APPROACHES TO COUNSELLING RESETTLED REFUGEE AND ASYLUM SEEKER SURVIVORS OF ORGANIZED VIOLENCE

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Abstract: The number of resettled refugees and asylum claims in minority world countries continues to grow. Some of the individuals and families who arrive in Western countries through the refugee process are survivors of organized violence. Despite the recognition in destination countries that counselling resettled survivors of organized violence necessitates a sensitive and responsible approach, the mental health field is polarized about responsible practice. An increasing number of mental health professionals challenge Western biomedical approaches to counselling, and seek to disrupt dominant notions of trauma and disorder. This article is a review of the literature on the topic of refugee mental health, the current debate in the field, and how this has led to divergent approaches to working with survivors of organized violence.

Each year a vast number of people leave their homes in search of safety and stability. Last year alone, the United Nations High Commission for Refugees (UNHCR) counted some 42 million forcibly displaced people worldwide. This includes 15.2 million refugees, 827 000 asylum seekers (pending decisions in host countries), and 26 million internally displaced people (UNHCR, 2009b, p. 2). One-fifth of them have settled in the minority, or "industrialized", world. According to the UNHCR, the number of asylum seekers worldwide rose by 12% in 2008 (UNHCR, 2009a, p. 3). Canada recently saw a dramatic increase in the number of refugee claims last year, with 36,000 claims filed in 2008-2009 alone – a 30% increase from 2007-2008 (Immigration and Refugee Board of Canada, 2009, p. 8). This number reflects the higher number of Mexicans and Haitians who entered Canada through the United States to claim asylum last year (Immigration and Refugee Board of Canada, 2009, p. 8), other asylum seekers, as well as those who are pre-selected by the Canadian government from refugee camps abroad through the UNHCR.

Once in Canada, selected refugees and asylum seekers begin the challenging process of starting a new life, usually in a new language. Children are registered in schools, parents take language classes and look for employment, and some seek out professional mental health services for assistance in dealing with the multiple stresses of processing the conditions of their departure, acculturation, and in the case of asylum seekers, the refugee claims process itself. Dominant discourse around the mental health of survivors of organized violence assumes that a sizeable proportion live with post-traumatic stress disorder (PTSD). An increasing number of mental health professionals contest approaches to treatment based on Western psychology, which has pathologised and medicalised human suffering (Blackwell, 2007; Bracken, Giller, & Summerfield,

1997; Goździak, 2009; Papadopoulos, 2007; Quosh & Gergen, 2008; Summerfield, 2002). This has served to polarize professional counsellors and psychotherapists around the issue of what constitutes best practice in this domain.

In recent decades, there has been a proliferation of research and therapeutic techniques aimed at better understanding and treating the mental health issues of refugees and survivors of organized violence (Bracken et al., 1997). An in-depth look at counselling approaches with children and youth, or families specifically, is beyond the scope of this paper. This review refers broadly to survivors of organized violence – which necessarily includes children, youth, and families – with the intention of exploring prevailing notions of refugee mental health and approaches to counselling. Three questions have guided this literature review. First, what are the current views on refugee mental health, and what is the current debate in the field? Second, how do these views inform different approaches to working with refugees and survivors of organized violence? Finally, how does culture impact approaches used in counselling survivors of organized violence?

Methodology

This review will attempt to answer the questions posed above with the secondary intention of identifying strengths and gaps in the reviewed literature. This is a general and multidisciplinary review of literature that addresses theoretical and some methodological issues. The review, which spans 13 years, will hopefully serve as the foundation for a more detailed and thorough future project of working in Canada with resettled survivors of organized violence. At the outset, the intention was to focus primarily on cross-cultural counselling with refugees, however the abundance of information around the debate on PTSD and work with refugees shifted the focus of the review. The literature used in this review was collected by searching the University of Victoria e-library databases, the Internet, the Journal of Refugee Studies, the Springer database, as well as the bibliographies and publications found on the websites of the Intervention Network for Persons Affected by Organized Violence and the Canadian Centre for Victims of Torture. When expanding on this review, it would be interesting to approach these two organizations and acquire more obscure resources, such as lecture/conference notes, internal reports/statistics, as well as intergovernmental organization (IGO) and non-governmental organization (NGO) reports and studies.

Key words employed in this search were *refugees, organized violence, trauma, post-traumatic stress disorder, counselling, cross-cultural counselling, culture, and Canada*. Different combinations of at least two of the above-mentioned search keywords yielded between 160 and 700 results. When the search terms included Canada, the number of results was extremely low. For example, the keywords *counselling, refugees, Canada* yielded few results in a search of the University of Victoria databases. Thirty sources were selected in total for the purposes of this review, of which only nine were Canadian. Considering the number of refugees that resettle in Canada, there seems to be a lack of literature on this population in the counselling and mental health domain. Many sources cited in this review originate in the United Kingdom or the United States.

However, in proportion to its population, Canada takes in twice as many immigrants and refugees than the U.S. and four times as many as the U.K. (Dyer, 2001, as cited in Li, France, del Carmen Rodriguez, & Cheboud, 2004, p. 46). Lastly, it is important to mention that the search turned up many articles dealing with counselling survivors of torture, but a specific examination of torture is beyond the scope of this review, which will deal more broadly with organized violence in its various forms.

Background

There are many issues bound up with counselling refugees and survivors of organized violence. While mental health professionals working with resettled refugees attempt to support their clients within the microcosm of the therapeutic relationship, the mental health issues presented often have socio-political origins. Dick Blackwell suggests that in the same way that asylum seekers have crossed borders, counsellors must also "cross borders" to work with asylum seekers, into the realm of history and politics, wherein an understanding of these contexts is a prerequisite for responsible practice (Blackwell, 2007). Survivors of organized violence are part of a collective or social suffering, which reveals the direct links between personal and social problems, the individual and the collective, psychopathology, ideology, and the political (Rousseau, 2000). What Rousseau alludes to as the link between the personal and the social, Reynolds (2010) cites as the activist and feminist analysis of "private pain/public issue" (p. 15). This nicely characterizes the complex space that counsellors inhabit with their clients. Before embarking on a review of the current literature addressing perspectives on mental health and approaches to working with the resettled survivors of organized violence, several key terms will be explored with the goal of laying the groundwork for a concise synthesis and analysis:

Refugees and Asylum Seekers

The 1951 United Nations Convention Relating to the Status of Refugees defines who is (and who is not) a refugee, specifies the rights of refugees worldwide, and the legal obligations of nation states. According to the Convention, a refugee is a person who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (UNHCR, 1951). Refugees differ from immigrants in that migration is predominantly unplanned, and often triggered by natural or human-caused adversity (Tribe & Keefe, 2007). Another important element to highlight, and one that is extremely relevant to work with migrants, is the distinction between refugees and asylum seekers. In Canada, the status of refugee describes someone who has either been pre-selected by the Canadian government to resettle from abroad, or someone whose claim from within Canada has been examined and accepted by the Immigration and Refugee Board (IRB). Accepted refugees ultimately become permanent residents, and have the eventual option of citizenship. An asylum seeker, or claimant, is an individual whose claim is in process, with a decision pending. The claims process, including appeals, can last several years, during which time people put down roots. The

longer an individual or family waits for a decision, the harder it is for them to deal with the possibility of refusal and return. Claimants live in a constant state of uncertainty and fear of being refused and deported (Tribe & Keefe, 2007). Furthermore, claimants in Canada have less access to social services than accepted refugees.

For the purpose of this review, the terms refugee and asylum seeker will both be used, as members of both of these legal status groups have sometimes been subjected to organized violence. These terms will be used with an awareness that immigration status should never be a totalizing definition, and efforts will be made in this paper to explore the complexity of the migratory experience. As Rousseau (2000) warns, misconception or lack of understanding of the complex process of being a refugee can do more harm than good.

Organized Violence

"Organized violence is the purposeful and systematic use of terror and brutality to control individuals, groups and communities. Through the use of overwhelming force, it causes fear and helplessness among its victims. Its methods include causing severe pain and suffering, killing, intimidating, threatening and in some cases destroying a community, ethnic group or political opposition" (Krane, 1995, as cited in Réseau d'intervention aupres des personnes ayant subi la violence organisée [RIVO], n.d.). It can also include hostage taking, torture, imprisonment without trial, cruel, inhuman or degrading treatment or punishment, mock executions, "or any other form of violent deprivations of liberty" (World Health Organization, 1997, as cited in Regel & Berliner, 1997, p. 291). Organized violence is perpetrated directly by government through its police, military or political organizations, or by a group of civilians acting independently (Regel & Berliner, 1997). According to Rousseau (2000), it is violence perpetrated by one group of humans against another based on political, racial, religious, ethnic, social, or sexual characteristics. Rousseau goes on to state that the West likes to speak about organized violence as though it were a far-off phenomenon, the "not-me" of wars fought "over-there", rather than a reflection of our own universal human nature. Part of the pain and suffering inflicted on the targets of organized violence is the rendering of that person's world "non-sensical" – a provoked feeling of absurdity, disorganization, and incoherence at the individual, family, and community levels, everything that constitutes someone's personal universe (Marotte, 1995, as cited in Rousseau, 2000). The state of chaos that organized violence creates, and the survivors' need to restore order, is mentioned in several articles (Summerfield, 2002).

Trauma

The word trauma in psychology and psychiatry refers to a psychological injury, a pathological state – an injury of the mind (Papadopoulos, 2007). Trauma stems from a traumatic event that generates extreme stress, "such that the resources of the person are overwhelmed" (Quosh & Gergen, 2008, p. 98). Definitions of what constitutes a traumatic event are broad, and include military combat, a natural or human-caused disaster, a violent personal attack, or a serious accident. According to Allen (1995), the

more the individual perceived that he/she was in danger, the more severe the resulting traumatization (as cited in Quosh & Gergen, 2008). Trauma can generate injuries both physical and psychological in nature. In terms of the medical model of diagnosable mental health conditions, psychological adaptations to trauma include post-traumatic stress disorder, major depression, dissociative phenomena, substance disorders, and anxiety disorders (Wilson, 2007).

Post-Traumatic Stress Disorder (PTSD)

The Vietnam Veterans Working Group (VVWG) in the United States was instrumental in pushing for a reconsideration of trauma in the 1970s. During their campaign to get PTSD recognized as a disorder, they extended their definition of trauma to include other forms of stress, as they believed that this would strengthen their case (Quosh & Gergen, 2008). In 1980, with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III), the VVWG succeeded in getting the symptoms of trauma pathologized under the title "Post-traumatic Stress Disorder" (Quosh & Gergen, 2008).

The diagnostic criteria for PTSD include a specific traumatic event, followed by the presentation of three main symptoms for at least one month: "1. the persistent re-experiencing of the traumatic event causing distress and signs of panic; 2. the persistent avoidance of stimuli associated with the trauma, numbing of general responsiveness; and 3. the persistent symptoms of increased arousal" (DSM IV, as cited in Quosh and Gergen, 2008, p. 98).

PTSD is classified as an anxiety disorder, but is the only disorder in the manual to specify an etiologic event as part of the diagnostic criterion (Quosh and Gergen, 2008). What was at first a disorder introduced through a campaign of recognition is still very political today. Veterans diagnosed with PTSD received compensation, and now the diagnosis of PTSD has become an important part of the refugee claims process. Without denying the impact that trauma has on the body and mind, especially for those who have endured unfathomable heights of violence, critics of PTSD and the trauma-based approach to counselling question the prevalence of this diagnostic category and its relevance across cultures.

Suffering

Some perspectives on suffering are pertinent to this review as the main critics of the trauma-based approach to counselling survivors of organized violence have claimed that the prevalence of PTSD in diagnosis and treatment has served to "medicalise" and "pathologise" human suffering (Blackwell, 2007; Bracken et al., 1997; Goździak, 2009; Papadopoulos, 2007; Quosh & Gergen, 2008; Summerfield, 2002). Goździak (2009) points out that suffering is "a universal aspect of human experience in which individuals *and* groups have to undergo or bear certain burdens, troubles and serious wounds to the body and spirit [author's emphasis]" (p. 147). In addition, Bowker (1997, as cited in Goździak, 2009) asserts that it is the relations of individuals together in a society that

attribute meaning to suffering, and in this way suffering needs to be viewed as more than the sum of its parts. This is a call to dig for the causes of suffering, which is in essence the job of the counsellor. Tribe and Keefe (2007) pose the important question, "do we not need to involve ourselves in campaigning for better conditions of asylum and for an end to the armed conflict and persecution which causes movements of refugees?" (p. 250).

The Term "Survivor"

The use of the term survivor is not without its complexities. Reynolds (2010) uses the term in her practice with survivors of torture, yet prefers the word "victim" as it clearly places responsibility for violence in the hands of the perpetrator(s). Use of the word survivor throughout this review is intended to honour the strength and resilience of people who have survived the heights of terror, brutality, and imposed degradation.

Perspectives on the Mental Health of Refugee/Asylum Seeking Survivors of Organized Violence

"[C]ontroversy about the impact of psychic trauma on populations exposed to mass violence and displacement has tended to dominate debate in the field, with two theoretical poles emerging…" (Silove, 2005, p. 32). Advocates of the universalistic or etic perspective assume that patterns of psychiatric disorder can be identified across cultures and contexts with minor variations (Silove, 2005). They believe in the pervasiveness of trauma in survivors of organized violence, and its psychological consequences, which can be categorized into diagnostic categories. They stand in opposition to transculturalists and post-modernists who regard culture as pivotal in both the framing of mental distress, and the way it is expressed (Minas & Silove, 2001, as cited in Silove, 2005).

A Critique of the Existing Research on the Mental Health of Refugees

While it is right to assume that survivors of organized violence experience varied degrees of pain and discomfort, it does not logically follow that they all suffer from a mental disorder such as PTSD (Papadopoulos, 2007). In the 1990s, mental health professionals in industrialized countries reached the consensus that there had been a severe lack of mental health resources available to refugees in previous decades. According to Bracken et al. (1997), the mental health disciplines in the 1990s, beset by a sense of responsibility, became preoccupied with how to better offer services to vulnerable refugee populations. This led to a proliferation of research and service programs designed and directed specifically at refugees and survivors of organized violence, which aimed to control, "the disorder provoked by suffering and loss through instituting programs of analysis and therapy" (Bracken et al., 1997, p. 434). Research and programming during this era were guided by assumptions that characterize dominant mental health practice: (a) psychiatric knowledge, like medical knowledge, is an applied science; (b) psychiatric knowledge is disinterested, neutral and objective, and its techniques are value-free; and (c) it is a rational discourse (Bracken, et al., 1997, p. 433). These assumptions are increasingly problematic for a growing number of practitioners

and researchers, particularly those who ascribe to transculturalist and postmodernist perspectives.

Studies in the domain of refugee mental health have only recently started to focus on experiences of socio-political violence, collective suffering, and the presence of disease and trauma as interrelated phenomena (Pedersen, 2002, as cited in Goździak, 2009). Research on survivors of organized violence has also centred on the West's individualistic conceptions of the self, which Goździak (2009) believes has contributed to several flaws in the majority of existing literature, and has led to the overestimation of psychiatric disorder among refugee populations. First, a large majority of research has been conducted with individuals who have actively sought out help, or who have been referred to mental health professionals (Eisenman et al., 2003; Fernadez et al., 2004; Hinton et al., 2000; all as cited in Goździak, 2009). Second, individuals requesting asylum may exaggerate experiences of trauma in order to strengthen their claims, which poses a challenge to accessing accurate data (Keller et al., 2003; Laban et al., 2004; both as cited in Goździak, 2009). Third, the majority of research with asylum seekers and refugees takes place in the camps before resettlement, or directly after migration – a period of time when stress is probably the most acute (Goździak, 2009). Additionally, studies have relied heavily on strandardized screening instruments, such as the Harvard Trauma Questionnaire (HTQ), the Clinician Administered PTSD Scale, and the Post-traumatic Stress Diagnostic Scale. In reference to their own use of the HTQ with Tamil refugees and asylum seekers, Steel, Silove, Bird, McGorry, and Mohan (1999) acknowledge that "the questionnaires, although appropriately translated and back-translated, are based on constructs of mental disorder that may not be identical to notions of traumatic stress in Tamil communities" (p. 430). Detractors of the trauma-based approach doubt the accuracy of these measurement tools that use three to five point scales to code for the frequency and intensity of symptoms linked with PTSD as set out in the DSM IV. Another point, which will be taken up in more detail later on, is the concern expressed by some professionals that existing research on refugee mental health has overlooked the large majority of refugees who display enormous capacities for resilience.

Trauma as Pathology – A Universalist Perspective

While statistics concerning the pervasiveness of mental health disorders among refugees vary, proponents of the universalist approach estimate disorder at a notably higher rate than those with transculturalist or postmodernist leanings. For example, according to Bemak and Chung (2002, as cited in Li et al., 2004), PTSD among the clinical refugee population is 50% or higher, and depressive disorders range from 42% to 89%. The pervasive belief in this approach is that refugee mental health is universally lower during acculturation due to stress, identity confusion, anxiety, depression, feelings of marginality, and alienation (Berry, 1990; Furnham and Bochner, 1986; both as cited in Li et al., 2004, p.125). During this process, refugees often do not get the support that they need, rendering them "vulnerable to mental breakdown" (Li et al., 2004).

Trauma as Pathology? Postmodernist Approach

It is difficult to define trauma according to a universal standard. As explored above in the background section of this review, the definition of trauma has become more expansive, and includes a wide range of diverse etiologic events. Parallel to this trend, critics of the universalistic approach to mental health, trauma, and PTSD have called the medicalisation of suffering into question. As Gergen and Quosh (2008) point out:

> In effect, mental health professionals, in concert with the pharmaceutical industry, contribute to the creation of the "illnesses" for which they provide the "cure." In the case of PTSD, by avoiding the political implications of the categorization, the mental health field has also succeeded in generating reactions to stressful events as abnormal: despite its political origins, the category has shifted to a pathological medical category. (p.103)

By framing the "problem" within the individual, mental health professionals, and society, are absolved of the responsibility to address the socio-political context that played a role in causing said problem. Further criticisms of the widespread diagnosis of PTSD challenge the ability of a diagnostic category to capture the multiple and complex effects of trauma. Even the term "post-traumatic" to describe a condition, which in the case of the refugee or asylum seeker may be ongoing, can be problematic (Goździak, 2009). The tendency to universalize the symptoms of trauma so that they fit within the symptomatology of the DSM IV can also mean that other symptoms go unrecognised, such as the existence of secondary distress due to migration and acculturation (Blackwell, 2007).

Between 1980, the year that PTSD was introduced into the DSM IV, and 1999, over 16,000 publications on PTSD have been written and stored in the database of the U.S. National Center for PTSD (Summerfield, 2000). While none of the critics of the pervasive use of PTSD diagnoses deny that there is tremendous suffering involved in being witness to, or surviving, horrendous acts of violence, they question the framing of normal reactions to traumatic events as disorders, which insinuates abnormality and disease. Blackwell (2007) emphasizes this when he cites yet another detractor of PTSD discourse, "Yet, as Yehuda (2003) has pointed out, the three symptom groups i.e., re-experiencing, avoidance, and arousal, are virtually universal reactions to extremely shocking experiences and should not be classified as abnormal" (p. 255). In the case of refugees or asylum seekers resettled in the West, those who were targeted in their countries of origin are declared sick in the host country by mental health professionals (Becker et al., 1990, as cited in Rousseau, 2000, p. 193).

As an alternative to using the PTSD model, Papadopoulos (2007) suggests a conception of trauma as an attack on one's capacity to be resilient, or what he refers to as an attack on the psychological immune system. How would mental health professionals approach work with resettled survivors of organized violence if trauma discourse were disturbed and reformulated on a mass scale in the ways discussed above?

Pathologizing Distress and Trauma – Impacts and Implications

Rather than assisting people to heal, the label of PTSD and the framing of suffering in biomedical terms may actually reduce people's ability to deal with suffering and pain (Rousseau, 2000; Summerfield, 1999, and Pupovac, 2002, both as cited in Goździak, 2009). Furthermore, dominant mental health discourse appropriates what may have been a natural response to unnatural events and situations, and constructs the problem as being beyond the capacity of the individual, thereby necessitating the intervention of professionals and experts to analyse and heal (Lock, 1997, as cited in Goździak, 2009). Survivors of organized violence involved in a therapeutic relationship based on prevailing Western notions of trauma may begin to consider their distress through the dominant framework, i.e., the language and structures available to them. In a post-structuralist analysis of this dynamic, insofar as speech is understood as an act that makes meaning, the dominant group thus translates, attributes, or lends its own meaning to what is said, rendering speech outside of dominant discourse "unspoken" (Spivak, 1988, as cited in Skott-Myhre, 2008).

With asylum seekers, there is also the added element of having to navigate a system that requires proof of persecution, where, for example, a person who would not necessarily qualify their experience as torture would do so to increase the likelihood of getting accepted (Bracken et al., 1997). The literature highlights two negative outcomes stemming from this. The first is that the person's ties to their meaning-making structure are loosened, weakening their connection to their culture of origin and its built-in coping strategies, thus undervaluing the individual's capacity to cope (Bracken et al., 1997). The second consequence is the creation of identities of victimhood among people who may not have considered themselves victims before the therapeutic encounter (Goździak, 2009), or assigning refugees a "sick" role instead of the opportunities that would be necessary to begin the healing process in a new country (Rousseau, 2000; Summerfield, 2000).

Lastly, the generalization that survivors of organized violence have been traumatized and damaged can contribute to the creation of a "spoiled identity" (Summerfield, 2002). This is particularly prescient if we consider the number of children exposed to war. The United Nations refers to children of war as a "lost generation", insinuating a damaged psychology that may never fully heal (Summerfield, 2002). The U.N. estimates that 10 million children were traumatized by war, or "lost", between 1990 and 2000. A 1995 report claims that 40% to 50% of all refugee children in the United States have a severe psychiatric disorder (Sack, Clarke, & Seeley, 1995, as cited in Summerfield, 2000). This leads Summerfield (2000) to pose some important ethical questions: Have people consented to having their identities defined in this way, and what might the implications be for assuming that refugee children affected by war will be psychologically vulnerable in the long term? To take it one step further, to what extent might diagnoses shape the identities of these young people?

Despite heavy criticism of PTSD, the field broadly recognizes the relevance of

diagnostic categories, and that to operate separately from them is not presently an alternative. As previously mentioned, Western psychotherapy based on the DSM IV may assist some people to make sense of their anguish and distress. On a practical level, the PTSD label is too bound up with insurance policies, legal codes, and corporate interests to be threatened (Quosh & Gergen, 2008). As Gary Fewster (2002) writes in his critique of the DSM IV:

> ... DSM IV has now become the power base of the service delivery system, the controlling mechanism through which services are funded and provided. Without a "diagnosis" people in trouble have very limited access to professional resources and service providers are unlikely to attract sponsors unless their patients or clients are judged to be suffering from some classified syndrome or disorder. (p. 379)

Thus until a viable alternative emerges, capable of taking the complexity of the human experience into consideration, mental health professionals have to learn to live and work with the DSM IV. The literature seems to suggest that mental health professions need to move towards an approach that utilizes knowledge from traditional psychotherapeutic models while recognizing that the bio-psycho-medical approach alone may harm the very people they are trying to help.

The following sections will explore numerous approaches, suggestions, and musings on how to work responsibly and appropriately with refugees and survivors of organized violence. The literature explores the inclusion of local knowledges and traditional approaches to mental health as a means of reconciling the two very distinct perspectives outlined above.

Diverse Approaches to Working With Resettled Survivors of Organized Violence

Putting the Migratory Experience into Context

Modern conflicts do not only target people, but entire ways of life that serve to connect humans to a particular identity (Summerfield, 2000). Women and children bear the brunt of modern conflicts (Summerfield, 2000; Goździak, 2009; Eisenbruch, deJong, & van de Put, 2004), and constitute the majority of displaced people worldwide. Leaving one's country unexpectedly, and indefinitely, is extremely difficult. The process of migration that asylum seekers and refugees undertake is a journey marked at first by extreme loss, which may include the loss of home, country, culture, family, homeland, profession, language, friends, social support, shared cultural, spiritual, political, or religious views, and, perhaps most importantly, plans for the future (Tribe & Keefe, 2007, p. 249).

The process of acculturation is no easier, as refugees who resettle in the West have to reconcile their idealized vision of exile with the reality of a sometimes hostile or racist host population (Rousseau, 2000). Asylum seekers in the West are thrust into a

legal process upon arrival, which first assumes that they are liars and fraudsters, and then requires them to prove otherwise by revisiting the events that caused them to flee over and over again (Rousseau, 2000). This has resulted in a shift in the public perception of refugees, which tends now towards considering them burdens on society. Within this context, counsellors and other mental health professionals are often called upon to offer proof of torture, mental illness, PTSD, etc., as part of the asylum claim. This places therapists in the undesirable position of having to either believe their client or not (Tribe & Keefe, 2007). The discourse around lies and "false refugees" can serve to trivialize the experiences of those who have survived traumatic events, and may need to be addressed in therapy (Rousseau, 2000). Many refugees are resilient; however, the people that do seek out help usually require assistance on multiple levels. Frequently articulated needs include welfare support, legal advice, access to social services, assistance in language learning, family reunification, and therapeutic support (Tribe & Keefe, 2007).

Considerations for Counsellors

Therapies aimed at assisting survivors of organized violence involve a discourse of "healing" and "recovery", which places an expectation on clients to solve a problem that exists within themselves instead of in society (Summerfield, 2002). Elaborating on the notion of internalized problem discourse, Summerfield (2000) writes:

> Indeed, Western psychological models have never really acknowledged that social action directed at the conditions of one's life might be a strategy for improving mental health. Psychotherapy promotes an ethic of acceptance: it is the individual who has to change, not society. (pp. 5-6)

Counsellors face the challenge of being able to understand the wide range of reactions to extreme violence as "normal", while working to alleviate the very real manifestations of suffering (Summerfield, 2002; Rousseau, 2000). Not many mental health professionals in the West have had the experiences that refugees have had, and thus an effort to comprehend the particular socio-political contexts that lead to migration is important. The literature also proposes that counsellors allow room in the therapeutic encounter for the individual to make meaning of their own traumatic experience, and "historicize" their experience (Lira, 1995, as cited in Peltzer, 2001). However, is this feasible within the dominant approaches to counselling?

Richman (1993, as cited in Rousseau, 2000) questions the dominant approach of "talk therapy" to treat survivors of organized violence by problematizing a model that ascribes a diagnosis, then asks people to relive trauma in order to work through it. Could the non-verbalisation of trauma help some survivors cope? It is clear that mental health professionals do not agree on one coherent approach to responding to the needs of survivors of organized violence. However, this general review of the literature has revealed that working with this population requires a commitment to address a diverse range of needs, and necessitates that counsellors wear different "hats". Refugees require support throughout the claims and resettlement processes, which necessitates that counsellors hold a genuine commitment to the right of asylum and engage on various

levels of the client's experience in order to develop a therapeutic alliance (Rousseau, 2000). Post-migration, practical and logistical issues present most urgently, and refugees and asylum seekers may initially value the mental health professional for advocacy work more than for anything else (Summerfield, 2000).

The Trauma-Based Approach to Therapy

Trauma assessment involves the identification of symptoms of disorders resulting from trauma, and in the majority of cases leads to medicalized interventions of conditions such as PTSD. The trauma-focused approach to therapy is grounded in the premise that patients need to reveal as many details about their traumatic experiences as possible to allow for catharsis and a process of meaning-making (Peltzer, 2001, p. 246). In working with survivors of torture, Peltzer (2001) outlines the following steps involved in trauma-based methodology:

> 1. Detailed recollection of past trauma (in chronological order and in precise detail), express suppressed anger, rage, grief, and hatred;
> 2. Analyze psychological defense mechanisms, uncovering unconscious memories, and actively reintegrating traumatizing experiences (Morris & Silove, 1992);
> 3. Focus on individual's own thoughts, fantasies, emotions, and aspirations;
> 4. Focus on torture and violation of personal integrity and identity. (p. 246)

It is important for counsellors using this approach to recall that traumatization is cumulative and, as mentioned earlier, possibly ongoing if the client is experiencing difficulties with acculturation. Also, it demands particular skills of the therapist, who must be careful not to become "overwhelmed by feelings of powerlessness" (Peltzer, 2001, p. 245).

It is important to mention Cognitive Behaviour Therapy (CBT) in particular as there have been many studies conducted on the effectiveness of CBT in the treatment of PTSD. Cognitive behaviour therapy is based on the assumption that reorganizing the way one thinks will result in the reorganization of behaviour. "Among the most prominent interventions in this tradition are training procedures aimed at establishing self-regulation through the development of self-monitoring, self-generated problem solving strategies and self-evaluations of outcomes" (Kendall & Braswell, 1985; Lochman & Curry, 1986; both as cited in Shirk, 1999). The use of CBT is centred around a belief in the universality of the symptomatology and expression of traumatic stress. According to the authors of a recent study conducted in the United States, intention-to-treat analysis revealed that 44% to 60% of clients with PTSD showed significant improvement after participating in CBT (Kelly, Rizvi, Monson, & Resick, 2009, p. 287). The study compared the use of cognitive processing therapy (CPT) with and without the use of written accounts, and a percentage of participants were asked to write down their worst traumatic event ever and read it repeatedly to themselves and their therapist. Although this study was not conducted with survivors of organized violence, it is instructive in that

it is an example of the type of technique that critics of traditional trauma-based approaches to mental health feel may be culturally, or even ethically, inappropriate.

As cited in Regel and Berliner (2007), the National Institute for Clinical Excellence (NICE) in Britain states in their guidelines that CBT is an effective treatment for PTSD. Regel and Berliner (2007) argue that not only is CBT effective in treating PTSD, but it is culturally appropriate for working with survivors of organized violence, including torture. Because CBT operates on a rich understanding of the relationship between behaviour, cognition, emotion and context, it is able to effectively focus on the problems presented. It is directive and collaborative, and "often fits the expectations of clients from other cultures who frequently desire practical solutions to their problems" (Regel & Berliner, 2007, p. 290). Based on the premise that substantive attitudinal change can only occur through a change in behavioural experience, Regel and Berliner involve their clients in the selection of techniques and treatment plans, thus making room to take into account social and political factors in order to debunk the "this is my fate" view of distress. What may also account for CBT's popularity is that it is a brief form of intervention, usually occurring over the span of several months, and is considered by service providers to be more cost-effective than other forms of mental health treatment (Regel & Berliner, 2007).

In reviewing work done with people living with trauma, other research states that there is no clear-cut evidence that psychological debriefing after a trauma is effective (Rafael, Meldrum, & McFarlane,1995, as cited in Summerfield, 2000; Bisson, 1998, as cited in Rousseau, 2000). However, different types of debriefing, based on alternatives to the Western medical model, have been developed. For example, similar to the written accounts discussed above, but framed by a completely diferrent theroretical orientation, "testimony therapy" was successfully used in Chile and Argentina with survivors of organized violence in the 1980s. Survivors wrote down detailed accounts of traumatic events, and the testimonies were subsequently used to document war crimes. Narrative therapy approaches, which will be discussed below, support clients in developing narratives using the client's vocabulary and meaning-making structures, and creates opportunities to link private pain with public issues.

A Strengths-Based Approach to Therapy

A recurrent observation encountered in the literature suggests that the number of people thought to develop PTSD and need professional mental health care in the aftermath of organized violence is grossly overestimated (Goździak, 2009; Papadopoulos, 2007; Rousseau, 2000; Summerfield, 2002; Wilson, 2007). By one estimate, the number of people who require psychosocial help or who actually experience the symptoms of PTSD after a traumatic event is 20% (Rousseau, 2000). More recent data claims otherwise (Fazel et al., 2005, as cited in Goździak, 2009):

> A meta-analysis of interview-based studies of the prevalence of PTSD, major depression, psychotic illness, and generalized anxiety disorder in refugees resettled in Western countries revealed that about one in ten adult refugees has

PTSD, about one in 20 has major depression, and about one in 25 has a generalized anxiety disorder.(p. 151)

The literature reminds us that post-traumatic reactions fall on a continuum between traumatized and resilient, but also that the reality that trauma "has the potential to dysregulate emotions and set up complex patterns of prolonged stress cannot be dismissed as statistically infrequent" (Kessler et al., 1996, as cited in Wilson, 2007, p. 25). This begs the following question: Is it possible to take all of these factors into consideration and build an approach based on the strength and local knowledge of clients?

There has been some research done on resilience and positive outcomes following trauma. Although this approach is not dominant in Western service provision, it offers interesting tools to reframe refugee mental health. Papadopoulos (2007) suggests that adversity can serve to strengthen individuals in certain instances, a trend he calls adversity-activated development (AAD). Other terms for similar ideas include: stress-related growth, crisis-related growth or development, thriving in adversity, post-trauma growth, positive transformation following trauma, positive transformation of suffering, etc. (Affleck & Tennen, 1996; Folkman, 1997; Harvey, 1996; all as cited in Papadopoulos, 2007). These theories are based on the belief that in moments of intense adversity, people are pushed beyond the limits of what they thought themselves capable of, permitting a new sense of self to emerge. Whereas resilience signifies the capacity to withstand pressure and stress, to retain qualities that existed before the trauma, AAD leads to the development of new strengths. Papadopoulos' article is extremely instructive in that it reminds professionals to avoid totalizing, generalizing, and assuming what their clients are experiencing. The complexity of the human experience is such that people often experience conflicting emotions simultaneously and, as previously mentioned, the role of the professional counsellor is to assist the client to make meaning of his or her own experience.

Narrative Therapy

Practices of narrative therapy are intended to assist people to re-author the stories that constitute their sense of themselves. White (2006) contends that trauma can cause people to experience a dislocation from "a particular and valued sense of who they are" (p. 26). Viewed in this way, part of the narrative therapist's role is to aid the person in getting in touch with their preferred sense of self (White, 2006). Referred to as "double listening", narrative therapists strive to uncover what the client values in his or her life, as well as moments when the person may have responded to or resisted trauma. Based on the power analytics of Michel Foucault, narrative therapy seeks to externalize traditionally internalized problem discourse so as to better understand oppressive discourses. This opens up interesting terrain in working with refugee survivors of organized violence, which often requires that counsellors move effectively between the personal and the public, the personal and the social, the individual and the cultural. Narrative practice offers an doorway into a heightened understanding of the political within the therapeutic encounter which, for some counsellors and survivors of organized

violence, may serve as the foundation for the emergence of a relationship of trust. Addressing this directly, Denborough (2008) asks, "How can we provide forums for the sorrow, anguish and hardship of the stories that we receive to be transformed into collective actions?" (p. 192).

Incorporation of Cultural Knowledge into Work With Refugees and Survivors of Organized Violence

In reference to Canada, Duran and Dana (1995, as cited in France, del Carmen Rodriguez, & Hett, 2004, p. 49) state that, "[C]ontemporary service delivery is still failing not only First Nations but other ethnic groups as well…Most providers are trained only in delivering services to the majority/dominant population". Dana (2007) outlines the lack of knowledge of the cultures of origin of immigrants and refugees in service provision. Therapeutic encounters with asylum seekers and accepted refugees in the West are usually "pluricultural" or "cross-cultural" in nature, and require that professionals possess an astute awareness, understanding, and sensitivity to their own cultural location and biases, to the culture of origin of their clients, the conditions that led to migration, and the challenges of acculturation. In the reviewed literature, the centrality of culture to working with refugees and asylum seekers is mentioned frequently. If we are to keep culture front and centre, we must ask ourselves, are Western notions of mental health universal, and can diagnoses be carried across cultural lines? What elements of the client's culture of origin can mental health professionals incorporate into therapeutic practice? Before exploring this, an examination of Canada's "multicultural" context, and approaches to culturally sensitive practice would be instructive.

Culture – Some Considerations

Refugees and asylum seekers who resettle in Canada enter a country that has defined itself as multicultural. Unlike models of assimilation, or interculturalism, multiculturalism posits that individuals of diverse backgrounds coexist peacefully side by side, retain their core values and beliefs, and share in the nation's common values. Critics of Canada's multiculturalist model say that it does not allow for the substantive understanding of diversity as it precludes the possibility of multiple and shifting identities, and has a tendency to be reductionist, thereby making invisible hierarchies and power structures (Moodley, 2007). Official multiculturalism in Canada is a policy of depoliticization, which Brown (2006) strongly cautions against when she writes, "[d]epoliticization involves construing inequality, subordination, marginalization, and social conflict, which all require political analysis and political solutions, as personal and individual on the one hand, or as natural, religious or cultural on the other…" (p. 15).

Many of the authors cited in this review call for an authentic understanding of the complexity of culture, both the therpist's and the client's, so that it may be integrated into practice. Authentic understanding of culture is difficult, if not impossible to attain, as there is always the risk that we fall into cultural relativism. Hoskins (2003) warns of inherent difficulties in interpreting cultural awareness as striving to understand all cultures as equal, as it may reduce the counsellor's capacity to be critical of culturally

embedded ideas that run counter to ideals of freedom and equality. Nanda (2004) criticizes the fetishization of majority world culture, and cautions against what she calls "culturalism". In what seems like a direct answer to post-structuralism, Nanda writes:

> The post-developmentalist notion of the non-Western cultures is shaped by the ideological needs of *Western* intellectuals…to invest other cultures with critical force against their own supposedly hyper-rational, one-dimensional scientist culture. This radical xenophelia of Western intellectuals has minimized the theoretical space for a critical assessment of non-Western cultures…*treating rationality and knowledge as completely constructed by culture puts culture beyond a reasoned critique.* (pp. 215-216)

Culture and Practice

Del Carmen Rodriguez, (2004) tells us that, "Worldview refers to the outlook or image we have concerning the nature of the universe, the nature of humankind, the relationship between humanity and the universe and other philosophical issues or orientations that help us define the cosmos and our place in it" (p. 31). While some of the symptoms of PTSD may be experienced across cultures, it is the variance of world view that leads to the difference in perceptions of mental health and healing (Wilson, 2007). Del Carmen Rodriguez (2004) suggests that by getting to know the world view of the client, counsellors can adapt their practice in ways that will resonate with that individual's cultural reference points. As Hoskins (2003) affirms, the goal is not to develop ethnic-based skills and strategies, but a flexible approach that is reflexive, and that strives to uncover one's own cultural biases and assumptions. France (2004) points out that all counselling is in essence multicultural, and urges the field to move away from the notion that cross-cultural techniques belong to a specialized knowledge kit.

Involving Local Traditional Knowledge

Every culture has its own psychological knowledge (Summerfield, 2000). A growing number of professionals have called for the inclusion and integration of traditional healing practices into counselling across cultures (Summerfield 2000; Goździak, 2009; Moodley, 2007; Wilson, 2007). Wilson (2007) urges openness among counsellors when he writes, "The concept of traumatic stress and the multidimensional nature of cultures requires a conceptual framework by which to address core issues that have direct relevance to understanding the nature of trauma as embedded within a culture" (p. 8). Goździak (2009) proposes an eclectic approach to working with survivors of organized violence, involving: indigenous healing strategies, the role of spirituality and religion, human rights and truth and reconciliation approaches, ethnography and participatory action research, and psychosocial programs. However Hoskins' (2003) approach to "cultural listening" may be the most instructive in terms of how to orient oneself to working with people experiencing distress and suffering. She states:

> What is really needed is the ability to sit and just "witness" the pain of years of oppression, to honestly admit that there is really no way of rectifying the kinds of

injustices that have been levied towards one culture for the benefit of another, and to listen so carefully to the contours of a person's experience that one's own perspective shifts considerably just through the act of listening. This for me is what it means to be culturally attuned. (p. 331)

Reflections on What is and What is not There

This literature review aimed to provide a broad overview of the main debates around conceptions of mental health and the resulting approaches to working with survivors of organized violence. Thus an exhaustive look at the literature on this topic was not intended. However, this review did succeed in highlighting several gaps in knowledge and information. First and foremost, as highlighted above by several authors, there is a lack of longitudinal research on survivors of organized violence in their countries of resettlement. These types of studies would allow for the long-term assessment of symptoms, and carries the potential to restructure the way in which trauma, PTSD, and treatment are conceptualized.

Secondly, there is recognition amongst the detractors of PTSD that what refugees need just as badly as mental health treatment upon arrival in new countries is a sense of order. This order comes from the stability and peace found in a predictable and safe day-to-day routine, which is wholly dependent upon having enough to eat, a place to live, and a sense of community. There is an abundance of information written by and for academics and mental health professionals, but very little research that focuses on community work and mental health. A collaborative project between front line community workers and mental health professionals is called for. There is also an absence of research conducted in collaboration *with* survivors. A community-based research project that involved survivors of organized violence in asking their own questions, and finding their own answers, would be an invaluable source of learning for counselling in this domain.

Lastly, there is a lack of Canadian research on this topic. Particularly because interactions with migrants are cross-cultural, local research is crucial in the formation of nuanced sensitivities around elements of the socio-political context of the host country that support and hinder healing. The literature on counselling resettled refugee and asylum seeker survivors of organized violence does not elucidate one coherent, fixed or clear approach to practice. However, it points to an important shift taking place within the mental health field that questions the universal imposition of the biomedical Western model. This shift urges counsellors to cross borders, blend the socio-political with the psychological, and open themselves up to cultural encounters that defy definition.

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