solace papers
surviving exile and persecution

Solace studies in therapeutic work with refugees and asylum-seekers

No. 4

To begin and how to begin: Seeking the 'pattern which connects' in working systemically with resettled refugee families

Mona-Karina Theodosius

solace
surviving exile and persecution

Editor's note: This is the fourth in a series of working papers reflecting on aspects of therapeutic work with refugees and asylum seekers undertaken by therapists and others working for SOLACE, a regional organisation based in Leeds (www.solace-uk.org.uk), and others associated with it. The views expressed here are those of the author. Anyone working in this area is welcome to submit drafts of short papers (3000-5000 words) to the series editor at Gary.Craig@galtres8.co.uk. This article originally appeared in Concept journal, to which we are grateful for permission to reproduce.

Introduction

To begin and how to begin: Seeking the ‘pattern which connects’ in working systemically with resettled refugee families

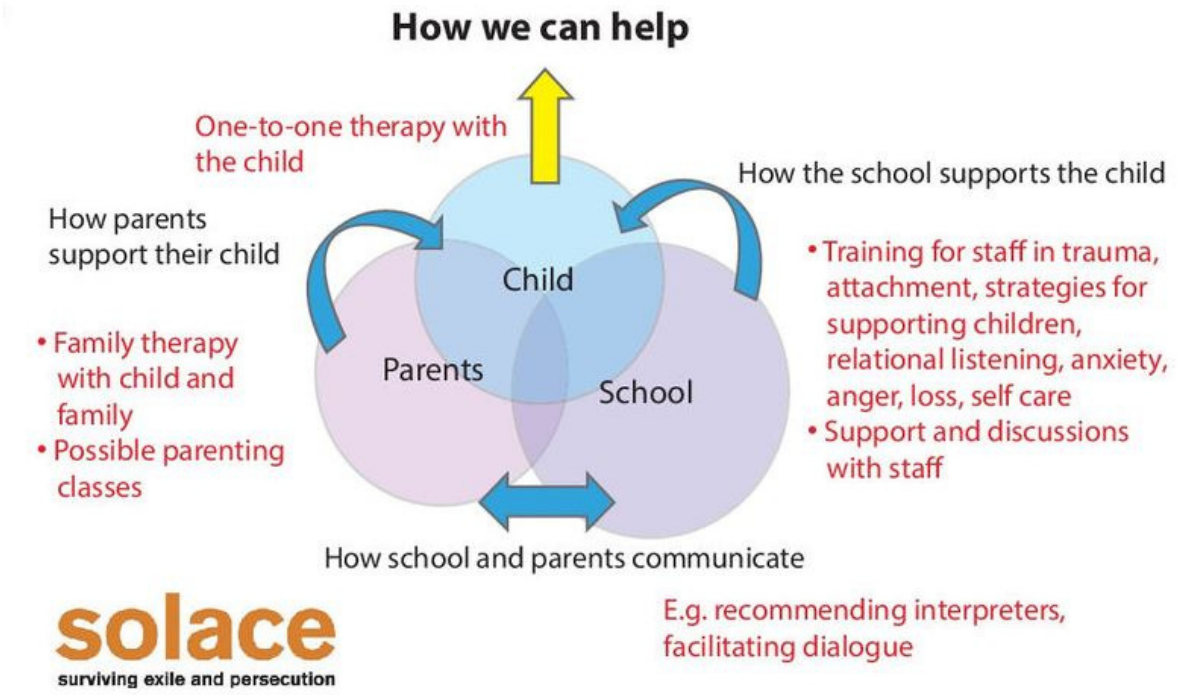
This article describes our team’s part in piloting a child and family wellbeing support project for resettled refugee families in Yorkshire, following recognition of a gap in specialist mental health provision for refugees settled under the government’s vulnerable persons’ resettlement programmes (VCRS and VPRS).

Our Context

The families fleeing conflict, mainly from Syria but also from other countries, have often spent time in interim countries before arriving in the UK. They have witnessed devastation of homeland, loss of loved ones and enforced migration, before resettlement in an alien culture.

Timeframes and experiences within this common process vary widely, layering complexity. Marginalised by their refugee status, they also have additional needs (fragile mental and/or physical health) that have led to their selection for the resettlement programmes. The families referred into our project then present with high levels of need. Concurring with Papadopoulos’ (2002) balancing proposition that being a refugee, even an especially vulnerable one, is not a pathological state, our intent in engaging with them is rooted in a desire to notice and facilitate resilience. Recognising our efforts as inevitably ‘raced’ (Thomas, 2005), and privileged; we have worked to name this in our journey with families striving to construct new lives.

This is a reflection on making a beginning both as a team and with the pilot project from the perspective of Solace, a pre-existing Leeds-based charity working primarily with adult refugees and asylum seekers. The Solace project is part of a broader Yorkshire and Humber-wide provision held under the umbrella of Migration Yorkshire, accountable to local authority, clinical commissioning groups and the Home Office. Its initial aim was to provide early interventions for newly arrived refugee children and young people flagged as in need through school, where behaviours were falling out of mainstream safeguarding guidelines. Staff members were reporting feeling inadequately skilled to identify and work with symptoms indicative of post- traumatic stress caused by living in war zones. In helping the children there was an intention to help the family more broadly, recognising that stressed parents new to the UK were not always best resourced to do this without additional support. From the outset, we faced the challenge of a systemic engagement with the parts as well as the whole (see diagram). It has proved “a complex, reciprocal process” (Jackson & Chable, 1985, p. 65).



The rationale for a systemic frame

The central challenge of the pilot has been its contextual plurality, our clients often at the heart of complex familial (UK and abroad) and interagency networks. As a team, we are also not singular: male and female practitioners from mixed modality trainings and professional backgrounds (individual adult, child and adolescent as well as family psychotherapists); international in our origins; some newer than others to working with the client group. In order to begin, we entered into a relationship with each other and an agency, Solace, which had, at its heart, a desire to offer refugees and asylum seekers hospitality, taking nothing of this diverse and disparate client group for granted, and transparent in ways perhaps harder won by agencies more allied with social control. This enabled us a freedom and creativity toward engagement, not as immediately available in less reflexive settings. However, it also left us potentially more exposed. It was evident from the outset that, if any interventions were to be meaningful, we would need not only to create an alliance with the referred child and/or family, but also those other agencies with whom they were already involved. A portion of our time was spent in trying to establish coherence about the narrative surrounding the family, aside from the family story itself, to understand and join with the broader systems impacting them. This complexity was at times overwhelming. Finding and maintaining a therapeutic foothold could be complicated, as we worked to bring forth our own project identity and its usefulness. We recognised that Woodcock's (2001, p. 24) advice of using, "a systemic framework as scaffolding to hold the different contexts … in some sort of perspective" when engaging with refugees' often-fragmented lives, is well- observed yet hard won.

Understanding boundaries in multiple contexts

Negotiating and defining the nature of our beginning has been a recurrent theme. In any family-oriented work, trying to hear and weigh the many voices speaking or remaining silent forms a core challenge. This challenge grew exponentially as we worked predominantly through interpreters, an integral part of our team from its inception, alongside the community of diverse workers whose voices likewise formed part of the family resettlement story (schools, adult language services, college, healthcare settings, resettlement support agencies, social care, the police, faith communities, befrienders, emergency respite and longer term residential children's homes).

In endeavouring to forge alliances, we frequently found ourselves disappearing down myriad rabbit holes. We were drawn into the overlapping demands of our families' resettling lives, often seeing them at home in attempts to better facilitate engagement amidst other competing demands. As a result, we sometimes succumbed to the risk of blurring boundaries. An example would be the situation of a team member making a home visit, exclaiming in passing at a set of new sheets gifted to a single mum for her young child, only to find the same sheets being pressed on her in an act of hospitality, as she later attempted to leave! Attuning adequately to the shifting sands of dignity when engaging with families experiencing disenfranchisement was a timely lesson. Each team member would have a different tale to tell around this, some more comfortable than others with finding themselves at times positioned significantly outside a more traditional therapeutic frame, the safety of which relied on previous professional trainings and experience. We have recognised how convening the work is "a process of induction that requires negotiation" both internal and external to the family unit (Woodcock, 2001, p. 24).

Establishing our voice

As a new service working within a remit that we were as much creating as fulfilling, we found our own emerging boundaries around provision of targeted mental health and wellbeing support at times thrown into sharp relief and challenged. This was as a result not only of the complex contexts and needs of our client group, but also our internal team and project evolution. For example, as part of our genesis as a team we have found ourselves asking questions about the exact nature of our roles. Are we family therapists, individual psychotherapists, social workers, advocates, caseworkers, befrienders – and does our training, competency and inclination allow for such diversity? Such boundary tracking and honing has formed an important part of our team dialogue, helping us better define roles both within and external to the team. Establishing common therapeutic ground and communicating this to all parties has been and continues to be an important part of our team and project journey. We have emerged as offering individual, family and group psychotherapeutic support and integrative interventions to resettled families, learning from each other's as well as our client group's differences and recognising that in such diversity lies strength.

The question of the referrer

Central to the question of convening the work across the pilot has been the referrer. Those able to refer into the project range from family members themselves to the variety of different personnel involved with their lives. From the outset, the intention has been for holistic engagement with the concept of core interlocking systems (for example, child/school/home). Many referrals have come directly from school settings, but also from other professionals (social workers, English for Speakers of Other Languages workers, health care professionals). Undoubtedly, the most straightforward pieces of work, in terms of process rather than content, have grown out of our successful initial collaboration with the referrer regardless of their inbuilt agency-specific bias regarding the referral.

Difficulties have arisen where transparency of role and intent has not been adequately clarified early on, for reasons including the sometimes-rapid turnover of multiple workers (for example, named social workers changing as a case moves through stages of service briefing). This has led to tangled communication and unhelpful triangulations, the family on the receiving end of well-targeted but ultimately competing interventions (Carpenter & Treacher, 1989). In already multiple contexts, this unclear communication has only served to complicate and disrupt family joining, even at times sabotaging work that might otherwise have unfolded more organically.

Part of our learning has been about our place, recognising that “therapeutic responsibility begins with seeing your own position in the system” (Cecchin, 1987, p. 410). However, although there is value in knowing your place, there are also times when not keeping it is indicated, not least when questions of advocacy in relation to work with marginalised communities enters the frame. Boyles (2018) captures this well when describing the integral nature of social justice to psychotherapy.

Built into our project from its outset was an intention to offer training to allied colleagues about supporting refugees resettled out of war zones. Sometimes this has happened organically in schools as a result of existing involvement with a particular family.
On other occasions, we have been asked to deliver psychoeducational input in different settings (council, case working, healthcare). We have also developed some group work with young people. Carried out in conjunction with school staff-members, the groups have served to enhance knowledge of the refugee context and so better facilitate integration. The warm encouragement of self-esteem and confidence in the group participants has enabled individual and group functioning, but also and importantly, served to challenge the broader system in terms of perceptions of difference. Such work widens the therapeutic net and increases safety by challenging, through highlighting, the subtle exclusions of racial intolerance.

How to begin: Clinical approach

Another question was how to determine an approach to the clinical work. Work took place variedly with mostly single, but some dual working. It included: one-to-one support in school carried out alone or with key staff; school and community-based group work; adult only and whole family working in homes and (less frequently) in therapy rooms.

Research suggests that, when working with resettled refugees, current Western- based models of family engagement can need adapting to account for cultural differences (Karageorge et al., 2018). This particularly resonates with us when considering our positioning when beginning the work. When working directly with the whole family, our generally more collaborative client-led stance has not always been intuitively received.

An example of this would be a meeting convened in school for one of our families. The meeting, attended by a team member, was facilitated by an educational psychologist also involved with the family. He delivered a highly creative child-centred session in the presence of the young person identified as struggling in school and at home, and their concerned parent, himself a victim of trauma.

Aimed at opening communication about the child's difficulties and better enabling the family as well as interagency support, collaboration was implicitly foregrounded as a methodology. Father and son engaged politely throughout, complying with all requests to input positively. Care was taken by professionals to use non-pathologising language and keep definitions fluid. It was, however, moments before departure at the end of the session that, turning to the interpreter, the boy's father asked the psychologist directly if he actually knew what was wrong with his son yet and how would he be treating him? It wasn't that he had missed the point of the collaboratively biased hour, but rather that a lack of genuine cultural attunement had rendered it more or less unhelpful to him. Complex intersectional processes, involving oppression and marginalisiation, are potentially at work in such unintended but complete therapeutic miscalculation (see Gangamma & Shipman, 2017).

Recognising our inherent privilege as insiders to the UK system, we have learnt to more fully account for visible and invisible differences in this regard (Burnham, 2012), adjusting where needed to better match our clients and their worldviews (Blow et al., 2012). In cultures where issues pertaining to mental health, if discussed at all, are viewed predominantly through a medicalised lens where the expert stance is favoured, negotiating a mutual therapeutic beginning has sometimes proved challenging. Our team of interpreters, some previously refugees themselves, have been our greatest allies in this task. The complex and dynamic role of interpreters in multilingual working is well documented, recognising them as, at best, far from neutral conduits, but rather cultural advisers, brokers, trusted co-facilitators in the therapeutic space (Raval & Maltby, 2005). Along with a number of particularly culturally adept referrers, they have helped us better understand how to begin relationships with particular sensitive handling of trust and exposure, for people whose sense of autonomy and dignity have already endured multiple affronts. This is especially pertinent when working with whole family groupings where generational inversions caused by displacement have disrupted traditional family hierarchies; for example, often rendering children, whose language acquisition tends to outstrip parents, chief communicators. Approaching parents first to negotiate a beginning in terms of their symptomatic children has formed an important part of our convening process from the outset, mapping on to cultural expectations where possible.

Establishing therapeutic focus

Establishing where the work lies in order to begin is not new territory and is well documented by those working in the sector. An important question for us has been “whether family interventions should focus on trauma-related symptoms or rather on daily living problems and a restoration of coping skills” (Slobodin & de Jong, 2015, p. 12). The first is often the reason for an initial referral into our service of a child in school; the second is embedded individually but also often manifest overtly in the wider family dynamic. A systemic answer as to which strand to pursue would, of course, be “both/and”. A casework example captures something of this dilemma of focus. A mother presented as deeply anxious and in a state of distress about practical issues regarding housing. At the end of the therapeutic hour, nothing concrete had, of course, changed in this practically and emotionally taxing regard. The therapist, perhaps sensing her own ultimate lack of agency within the client’s complex circumstance, yet wishing to ally with her in her need, observed how it might feel a little like the woman having gone to a mechanic for car repair, was leaving just having had the windscreen washed instead! The mother’s response was that, even if this were so, she would still rather have come to speak to the therapist than not. As well as reassuring, this response was also in line with our learning about recognising our role in accepting the family as they are, even if this comes at the expense of therapeutic structure (Carpenter & Treacher, 1989).

A return to the beginning

Arriving at the end of our pilot, we look to make a new beginning. We have accumulated learning along the way about our clients, each other and ourselves in relation to: our remit and its limits; interagency working with its common and less common ground; and those places we have yet to explore including a planned support-group to empower parents around the school system and parenting in a new culture more generally. Recently, as we have gathered evidence toward a formal evaluation of the project, listening centrally in this process to family voices, we have been reassured.

We have learnt that whilst at times we have been professionally preoccupied with more precisely delineating our role, not wishing to mislead or confuse as to the nature of our involvements; the families themselves have generally had no such qualms. More often than not they have recognised, embraced and benefitted from our desired intent to facilitate an easing of psychological and emotional distress where it has arisen, by working to enable better relationships within and outside of the family. This has been reported by families who from the outset already had a positive relationship to and understanding of therapeutic help, but also those who did not. If we have felt at times as if we were inhabiting the edges as we tried to establish our team and pilot voice amidst many competing voices, then perhaps our lack of surety was in the end a strength; allying us more closely with the often edgy reality of the resettlement experience. This last point is something we need to take seriously in any future formulations, ensuring that we maintain the curiosity needed to hold the neutral stance that helps guard against our own, partner agencies' and families' "oppressive assumptions" about self and other (Dallos & Draper, 2005, p. 154). If that is the 'pattern which connects', then it certainly seems worth seeking.

The Author

Mona-Karina Theodosius is a systemic and family psychotherapist working as part of the Solace, Child and Family Wellbeing Project, and in private practice. Email: mo@solace-uk.org.uk

Acknowledgment

With thanks for contributions from: Anne Burghgraef, Paula Boston, Philippa Kempe, Hernan Sosa-Canal and Kate Graham. Special thanks to Anne and Paula for driving the project forward. We wish also to recognise the work of our partner colleagues: Agnes Ndebele, The Haven Project, Hull; Julie Angelidou and Jude Boyles, Refugee Council, Sheffield. Finally, thank you Amina for letting us share your work.

References

Blow, A., Davis, S. & Sprenkle, D. (2012) Therapist- worldview matching: Not as important as matching to clients. Journal of Maritaland Family Therapy, 38: 13-17.

Boyles, J. (2018) We are here... but. Therapy Today, 29(10): 20-23.

Burnham, J. (2012) Development in social GRRRAAACCEESSS: Visible-invisible and voiced-unvoiced. In: I-B. Krause (ed), Culture and Reflexivity in Systemic Practice. London: Karnac.

Carpenter J. & Treacher,A. (1989) Problems and Solutions in Marital and Family Therapy. Oxford: Blackwell.

Cecchin, G. (1987) Hypothesizing, circularity, and neutrality revisited: An invitation to curiosity. Family Process, 26(4): 405-413.

Dallos, R., & Draper, R. (2005) An Introduction to Family therapy. OU Press: Maidenhead.

Gangamma R. & Shipman, D. (2017) Transnational intersectionality in family therapy with resettled refugees. Journal of Marital and Family Therapy, 44(2): 206-219.

Jackson, S. & Chable, D. (1985) Engagement: A critical aspect of family therapy practice. Australian and New Zealand Journal of Family Therapy, 6(2): 65-69.

Karageorge, A., Rhodes, P. & Gray, A. (2018) Relationship and family therapy for newly resettled refugees: An interpretative description of staff experiences. Australian and New Zealand Journal of Family Therapy, 39(3): 303-319.

Papadopoulos, R.K. (2002) Therapeutic Care for Refugees: No Place like Home. London: Karnac.

Raval, H. & Maltby, M. (2005) Not getting lost in translation: Establishing a working alliance with co-workers and interpreters.

In: C. Flaskas, B. Mason & A. Perlesz(eds) The Space Between: Experience, Contextand Process in the Therapeutic Relationship. London: Karnac.

Slobodin, O. & de Jong, J. (2015) Family interventions in traumatized immigrantsand refugees: A systematic review. Transcultural Psychiatry, 52(6): 723-42.

Thomas, L. (2005) Intercultural: Where the systemicmeets the psychoanalytic in the therapeutic relationship.

In: C. Flaskas, B. Mason & A. Perlesz (eds), The Space Between: Experience,Context and Processin the Therapeutic Relationship. London: Karnac.

Woodcock, J. (2001) A dozen differences to considerwhen working with refugee families.Context, 54: 24-25.