses on self-awareness and relaxation techniques, in order to give the patient a range of methods to use. In addition, she treats patients with injuries which are a result of being tortured. The center is in the process of searching a forensic doctor, for the medical part of torture documentation, as described below. Catherina Karlsson, the social worker in the center, takes care of the difficulties the refugees meet in legal processes and building a new life. She is also responsible for the two groups of volunteers who are active for the Red Cross center.

Contact persons form one of the groups of volunteers, whose roles exist of individual contact with and companionship for a patient. Although practical help is a large part of their work, the interpersonal relationship between the refugee and the contact person is essential. The second group of volunteers consists of family supporters, who, with two or three volunteers per family, assist very badly traumatized refugee families, who are not necessarily patients, to cope with everyday life and to keep the children's health as good as possible. All volunteers are educated on refugees and trauma, regularly given further training in relevant issues and supervised.

¹ Crisis and Trauma Unit, Gothenburg.

² Frölunda Health Center, Gothenburg.

³ Swedish Red Cross Centre for Victims of War and Torture, Skövde.

Catherina Karlsson, social worker, 'Svenska Röda Korsets behandlingscenter för krigsskadade och torterade'⁴

Central in the tasks of the social worker in the Red Cross center, Catherina Karlsson, are all assistance, advice and mediation in subjects of concern to the refugees who are treated in the center, ranging from the asylum-seeking procedure and family and reunion matters to financial concerns, looking for employment or practice and residential issues. Furthermore, the social worker organizes and oversees the two groups of volunteers active as contact persons and family supporters. Besides recruitment, arranging for training and informational meetings, where relevant professionals talk about their expertise, varying from the legal aspects of the asylum-seeking procedure to the current situation in Kosovo and its consequences.

Finally, Catherina Karlsson is responsible for part of the torture documentation executed within the scope of the Istanbul Protocol on investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. In addition to the medical and psychological evaluation, which is carried out by a physician and a psychotherapist or psychologist, an extensive and meticulously detailed account of the place, time, acts, experiences and emotions related to the torture is drawn up in collaboration between the refugee in question and the social worker.

2.4 (Informal) Participant Observation

Although the observations made in the Liberian refugee settlement in Gomoa Buduburam in Ghana merely function as an illustration of the situation and treatment of traumatized refugees that gave rise to the questions on which this thesis is based, some insight in the methods through which the information was collected may not be missing.

For a period of 35 days I lived in a, to Ghanaian and camp standards very comfortable, room in a compound of which the backdoor leads in to the camp. Although lacking electricity and running water, which is similar to the situation of most refugees in the camp, I had the luxury of having my own bathroom, thus not having to use the communal toilet and bath in the courtyard, and a more spacious room than is usual for a person living alone. Mainly Ghanaians live in the compound, social welfare officer O., and a midwife working in the camp clinic among them.

During this period I spend the major part of my days in the camp, either going along with C., the project manager of an NGO operating in the settlement, or observing the activities of volunteers and professionals working in several projects that C. introduced me to. I was introduced to volunteers, professionals and clients or participants by profession, being a social worker, and the purpose of my visit, which was observing the social work related activities in the settlement. Observations of traumatized refugees in the camp were noted down afterwards.

My role as an observer during my field placement in the refugee settlement could be described as a *complete participant*, as defined by Gold (in May, 2001: 155-157). "The researcher employing this role attempts to engage fully in the activities of the group or organization under investigation. Their role is also covert for their intentions are not made explicit" (May, 2001: 155).

Due to the short time spent in Buduburam and the ambiguous role of the observer—primarily as a student conducting a field placement as social worker in the camp and only secondarily observer—the data collected during the observation are limited and incomplete, making the usefulness of questionable. Consequently, the results will be used mainly for descriptive purposes. The positive side of visiting Buduburam for a different purpose and the participant observation only being of secondary importance is the fact that I did not have any pre-established ideas or expectations, since I did not do any preparatory literature study into either the refugee settlement or its inhabitants.

⁴ Swedish Red Cross Centre for Victims of War and Torture, Skövde.

2.5 Analysis

The most difficult aspect of writing this thesis has been not to get overwhelmed by the plausibility of each one of the perspectives presented. While I understand and largely agree with the ideas behind talking through trauma, I am simultaneously aware of that approach being part of my culture. At the same time I feel strongly for the necessity of building a meaningful and at the same time ordinary life in order to be able to cope with adversities and sorrow. In addition, the experience of being a foreigner myself, even though I am not far from home, makes me susceptible to the conviction that factors related to migration itself affect one's feeling of wellbeing and have their influence on dealing with hard or traumatic experiences. Being raised as I am and being educated as a social worker in the Netherlands, I have learned to attempt to be aware of and look at a situation from different perspectives, which, however valuable that effort may be, also makes it easy to lose focus. Only after going back to my 'roots', to the perspective that I experience as compatible with my view on social work—partly because it fits me as a human being, partly because it is what I learned as a foundation for my profession—did I manage to regain my focus and the ability to take a step back to critically look.

The analysis of the written material and the interviews collected for this thesis is an interpretation of the content and the strengths of the different approaches to traumatized refugees. After carefully reading the written material, I selected that material that was relevant for the research questions, sifting out material that was too general. The remaining articles and book chapters were incorporated in the different chapters of the thesis.

The interviews were transcribed verbatim and searched through for remarks focusing on any of the three broader perspectives in this thesis 1) talking through; 2) working practically; and 3) an ecological perspective. While analyzing the interviews however, the categories became more nuanced and new categories were added for new or specifically interesting information. After categorizing I compared the insights of the different interviewees with each other and with the literature.

2.6 Ethical Considerations, Limitations and Generalizability

As mentioned before, each interviewee was asked permission to use her full names, function and the organization she works for, prior to starting the interview. Each interviewee agreed. By obtaining their permission, I have treated my interviewees in an ethically correct way.

The limitations of this thesis lie within the boundaries of the used databases and the availability of written material. In addition, the fact that two of my four interviewees work as psychotherapists and a third works in a center where psychotherapy is the main treatment, results in ideas and insights with regard to the perspective of living a normal life is underrepresented being underrepresented in the interview material.

The findings of this thesis are the result of an extensive search through the existing knowledge base on traumatized refugees. In trying to carry out a comprehensive exploration, I searched databases, the major journals and books on the subject. Comparing the different written sources and combining them with the insights of four professionals, I tried to outline the different views with their strengths. I have not expanded on the material, but raised questions as a result of them and interpreted my sources. To generalize any of the approaches used would not do justice to either the material used or to the value of the other perspectives.

3 TALKING THROUGH: THERAPY

“No longer imprisoned in the wordlessness of the trauma, ... [the victim] discovers that there is a language for her [or his] experience” (Herman, 1992: 158).

As a response to deeply traumatic situations, talking through this trauma is widely used. Giving testimony of experienced hardship and injustice has been utilized in both trials and resistance against oppressive governments in South-Africa, Bosnia and Chile, among other countries (Agger and Jensen, 1990; Summerfield, 1999). Besides its political purpose, talking through trauma is used in a treatment oriented approach, which is the focal point of this chapter.

3.1 Three Phases in Trauma Therapy According to Herman

The work of Herman, a medical doctor and an authority in the field of trauma recovery, portrays a general perspective on trauma and trauma therapy. Herman describes trauma, its effects on a traumatized person's life and the process of recovery founded on talking through trauma, which forms the basis for therapeutic interventions with traumatized persons. The underlying conception to these therapeutic interventions is that, although the normal response to traumatic experiences is to exile them from the consciousness, the memories of those experience will sooner or later re-appear and should therefore talked through, in order to restore the social order and for the individual victim to recover (Herman, 1992). While the focus of Herman's work is on victims of sexual and domestic violence and combat veterans, throughout she mentions other groups of trauma victims, amongst who traumatized refugees.

For trauma victims in general, Herman describes three phases that according to her should be a part of trauma therapy, or the trauma rehabilitation process: safety, remembrance and mourning and reconnection with ordinary life. “In the course of a successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection” (Herman, 1992: 155). In a process as turbulent and complex as recovery from trauma however, these stages can be seen only as a guideline, rather than a schedule that should be followed rigidly.

The stage of establishing safety forms an essential basis for the phases of remembrance and mourning and of reconnection with ordinary life, but is too often cut short, as a result of the therapist's lack of recognizing its importance or of the victim's desire to start talking about the traumatic events without delay. “Patients at times insist upon plunging into graphic, detailed descriptions of their traumatic experiences, in the belief that simply pouring out the story will solve all their problems” (Herman, 1992: 172).

When establishing safety, both physical and emotional safety should be considered. Without creating safety, no therapeutic work can be successful. Family, friends and loved ones can play a role in establishing safety as well. In addition to finding a physically safe environment, regaining a feeling of control over one's body and of trust and safety in oneself and in relationship with others are essential. This enables the client to reclaim “a sense of competence, self-esteem, [...] freedom” (Herman, 1992: 167) and autonomy. In the case of refugees, taking back their freedom has meant that they had to leave their homes and often even their native country. In order to achieve safety and recovery however, this freedom is of vital importance. Finally, a therapeutic relationship in which trust and emotional safety are present is founded during this initial stage of safety.

In the second stage, that of remembrance and mourning, the client reconstructs the traumatic event, exhaustively and in detail, so as to make it possible to integrate the experiences into his or her life story. Starting out with fragmented memories, factual descriptions devoid of emotions, by remembering, retelling and reliving the traumatic experience, the client develops a comprehensive trauma narrative. In this narrative not only facts, times and places, but also a detailed explanation of physical sensations and emotional responses connected to the traumatic experience

matter greatly. Reconstruction should come about in a for the client tolerable pace, with attention for the balance between the need to talk through and for maintaining a sense of safety. For victims of multiple traumas, as is the case for traumatized refugees, singling out specific traumatic events is a difficult task. One traumatic episode however, may stand for other similar experiences, making it possible to focus on a number of exemplary experiences.

Also a part of this second stage of recovery is mourning. “Trauma inevitably brings loss” (Herman, 1992: 188). Although a victim often fears mourning and regards grieving as a way of granting victory to the perpetrator of the trauma, it is essential for empowerment and regaining control and responsibility over his or her life. Only by mourning the losses that he or she suffered as a result of the trauma, can the client retract the power the perpetrator has over his or her life.

Reconnecting to ordinary life and creating a future are the central points in the final phase. The client “has mourned the old self that the trauma destroyed; now [he or] she must develop a new self” (Herman, 1992: 196). To re-shape this new self entails reconciling with oneself, reflecting on who the client wants to be—what he or she liked about him- or herself before the trauma and which abilities and strengths the client discovered in him- or herself as a result of surviving the trauma and during therapy. Together, the client and the therapist re-examine old hopes and dreams and fantasize about new wishes. Furthermore, this third phase is one of reconnecting with others, with the outside world. The client learns to build trust and a new bond, based on autonomy and respect for the own boundaries and those of others. Additional focal points of the stage of reconnection are to take control over bodily and emotional reactions to danger and to reexamine and change defective behavior.

After completing the three stages of recovery, discontinuing the trauma therapy will be a logical step. Having achieved a satisfactory level of recovery, the client will continue with ordinary life. Nevertheless, to accomplish this ability to return to daily life does not mean, that the trauma is completely healed, because it never will, and it is very well possible that future (life) events will cause a re-surfacing of the trauma. Therefore, “[w]hen a course of treatment comes to its natural conclusion, the door should be left open for the possibility of a return at some point in the future” (Herman, 1992: 212).

3.2 Six Processes: The Purpose of Talking Through Trauma

Under the umbrella of the three phases elaborated upon by Herman, talking through trauma, or creating “trauma narratives”, is utilized as a tool to complete different process, as identified by Kaminer (2006). Although being distinctive in that sense that Kaminer’s is the only article which deals with the treatment of trauma that is published in an African journal, the sources used for her review are European and North-American. In addition, Europe and North-America are also where the focus of almost all of them lies, with the exception of only two studies, which are written about African people.

In her review Kaminer identifies six therapeutic processes in trauma therapy, which originate from cognitive-behavioral, psychodynamic and debriefing models of trauma intervention. Within Herman’s phases, these processes take place in the middle phase, that of remembrance and mourning. While talking through trauma, these processes enable the client to recover from his or her post-traumatic distress. Although depicted here as separate from each other, these processes often run parallel or are even intertwined with one another. In addition, their order is not necessarily fixed, with exception of the sixth process, which should not be started unless the other five processes are completed. To identify and be aware of these processes is critical for any trauma counselor or therapist, given the risk of re-traumatizing as a result of a lack of theoretical coherence.

Having a long history in psychotherapy, the first process described, *emotional catharsis*, is “the process of relieving an abnormal excitement by re-establishing the association of the emotion with the memory or idea of the event which was the first cause of it, and of eliminating it by abreaction” (Oxford English Dictionary, 2008). By re-telling and re-living the trauma in detail,

expressing the strong emotions connected to it, emotional catharsis may be a factor in a client's recovery from trauma through being part of other therapeutic processes, although it is, in itself, possibly ineffective to realize full recovery (Kaminer, 2006).

The *creation of linguistic representation*, the second process, forms a basis for trauma therapy which includes talking through. This process is founded on the view that traumatic experiences are too different from other, ordinary experiences, to be understood and explained on a conscious level. These experiences are thus being stored as subconscious, fragmented and sensory memories. Post-traumatic symptoms are seen as the expression of an inability to process trauma-related information adequately. By helping a client to develop a coherent trauma narrative, the subconscious memories and emotions connected to the trauma are repositioned to the conscious level, consequently "reducing the intrusive and involuntary memories that characterise PTSD" (Kaminer, 2006: 486).

Re-telling a traumatic event contributes to diminishing a client's anxiety related to the trauma. A third process, *habituating anxiety through exposure* entails repeatedly exposing the client, in a safe and trustworthy therapeutic environment, to the feared stimuli, which in the case of a traumatized client are the traumatic memories, in order to reduce the physiological anxiety. Relaxation and visualization can help the client to cope with his or her anxiety. Emotional catharsis and creation of linguistic representation are a means to realize the exposure.

Through *empathic witnessing of injustice*, the fourth process described by Kaminer, the trauma therapist helps the client to "re-establish trust in the benevolence of others" and to develop "the survivor's sense of trust in the reality of his or her own experiences" (Kaminer, 2006: 488). As an empathic listener the therapist abandons his or her usual therapeutic neutrality and acknowledges the injustice and grievance the traumatized client has suffered.

Developing an explanatory account enables a traumatized person to attach meaning to the traumatic event. Often "narrative about deviations from the ordinary need to contain reasons, to answer the question *why?*" (Original italics, Kaminer, 2006: 489). The explanatory accounts a client develops carry the risk of not being supportive to his or her healing, instead creating a negative perception of the self, relationships with others and the world. As a replacement the therapist should assist the client in searching for explanations of why the person who brought about the trauma did what he or she did. Such explanations are found to be helpful and clients who manage to develop explanatory accounts focusing on the perpetrator's behavior show "less psychological distress and better social adjustment than those who did not" (Kaminer, 2006: 491).

The sixth process, that of *the identification of purpose or value in adversity* allows the client to attach positive meanings to the traumatic event, by learning to interpret the event as a source of personal growth, to recognize skills and knowledge necessary to endure the experience or to appreciate one's life in a more positive way. This process however, should only be the focus of treatment when post-traumatic symptoms are dealt with and the client went through the five other processes and may not be suitable or meaningful for all clients.

3.3 Research on Talking Through with Refugees

Although literature on the effectiveness of talking through as a method of therapy, specifically focusing on traumatized refugees, is not readily available, different authors offer insights into the matter from various angles. Based on their work in Denmark, for the Treatment and Counseling Center for Refugees in Copenhagen and the Transcultural Team of the department of psychiatry in the general hospital in Hillerød, Agger and Jensen (1990) for example, describe the value of the testimony method in psychotherapy with traumatized refugees and victims of torture. Giving a testimony of the endured hardship and horror is a method proposed by the therapist, but the decision to actually give a testimony lies entirely with the refugee. Refugees, with whom the method was used, were diagnosed with the post-traumatic stress disorder. The method functions

not only to relive and process the trauma, but also to help the refugee come to terms with feelings of shame, guilt and of being abnormal.

After a basis of trust is established between the refugee, the therapist and if necessary or desirable an interpreter, the refugee gives a detailed account, including the emotional level, of the situation up to the traumatic event, the endured trauma, the flight, life in exile and of dreams, hopes and possibilities for the future. During the sessions the testimony is recorded or written out by hand. When finished, the refugee, the therapist and the interpreter together edit and revise the testimony, which in a ritual is read out loud by the refugee or the interpreter and signed by all parties. The refugee is free to use his finished testimony as he or she wants. It can for example serve as evidence in the asylum case, as a political statement or documentation for international organizations of exile groups or as informative material for a professional context.

By talking, reliving and reframing the hardship and horror he or she experienced, the refugee gets the opportunity to process the trauma and to transform it from personal pain into a statement and evidence, possibly against the regime that inflicted the trauma. Although the article focuses on torture victims, Agger and Jensen stress that the method can also be used to help refugees that are traumatized in any other way, both in their country of origin and during their flight. As presented in the study, refugees who gave testimony, perceived a decrease in symptoms related to PTSD, such as nightmares, sleeping problems, being afraid of being alone at night, weak emotional contact and concentration problems.

Ghorashi (2007), a cultural anthropologist in the Netherlands and a political refugee from Iran herself, used life stories as a method in her research among Iranian women in exile in the Netherlands and the United States of America. Besides the value for the research itself, in creating space for silences and the expression of emotions, consequently enabling the researcher to focus on multiple layers of communication, Ghorashi points out that “[b]y telling their life story, some women were not only confronted with a past they would rather forget, but finally, they were offered an opportunity to give this past a place in the presence” (2007: 121). Even though talking through trauma and thus reliving traumatic events in the past may be painful, from time to time too painful even to put the experiences into words, it does allow for these memories to find their place in the presence and may prevent them from being or becoming an obstacle in the future.

Founded on research with refugees and survivors, which they conducted over the course of several years in a mental health day hospital in London in the United Kingdom, Derges and Henderson learned that “[t]alking was an activity that was initially unfamiliar and even fearful, with words such as ‘confessing’, ‘secrets’ and being ‘judged’ featuring regularly” (2003: 94). Eventually though, talking became easier, a change which Derges and Henderson mainly ascribe to the long periods of time in which a confidential relationship was established with the refugees. Some statements express the appreciation some refugees participating in Derges’ and Henderson’s study experienced for talking through their traumas.

It is hard when you have a lot of pain to keep everything inside (Mrs. B.; Derges and Henderson, 2003: 94).

Some people to trust, that’s very important to me (Mr. J.; Derges and Henderson, 2003: 94).

I find it hard to communicate...I can take my emotional burden out, she [the counselor] really tried to help, you can sense the difference, the way she talked to patients, the way she looked—for me it helped, I confide my secret, she support me. A process it’s good, you can cry even if you can’t talk (Mrs. H.; Derges and Henderson, 2003: 95).

They help me get back to normal life—push me back to normal life [...] I talked my problems, my life, I very relaxed and comfortable (Mr. P.; Derges and Henderson, 2003: 95).

Although talking through their trauma was an unfamiliar and possibly even threatening experience for many of the traumatized refugees pictured in the studies described above, ultimately talking about traumatic experiences and events turned out to be appreciated and valuable in healing the trauma. These therapeutic interventions however, took place in a safe environment in western countries, far away from the horror and hardship of war and torture.

In a distinctive study Neuner, Schauer, Klaschik, Karunakara, Elbert (2004) investigated the effectiveness of narrative exposure therapy in refugees who have not resettled in western countries, but who resided in a refugee settlement in northern Uganda. Neuner, Schauer, Klaschik and Elbert are connected to the Department of Clinical Psychology at the University of Konstanz, Germany. Karunakara was previously active at Johns Hopkins University School of Public Health in Baltimore, United States, but worked at the time of publishing for Médecins Sans Frontières in the Netherlands. All authors are involved in Vivo Foundation, an organization which aims to overcome and prevent posttraumatic stress in individuals and communities. The study is unique in the sense that, although the effectiveness of psychotherapy in stable and secure conditions has been investigated, research into the use of therapy with refugees who continue to live in dangerous and difficult conditions is, according to the authors, non-existent.

Narrative exposure therapy is a short-term therapeutic trauma intervention which has been developed by Neuner and Schauer by merging exposure therapy—which bases its effects on repeatedly exposing the client to the traumatic event, until habituation to the emotional reactions takes place—and testimony therapy—which focuses on developing a detailed chronological narrative of the client's life, with special attention for those traumatizing events the client experienced. During short-term treatment, in this study four sessions of 90-120 minutes, the client, helped by the therapist, constructs a detailed life story, with special attention to and habituation of the emotional responses associated with the traumatic events he or she went through (Neuner et al., 2004).

For the study the effectiveness of narrative exposure therapy was compared with supportive counseling and psycho education. Supportive counseling consisted of four sessions of talking with the client about current problems, decisions, hopes and dreams, but not about specific traumatic experiences. All three groups of refugees studied had suffered war related trauma and were diagnosed with posttraumatic stress disorder. As part of the research all participants received one session of psycho education, with additional sessions of narrative exposure therapy and supportive counseling for two respective groups. Participants were re-diagnosed for PTSD four months and one year after the treatment. Generally Neuner et al. found at the one-year follow-up that of the refugees who took part in the narrative exposure therapy, only 29% still fitted the diagnosis of PTSD, while for the supportive counseling group and the psycho education group this was 79% and 80% percent respectively (Neuner et al., 2004: 584). Furthermore, most participants from the narrative exposure group had moved out of the refugee settlement to more secure areas and started rebuilding their lives, whereas almost none of the others had done the same (Neuner et al., 2004).

3.4 A Culture of Talking

Although being widely used, the origin of talking through as a cure for traumatic experiences lies in western societies, where Christian believes encouraged “confession and sharing distress” (Hjern, 2005: 129). Notwithstanding the strong narrative traditions existent in many other cultures, sharing traumatic experiences and feelings of poor mental wellbeing is not universally common and accepted, often as a consequence of a culturally different perception of sickness and healing and the

stigma attached to mental illness. Angel et al. (2001) remind to be aware of the cultural context from which refugees originate, in order to get a better understanding of the values that apply concerning sharing distress and trauma. Although in most western societies, talking through is highly valued as a method of dealing with trauma, there are many cultures in which this is not the custom or even accepted. This has its implications on both refugees' willingness to talk about their experiences, on the importance that is attached to it and on the way it is received in the refugee's social environment. "In contexts where disclosure is encouraged, it is likely to increase support and emotional involvement for the victim; in those where it is discouraged, it may evoke contempt and hostility" (Angel et al., 2001: 15).

Derges and Henderson (2003), who are mentioned before in the context of their study in a mental health day hospital in London, point out the importance of being sensitive to the socio-cultural tradition a refugee originally comes from, in order to understand the perception of talking about and seeking help for the processing of trauma and in dealing with mental health problems, within that culture. This is both significant for understanding the manifestation of problems and symptoms and in getting a grip on the customary, and thus familiar, way of acting and reacting refugees which may adapt with regard to trauma.

3.5 Talking Through: Summary

Talking through is an approach commonly used in western societies in order to heal trauma. Foundation for this approach lies in the conception that, in order to restore the social and individual order that was destroyed by the traumatic experience, one has to work through the trauma and transform subconscious fragments into a conscious memory. Therapy-based treatment starts with creating an emotionally and physically safe environment, followed by the actual working through the trauma, mourning the losses suffered in relation to it and, finally, reconnection to a normal daily life (Herman, 1992). In the middle stage of this therapeutic intervention, that of working through and mourning, six therapeutic processes need attention, these being emotional catharsis, creation of linguistic representation, habituating anxiety through exposure, empathic witnessing of injustice, developing and explanatory account and, finally, the identification of purpose or value in adversity (Kaminer, 2006).

These general theoretical perspectives are utilized in treatment of traumatized refugees in European countries, as in the studies of the use of testimony by Agger and Jensen (1990) and talking through trauma more generally in a psychiatric setting by Derges and Henderson (2003), but also form the basis for the narrative exposure therapy developed and studied by Neuner et al. (2004) in their study in an African refugee settlement. In addition, Ghorashi (2007) elaborates on talking about traumatic experiences in the context of anthropological research. The culturally different perception of talking through and dealing with trauma is made notice of by Hjern (2005), Angel et al. (2001) and Derges and Henderson (2003), who point out that talking through trauma is a western concept that is not universally used and accepted. In general however, the four studies discussed here found talking to be appreciated and have a healing effect in relation to posttraumatic symptoms, despite the unfamiliarity and sometimes initial unwillingness of several of the refugees to talk about traumatic memories and emotions.

4 WORKING PRACTICALLY: THE IMPORTANCE OF NORMAL LIFE

While talking through trauma seems by many to be considered a universally exploitable treatment method for traumatized refugees, some authors, although just a few, are of the opinion that the importance and priority attached to it are unjust. Critique on the naturalness with which western helping professionals impose their view and treatment on refugees with different cultural backgrounds is only part of the reasoning. The disabling power of socio-economic disadvantages and, more importantly, the healing power of moving on and living a normal life are the main focus.

4.1 Critique on Assumptions behind Talking Through

Both the importance of talking through trauma, the legitimacy of the priority this form of treatment often gets even in cultures where talking is not the norm and the desirability and rightfulness of universally applying concepts of trauma and posttraumatic stress, are subject to discussion. While criticizing the assumptions behind trauma programs in war-affected areas, Summerfield (1999), a British psychiatrist, honorary senior lecturer for the Institute of Psychiatry at King's College in London and connected to the Medical Foundation for the Care of Victims of Torture, makes some points about validity of the concept and psychiatric treatment of trauma where it relates to victims of war and torture. He questions the applicability of western psychological frameworks and the concept of posttraumatic stress as a universal reaction to trauma, stating that in trauma treatment programs this 'truth' is imposed, irrespective of the ideas and opinions of the victims concerned. Much of traumatized refugees' response to the experienced distress, even many of the features used to reach a diagnosis of posttraumatic stress disorder, are "normal, even adaptive, and [...] coloured by their own active interpretations and choices" (Summerfield, 1999: 1454).

According to Summerfield, professional help is not necessary and desirable for as many traumatized refugees as major organizations, such as the International Rehabilitation Council for Torture Victims and Médecins Sans Frontières, portray. Additionally, by focusing on professional help, the traumatized refugee is robbed of his autonomy and control of the situation and "what is important about the events experienced seems to pass from ordinary people to others deemed to know better" (Summerfield, 1999: 1454), based on their professional background. Also, the belief that facilitating for traumatized refugees to talk through their trauma exclusively is the terrain of professionals such as psychologists and counselors completely dismisses the value of family, friends and colleagues in this process.

Moreover, obliging traumatized refugees to talk through their trauma, may often draw away attention from the aspects in life that they themselves consider important or things they would want to put time and energy in, such as building a new life for their children or reuniting with their family. Furthermore, in many cultures stigmatization and the fear of it is a reason not to talk about traumatic experiences. Finally, when a traumatized refugee decides to talk, this may be a decision in the context of human rights testimonies, rather than for the purpose of treatment.

In their evaluation of the Transcultural Psychosocial Organisation program Eisenbruch et al. (2004) note that one of the vital aspects of the program is the effort to gain insight in expressions and perceptions of illness and distress and in methods of healing as they exist in the culture of origin of the refugee. These insights and methods are integrated with western ideas of illness and healing and used to complement each other and the traditional healing sector is actively involved. Indigenous healers, traditional birth attendants and mediums have an important role, both in obtaining information and in integrating local practices with traditional medicine. This seems to be significant as several researchers confirm that "refugees do best if they acculturate and at the same time keep a grip on their cultural identity" (Eisenbruch et al., 2004: 128).

4.2 Building a Normal Life

Eastmond, a Swedish social anthropologist specialized in refugee integration and trauma, extensively studied two groups of Bosnian refugees living in Sweden and their way of coping with traumatic experiences and rebuilding their lives. Based on her research, she argues for the value of living a normal life in relation the healing of trauma and increasing mental wellbeing. One group of Bosnian refugees in the study was upon arrival taken care of by a team of helping professionals, amongst them specially trained psychologists, while the refugees in the other group did not receive such help, but were employed in a temporary building project instead. After one year, all adults in the group that received specialized help were on sick leave with a diagnosis of PTSD and not able to attend Swedish classes, whereas those Bosnians who had started working without delay, did not experience this problem (Eastmond, unpublished⁵).

In the Bosnian refugee community, as in their country of origin, high value is attached to 'normality'—living a normal life, having a job which enables one to financially look after one's family and participating in a social network. Working as a part of this 'normality' is considered to be an important way to move on with life and to deal with a difficult past and with intricacies in the present (Eastmond, unpublished). This strategy of normalizing life and living for the present and future instead of dwelling in the past, was also observed among Bosnian refugees in northern Carolina, as studied by Weinstein, Lipson, Sarnoff and Gladstone (in: Eastmond, unpublished). For the Bosnian refugees in Sweden, strict requirements of language sufficiency and the lack of recognition of professional qualifications form a barrier to entering the labor market. Thus being unable to build a normal life in the host country, causes great distress for many of them. An unemployed refugee in Eastmond's study states:

"Not strange that one gets nervous, sitting around all day [...]. I want to work and support my family! They send me to psychiatric therapy, and it provided relief but I don't get better doing nothing for my family and myself" (Eastmond, 2005: 160).

In addition to work, 'sociability', the building of tight networks of social contacts with family, friends, neighbors and colleagues, is an essential part of 'normality'. After break down of these networks as a result of having left their home country, re-creating 'sociability' is difficult. While talking about the traumatic past in a treatment oriented environment is not always shunned and is sometimes even experienced as helpful and relieving by the refugees in Eastmond's study, socializing as an "informal social coping strategy" (Eastmond, unpublished: 28) is, in particular among women, seen as the preferred and most effective way to release suffering and regain health, as opposed to individual therapy.

'Normality' should not only be seen in the context of restoring a normal life and social networks, but also with regard to the Bosnian refugees' expressions of their experiences during the war. Rather than articulating hardship suffered during the war as an individual's experiences, the Bosnian refugees in Eastmond's study generalize their suffering, in a way distancing themselves from it. For people who have suffered particularly extreme cruelties, who do not talk about their experiences at all, nor are they asked about it by members of their community, to cope with their experiences, the healing effects of building and living an ordinary life may be even more important.

Supported by her findings, Eastmond points out that the categorization of refugees as being traumatized victims, despite their value in obtaining a refugee status and residence permit in the host country, is a barrier to integration and normal contact with the, in this case Swedish, host population. Besides distracting refugees from the present and drawing away attention from distress caused by their current situation, a "focus on events in the past, in the war-torn home country"

⁵ This manuscript, which Eastmond submitted for revision in 2004, has, according to data from the bibliographic database GUP ('Göteborgs Universitets Publikationer'), apparently been published in *Social Science and Medicine* in 2007. However, after conducting a very thorough search through all the volumes of that journal, I was not able to retrieve further information on the actual publication of the article.

(Eastmond, 2005: 150), focusing on traumatization disables refugees to participate in their host society as full members and places them in an extraordinary position.

For their research to the contribution of war experiences and exile-related stressors to the level of psychological distress, Miller, Weine, Ramic, Brkic, Bjedic, Smajkic, Boskailo and Worthington (2002) administered questionnaires to both a clinical sample, consisting of Bosnian refugees attending the Bosnian or Refugee Mental Health program, and a community sample, which existed of Bosnian refugees who were in some way involved with the Bosnian Refugee Center, both in Chicago. While Ramic, Brkic, Bjedic, Smajkic and Boskailo are connected to the Bosnian and Refugee Mental Health Programs in Chicago, Miller and Weine have a background in academics in Psychology and Psychiatry and Worthington is attached to the Chicago School for Professional Psychology. Their research focuses not only on symptoms related to posttraumatic stress disorder, but also on depressive symptoms. While variance in the former is hypothesized to be related to war experiences, variance in the latter is thought to be mainly account for by exile-related factors.

For the community group social isolation, one of the exile-related factors, was found to be the strongest predictor for both PTSD and depression. Miller et al. question however, in the case of PTSD, whether social isolation is either cause or effect of the symptoms. It may, on one hand, be possible that social isolation aggravates the symptoms through little supportive interaction and distraction. Social isolation could on the other hand also be the effect of self-isolation in order to avoid stimuli that may stir up memories of the traumatic event.

When linking their results to intervention, Miller et al. suggest that clinical-based services might not be suited to assisting refugees in creating “new social networks [... and] new social roles, that can provide structure and meaningful activity to their days” (2002: 386), but that these functions instead could be fulfilled by community-based programs by “bring[ing] people together to provide mutual support, engage in collective problem-solving, and learn about local resources” (2002: 386).

Even though children are not the main focus of this thesis and their reactions to and their resilience with regard to traumatic events is surely different from adult's, a number of studies with refugee children reveal interesting results. Some studies were carried out with refugee children who moved to Sweden in the late 1980's and show the improvement of trauma related symptoms over the course of several years time, without any therapeutic intervention or the children working through their trauma (Hjern, 2005). From their academic backgrounds in Child Psychiatry, Clinical sciences and Intercultural Psychology respectively as a basis, Angel, Hjern and Ingleby (2001) conducted research into the effects of war and organized violence on a group of Bosnian refugee children in Sweden. This study found that the majority (70%) of the parents interviewed, tried not to talk with their children about the traumatic events, in order not to remind them of the suffering. These children were doing well and did not suffer any problems from their traumatic experiences (Angel et al., 2001: 11). As Angel et al. notice, this majority of parents thus disregarded the view which is common among western professionals, that talking through trauma is necessary in order to process the experiences and attain mental health.

These findings have, according to Hjern, drastic implications for therapeutic trauma interventions, as “[m]any preventive strategies for refugee children are based on the discourse of traumatic stress and the assumptions that working through trauma has long lasting effects on mental health” (Hjern, 2005: 132). Although talking through seemed to be beneficial for children who had experienced stressors which were comparatively minor, most of the children who's parents did talk with them about the war, had been exposed to more severe incidents and talking about these traumatic events worsened problems. Hjern notices about the aggravation of posttraumatic symptoms as a result of talking about the experiences where an improvement would usually be expected from a western therapeutic point of view, that “[t]hese divergent effects of working through seem to indicate that the effect of a working through program in one context cannot

automatically be translated to a different population with a different cultural discourse for dealing with painful memories” (2005: 130).

Probably more important for refugee children’s mental wellbeing than talking through their traumatic experiences, are socio-economic factors. The positive outcomes for the Bosnian refugee children could, according to Hjern (2005) be explained through the strong system of social support in their refugee community, with strong emphasis on social networks and family ties. Furthermore, social factors such as employment, education, accommodation, were found to highly influence the wellbeing of refugee children. In one research adults who entered Sweden as refugee children from Chile and Iran and Swedish-born adults with two parents from Latin-America were studied for suicide attempts and psychotic disorder. When socio-economic disadvantages were added to the analysis, the higher risk these groups had in comparison to the majority population, decreased or even disappeared completely. Hjern concludes that, in spite of the fact that talking through forms the foundation for many trauma interventions for children, the research presented “rather seems to favor interventions, which target the socio-economic disadvantage of refugee families in the host society with particular focus on the labor market” (Hjern, 2005: 132). In doing so, he distances himself from traditional therapeutic ways of dealing with trauma.

4.3 Effects of Employment

In their research to the relationship between mental health and employment among refugees from Bosnia-Herzegovina, Johansson Blight, Ekblad, Persson and Ekberg (2006) studied the connections between mental health, employment and gender within this group living in two regions in Sweden. Interestingly, whereas Johansson Blight from the Department of Clinical Neuroscience within Psychiatry and Ekblad from Immigrant, Environment and Health at the National Institute for Psychosocial Medicine, both in Stockholm, have a background in medicine and social sciences, Persson and Ekberg add an economic perspective to the study, from their background in Mathematical Science and at the Department of Economics at the Centre of Labour Market Policy Research. In previous research it was found that “[u]nemployment is one of the most frequent resettlement stressors for refugees and immigrants” (Beiser and Hou, in: Johansson Blight et al., 2006: 1697) and that it is “a risk factor for poor mental health, suicide and increased mortality” (Johansson Blight et al., 2006: 1698).

Despite these earlier findings’ focus on the sickening influence of unemployment rather than the healing power of employment, it seems likely to me that, when unemployment is found to be connected to poor mental health, there may as well be a link between employment and psychological wellbeing. Taking into account the underlying assumptions to the study, which are that “poor mental health is a barrier to employment” and that “exclusion from the labour market creates psychosocial stress” (Johansson Blight et al., 2006: 1698), this may be a two-way effect.

For their research Johansson Blight et al. compared a group of Bosnian-Herzegovinian refugees living in an urban area, where employment among the study population was low, and a group living in a rural region, with high employment. They found that, for men, self-assessed unemployment was related with high levels of symptoms of poor mental health. For women however, such a relation was not found. Instead, for them poor mental health seemed to be linked to living in an urban area, irrespective of employment status, and to having worked for a longer period of time. Johansson Blight et al. suggest that an explanation for these differences may be the importance of employment and with it the stigma of being unemployed for men rather than women and, for women, the possibly greater obstacles of living in an urban region, “such as greater gender inequality or lack of social support” (2006: 1705).

4.4 Working Practically: Summary

Although talking through is an often used method of trauma therapy, this approach does not go without criticism. Summerfield (1999) questions the way in which western psychological frameworks and with them the concepts of trauma and posttraumatic stress are imposed on refugees from other cultures, where these concepts may not be suitable, as a result of their different perceptions of mental illness and fear of stigmatization. He further disputes the necessity of trauma treatment for large groups of refugees and the way in which refugees are deprived of their sense of control when this treatment is more or less force upon them by professionals. Finally, Summerfield draws attention to the fact that trauma treatment, by attending to the past, distracts refugees from the present and future they themselves may want to focus on.

This focus on the present and the future is the main argument in Eastmond's account (2005; 2007), who describes the longing for, the importance attached to and the healing power of living a normal life, having a job and be part of a social network in a Bosnian refugee community in Sweden. For these refugees 'normality' and moving on is the chosen way to cope with a traumatic past. Miller et al. (2002) also suggest, based on their research among Bosnian refugees in Chicago, suggest social networks and meaningful daily activities as a means to assist traumatized refugees.

Hjern (2005) describes the negative effects of talking about traumatic experiences on Bosnian refugee children and the tendency of their parents to avoid such talking. Additionally, in their account on refugee children, Hjern (2005) and Angel et al. (2001) clearly show the strong effects that socio-economic factors have on the healing of trauma. When taking these factors into account in a comparison of mental wellbeing between refugee children and the Swedish majority population, the differences between the studied groups and the majority population vanished almost or completely. Finally, a study of Johansson Blight et al. (2006) shows the positive effects of employment on the mental wellbeing of male Bosnian refugees. In conclusion, a number of studies do not only question the appropriateness of talking through traumatic experiences for refugees of different cultures, but in addition show the positive effects of not talking and instead working practically—living a normal life with a job and social networks.

5 PROFESSIONALS' INSIGHTS

To add to the insights gained from theoretical explorations and research reports, I interviewed four women working with traumatized refugees in different settings. Both being psychotherapists and working in a setting where talking through forms the main element of the treatment, Elisabeth Sandén and Elisabeth Axelsson feel strongly about the value and the necessity of talking in order to heal trauma. As a social worker, Catherina Karlsson nuances the importance of a refugee's situation, though still with talking through as a central point. Tina Tyrchan, a general practitioner, puts more emphasis on the wider context and is more critical of the universality of talking through, although she takes the view that ultimately, traumas need to be worked through.

5.1 The Necessity of Talking: A Matter of Time

As previously discussed, despite its general use as trauma therapy in western societies, talking through is for many refugees an unfamiliar manner of dealing with trauma. Tina Tyrchan points out the difficulties many refugees have with talking about their traumatic experiences. Much of their reluctance is shaped by culturally different perceptions of mental illness and healing and unfamiliarity with talking through problems. Feelings of shame and guilt also play a role. The points Tina Tyrchan makes are similar to the ones Summerfield (1999) mentions in his critique on the assumptions behind talking through.

"[F]or the patients who come here, it's often very difficult to really express what they've been through and to want to express what they've been through. I mean, we think, [...] you can talk about everything, you don't have to be ashamed because of things. [...] One of the main problems here is that [...] we at least begin to accept that psychiatric illnesses are normal illnesses as well, but if you come from Arabic [...] or African countries they think you're possessed or you're evil or it's nothing you talk about, it's something you hide from your family. So it's very hard to approach the problem, that there is something that they might need to discuss and that they might need to open up about. Then also there's a problem of the combination of feeling guilty, being maybe guilty of something and then trying to make a clear break, make a new start, hide those feelings" (interview T.T., 2008-08-22).

In addition, she illustrates the fact that talking through as a manner of dealing with trauma, even in western societies where it is now viewed to be necessary to be able to cope, has not always been the norm.

"[S]ome people don't need to talk about everything to the detail, like I said it's just our culture. [...] just to get over things is, and was for like hundreds of years a very good way to [deal with trauma], "Let bygone be bygone", [...] forget what happened [, ...] put a plaster on and go on and raise the children. [...] I've had patients like 80 old women who've never talked about what happened [...] when] the Russians invaded Berlin, but they scream at night when a male nurse comes into their room at the hospital. [...] They've been raped, but they've never talked about it, no one in their family knows, it just breaks out. It's "chique" to talk about things now and it did not use to be, there was no time, there wasn't the place, so it's not even about different cultures, it's just what people feel necessary to survive" (interview T.T., 2008-08-22).

However, talking being a phenomenon of present-day western cultures does not mean that talking through trauma is not important. Although people may try to forget traumatic experiences

and could succeed in that for a shorter or longer period, these traumatic memories are likely to re-appear at some stage and demand attention.

“I don’t think you ever really forget, but I think you can sort of close up and minimize problems to an extent that you need to be able to go on. But, if those problems burst up like a bubble of puss again after maybe some minor insult or whatever happens to you, that’s always like the insecure part. We were trained in university to clear out the past, meaning in this terms that is to talk about everything, to really get to an understanding about this, but for World War II victims it worked 60 years to shut things down, shut things away, get on with life, but as I said most of the times it comes back to haunt you in one place or the other” (interview T.T., 2008-08-22).

In this view Tina Tyrchan is supported by Elisabeth Sandén and Elisabeth Axelsson, who both deem talking, at some point in time, to be necessary to cope with trauma.

“[O]f course even grown-ups who have been exposed for trauma, some are healed without any treatment. [...] But then, there can go five years, there can go more and then they cannot any longer hide their memories or forget their memories. [I]f you ask people coming in they say: ‘We just want to forget’. That is normal. And I think also it’s not professional correct if you would, so to say, if you would stand at the airport; ‘Come now we’re going with trauma therapy’. [...] They believe themselves that if they get a normal life, things will pass and they will forget. And then for some, they have to learn the bad, the difficult lesson that life is getting normal, but [...] they still [have] their nightmares or their bodily tensions or [...] their restlessness or their aggression or whatever the symptoms are. And then they come here and then there have gone maybe five years, even ten years” (interview E.S., 2008-08-12).

5.2 Stages of Talking Through

In line with Herman (1992), who describes that trauma treatment should start with creating a safe and secure environment, which includes both physical safety and a secure, trustworthy therapeutic relationship, Elisabeth Sandén explains the start of therapy.

“[The] first phase in the working is stabilization [..., which] means in the contact as well as if there is much instability and insecurity in their lives. [...] Many are of course unemployed, they have no money, they have money from [the] social welfare office and so on; they’re often very much disturbed by the challenge from daily life. [...] We cannot say: ‘Okay, your situation is too instable, we cannot work with you’ [...] Let’s say, if you are living in a car, you cannot work with your nightmares. [The] first step is to see, can this person have life a bit more stable? And [...] parallel with [...] stabilization, which means looking out of therapy rooms, it’s also the phase where you have to build trust, because people [who come] here, who have been exposed for war, or even those more who have been tortured, be imprisoned and tortured, women and men who been exposed to rape and so on, they are really scared of people. They wouldn’t say it [...] but they show it in different ways and it got to take time until they trust” (interview E.S., 2008-08-12).

Although not familiar with Herman’s work, the elements of therapy described by Elisabeth Axelsson follow the same line. Building a relation of trust between therapist and patient and stabilizing the patient’s emotional experiences are most important in the initial stage of therapy.

Attention for stability and security in the refugee's life situation is not a precondition to be able to start therapy. When a more or less stable foundation is built, the actual working through the trauma begins. Lastly, a stage of mourning completes the therapy. Reconnecting, Herman's final phase, is done in a parallel process during the entire treatment, as described below.

"[T]he first thing to deal with is the fact that [the patient ...] has been traumatized at the hands of other people, which is also true for rape victims of course. Which also means that the first problem, the first and most difficult problem is a sense of trust. [...] So we work with trust a lot and [...] working in the Red Cross gives us an advantage because we're an organization that is generally trustworthy in most places of the world. [...] And that is probably also why it works to come and say hello every time in the waiting room, to be the same people all the time, to be the same faces all the time and they know all of us, [...] none of us are anonymous, which means that no stranger can come up behind you and bash you on the head I suppose. [...] And after trust, [...] we also work with stabilization of anxiety and fear. [...] I work with it very much, by trying to see what techniques this person has used before, previously in life, to stabilize. Whether it's breathing techniques or whether it's singing in the shower or whatever, it doesn't matter what it is. [...] Then we have the actual trauma. [...] What we need to do is break those memories down, make the bits smaller, so that you can think about them intellectually and so that you can also bring up the feeling associated with that bit of it. Because in the end, when you nibble away at it like that and take it from backwards and frontwards and sideways [...], in the end it's become a memory and not an imprint. [...] And then there's also the sorrow side of things. The trauma is one thing and then there's grief. Because I don't think that there is very many people who are here that haven't lost so much. [...] They may have lost their childhood, they may have lost their youth, they may have lost their parents, their children, you name it, their houses, their jobs, their life, as in the life they know. So grief always comes in some time, at some stage" (interview E.A., 2008-09-10).

5.4 Trauma in a Wider Context

That traumatizing experiences are not limited to war, torture, sexual assault or other hardships in their country of origin, but that the circumstances in which many refugees find themselves in the host country can also be traumatizing, is something all interviewees agree on.

"I believe that trauma is not only something [...] like torture or rape or war that happened to you in the country that you came from, the trauma also is that you had to immigrate, that you had to flee to a different country, that you come here and you have nothing whatsoever. You might have good education, you might come from a more or less rich family, but you've lost everything, you start here, everyone looks at you, everyone knows you come from somewhere else, you're an immigrant, you're nothing, [...] that's trauma in itself" (interview T.T., 2008-08-22).

The importance ascribed to the refugee's social and economical circumstances however, differs slightly between the interviewees. For Tina Tyrchan, stabilizing a traumatized refugee's situation is necessary before there is place for therapy and healing of the trauma.

"[E]nvironmental factors are a necessary basis to be strong enough and to be flexible enough, to be willing enough to work on whatever it was what happened. [...] So without the environmental basis there is no use whatsoever in just taking someone out of the situation again and sort of forcing them to speak about this, forcing them to bring it to light, but if you're more or less well settled [...,] if you can

more or less relax, if you know that you have enough money and that also the rest of you family is safe and are taken care of and that you can see a future for your children, then can patients, refugees relax and try to: 'Okay, now it's time to take care of myself, to maybe discover maybe what I need to work on. [... Y]ou can't have this difficult and lengthy psychiatric treatment without having a more or less stable life situation first" (interview T.T., 2008-08-22).

For Elisabeth Axelsson, taking care of those surrounding factors is not a precondition for trauma therapy. Attending to additional problems in a refugee's life, aside from his or her traumatic memories, can be done parallel to the therapeutic intervention, although at some stage during therapy these problems may become so prominent, that they, temporarily, get priority. Ultimately it seems however, that the motivation to deal with such difficulties is largely to prevent them from interfering with the therapy.

"[P]arallel connecting with a new life, [...] a new refugee would need that all the time. Which is also why the social worker [Catherina Karlsson] is quite important. Because there's so many bits and pieces in this trying to make a new life that these people know nothing about. [...] Connecting to ordinary everyday life [...] is] a vital process and a lot of it is quite difficult [...] But we do feel definitely that we make therapy much more efficient if we don't bug it down with all sorts of other difficulties" (interview E.A., 2008-09-10).

As Catherina Karlsson explains, therapy cannot be effective if the patient is worried about all sorts of other difficulties, such as the asylum-seeking procedure, financial problems, the living situation and family issues. In order to optimize the effectiveness of therapy, the traumatized refugee needs to be assisted and supported in these areas.

"You can't speak about what has happened when you were tortured in jail, you can't speak about feelings, about being raped, when you don't get the money from migration board because they say you have failed to do something and you don't understand. You can't talk about it when you think that, this lawyer I have, he hasn't written everything that I told him. And you can't talk about that if you think that my kids who are still back in Iraq with no one to care about them. You can't talk about anything that's doing with the therapy progress" (interview C.K., 2008-09-20).

According to Elisabeth Sandén, for a traumatized refugee to be able to rely on an existing social network and support as well as having other kinds of social contact, such as with colleagues, promotes the recovery of his or her trauma. Being traumatized however, obscures a person's ability to form and hold on to relationships.

"[P]eople who are severely traumatized, they have often difficulties in relationships, they're too burdened to be in the mood for having good relationships with the family. But, if they have family who can support them, that's the best treatment. I can see that as my co-therapists in a way. Because I'm there one hour every week or every second week, but, let's say if it is a woman, if she has a supportive husband, who tries to [...] mentally hold hands and pushes her in a nice way and so on, then my work is so much easier [...]. And also, [...] personal exclusion, people are scared to go out working, seeing other people and that's often a complication. But if they got a supportive family, they can assist in trying and being out and whatever. And of course the same goes if they got a job" (interview E.S., 2008-08-12).



Tina Tyrchan adds to these social contacts in general, the value of having contact with other refugees and more specifically, with people from a similar ethnocultural and religious background. In addition to integration in the host society, such contacts with kindred spirits are vital for refugees' wellbeing.

"[N]ot only as a refugee but also as someone who just moves to a different country, you need things from home, you need to be able to speak your language once in a while, you need to be able to eat stuff from home once in a while" (interview T.T., 2008-08-22).

5.3 Working Practically, Living a Normal Life

Understandably, considering their professional background as psychotherapists, both Elisabeth Sandén and Elisabeth Axelsson do not agree with the literature that proposes not to talk about traumatic experiences, but to build and live a normal life as a way to cope (Angel et al., 2001; Eastmond, 2005; Eastmond, unpublished; Hjern, 2005).

"A lot of our people who come, the refugees who come say: '[... H]elp me forget about it'. I said: 'Sorry, but I can't do that. There's no way you could ever forget what happened. All we can do is try and change the way the memory affects you' " (interview E.A., 2008-09-10).

As previously mentioned, Elisabeth Sandén and Elisabeth Axelsson, as well as Tina Tyrchan, feel that, even if a traumatized person moves on with his or her life, there will come a certain point where trauma memories become a problem again and the only way to really deal with those memories, is to talk through the trauma. There is however an aspect of time involved here, in the sense that traumatic experiences can be pushed away for a period of time, until they resurface and in the end have to be dealt with.

Although Tina Tyrchan, as stated before, does not feel that talking through is appropriate for refugees from all cultures and she is impressed by the human capacity to overcome adversity and move on with life, she is equally puzzled about the point in time that a traumatized person can no longer keep his traumatic memories at bay.

"I've seen traumatized people in a lot of different places, I've been to Nepal where they had [...] Tibetan refugees or in Africa and it always amazes me how well [...] people can cope with really drastic and dramatic life changes or injuries or hurts, be it psycho hurts or real bodily harm, this amazes me. It's incredible what a human can bear and how they can start again. And then it amazes me why and when they break down" (interview T.T., 2008-08-22).

5.5 Other Focus Points

In addition to their opinions on the three perspectives, the interviewees mentioned some interesting factors of which no notice is made in the literature used. For example, all interviewees refer to the importance of connecting with and acknowledging the body. Bodily awareness, relaxation techniques and physical activities are a part of both the reality of the different work places and of the ideal depictions sketched in the subsequent section.

"[I]t's more excepted [to talk] about stomach ache and also they got pain in their body. [...] Anxiety can be expressed by heart pain or difficulties in breathing. We know that if you got a panic attack you may feel as if you can't get any air. So, in one

way, it is the body who talks, but the reason is of course the mental illness. [...]he physiotherapist [...] can be important [in that case] because she can be with a patient, learning different coping strategies of relaxation or better getting to know the body and the body functions and so on" (interview E.S., 2008-08-12).

"[For] most of the people she [the physiotherapist] meets it has to do with all the tension that builds up, particularly from the asylum-seeking process or living without papers, it's a very, very, very tense life. [...] Sometimes physical work, physical treatment can help emotional growth as well, or can help emotions to come out [...] The physiotherapist works a lot with tension; she works very much with the capacity to feel your own body's reaction, [...] bodily awareness, which is something that very, very, very, many refugees lack, completely. [...] And] also tension relief, the goal is to give the patient their own arsenal of methods to use for themselves" (interview E.A., 2008-09-10).

Consciousness of the diversity in perceptions of illness and healing among different cultures and physiological ways of expressing psychological problems lies at the basis of this attention for the body. However, the consideration for this cultural difference seems not to be in line with the way in which both Elisabeth Sandén and Elisabeth Axelsson hold on to the value of talking through, despite this being a way of expressing distress that is unfamiliar for many refugees.

A factor that as mentioned by Elisabeth Sandén as being important to be aware of, is the complexity and intensity of traumas that refugees often have suffered.

"[I]f you compare with local people, they may have a single trauma, they might be out for a robbery, for a rape, for a car accident or whatever. [...] It is very, very different from the refugees. They may not just have a number of traumas, but different kinds of trauma. [...] Living in the war means that different kind of trauma. You may see your child half starving, you may have been exposed to death, you can understand, different kind. And then we can see that there [...] is a] certain smaller group [of refugees who] have been very difficult in healing, they have [been] working for quite a long time and can understand sometime that it's also [...] childhood trauma, maybe father beating or whatever. [...] It means that they are much more vulnerable since childhood and then that comes on top of the trauma from let's say war or torture. [...] And also], torture, [...] there is] always a human being behind [that], which is much more complicated than if it is nature, even if you can say that we are destroying our earth and so on but it's not so clear, it's not really a man, a human being behind it" (interview E.S., 2008-08-12).

In addition, Elisabeth Axelsson mentions the culturally different impact of trauma.

"[Refugees from different cultures ...] have different [...] temperatures of trauma; [...] the cultural factors have different consequences depending on what they've experienced. But that is knowledge, [...] that is knowing what faces the raped woman from Kosovo for example, she will be shunned by the entire family and the man will take her kids and go. [...] That is simply a consequence of being raped in Kosovo. It is not necessarily a consequence, it's definitely not a consequence of being raped in Somalia. [...] It's not the same thing." (interview E.A., 2008-09-10).

5.6 Unlimited Imagining

As a final question, three of the experts who were interviewed were asked to describe which elements an ideal treatment for refugees should contain—to imagine, not restricted by funds, staff or time. This question gave rise to passionate visions and extensive fantasies.

Elisabeth Sandén's initial reaction to my invitation to fantasize freely was one of appreciation.

"[T]hat is something what I ask people: 'If you could dream anything, what would you like then?'. Because people have finished [...] dreaming [and ...] having any goals because they're so depressed. And that means that, if you don't even dare to dream, you cannot start living. So I like your question. You have to have goals and wishes and dreams, I think that is important" (interview E.S., 2008-08-12).

For ideal treatment Elisabeth Sandén would want there to be a physical place, where traumatized refugees can meet each other. In addition to the psychotherapy, this place should give people the possibility to carry out various practical activities, because *"certainly not everyone can or wants to talk, [...] some people need to be active in a practical job"* (interview E.S., 2008-08-12). In this center refugees should get support in finding a job and a decent place to live. Moreover, physiotherapy should be further build upon, in the form of physical group activities, such as walking groups. Finally, Elisabeth Sandén would like to be able to work more with families of traumatized refugees, besides working with individual patients.

Special attention should be paid to male traumatized refugees, especially for men who have difficulties talking about their traumatic experiences. While activities often focus on women, partly because the helping professions are dominated by female staff and it is therefore easier to develop activities for women, activities for men should be expanded. Although women should of course not be forgotten, Elisabeth Sandén believes that by putting energy in men, to restore the confidence they have lost and to put energy in making their life better, will improve life for the women as well.

When reflecting on an ideal center for treatment of traumatized refugees, Elisabeth Axelsson is of the opinion that psychotherapy should be combined with facilities to address both physical and socio-economical issues and services to make everyday life a bit more pleasant, expanding the already existing concept of the Red Cross center. The center will be a place for both refugees with a residence permit and those who are still waiting for a decision or who have been denied the right to stay in the country.

A perfect center would be one place where all aspects of life are taken care off. Elisabeth Axelsson would like to see more group therapy to be utilized for the purpose of psycho education and psychotherapy. A warm pool that is adjacent to the center will be the place for physical group therapy under supervision of the physiotherapist. The use of expressive forms of therapy, such as art and music therapy, should be further developed.

Moreover, the center should be a center where refugees can develop themselves and pursue their interests. Someone who functions as a mediator to the labor would help patients to find a job or a practice placement, based on their abilities. A creative center, with among other things fabric, clay and paint, will be a place where refugees can freely express themselves artistically. In a learning center, refugees should be able to study anything they wanted, in an effort not only to develop themselves, but also to educate themselves for voluntary work or the labor market.

Finally, to increase interpersonal contact, with both other refugees and citizens of the host country, and to make life somewhat easier and enjoyable would be an important objective of the center. More volunteer workers could play a role, in organizing trips for example. Also a play center for children would both release parents and give them and their children a possibility to have contact with other people. Although most of these elements can be found in society already, gathering them



in one place specialized and professional place would contribute to creating clarity and emotional security and to simplifying a refugee's life which is already complex in itself.

From her perspective as a general practitioner Tina Tyrchan argues that for each refugee or refugee family, there should ideally be one or two case managers, who are there from the first moment to help stabilizing the migration process and assist the refugee in organizing his or her new life. These case managers could be the ones the refugee can turn to when he feels unsafe or concerned about anything, but also function as contact persons for other professions, such as medical staff, who come in contact with the refugee in question and who need additional information.

6 AN ECOLOGICAL PERSPECTIVE ON THE MIGRATION PROCESS

Based on the previous discussions, it seems relevant to focus more on a perspective that can encompass both the therapeutic and the access to normal life perspectives. A broader process oriented perspective on migration focuses on the refugee and his wellbeing as surrounded and affected by structures and factors in his social and economical environment. While some research shows these factors contribute to the general wellbeing, other studies investigate their potentially traumatizing as well as protective qualities.

6.1 Ecological Approach

A perspective that includes attention for the individual as well as, and in relationship to, the broader social, cultural and economical environments he or she is a part of, forms the basis for my education. Respect for a person's autonomy and choices are highly esteemed values. In addition, much worth is attached to working from a positive viewpoint, taking a person's and his or her systems' strengths as a starting point and further developing these strengths (e.g. de Bie et al., 1997; Ebskamp and Kroon, 1997; Kloppenburg and Heemelaar, 1999). From this background, in general, but also more specifically in the case of traumatized refugees, to dismiss either the value of talking through, oriented towards the individual, or the importance of living a normal life, appears impossible and does no justice to the complexity of the circumstances in which traumatized refugees find themselves. Therefore, a more holistic approach to the wellbeing of traumatized refugees seems suitable.

Several authors have written about traumatized refugees and trauma treatment from such a holistic point of view. For instance, Adamson (2005) suggests an ecological perspective on trauma practice, which proposes a holistic and eclectic approach to the traumatized person and his or her environment, utilizing not one specific theory or methodology, but a combination of several, and concentrating on both physical and behavioral aspects of trauma and the broader social, cultural and spiritual consequences of the trauma. Extending on a systems perspective, in an ecological perspective there is not merely attention for the different systems, but on the relationships between and different perspectives and perceptions of these compartments. According to Payne (2005), central to the ecological perspective are "connections between and resources of families and groups and their effective functioning, rather than, as with health work or counselling, seeing the family as helping or hindering the function of improving the health or well-being of the individual patient" (2005: 143).

As Adamson points out, "[c]ontrary to the assumption that intervention with trauma should always start with healing the trauma, attention to the environmental context is in many cases as, or more, appropriate" (2005: 68). When working with traumatized refugees from an ecological perspective, there is recognition for the fact that a person's environment plays an important role in both creating trauma and recovering from it, as well as for trauma's impact being holistic, rather than merely or mainly of psychological nature. Payne adds to this, that instead of rejecting psychological theories, the ecological perspective enables their merging in its broader structure.

Adamson (2005) is of the opinion that making use of the strengths of an individual's networks and relationships should be a central part in working with a traumatized person. While addressing a traumatized person's social, cultural and spiritual needs, there should also be attention for and use made of the strengths of the wider ecological systems from which these needs originate and which play a role in fulfilling those needs. In addition, Payne emphasizes the positive approach in working from an ecological perspective, with regard to focusing on the possibilities and strengths in individuals and the systems they are part of.

In essence, the ecological perspective has been proposed to be a logical and valuable foundation for working with traumatized refugees because its "understanding of the importance of context, of building social support, resource bases and networking, suggests that any intervention

that focuses explicitly on trauma memories and post-traumatic impact must be based soundly on the establishment of supportive environments and therapeutic safety” (Adamson, 2005: 71).

6.2 Perspectives on Post-Migration Adaptation and Wellbeing

Ryan, Dooley and Benson (2008) explored three theoretical perspectives on post-migration adaptation and psychological well-being. Their work includes the ‘stress model’, the ‘acculturation framework’ and the ‘conservation of resources theory’. Research conducted by Ryan as part of his PhD in Psychology at the University College in Dublin and supervised by Dooley and Benson, forms the bases for their exploration. In the stress model, an individual’s ability to make sense of his or her environment and individual coping responses are the focus of attention. This model however omits more objective and external factors, such as the uneven distribution of resources and social demands, that may affect a person’s coping capacity.

To the stress model’s focus on an individual’s understanding of his environment and his coping mechanisms, the acculturation framework adds a dimension of the demands of and stress cause by contact with and integration in a new culture. However, Ryan et al. argue that the demands of intercultural contact are only part of a wider range of stressors that migrants face as a result of their relocation, which is a stressful event in itself. By describing the difficulties faced as “acculturative stress” (Ryan et al., 2008: 5), the acculturation framework does not take into account that problematic factors such as unemployment, family separation and living conditions are demanding to all humans, irrespective of ethnocultural background.

Central in the conservation of resources theory is the conception that “individuals strive to obtain, retain, protect and foster things that they value” (Hobfoll, in: Ryan et al., 2008: 5). By leaving their countries of origin, their possessions, (part of) their social network and all that is familiar to them, migrants partially give up their resources, in order to secure others, such as personal safety and avoiding the negative aspects in the environment that they left. It would thus be too simple to say that an individual’s only interest is to obtain and maintain resources, since by leaving everything behind, migrants give up a number of resources. Together with unaccompanied minors, elderly people, single mothers and people from culturally distant societies, Ryan et al. describe migrants who have experienced torture or severe trauma to be the group within the migrant population which has fewer resources compared to other migrants, is most vulnerable to resource loss and may have greater difficulty in accessing new resources.

Ryan et al. criticize these three theoretical models for their one-sided representation of the issues that influence migrants’ psychological well-being and suggest incorporating them into a resource-based model of migrant-adaptation, in which personal, material, social and cultural resources merge with a migrant’s needs, goals and demands.

6.3 Refugee Wellbeing from an Ecological Perspective

Much research has been done investigating the way in which socio-economic factors in traumatized refugees’ life situations affect their feeling of wellbeing and what deteriorating or protective effect these factors have in relation to posttraumatic stress symptoms. Several authors mention the further traumatizing effects of social, economic and cultural factors that refugees face in the country where they resettle, in addition to the trauma caused by events and experiences in the country of origin and during their flight. Unfamiliarity with the host country, the different culture and language (Miller, in: Ager et al., 2002) and the uncertainty of being a refugee and the legalization processes associated with that, are such factors (Michultka et al., 1998). Furthermore, the vanishing of the life that refugee had before fleeing his or her country, with that the loss of social networks, “social and occupational roles, [...] material and financial resources” (Miller, in: Ager et al, 2002: 72) and the absence of life goals and the possibility to utilize personal skills and knowledge in which this

often results (Ryan et al., 2008), are considered to have a negative impact on refugees' general wellbeing. Unfortunately, the importance of attention for these personal, social and cultural losses and changes is frequently neglected in working with refugees (Derges and Henderson, 2003).

In contradiction to studies showing the harmful effects of such factors, others have focused on the protective qualities they may contain. For refugee children, not only personal characteristics and the perception of a traumatic event, but also the social factor of a relationship with and presence of a parent or other significant caregiver, were found to affect their ability to handle traumatic experiences (Loughry and Eyber, 2003). This positive influence of social relations on people's capacity to deal with traumatic experiences, was found as well in a comparison of a number of studies on posttraumatic stress disorder and depressive symptoms, caused by different incidents, ranging from combat and exile to sexual assault and breast cancer (Guay et al., 2006). However, Guay et al. also discovered that negative social interactions had a stronger effect on posttraumatic stress than positive social support.

Nevertheless, social networks and social support within families, clans and tribes are in the native countries and cultures of many an important safety net with regard to coping with difficult circumstances (Briant and Kennedy, 2004). Although fleeing their country entails either a severe cut in or a complete loss of these traditionally essential safety nets for the majority of refugees, rebuilding social networks to re-create a feeling of belonging, of contributing to the society and of building a safe future are found to be crucial for a feeling of wellbeing and to be able to cope with a traumatic past (Ghorashi, 2007). In addition to social contacts and moral support, practical assistance and meaningful daily activities are deemed to be important by refugees themselves (Ager et al., 2002; Derges and Henderson, 2003; Hampshire and Porter, 2006). Actively involving already settled migrants, as well as autochthonous members of the community in which traumatized refugees are resettled, is a way to support refugees in the process of both re-establishing their social networks, building a new life and improving their mental wellbeing (Ager et al., 2002; Nash, 2005).

As Derges and Henderson point out, "it is [...] not sufficient to address only past traumas, as significant as these are. Time must also be given to the rebuilding of lives that includes an active engagement in the past, present and the future" (2003: 97). Given the manner in which numerous aspects are found to affect a traumatized refugee's life, his or her feeling of wellbeing and the intensity of posttraumatic symptoms, it seems indeed necessary to pay attention to these factors and approach a traumatized refugee within his wider social, economical and cultural systems.

6.4 An Ecological Perspective: Summary

To make a choice between the 'talking through' perspective and the 'working practically' viewpoint appears not to do justice to the complexity of being a traumatized refugee. Working with traumatized refugees from an ecological perspective, as described by Adamson (2005) and Payne (2005), focuses, in addition to the physical and behavioral aspects of trauma, on the broader social, cultural and spiritual consequences. Rather than to start with healing the trauma, Adamson suggests to first deal with the refugee's environment. Ryan et al. (2008) recommend, based on comparing three perspectives of post-migration adaptation and wellbeing, a holistic model where a migrant's personal, material, social and cultural resources with the needs, goals and demands which arise from both within the person and as a result of the migration process.

Ryan et al. (2008), Hampshire and Porter (2006), Derges and Henderson (2003) and Eisenbruch et al. (2004) all notice the importance of looking at traumatized refugees in a broader context. Other authors identified the traumatizing effects of factors in the refugee's new environment (Ager et al. 2002; Miller in: Ager et al., 2002; Michultka et al. 1998). Guay et al. (2006) found social support to be a protective factor for the occurrence of posttraumatic stress. To see the process of post-migration adaptation and increasing refugees' mental wellbeing from an ecological perspective implies to make use of and to reinforce these social networks and to have attention for the influence of factors in and from wider social, cultural and spiritual contexts.

7 BETWEEN THERAPY AND ECOLOGY: ANALYSIS AND DISCUSSION

Writing this thesis has been a journey with the aim to answer the research questions posed at its outset. Working with traumatized refugees is working with people who are all unique in their perceptions, experiences and wishes, which implies that it is impossible to find one final answer. However, this is my attempt. Although the principal part of the first three research questions is already dealt with in the previous chapters, for the purpose of completeness, I will repeat all questions here.

- Which are the underlying ideas and the effectiveness of the “talking through” approach in working with traumatized refugees?
- Which are other possible approaches in working with traumatized refugees?
- What other factors are of influence in helping refugees to cope with and process their traumas?
- Which combination of approaches and influential factors seems appropriate in helping refugees to cope with and process their traumas?

Both in the literature and as said by the professionals I interviewed, talking through is highly valued as a method of treating trauma. Working through traumatic experiences as a way of dealing with distress is criticized as a method that is not used in many of the countries and cultures where traumatized refugees originate from. However, the effectiveness, even with refugees who are unfamiliar with the concept and initially reluctant, has been shown in several studies and is confirmed through the experiences of professionals who work with traumatized refugees on a daily basis. The fact that three out of four interviewees work in an environment where talking through is the main treatment for traumatized refugees does not necessarily make them prejudiced with regard to the effectiveness of talking through, it merely gives them the opportunity to be witness of this effectiveness on a regular basis.

Nevertheless, looking deeper into the experiences of the interviewees compels me to make two, very important, comments in connection with the necessity of talking through trauma. Firstly, the traumatized refugees treated in either of the therapy centers, generally come to the center after being referred by for example a general practitioner, a community refugee worker or a teacher from Swedish language class. These referrals are made based on symptoms a refugee experiences or complaints he or she has, which suggests that he or she is not feeling well and wants to deal with the experienced problem in one way or the other.

Secondly, as indicated by three interviewees, there is a time aspect connected to trauma related problems. Although trauma may not heal just over time, people can manage to live and feel reasonably well without trauma therapy, by trying to forget about traumatic events, for a longer or shorter period of time. However, the memories of traumatic experiences will almost surely resurface and along with it will the posttraumatic symptoms. While trauma therapy may seem to be necessary at the moment that the traumatic memories reappear, trauma treatment should only begin when the traumatized refugee experiences the need for it.

The same aspect of time plays a role when looking at the argument of the advocates of working practically, when they state that the refugees in the study are doing well, without undergoing any trauma therapy. Although the refugees were found to be capable of coping with their traumatic experiences at the time of the study, the conviction the interviewees have that it is possible to suppress traumatic memories, but that they will recur at some point in time, puts forward the possibility that their ability to cope and maintain a feeling of wellbeing is just of temporary nature. In addition, when relating to Eastmond’s studies, it may very well be possible that the reception of specially trained professionals that on the two groups of Bosnian refugees arriving in Sweden got, would have turned out to have a more positive effect if the circumstances for that group had been different or if the professionals had been deployed at a different point in time.



An important message put forward by the different studies on working practically however, lies in the positive consequences of living a normal life, with the job and the social networks that are part of that. In addition to a normal life being what many refugees themselves wish for when they flee their country and the possibility to regain some sense of control and autonomy building that normality encompasses, several studies show the capacity of social, economical, organizational, cultural and spiritual factors to affect refugees' lives and their feeling of wellbeing in a positive way.

Looking at 'talking through' and 'working practically' and the strengths and comments of both approaches, it seems to me that both contain valuable elements which have the power to contribute enabling traumatized refugees to live with, cope with and possibly heal their trauma. Choosing one over the other would imply the loss of valuable resources. To incorporate talking an ecological perspective however, makes it possible to see a traumatized refugee as an individual within broader contexts and in relation to other people and to care for all those parts, when the refugee needs it.

Finally returning to the Liberian refugees in the settlement in Gomoa Buduburam, Ghana, for many of normal life as they have known it for the past years seems to be about to drastically change once again. After a few weeks of nonviolent protests on the camp's football field, high demands that will not be granted and not obeying orders to leave the side of the demonstration, the Ghanaian government has asked the Liberians to return home to Liberia. Dreams, goals and expectations will be adjusted once more and again, people will to re-build their lives in a new place, as they have done over the course of several years in Ghana. Normal life will re-begin or maybe just continue somewhere else. And it is very well possible that nobody will ask these refugees what to do with their traumas...

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