Working as psychological therapists in global systems - Between solidarity and defense

Introduction

Refugees and survivors of torture and other human rights violations represent a tragic consequence of politics, warfare and human trafficking. The debates around this issues have engaged health professionals and specifically psychologists in Europe and Germany in the wake of recent humanitarian catastrophe that sends so many people form the Middle East on the move towards what they hoped was safety.

The work with people that have been uprooted, violated, tortured and are in or after flight is highly demanding for health workers involved. Professionals working in conflict areas or with asylum seekers in Germany run risks of burnout and or trauma-related burnout and they often work under many social and moral pressures, including heated political debates in wider society. European institutions providing healthcare and support to survivors as well as non-governmental organisations (NGOs) working in war and conflict areas point to a need to link support, treatment and advocacy. This too has raised many tensions and challenges for health professionals, for example, of how to negotiate professional neutrality in a political context, whilst ensuring what is in the best interest of survivors and their families and communities.

This paper explores some of the challenges in developing an approach to working with survivors of war, torture and other human rights violations, and offers some broad principles based on our own experience of working in this field for nearly three decades.

Current context of global conflicts

Currently, there are over 42 armed conflicts globally, a decrease from a decade earlier, though with an intensification of violence and a tripled increase in fatalities amounting to 180,000 deaths, compared to an estimated 56,000 in all armed conflicts in 2003 (ACS, 2015). One of the most devastating conflicts historically in terms of its duration and impact on civilians is the Syrian conflict. The failure to find a political solution to ending this conflict and the recent reduction in funds available to the United Nations in contributing to humanitarian aid, amongst other factors, has led to the unprecedented and recent rise of mass refugee movements from Syria and neighbouring countries, to Europe. This long-lasting and devastating conflict in Syria has forced people to leave their home and approximately 11 million Syrians on the move (UNHCR, 2015). They are either internally displaced people

(IDPs), or have fled to the neighboring countries Turkey, Lebanon and Jordan, where they often live under precarious economic, social and health conditions.

Along with flight and displacement, many of those seeking shelter have also experienced physical violence, witnessed the killing of family members, torture and other human rights abuses which have directly influenced their social and mental wellbeing. Some international organisations are therefore working alongside local volunteers and experts to address what are referred to as 'mental health and psychosocial support (MHPSS) issues' in the region. Interestingly, in Europe, where many refugees are fleeing from armed conflict, torture and other human rights violations, the dominant discourse remains the 'trauma discourse', depicting refugees as traumatized, damaged and in need of expert psychological therapy. In regions where these conflicts continue, and survivors have nowhere to go, and the numbers of survivors far exceed those we see in Europe, the dominant discourse amongst health practitioners is the discourse of 'MHPSS and humanitarian intervention', which is often presented as an oppositional discourse to the trauma discourse. Both discourses, however, have their limitations and consequences.

Limitations of 'MHPSS' as a conceptual framework

What precisely MHPSS means in the context of war and humanitarian crises is an area of some confusion and contradictions in practice. Humanitarian agencies use the term MHPSS to "describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" (IASC, 2010, p.1). However, in practice, it is clear that war and human rights violations affect everyone, children, adults, families and whole communities; and they impact in different ways on different people. War and human rights violations also have particularly serious consequences for those who may already have mental health problems or those considered vulnerable on mental health grounds. Thus, meeting the 'MHPSS needs' of those affected requires a complex and comprehensive approach which addresses the psychological, welfare and social needs of whole populations, adults, children, families and communities; as well as the needs of those who have experienced torture and other gross human rights violations; and of those already marginalized, stigmatised and suffering from mental health problems.

Current approaches to MHPSS in service provision in contexts of conflicts and humanitarian crises are characterized by a combination of general psychosocial assistance and a psychiatric diagnosis-driven approach (e.g. mhGAP) promoted by the World Health Organisation (WHO,

2010). Little to no attention is given to those who amongst the refugee people, have also experienced torture and other gross human rights violations. Whilst immense progress has been made in formulating manuals and guidance on MHPSS interventions in humanitarian crisis and conflict, there remain some questions about the validity of the concept of MHPSS, its implementation and the extent to which MHPSS interventions can address the diverse and complex needs of all those affected by war and humanitarian crises.

One question which arises here is: What exactly is the psychological impact of war and humanitarian crisis? A related question is: Can the impact be understood and appropriately addressed by focusing predominantly on trauma symptoms, mental health and psychiatric diagnoses?

War and related large-scale humanitarian crises impact on individuals, families, communities and whole societies in diverse and multiple ways. War and human rights violations during war destroy the basic infrastructure of society, annihilating any semblance of order and mechanisms to ensure safety, welfare of citizens and accountability for injustices and human rights violations. It can obliterate the social fabric of societies, social networks and cohesion, engendering intense and chronic panic, fear, mistrust and enormous loss and grief. Families can be torn apart, with multiple deaths and losses, children left without parents or other adults who can protect and take care of them, family members scattered and separated in fleeing for safety. Children and adults may suffer enormous economic hardships, poverty, lack of food, shelter, basic education or schools, means to support themselves, access to healthcare and required medication and support.

Psychosocial support as a component of MHPSS can go some way towards addressing the basic needs and ongoing impact of war. Psychosocial support in these situations is generally characterised by the provision (sometimes) of minimal social welfare alongside individual counselling or general psychological support which addresses the impact of social conditions on psychological well-being. However, it does not address the particular needs and contexts of those with ongoing or severe mental health problems or those who have experienced torture.

The mental health component of MHPSS seeks to address the needs of individuals as identified according to particular diagnostic criteria and protocols, driven by psychiatric classification systems. Whilst mental health needs, according to the mhGap system, can be identified by non-specialists, the interventions offered invariably require specialist skills and medication often lacking in low and middle-income countries and settings where there is

ongoing conflict and humanitarian crises. Interventions aimed at families and communities are largely assumed, or expected to be assumed, by those ‘non-specialists’ providing psychosocial support via non-governmental, community and sometimes, international aid organisations.

Limitations of ‘trauma paradigm’

Alongside, or sometimes seen as a component of specialist mental health interventions, are ‘trauma-focused interventions’. Psychological therapists engaged as international experts are often imported by international agencies to train local staff or to provide ‘specialist’ trauma - focused interventions to local populations themselves. This may include whatever is currently marketed by international experts as western evidence-based methods – such as cognitive behavioural therapy (CBT) with a focus on trauma-focused interventions, Eye Movement Desensitisation and Reprocessing therapy (EMDR) or more fashionable of late, Narrative Exposure Therapy (NET). All these approaches draw on the traditional psychological trauma paradigm.

This traditional trauma paradigm is based on various broad premises and assumptions with variation in theoretical explanations for why certain symptoms of psychological trauma persist, such as intrusive phenomena. Many psychological therapists would argue that traumatic experiences cannot be adequately narratively reconstructed retrospectively. For some, certain details of the trauma are preserved in body memory–particularly sensations and individual perceptual impressions which are involuntarily activated by external triggers (e.g. hearing a siren or seeing an armed policeman) or internal triggers (e.g. thinking of an incident or a place or person related to the traumatic event). Therapists who draw on the traditional trauma paradigm conceptualise trauma typically as constituting one or more discrete events, memories of which may be intrusive and considered trauma memories. Trauma-focused CBT, EMDR and NET all to some extent rely on exposure and on cognitive restructuring as key methods, though their theoretical justifications vary to some extent. However, many therapists argue that exposure may be necessary for some people, at some stage and may sometimes be helpful – but not always – and that exposure can sometimes even be harmful and unethical. Ensuring safety and stabilizing the psychosocial conditions as far as possible, alongside the provision pf psychological support according to the needs and circumstances of the person affected by the traumatic events, is considered more appropriate – and for some people, some form of exposure may be useful at the appropriate time.

One would not question the assertion that someone who, as victim or witness, is caught up in devastating violence needs the subsequent restoration of damaged integrity; since every wound requires a subsequent healing process, though this does not always need professional, specialist interventions. For many people, this is achieved without professional help and symptoms may resolve completely; others are burdened with lasting psychological difficulties.

Whilst some therapies are aimed only at those individuals meeting the diagnostic criteria of post-traumatic stress disorder (PTSD), there are many, many survivors who do not meet this diagnostic threshold but suffer nonetheless. Many assumptions are made about those given diagnoses of PTSD, yet we know near to nothing about what aspects of a person's background, difficulties, resources or pre-existent factors mediate how they suffer (and cope), if their suffering can be seen as sufficient to meet the diagnostic criteria of PTSD and if it is worthy of psychological and social support. Numerous questions need to be asked to those of us deciding how we make sense of the suffering of survivors and what they tell us or not: Is the narration dependent on the circumstances of communication, on the situation and context? Is it dependent on the content or the context of the event, or on the distinct and exceptional character of the experiences that were suffered? What role does the meaning of suffering or having to deal with extreme violence play within the sociocultural or religious background, context and community survivors come from or live in currently? Is the suffering a psychiatric disease such as PTSD, or a normal reaction to extreme violence, violations of human rights and the prevailing sociopolitical and humanitarian situation?

Whilst the trauma paradigm – with a focus on the impact of war as a form of psychological trauma – may be familiar and 'comfort-zone' territory for Western-trained psychological therapists, it is a paradigm deeply compromised in its usefulness in the context of current global armed conflicts and related gross human rights violations. The narrow focus on psychological symptoms in traditional psychological approaches may in part address the impact on individuals, but creates both an illusion and further problems. The illusion promoted by a focus on the trauma paradigm is that everything which happens in war can be reduced and understood within a psychological framework which focusses on psychological symptoms, as if located within the individual. Context is ignored, and the causes of those symptoms obscured completely or reduced to single 'traumatic events', rather than recognizing the reality of multiple and ongoing traumas which are never 'post'. These 'traumas' should include the trauma of sustained hunger and starvation; the trauma of physical pain, injury and loss of limbs; the trauma of losing one's home, livelihood,

education, work and home; the trauma of being separated from family members and witnessing deaths of family members and others; and the trauma of an absence of legal accountability for crimes in war and an absence of humanitarian aid and support from the international community, experienced as bystanders engaged in political rhetoric and economic negotiations whilst the lives of people are destroyed day-by-day.

The problems a traditional trauma paradigm focus creates are manifold. It leads to a neglect of context and an approach to 'MHPSS' interventions which focus on individuals and their psychological trauma symptoms whilst ignoring both the needs and resilience of families and communities, and their capacity to help restore some degree of functioning and well-being of individuals, families, communities and their society. Methods promoted as 'trauma-focused interventions' also rely on a normative model of narrative, the idea of a 'clean' story, ordered, coherent and organized around discrete events, stripped of social and political context. Such a conceptualization of narratives and 'healing' does not take into account the potential creativity and for us unexpected ways of narrating about potentially traumatizing occurrences and seems to serve most of all the needs of psychotherapists for a quick fix. It ignores that we live in a global context and that we should know that there are many different ways of understanding suffering and what people and communities need to 'heal' – which is and should be culturally and socially-defined (Watters, 2011).

Other consequences of adopting a traditional trauma paradigm are the stark divisions and hierarchies of expertise created by introducing so-called 'international experts' and international agencies, promoted as having the necessary knowledge, skills, resources and expertise seen as apparently lacking in local communities – without scrutiny of the inherent Eurocentric bias and the propagation of the colonialist mantra of 'west is best'.

Refugees as the 'other' in Germany in need of 'trauma treatment'

Another question which is highly pertinent in the German context is what are the limitations of adopting an MHPSS approach to the refugee influx into Germany?

In Europe, the dominant discourses midst psychological health professionals seem to centre around the traumatisation, the need for specialist trauma therapy and integration of the refugees and asylum seekers into society and – most recently – on the potential danger of traumatised and or psychologically ill refugees of becoming violent (see also Zeit, 2016). The fear is understandable and has to be taken seriously. Germany has received 476.649 asylum applications during the year 2015, the highest number of asylum applications worldwide

(BAMF, 2016). But those discourses run the risk of reinforcing an image of a refugee as either a helpless person in need of health professionals taping into our resources or as a dangerous person who has to be caught and detained or 'fixed' psychologically. In a systemic discourse however, one could also lay emphasis on empowerment and the potential of refugee people as individuals or families, who might need orientation and support, but who can at the same time contribute to the shape of a society as community members and as survivors.

In the aftermath of the humanitarian crisis in Syria we have seen a historically unique movement of support by volunteers – among them many psychotherapists providing counselling and psychotherapy for traumatised refugees as well as supervision for the helpers. We have also seen an extraordinary increase in demand for training and coaching on how to deal with traumatised refugees from kinder gardens, schools and psychotherapeutic training institutions, to mention just a few. All of a sudden Germany was in need for the sort of crisis intervention that was usually done by German or Western experts in conflict areas. This situation brought up a lot of trauma treatment specialists and methods or manuals. We have even been asked if we could provide a "trauma light" course for non-professionals that want to help or counsel in reception centres. This one-dimensional focus on "trauma" does not only reinforce the above mentioned claims, but decontextualizes and pathologises the situation. In fact, effective MHPSS for refugees in Germany are not that different from MHPSS in other crisis ridden areas. Based on safety and recognition of suffering, rights and obligations - support has to be meaningful in the context and under the respective living conditions. It has to be participatory, empowering and also allow for specialised psychosocial support or treatment. There are no alternatives or compromises when it comes to the consideration of safety and the need to participate, as well as the creation of a future in a social and political context.

Working with survivors of war and human rights violations

Our experience in working with survivors of war, torture and other gross human rights violations, as well as practitioners and agencies who work with them, is based on several decades of work in Europe in many other countries, including Yemen, Jordan, Palestine (Gaza and East Bank), Lebanon, Kosovo, Mozambique and South Korea.

In the following we offer some broad principles based on systemic thinking and a human rights framework (for further discussion see Bittenbinder, 2010; Patel, 2011) which have both influenced our approach, that we would advocate as a useful way forward for practitioners, health and social care service providers.

1. A 'client' is a person, a human being who does not exist in a vacuum, but within a social system and as such, working with a survivor, adult or child, you must always attend to the person's family, whether present, absent, separated, lost or deceased.
2. Suffering and survival must be understood in their context: past and present, cultural, social and political. Psychological work requires attention to the social context within which people exist, suffer and survive.
3. Psychological interventions should not simplify the experiences of multiple traumas and losses using a traditional, reductionist and medicalized approach to trauma, but recognize that the experience of trauma is a sequential process[1], where individual suffering and social processes are defined in relation to each other and traumas can occur in the past, in the country of origin; during exile and flight; and during life in exile in another country where survivors may face isolation, poverty, unemployment, racism, marginalisation, exclusion, hostility etc. In this sense, trauma is never 'post', nor solely located in the past.
4. Psychological interventions must address the complexity and multidimensionality of the survivor's experiences, strengths, difficulties and sufferings. Interventions should not be solely symptom-focused, but address the person's social and welfare needs and the impact of the social, economic and political context on their well-being.
5. As such, interventions need to be offered within a multidisciplinary and multiagency framework which adopts a holistic approach that encompasses needs, abilities and strengths of the person and family.
6. Interventions should not be deficit-focused or only symptom-focused and 'needs-based', they should also identify, acknowledge and mobilise strengths and resources of the person and family in a way which supports the self-organisation and self-healing processes of individuals and families.
7. Interventions should aim to work in a participatory way with individuals, couples, families and communities – supporting and strengthening existing social networks and social resources within the community; or facilitating the reconstruction or formation of new social networks and resources where relevant; and maximizing opportunities for

[1] In a series of long-term studies, the German-Dutch physician and psychoanalyst Hans Keilson developed the term 'sequential traumatisation' to draw attention to the nature of trauma as a process (Keilson, H. (1979). Sequentielle Traumatisierung bei Kindern. Stuttgart: Enke.)

them to challenge and influence the social and political realities (e.g. dominant negative discourses of refugees, racism etc.), which impact on their lives and their well-being (Patel, 2003).

8. Interventions should address basic safety and social and welfare needs as a matter of priority, but some people may need further, specialized and longer-term psychological support.
9. Services and interventions should be non-discriminatory and non-exploitative of individuals, families and communities they seek to help and support.
10. Services are more likely to be accessed and sustainable if they are based on a collaborative, participatory model which seeks to engage service users who themselves have experienced exile, human rights violations and war in influencing and shaping services which are relevant to them and culturally appropriate.
11. Practitioners and services should work with refugee community-based organisations, including those run by refugee communities, to ensure meaningful collaboration, partnership and culturally-appropriate services.

12. Interventions and services should adopt a human rights approach and explicitly acknowledge that the suffering they seek to address is not a pathology, illness or disease, but the impact of social, economic and political abuses and human rights violations.
13. Services should engage in prevention activities, including awareness-raising, training of decision-makers and others (e.g. police, legal representatives), human rights monitoring and advocacy targeting decision-makers and institutions.

14. Services should engage in the legal process where relevant, to facilitate access to reparation, including psychological support, and justice, for survivors.

15. The impact of services is more likely to be sustainable if staff teams are adequately supported with provision for clinical supervision as well as a range of support structures for all staff.

Concluding reflections

One of the contributions of systemic thinking to our work has been the commitment to work in a way which does not shoe-horn survivors into our pre-existing, Western notions of suffering, symptoms and psychiatric disease, or into our preferred theoretical models and therapies – but focusing on context in every sense: linguistic, cultural, social, religious, economic, political, therapeutic contexts etc. Working with people with such complex realities and extreme experiences brings its own challenges, not least the intense feelings of helplessness, and of being overwhelmed, deskilled and the defensive urge to organize the enormity and messiness of clients' suffering into neater explanations, models and 'solutions'. Our own context as therapists with our own baggage, limitations, cultural, gender and other biases also influence the communication and meaning-making with survivors. Thinking systemically has enabled us to draw on different approaches and to engage survivors as active participants in their own recovery – not imposing exclusively Western, professional, technical solutions, but working in solidarity as far as possible with them, using their meaning-making systems and their own personal and social resources, whilst recognizing, exploring and elevating their own capacities to survive, develop and move forward. Of course every survivor from a different cultural, political and social context brings their own rich and complex realities. For us as therapists, the immense learning and joy of co-discovery with survivors comes from using the encounters to not be defensive and package the survivor into what feels more comfortable for us, but to be curious, to ask more, to understand more by respecting the survivor as an expert in their own experiences and understanding of their context, to manage and contain our own feelings and fears of not-knowing, fears of 'the other'. In this sense, interventions are not the technical solution, but simply openings or catalysts for change.

Working in Europe or Germany this work obviously includes ensuring that the basic needs of safety, food, clothing and shelter are addressed, as well as the legal, social and living conditions. In addition, it means addressing all the multitude of traumatic experiences, ways of coping and adjusting to the exile conditions with differing climate, food, value-systems, language etc. In our experience it means organizing safe spaces for listening, encounters and human interaction. This applies to the therapeutic spaces but also to the activities run by volunteers or/and professionals volunteering their services. It means supporting actively self-healing processes and offering counselling and treatment but also working with and intervening with the wider community and advocacy and human rights work.

We have sadly recently seen an increase in racism and most recently the rise of defensive, discriminatory and persecutory discourses in the media and general public, which depict

survivors as potentially ‘dangerous’ – rather than seeing them as ‘in danger’: of further persecution, violence, disenfranchisement, exclusion, ongoing traumas and of a future living on the margins of humanity, being feared and hated by those from whom they sought safety. But we have also seen solidarity and support and the opening of safe and therapeutic spaces.

Literature

Bittenbinder, E. (2010). *Good practice in the care of victims of torture*. Karlsruhe: von Loeper Literaturverlag.

IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2010). *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?* Geneva: IASC.

Patel, N. (2003). Clinical Psychology: Reinforcing Inequalities or Facilitating Empowerment? *International Journal of Human Rights*, *7,1,* 16–39;

Patel, N. (2011). The Psychologization of Torture. In: M. Rapley, J. Moncrieff, J. Dillon. *De-Medicalizing Misery* (p. 239–254). Basinstoke: Palgrave Macmillan.

Watters, E. (2011). *Crazy like us-The Globalization of the American Psyche*. New York: Free Press.

World Health Organisation (2010). *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health setting*. Geneva: WHO.

Internet Sources

ACS, (2015, Mai 20). Armed Conflict Survey 2015 [Report]. Einzusehen unter: https://www.iiss.org/en/publications/acs/by%20year/armed-conflict-survey-2015-46e5

BAMF, (2016, Januar 6). 476.649 Asylanträge im Jahr 2015 [Pressemitteilung]. Einzusehen unter: https://www.bamf.de/SharedDocs/Meldungen/DE/2016/201610106-asylgeschaeftsstatistik-dezember.html

UNHCR, (2015). Protecting and supporting the displaced in Syria – UNHCR Syria End of year report [Report]. Einzusehen unter http://www.unhcr.org/news/editorial/2016/2/56cad5a99/unhcr-syria-2015-end-of-year-report.html

Zeit online, (2016, August 21). Bringt ihre Seele in Sicherheit [Zeitungsartikel]. Einzusehen unter: http://www.zeit.de/wissen/gesundheit/2016-08/fluechtlinge-traumatisierung-psychologische-beratung-angebote