Working with bereaved asylum-seekers and refugees

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Editor's note: Asylum-seekers are often unwanted in their own countries and in the new. Sadly, that neglect may extend to those who should be providing them with help at times of great need. This important paper will be of value to all those working to help asylum-seekers and to the many professional and voluntary bereavement workers who would like to, but don't know how. **CMP**

Abstract: Asylum-seekers and refugees have usually sustained multiple losses by the time they arrive in the host country – their homeland, personal possessions, their occupation and traditional way of life. Many are fleeing persecution and death as a result of their ethnicity or religious beliefs. War or civil unrest may have led to the murders of their families. In many cases these atrocities have been witnessed by the refugee, leading to complicated bereavements. Survivor guilt may make it difficult for the person to move forward. In order to help this client group, bereavement counsellors need to familiarise themselves with the belief systems and mourning rituals of people from a wide range of cultures, as well as the features of traumatic bereavement and the new skills of working with an interpreter. This paper offers an introduction to this complex work, drawing on the literature and composite examples from the author's therapeutic work.

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Asylum-seekers by definition are fleeing persecution in their homeland and are seeking refugee status under Article 1 of the 1951 United Nations Refugee Convention (UNHCR, 1951). This provides the following definition of a refugee:

> 'People who, because of a well-founded fear of persecution, for reasons of race, religion, nationality, membership of a particular social group or political opinion, leave their country of origin and are unable or unwilling to avail themselves of the protection of that country.'

Often asylum-seekers love their own countries and families but their lives have been threatened, leaving them no alternative but to flee. Life in the host country brings a welcome sense of relative safety tempered by an overwhelming sense of loss. Eisenbruch (1991) developed the term 'cultural bereavement' to encompass what he summarised as:

> 'the experience of the uprooted person – or group – resulting from loss of social structures, cultural values and self identity: the person – or group – continues to live in the past, is visited by supernatural forces from the past while asleep or awake, suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade, but finds constant images of the past (including traumatic images) intruding into daily life, yearns to complete obligations to the dead, and feels stricken by anxieties, morbid thoughts and anger that mar the ability to get on with daily life.'

It is helpful to remember that many asylum-seeking clients come from societies that may be described as interdependent, in contrast to the more independent cultures normally associated with western, industrialised nations. In an interdependent culture the person's frame of reference is always the family or the wider social group. To lose the family or group is, in many ways, to lose a fundamental sense of self.

Cultural bereavement, therefore, forms the backdrop to any more focused bereavement work that may be carried out to explore the loss of members of the family through traumatic events.

The person who is an asylum-seeker in the UK will concurrently be managing the many constraints that are inherent in this role: forced dispersal to accommodation across the country, prohibition on working, limited financial resources, restricted educational opportunities, and the public's

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generally negative and misinformed perception of them. Asylum-seekers throughout the world face similar issues. The asylum-seeker is in a state of limbo, which in some cases can last for years. People frequently say that they feel they are in prison or are losing themselves (Douglas, 2010).

On gaining refugee status there is often an initial sense of joy, followed by the harsh realities of carving out a role in a new country and dealing with the complexities of securing employment and finding suitable accommodation. Invariably this means starting at the beginning again, which can be experienced as deeply humiliating. One client described feeling like a new-born baby; another how literally he had to learn the alphabet again.

The complex nature of the losses

Traumatic losses

Clients may have witnessed the brutal murder of their parents, siblings, children or friends. Horrific images of mutilated bodies will continue to haunt them as they attempt to start a new life in the host country. The literature suggests that, if a loved one's death is complicated by traumatic features, often these elements may require processing (Raphael, 1983) before the person can proceed to more usual mourning work. Many people will not have had the opportunity to bury their dead and conduct their own mourning rituals. This can lead to an extreme sense of guilt and unfinished business. In Amharic, 'illness' (*beshita*) literally means 'not having put things in order with the ancestors' (Losi, 2006, p27).

Personal experiences of torture and rape

Personal experience of torture and/or rape may have led to a sense of losing the person they were before. For example, in some cultures women who have been raped say: 'I have lost my honour.' This is a profound loss of perceived status in their culture, impacting not only on the woman but on her husband, family and extended family too.

Survivor guilt

The person who survives where others have died often feels guilt. For some asylum-seekers, the others' deaths seem clearly linked to their own behaviour (for example, marrying someone from the 'wrong' ethnic group or involvement in prohibited political activities).

Asylum-seekers need a sense of safety in their lives and in the therapeutic relationship before the remembering and mourning work can begin. Photo © puravidaphotos@yahoo.com

Thomas was involved in a banned independent political party in a totalitarian state. His and his wife's lives were threatened on a number of occasions so they fled with their children to a safe country. Some time later he found out that his parents had been murdered by government forces looking for him. Thomas presented to his therapist in a distraught state, repeating: 'I murdered my parents, I am the reason they were killed.'

Lifton (1983) draws a distinction between 'animating' guilt and 'static' guilt. Animating guilt allows the person the possibility of eventually psychologically moving on from the event. Static guilt, by contrast, keeps the survivor bound to the experience, unable to move on.

Thomas attended therapy for over a year and, in time, was able to see that he had not wished for the death of his parents and that a corrupt government was responsible. One day he came in and said that he had dreamt that he was at his mother's grave, weeping, and she told him it was time to change out of his mourning clothes. This dream marked a change in his therapy.

Parents may have paid agents to help their children and young people to escape danger but later may have been killed themselves. These young people may feel they do not deserve to live and wish only to kill themselves so they can be with their dead parents. Their natural attachment is to their family and they need help in therapy to remember their parents' aspiration was that they would have a new life in a safe country.

Peter (17) required several years of psychotherapy and drug treatment for his significant depression in order to recover from the traumatic events in his own land, including the murder of his father. One day he announced in his therapy session: 'I need to stand now and be a man.' He was ready to allow himself to take responsibilities and move towards life rather than death. When asked how therapy had helped him he said: 'My heart is stronger now.'

Missing relatives and friends

When, for example, a village is raided, people scatter and hide or flee. In this confusion people may lose contact with their relatives and then not know if they are alive or dead. Likewise, if a number of people have been detained – for example, after a political demonstration – and one has managed to escape, he/she may not know the fate of their friends. To enquire about them may be impossible as this would mean approaching the authorities, compromising the survivor's own safety. Mourning in such circumstances is also complex.

The Red Cross Family Tracing service provides a valuable function in trying to find people's lost loved ones. Some people, however, feel that no news is preferable to bad news. This can leave the person in an intolerable psychic state. As Preitler (2009) outlined, when a person is coping with the fact that a relative or friend is missing, should their emotion be hope or despair? She cautions against attempts to prescribe how the person should manage such an intolerable situation; rather, we should respect the ways they have chosen.

A cross-cultural perspective

Grief is expressed in many different ways around the world and the rituals surrounding death and mourning are varied (Eisenbruch, 1984). What is an appropriate expression of grief differs widely across cultures. In a helpful review Rosenblatt (2008) cautions us that 'no knowledge about grief is culture-free'. For example, some cultures permit or encourage the open expression of anger in bereavement, whereas in other cultures anger is suppressed (Rosenblatt, 1993). The bereavement therapist thus must be familiar not only with the teachings of a range of religions on death and the after-life, but also with how these beliefs are observed in different cultures, and how grief might typically be expressed. For example, Aboriginal people do not consider it appropriate to mention the name of the dead person, or to ask directly about them (Raphael, Delaney & Bonner, 2007). Although background reading will be important, the bereavement therapist can also sensitively ask the client: 'In your culture what happens (practically) after a person dies?' The client can then educate the therapist about his/her own culture, religion and rituals.

The person's faith may have been shaken or strengthened by the traumatic experiences they have survived. If it is acceptable to the client, it is important to gain some kind of understanding of this process. It is also important to bear in mind that, even within one culture and religious group, there may be many cultural variations.

A Moslem asylum-seeker from Iran told me that she was afraid her house was haunted. I asked her if she thought it was haunted by the Jinn (spirits that can be evil). She replied: 'Oh, only village people believe in the Jinn!'

If a person has been unable to carry out their required mourning rituals they can feel very distressed. Schreiber (1995) illustrates this point with a poignant case study of an Ethiopian woman whose distress related to her inability to carry out prescribed purification rituals for her baby, who had died during her flight from Ethiopia to Israel.

It may be impossible in the host country to replicate the mourning rituals of home. As mentioned above, usually the loved one has died traumatically in their homeland or is missing, feared dead. Having reached as full an understanding as possible of what might have happened at home, it may be possible to work with the client to find some kind of acceptable ritual in the host country. Zwart and Nieuwenhuis (1998) describe the use of a number of mourning rituals that were constructed in the therapeutic setting between a young man from West Africa and his therapists to mark the anniversary

of the murder of his family. Catholic clients may welcome the suggestion of holding a mass to remember the dead relative.

Bereavement work

Therapists will probably wish to work from their usual theoretical framework, be it psychodynamic, person-centred, cognitive-behavioural, integrative or other, and adapt their approach to take into account the factors mentioned above. Several other theoretical concepts or approaches may also be useful.

Judith Herman (1992), an American psychiatrist and trauma specialist, outlines a helpful framework to guide therapeutic work with all survivors of complex trauma. Given that asylum-seekers and refugees have often survived years of oppression, they fit well into her framework. She highlights the fact that survivors of prolonged experiences of trauma have many features in common: for example, loss of trust in others, feeling helpless and isolated. Likewise, she suggests that the healing process has common characteristics. She talks of three stages: establishing safety, remembrance and mourning, and reconnection.

It is essential to ensure that the client has some sense of safety in their lives (ie. they are not at the end of their asylum claim and in danger of being deported) before the remembering and mourning work begins. It is also important that some sense of safety has been established in the therapeutic relationship before the person expresses their most distressing memories. Sometimes the client fears forming a new attachment, feeling that everyone s/he gets close to might die. Establishing trust takes time. The client often has the need for someone to bear witness to what s/he has survived and the circumstances surrounding the death(s) of his/her family. It is helpful for clients to tell us about their family, where they lived and the lives they led, before the traumatic events occurred. Often the client will have no one to whom s/he can speak about his/her relatives and reminisce. If the therapist has built up a mental picture of the client's home, family, and the characteristics of their parents and siblings, it will allow the client the opportunity to 'visit' his/her family in the therapy session.

For the person preoccupied by horrific details of what they have witnessed and experienced (in daytime through re-experiencing, flashbacks and intrusive thoughts, and at night in sleep disrupted by nightmares), there is usually the need, in time, to talk frankly about those details. This is the remembrance and mourning stage, which can facilitate cognitive and emotional processing of the grief-laden memories. The reconnection phase is when people feel able to make new connections with other people and their new country. This is, of course, more possible when the person has been granted refugee status and knows that they can stay. For the person preoccupied by survivor guilt, getting on with their new life itself is very difficult. If the traumatic features of the events have been worked through, cognitive therapy can be used to challenge dysfunctional beliefs.

Narrative therapy, an approach developed by Michael White (1989), David Epstein and others, can also be helpful in working with clients who are bereaved. Payne (2006) has written a useful introduction to this work for counsellors. Narrative therapy developed from systemic family therapy. It focuses on the stories or narratives that people tell themselves and others about their lives. It suggests that the way people construe these narratives can often limit their ability to be aware of other ways of looking at their lives and difficulties. It also encourages workers to be aware of some of the limits placed on their practices by professional stories/discourses of grieving. Thus, for example, the common metaphor of needing to 'say goodbye' can limit ways in which conversations can be heard about people's ongoing relationship with the person who has died (White, 1989). Narrative therapy encourages people to become aware of other possibilities. So, for example, an asylum-seeker who wishes to kill him/herself because they feel responsible for the fact their parents were murdered may be asked: 'What would your parents wish for you if they were alive?' or 'How might you honour the memory of your parents?'

Working with an interpreter

Working with an interpreter is often an essential part of therapeutic work with asylum-seekers and refugees. This may be unfamiliar to the therapist who is used to the intimate and confidential traditional therapy setting. It is, however, necessary for the distressed asylum-seeking client who wishes to communicate his painful story. Developing the skills necessary to work with an interpreter takes time. Tribe and Raval's (2003) book provides a useful introduction to the area. It is essential to put some thought into the choice of the interpreter in terms of issues such as gender, religion and language chosen (where the client speaks more than one). The interpreter may have suffered similar losses to the client and the therapeutic process can stir up pain for them as well. This is heightened by the good practice requirement that the interpreter use the first person when interpreting. To interpret 'then *my* mother was murdered' can be distressing for the interpreter, who may show his/her upset.

It is helpful if the therapist can meet the interpreter before the session begins, to brief them on the nature of the interview and what is likely to be discussed. This gives the interpreter the opportunity to prepare themselves for potentially distressing topics. If client and interpreter come from the same culture, the possibility of over-identification and over-involvement are a risk. Some interpreters may need help to keep their professional boundaries when they feel a strong pull to get involved in a more practical and personal way with the distressed client – by, for example, giving the client their own home phone number or meeting them outside the sessions. The danger is then that the interpreter feels overwhelmed by the demands on his/her time and withdraws from the client and the work. It is good practice to spend a little time debriefing the interpreter at the end of the

session and checking that they are not feeling too upset about the session. If necessary, it may be helpful to reassure them that they are not personally responsible for the client's distress and that they can leave those issues for the therapist to manage.

Impact on the counsellor

It is not only the interpreter who is in danger of being overwhelmed by this work. Even skilled therapists can feel unprepared for the scale and the extent of the horror experienced and expressed by a survivor of major trauma, such as genocide or torture.

The therapist should be alert to how the client is making him/her feel both during the session and afterwards. If the therapist works with too many clients with multiple traumatic bereavements, he/she may begin to experience symptoms of vicarious traumatisation (McCann & Pearlman, 1990). This means that the therapist may start to have nightmares relating to the client's traumatic material, intrusive thoughts and a wish to withdraw from others. It may also affect the therapist's attitudes, as Herman (1992, p141) has written: 'Repeated exposure to stories of human rapacity and cruelty inevitably challenges the therapist's basic faith.'

There are a number of ways in which the therapist can protect him/herself against vicarious traumatisation. Regular supervision is crucial, as is limiting the number of clients seen with histories of traumatic bereavement. Ensuring that work and life are well balanced is also vital. It is also essential to stick to the boundaries of the therapist's role. The isolated client will frequently try to put the therapist in the place of the missing relative(s). They may say to the therapist: 'You are my mother now' or 'You are my family now'. The therapist can acknowledge how important the therapeutic relationship feels – saying, for example, 'It's *as if* I am part of your family' while sensitively reminding the client that the professional relationship has its limits. At the right time, however, if the client is interested, the therapist can put them in touch with local asylum-seeker/refugee or indigenous groups, which may begin to form some kind of supportive network.

Working with other colleagues

Asylum-seekers and refugees often have mental health problems, including depression, anxiety and post-traumatic stress disorders. Some of these problems may have developed in response to the traumatic events that led to their flight. Other difficulties are a more direct result of stresses in the host country and the asylum-seeking process. Non-medically trained therapists may need to refer clients to their GP or to a psychiatrist if they think the client has a depressive illness that requires treatment. It can be a mistake to presume that the client will be depressed after all they have been through and miss the fact that the person now has an illness requiring medical or psychiatric treatment.

Clearly, if the therapist and their supervisor are concerned about a risk of suicide, they should not hesitate to refer the client to a GP or psychiatrist, as appropriate. Once again, expert advice needs to be sought about symptoms that appear psychotic as it can be difficult sometimes to distinguish between acute post-traumatic symptoms, cultural expressions of extreme grief and psychosis. Clients who continue to be plagued by post-traumatic symptoms may need to be referred to a psychologist or other mental health worker trained in trauma processing therapy. ■

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