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Refugee families in therapy: from referrals to therapeutic conversations

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Refugee families referred for therapy present a wide array of problems and expectations, not always in accordance with what therapy may offer. Major differences between referring professionals, families and therapists regarding problem definitions and solutions may complicate collaboration. Interventions that may overcome these barriers and move initial interviews into a therapeutic context are described. Three patterns regarding referral process, problem presentation and expectations (here called referral contexts) are outlined: 'the relational', where families ask for psychological and interpersonal assistance, 'the unfocused', where families are referred to therapy without expressing any wish for it, and 'the fixed solution', where families seek support for solutions that are not of a therapeutic nature. The interventions described form part of a negotiation where motives and interest for therapy are explored and agreements regarding further therapy are outlined.

Introduction

The circumstances surrounding the referral process when refugees are referred for therapy seem particularly important to explore. Refugees are frequently involved with a comprehensive system of helpers engaged in assisting families in their process of adaptation and integration into the host society. The surrounding helpers often constitute what has been described as problem-organizing systems (Anderson and Goolishian, 1988); namely, systems of concerned people being built around a problem. This system usually forms the referring system, defining the refugees' problems and their need for therapeutic assistance. Clarifying the ideas and solutions of the referring system as well as their relations to the families are essential steps in all family therapy work (Boscolo *et al.*, 1987; Imber-Black, 1988; Palazzoli *et al.*, 1980), but it attains a

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special significance when approaching refugee families referred for therapy (Sveaass and Reichelt, 2001). The therapeutic context is necessarily transcultural and the families have often been exposed to gross human rights violations. In addition, the exile situation implies stresses on many different levels. All this represents special challenges in the context of therapy.

Former traumatic incidents, losses and ongoing difficulties relating to resettlement and adaptation may create reduced psychological and social functioning, often resulting in referral for treatment, but psychological treatment is not always in line with the refugees' own perceptions of their problems or with their expectations of assistance (Gong-Guy *et al.*, 1991; Reichelt and Sveaass, 1994a, b). In addition, conversations focusing on former traumatic events, as therapeutic conversations often do, may seem contra-indicated or meaningless from the refugees' point of view, who may consider it more urgent to deal with the present exile-related questions (van der Veer, 1992; Westermeyer, 1991).

These contextual aspects must be taken into account when the question of therapy is raised and the motivation and preparedness for therapy is evaluated. The experiences described below are based on a family therapy project[1] exploring the possibility of creating meaningful conversations with refugee families and the larger systems (Reichelt and Sveaass, 1994a, b; Sveaass and Reichelt, 2001). Steps or interventions that facilitate the process of taking referred refugee families into therapy are outlined and discussed. The focus in this article is on the creation of therapeutic environments rather than on the outcome of the therapeutic process as a whole.

Our therapeutic context

The interviews were conducted at an outpatient clinic connected to a centre of excellence for psychosocial work with refugees in Norway (Psychosocial Centre for Refugees at the University of Oslo).[2] All referrals were individuals, but where there was an

[1] The family therapy project was initiated as a collaborative project between the Psychosocial Centre for Refugees and the Institute of Psychology, both at the University of Oslo.

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explicit reference to family members in distress or to a family deeply involved in the problem the families were offered to attend together with referral agents or other relevant professionals. In twenty-seven out of fifty cases the referring professional or other representative from the larger system (that is, primary healthcare doctors or nurses, social workers, child protection agents, refugee councillors, etc.) joined the first family interview. The families had come to Norway as refugees; half had status as political refugees, the rest had other kinds of stay permits. The families were from the Middle East (49%), from Europe (15%), from Africa (10.5%), from Asia (18%) and from Latin America (8%). Most of the families had been exposed to serious human rights violations prior to leaving their country of origin or during their flight: political prison or concentration camp (32%), physical and psychological torture (38%), witnessed executions of family members (14%), serious threats, combat experience and life in war zones (85%). More than half of the families had lost close family members as the result of war, torture or executions.

During the first interview, families and referring professionals were asked about reasons for referral, the problems and the solutions as they saw them. This disclosed considerable differences between families and the referrer with regard to the possible benefit of therapy. Many families had considerable problems relating both to past and present stress, but did not have any specific wish for therapy. They were often preoccupied with their ongoing acculturation and integration process, struggling to come to terms with a situation in exile. Negotiations about whether to initiate therapeutic work or not, what problems could be worked with, and with what goals and methods, represented a substantial part of our contact with families and helpers. The challenge for the therapists was to find ways of dealing with this process.

In the work with the families some therapeutic guidelines stood out as more salient and useful than others. A non-expert position from which the ideas and expertise of the families could be explored was chosen (Anderson and Goolishian, 1992). A not-knowing stance (ibid.) seemed useful in a transcultural context where the therapists necessarily have limited knowledge regarding cultural background and traumatic events (Toledano, 1996). Entering the system and exploring perspectives and positions as ways of creating a different kind of dialogue seemed promising in a situation where there was little movement in the conversations about the

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problems (Anderson and Goolishian, 1988). A focus on solutions, resources and possibilities seemed important in work with people whose stories are dominated by problems, and where alternatives and options are easily overlooked (de Shazer, 1988; White and Epston, 1990). The reflecting team model described by Andersen (1987) inspired us to reflect openly on the different issues raised in the conversations.

Three referral contexts

Findings from a study of the first family interviews have been described in a separate paper (Sveaass and Reichelt, 2001). The differences found between families and referring professionals can be understood as constituting different referral contexts. The importance of mapping the referral context (that is, exploring the story of the referral process, the opinions regarding problems and what should be done, as well as the relationship between referring professionals and family) has been described by Boscolo *et al.* (1987). In the following, the term *referral context* will be used to describe the situation surrounding the referral process with special emphasis on the way the family perceives the referrals. The referral contexts must be understood as ways in which the family presents itself to us with regard to the referral. The concepts are purely descriptive and do not include any analysis of why the situation was presented or experienced in this way or any other. Three referral contexts were delineated: the relational, the unfocused and the fixed solution.

The relational context

Families in this context presented problems where work with relations and emotions within the family seemed natural. Despite a number of different kinds of problems in their present lives, the ideas regarding help coincided rather well with a therapeutic approach. The referrer had mentioned relational problems and in some cases family therapy had been suggested. Seven of the families had been forcibly separated and reunited in Norway: *'We need to become one family again'* or *'We must find a way to live together as a family and accept the differences that have developed during our time apart'*. Several of the families had been exposed to severe traumatic events and two explicitly asked for psychological help in relation to post-

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traumatic reactions. The remaining families wanted to talk about problems relating to the process of acculturation. They had lived under extreme stress, were trying to establish new lives in exile but experienced their daily lives as conflictive and stressful: *'We have never lived like a normal family before – many years in war and camp – and now in a totally strange place – it is very difficult, we fight a lot.'* A working alliance regarding therapy was established with eleven families in this context. Further contact (that is, agreeing on a new session, but with no clear therapy contract) was decided upon in the case of five of the families, whereas no further contact was agreed with two families. Altogether there were eighteen families in this context.

The unfocused context

Seventeen families came to the interviews primarily as a response to the wishes and ideas of the referrer or other helpers in the system. They did not present any problem they wanted to work with in therapy and there was no connection between what the families experienced as difficult in their lives and talking to us. They might tell us during the first interview, '*The consultant at the refugee office told us to go*' or '*We received a letter so here we are*'. In this context, helpers were often present during the first interview to present their viewpoints on the situation: *'There are many conflicts in the family and they need to work with their relationship to each other'* or '*The family needs to talk about the traumatic events they have been through'*.

The families described themselves as being in a powerless situation. They often felt overwhelmed by Norwegian society, and families in this context, more often than in the others, explained that they felt some pressure to assimilate into the host society: *'They want us to become Norwegians.'* Some said that their main difficulty was the problem definition of the helper: '*They keep telling us that our matrimonial conflicts affect our children. That is not so.'* The family members often presented general complaints such as sadness, depression, personality changes and isolation: '*I feel sick, aggressive and nervous, and do not have the energy for anything at all'* or '*I used to be able and competent, but now I am without force'*. To summarize, these families saw themselves as disempowered, lacking self-agency and with little control over their own lives. Therapy contact was made with five of these families, further contact was decided upon with seven families and no further contact with five families.

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The fixed solution context

Thirteen families had clear problem presentations and often a ready and fixed solution that was not related to therapy. The families argued strongly for their solution and wished to involve the therapists as 'door openers' in the system. The families expected support with regard to their goals, such as moving to a different area, securing a stay permit, obtaining family reunion, etc. These were often presented as solutions to a wide range of problems.

The families in this context had all been exposed to extreme events, and the referring professionals had suggested psychological work with the traumatic experiences, but the families were determined to solve their problems differently. The relations between families and helpers were rather tense in some of the cases. Therapeutic work was agreed upon with three of the families, further contact with eight and no contact with two of the families.

Conducting the initial family interview

In the first interviews substantial space was devoted to exploring ideas and reflections regarding problems, possible solutions and expectations of help. When referring professionals or others from the larger system were present the families were interviewed on the same issues, and when not present they were encouraged to reflect upon the possible motives behind the referral. One of the main goals during the first session was to reach an agreement with the families regarding further contact and what kind of contact.

A question posed to most of the families was what they would have done in their country of origin. Exploring how they would have dealt with this in their own context was useful in some cases, and afforded us ideas and metaphors to be used in the conversation. In other families this move gave no associations at all. As a continuation of this we usually explored as fully as possible their thoughts about what would help, and how talking and sharing experiences in the families was considered. It seemed important to clarify this early in the process to avoid inviting families into something not in line with their way of thinking. The transcultural context underlined the importance of this mapping. The following extracts from conversations with two different families which had been asked what they thought about sharing stories (for instance, about

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traumatic events in the family) clearly showed us the necessity of never taking anything for granted.

Behroz and Parvin came to therapy with their two children. Behroz had been imprisoned for many years, and exposed to extreme violence. When asked about their opinions with regard to sharing such experiences, they answered, 'We are an Iranian family – we are used to being open and not hide things from each other. It is an important part of our tradition.'

Parisa came with her five children to the first interview and told us that many things had happened before coming to Norway, but she quickly added that she did not wish to speak about this with everybody present. She said, 'We are an Iranian family, and we are used to protecting each other and not talk about all the problems openly. It just is like that, it is our culture, you know.'

In both cases we made it clear that we would respect what they thought was best for the family and what seemed right to talk about from their point of view.

A way of clarifying the issues raised and to avoid incoherent conversations that skipped from one problem area to another was to draw simple figures and maps on paper. This helped us structure the conversation and create a common focus, especially useful when conversations were conducted with an interpreter, where the flow of conversation could be interrupted by the pauses caused by the translations.

In the following, excerpts from conversations with families in the different referral contexts will be presented together with 'interventions' or moves that seemed capable of taking the first interviews into agreements about therapy.

First family interview in a relational context

The Zamani family (parents and two children aged 10 and 12) was recently reunited in Norway after almost ten years of separation. Mr Zamani was arrested shortly after their second child was born. He had seen his wife regularly for the first three years, but was then transferred to another prison where no contact was allowed. He had not once seen his children during these years. Mrs Zamani eventually left the country with the children, and after three years the husband was released and the family was reunited in Norway. The family presented itself as a close, warm, but wounded family. The violence committed and the long separation had changed

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many things for them and now they wanted to become one family again.

Exploring the value of help. Exploring the family's ideas of help often clarified the differences in the family in relation to problem definition and ideas of help. The family members often seemed to profit from listening to each other's ideas. A thorough interview on ideas and expectations regarding help could often create a platform for future work that could be referred to in situations where other issues less related to the therapy emerged. In the Zamani family the members had different ideas as to what would help, but as this was brought out in the conversation they agreed upon working on the relationship between father and daughters.

Exploring expectations within the family. Families were interviewed both on their expectations of us and each other. Refugee families have been described as 'emotionally overburdened' (Orieta and Samaniego, 1988), often being socially isolated and relying totally on other family members for social support and contact. High or contradictory expectations of each other seemed fruitful to clarify, and in many cases this became the issue which the family defined as the subject for further talks. It also seemed to motivate the participation of the whole family in conversations about problems that initially had been regarded as individual problems. Interviewing the Zamani family, it became clear that the daughters were very disappointed with their father because they had expected a much stronger parental engagement from him, as he had been away from them for so long. He felt that they did not understand his sufferings, and that they had not shown him the kind of concerned affection he had expected. Talking about this gave way to the next direct intervention during the first interview.

Focused structural or strategic interventions. Direct structural or strategic interventions during the first interview were done in situations where the problem raised by the family seemed clear and agreed upon. The Zamani family agreed that the relationship between father and daughters was a major issue. First we drew a line asking them to indicate how far father and daughters had grown apart, then to indicate if they had come somewhat closer and finally who had made the most effort. They responded that the father had moved most. We suggested that the daughters should try to move

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towards their father, and that they take the responsibility for this movement. Then the mother exclaimed that they should do this themselves, that she would not be the 'go-between'. The girls agreed, and when the family came back they told us that the mother had managed to move out of her central 'switchboard' position and that the father and daughters had communicated directly. This inspired the family to come back for what turned out to be a quite lengthy therapeutic contact.

First family interview in an unfocused context

The Nguyen family was referred through the childcare agency. Their son was born prematurely with a congenital illness requiring special attention. The child was taken into custody because parental conflict made this special attention difficult. The husband had been in Norway for many years, but the wife arrived several years later and had serious problems adapting. They had frequent fights but shared the worry about their child. Family therapy was suggested. The couple consented because they wanted their child back.

Exploring ideas surrounding referral. This exploration was more meaningful when the referring professional was present and everybody could listen to the different perspectives presented on the problems and solutions. The families were encouraged to express their reactions and feelings in connection to the referral, as well as comment on the solutions presented by the helpers. When the helpers expressed their concern about the Nguyen family and said that the conflict between the couple had to be worked with, the couple argued that they wanted their child back but did not believe in talking about their problems. In this case the exploration itself did not open for movement regarding therapy, but with other families in this context we experienced that listening to our interviews with the helpers and to their reflections gave them a different view on talking with us.

Respecting self-determination and strengthening self-agency. When families did not want to talk about their problems, and did not wish to come back, we always respected this and emphasized that was their decision, even if their helpers recommended it strongly. The Nguyen family made it clear that it was not interested in coming

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back for a second session, but agreed to stay for the first interview. The therapist then focused on the couple's experience of having changed things and of collaborating. The wife explained that her husband understood the situation better and the therapist invited her to explain what she had done to make this happen. The fact that they had worked with the problems themselves was commented on positively and they were invited to come back if they wished. After two months the husband called, a session was scheduled and a long-term couple therapy combined with regular contact with the helpers was initiated. After a while their child was returned to them.

Focusing resources, problem-solving capacities and potentials. First family interviews both with families and referring professionals must certainly devote some time to the problems that have motivated the referral, but the interviews must focus on the alternative situations as well. With families in this context, often in a disempowered and unclear situation, the importance of giving substantial space to resources and possibilities is emphasized. When interviewing the referring professionals, they were specifically invited to talk about the strengths and resources they saw in the families, to pinpoint examples of good exceptions to the problems and to describe the families' capacities for problem-solving. This often brought out different kinds of information, and some of the families, after having listened closely to these interviews, decided they wanted to come back to sessions.

Reflecting upon different perspectives and experiences. Interviews in this context could often lose their dynamics, as the families did not have a clear notion of why they were there or how therapy could be of any benefit to them. Different ways were used to move the conversations forward. One option was to have the two therapists engage in a dialogue with each other, reflecting upon the different positions presented and the situation as conceptualized by the therapists. These reflections could open up for different conversations with everybody involved, but they also provided an opportunity to present more general information, for instance, on stress reactions, frequent problems encountered by parents bringing their children up in exile, etc. In one case where the family had denied any need of further conversations, the wife, after having listened to some general reflections about family stress and

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acculturation, said: 'Yes, there are things that we must talk about – I just haven't thought about it this way.' A new session was decided upon and therapy initiated.

First family interviews in a fixed solution context

The Roushan family was referred by the primary healthcare because both parents seemed very depressed, and the referral agent feared they were incapable of caring for their three young children. Prior to coming to Norway, the family lived for more than six years in a refugee camp under rather harsh conditions. They had been forced to leave their country together with the husband's brother and his family. The two families had lived together closely all these years. They were separated when the Roushan family was accepted as refugees to Norway. During the first session they made it clear that the only thing that could reduce their depression was if the husband's brother, his wife and seven children were reunited with them. Other aspects of their life situation and other potentially helpful events were explored, but the message was clear: the only way to help the family was to assist them in their struggle for family reunion. Discussing alternatives seemed quite fruitless at this point.

Exploring their solutions. Family reunion, moving and a strengthened economy were among the most frequent solutions suggested by the families. The families presented their solution as the only event that could cause any meaningful change in their lives. Sometimes the designed solution lacked substance in the sense that it resembled a dreamlike picture of a better life situation more than a realistic plan. Exploring the solution together with the family sometimes proved to be a helpful intervention. Interviewing them on how the solutions would change their lives, or what would happen if their designed solution did not happen, opened up nuances in some of the families that led to further contact.

Working with time and future possibilities

Stuckness in time perspectives has been reported as a consequence of exposure to traumatic events like organized violence (Agger, 1994; Axelsen and Sveaass, 1994; Bustos, 1992). Making plans for the future is often limited in an exile context, and traumatic experiences may have changed the sense of control and the feeling of

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having options. Exploring possible future perspectives in general, and more specifically, exploring what could be done *in the meantime* while working for the primary solution, was attempted as a way of getting out of the stuckness. In the case of the Roushan family we joined their main solution and promised to assist them in this project, but suggested that they came to sessions to work with the other problems in the meantime.

Zahra and her three children were referred for family therapy. Zahra's husband had been killed and she herself had been seriously maltreated before leaving their country of origin. Four years were spent in a neighbouring country before the family was accepted as refugees to Norway. Zahra contended that more medical assistance and a new house would help them, whereas the referring professional underlined the importance of working with trauma and its after-effects. Both family and referrer came to the first interview.

Exploring differences in perspectives. The joint interviews often provided an opportunity for helpers and families to present their points of view in a more detailed way than before. Limited time and lack of interpreters would often result in conversations where the conclusions and the strong arguments dominated reasoning and reflection. A more elaborate presentation of the situation, where different aspects could be presented, was aimed at during the first interview. Important in this context was the possibility of exploring the beliefs related to what might help, both from a professional point of view and the family point of view. This created a chance of presenting information, both related to the families' usual way of doing things and professional beliefs.

Sometimes different viewpoints within the helper's network could be explored as well. This afforded an opportunity to discuss different options and solutions, and not just the family solution 'against' the helpers' solution, as it was often presented. In the case of Zahra's family, listening to the different viewpoints within the helping system was experienced as supportive and something that made her more curious to try out alternative solutions as well.

Division of labour. The families within this context defined their situation, and especially the solution, quite differently from the referring professionals, who often emphasized that the families' traumatic experiences were causing present family conflicts and individual distress. The solution presented by the family was often

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regarded as a vicarious solution by the helpers, and sometimes as a way of challenging the loyalty of the Norwegian helping system. It seemed important to re-establish a working relationship between helpers and family. Dividing the tasks between the helpers in the system was a way of enabling agreements regarding future psychologically oriented work. When the solutions of the families were taken seriously, and somebody in the system defined it as their duty to collaborate with the family regarding these solutions, some space was created for the families to agree upon psychological work.

In the case of Zahra, a clear division of labour was among the moves that made her agree to come back for therapeutic conversations, both alone and with her children. Clarifying and dividing the responsibilities served both to elucidate the differences in helping the system, and made it easier for the local helpers to work with the practical issues once they knew that the psychological issues were taken care of by others.

Therapeutic challenges: reflecting upon the findings

The interventions described above aimed at creating room for meaningful conversations in the midst of many ongoing and pressing events. It also seemed important to avoid dragging people into therapy. Our intention was to create a common ground or a negotiated base on which future work could be established. Conversations without such a base or common ground may easily lack direction and aim, and to appear detrimental to the motivation both of therapist and client. On the other hand, confronted with the severe traumas and the present difficulties of the families, we, as well as the other helpers in the system, were eager to help and to be available, presenting the different options regarding help and how these could contribute in their present situations. This eagerness or wilfulness on the part of the therapist to help, intervene and change may of course in itself be complicated or counter-productive, as described by Atkinson and Heath (1990).

The three referral contexts confronted us with different therapeutic challenges. In the relational context the families presented problems of a psychological nature, but they were constantly struggling with other issues as well, which were related to their process of integration into a new society. How to adhere to the conflict or problem presented by the family without constantly being moved off the track by the many problems arising along the way was a

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constant challenge. Our response to this was primarily to reflect upon this as a dilemma, referring to the common working ground that had been defined, exploring what seemed most important for the family to work with and always keeping the option open for a renegotiation of the agreement.

In the unfocused context we were confronted with the challenge of engaging people in therapeutic conversations when they in fact did not ask for such help and at the same time communicating a sense of disempowerment and lack of control. Loss of sense of agency and reduced control over own lives have been described as effects of traumatic events (Adams-Westcott *et al.*, 1993). Most of these families had been exposed to serious human rights violations. These often constituted the central point in the referrals, although the families rarely mentioned these experiences themselves. How to present our offer and at the same time avoid overwhelming them with 'good intentions' that would confirm their dependent and disempowered positions was our main dilemma. Our response, as described earlier, was to focus on the families' own attempts at changing a difficult situation, communicating that they had the right to refuse therapy, and that talking about the problems was not necessarily the only way to change them. Finally, if they wanted to explore a therapeutic option later, they were free to do so. We found that a clear statement of the families' right to make these decisions themselves and at the same time support their own attempts at solving the problems seemed beneficial in this context. In some of the cases the contact ended with this; in others the families wanted to come back.

Meeting families in the fixed solution context represented a complex situation. The families had been exposed to extreme violence and loss, and they communicated distress and general dissatisfaction with their present life situation. Conflicts with helpers in the local community, combined with feelings of being resisted or treated unfairly, often reinforced the stress level in these families. Being offered therapeutic assistance when other measures were asked for emphasized this difficult situation. At the same time it was often obvious that the families were burdened with difficulties both on the individual level and in relations between family members, and we were faced with the dilemma of whether to support their paths to solutions, as would be in line with our general model, or explore the issues further with the intention of making therapeutic conversations an option for the family.

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This was without doubt the context where creating therapeutic contracts proved the most difficult, and it was also in this context that we put in a lot of activity trying to persuade the families to enter our 'therapeutic territory'. The helpers in the system had done this before us, often creating tensions and conflicts in the relationships. We observed that the families were suffering and, despite our intentions to understand, we often found ourselves not sharing their beliefs about the solutions. We tried to move towards their ground by agreeing to work for their solutions, but this may have been motivated by our wish to find other areas more likely to be worked with in a therapeutic context, such as family relations, traumatic experiences, etc. It may well be that our therapeutic determination to change their way of solving the problems resulted in our doing more of the same as the other helpers, and in our becoming ineffective. Our attempts at breaking through their rather rigid ideas regarding solutions were often counter-productive. In the families with whom therapeutic work was initiated, the following moves seemed beneficial: a focus on the family solution, but agreement to work with other issues in the meantime; a focus on what the family could do in order to move towards their own solution, and presenting the thinking and perspectives of the helpers in a more elaborate way; finally, clarifying who in the system could help them with what also seemed to clear some ground for therapeutic conversations. However, the negotiations about grounds could often follow the process (Reichelt and Sveaass, 1994a, b).

Conclusion

Refugees in a host society must remodel and reformulate their life projects in a context where lack of cultural competence, changes in the social support system and lack of social and economic self-determination represented central features. The refugees must renegotiate their roles and responsibilities both within the family and outside it. Psychotherapy may be one of the responses, and may even be a sensible one, but very far from a sufficient response. Nobody knows this better than the refugees themselves. The therapist must be aware of the total context in which the refugee finds himself and take care to present therapeutic services as limited but potentially useful help. Many refugees are not offered psychological help and many therapists find their role in these situations confusing and too impermeable to be able to do a reasonable job as therapists. The

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many different expectations of helpers, the multitude of different problems faced by the refugees, combined with a sense of being without power and control, may be aspects explaining why conversations either do not get started, get stuck or are even pointless. Thus, the main challenge in psychological work with refugees may be the process of creating space for therapeutic work to take place. We hope that the experiences described in this article may serve as ideas in this important process. Exploring useful therapeutic moves, combined with a willingness to see therapy in combination with other psychosocial and integration measures like work, network and training, may be steps in the process of taking difficult conversations and complicated lives into more fruitful contexts.

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