Chapter 1
Introduction

1.1 RESEARCH RATIONALE AND AIM

South Africa harbours approximately 26 000 legal refugees (UNHCR, 2004) and a further 140 000 undetermined asylum seekers, arriving from Angola, Burundi, Congo-Brazzaville, the Democratic Republic of the Congo, Ethiopia, Rwanda, Somalia and Sudan (Landau, 2006) and more recently Zimbabwe. South Africa continues to struggle to find an appropriate supportive system for the increasing number of asylum seekers (Handmaker, 2001; Landau, 2006; Palmary, 2005). This has led to asylum seekers struggling to establish legality and access basic social support systems. South Africa's refugee system is also complicated by the general migratory patterns of other African people seeking to better their economic prospects, as they have learnt to make use of the asylum seekers' process of establishing legal status, as the overburdened and corrupt immigration system often allows for a relatively easy legal ticket into South Africa. The confusion between economic migrants, as well as other migrants from within South Africa has led to general public and government misunderstandings and has increased xenophobic tendencies in all corners of South African society. Refugees in South Africa are confronted with an immense struggle to gain legal status and as a consequence very few social support systems are available to them. This has made South Africa not as safe a haven for refugees as, for example, Europe or the United States of America. This research report argues that the relatively unsafe and unstable setting that refugees find themselves in impacts on the type of psychotherapeutic intervention appropriate for them.

Therapists in the South African context working with African refugees/asylum seekers (A.S.)[1] have very little established theory and practice to draw on, which makes it difficult for them to manage such therapeutic work. In order to support therapists in South Africa with their psychological work with African refugees it seems important to

[1] The terms refugee and asylum seeker (A.S.) are often used interchangeably, although the term refugee is the more common term used in the literature.

give voice to both the subjective experiences of the therapists and of African refugees who have undergone psychotherapy. In so doing, the aim of this study is to gain a clearer understanding of the strengths, dilemmas, potential solutions and emerging guiding principles encountered in such work. These experiences can then be compared to documented experiences, issues and solutions found in more Western settings and some in less stable settings. Important is to see whether the contexts are at all comparable and whether different or similar solutions are useful. In order to do this, one needs to get a clearer understanding of the therapeutic experience from therapists and asylum seekers themselves. There appears to be no formal literature concerning therapeutic work with African refugees in South Africa or on refugees' subjective experiences of psychotherapy, and there is very little literature concerning similar contexts. Authors such as Landau (2006) and Palmary (2005) suggest that research into health service provision for refugees is much needed. This includes mental health services, including psychotherapy.

1.2 OUTLINE OF THIS REPORT

In order to gain an understanding of the therapeutic task set for therapists when working with refugee clients, Chapter 2 commences by examining the psychological impact of the entire refugee experience. The consequences of forced migration are layered and the psychological distress resulting from this experience is influenced by social, cultural and political heritage and present context. This section outlines the importance of recognizing contextual and cultural meanings when working with African refugees in a South African context. The second section of Chapter 2 discusses the impact of the South African refugee context on the refugee experience as well as its influence on therapeutic interventions with refugee clients in this context.

Keeping the impact of the unsafe South African context in mind, Chapter 2 section three looks at different counselling approaches used to assist refugees around the world. The literature speaks of a variety of approaches including: Cognitive-Behavioural Therapy, Rational Emotive Behaviour Therapy, Testimony Therapy, Narrative Therapy, integrative approaches such as the Wits Trauma model and various forms of on Psycho-

dynamic Therapy (Ager, 1999; Eagle, 1998; Kinzie, 2001; Levy, 1999; Luebben, 2003; Neuner et al., 2004; Paunovic & Ost, 2001; Woodcock, 2001). These approaches are touched upon, as well as general therapeutic principles, cross-cultural counselling principles and an understanding of the two pronged psycho-social approach. Section four discusses the usefulness of therapeutic approaches in unsafe contexts, noting the possibility of sequential traumatization as a consequence of therapy, and the beneficial impact of Testimony Therapy, Narrative Exposure Therapy and the Psycho-Social model.

The last section of Chapter 2 focuses on the main difficulties confronting therapists working with refugees. As there is no literature concerning therapists' experience of working with refugees in South Africa, and very little literature concerning similar contextual settings, this study will compare what has been found in the literature to the South African setting and attempt to explore possible solutions or guidelines to therapeutic work in this specific setting.

Chapter 3 discusses the research method used in this study. The aims of the study as well as the methodological approach appropriate to this aim are elaborated on. An outline of the research questions is presented as well as details about the research participants and how they were located. Details of the data collection and analysis are provided. This chapter concludes with reflexive and ethical considerations intrinsic to the research.

Chapter 4 discusses the South African refugee experience as depicted by the interviewed refugees and therapists working with refugees. The discussion first explores *the general refugee experience* in greater detail, and secondly explores *the urban South African refugee experience* more specifically. Having outlined the lived experience of being a refugee in South Africa, the second section discusses refugees' experience of counselling. The last part of this chapter outlines refugees' descriptions of their psychological distress.

Chapter 5 comprises a discussion centered on the main findings of this research. These findings are guided by the research questions and centre on the benefits of therapy; the dilemmas that therapists struggle with; and possible solutions to many of these

therapeutic dilemmas. Although several aspects of the themes arising from the data are supported by themes in the literature review, other aspects of themes were noted to be unique to this research project. The discussion addresses the aims of this study, addressing each research question separately, and ends with a holistic summation of possible solutions and recommendations for therapeutic work with refugees in the South African context.

Chapter 6 provides a brief discussion of interpretive reflections concerning the process of therapeutic work with refugee clients. It focuses on the impact of the distress of the refugee experience on both the refugee clients and the therapists. It poses some questions about possible defensive processes at play in such therapeutic work and also touches on the powerful transference and countertransference dynamics between refugee clients and therapists, the impact of this and possible psychological pitfalls.

The final chapter presents a summary of the main findings of the study and notes the limitations of this present study. Reflecting on these findings and limitations, it then provides some thoughts on the implications of this study for future research within the area of therapeutic work with refugees in unsafe contexts and the South African context in particular.

CHAPTER 2

Literature review

2.1 Introduction

As mentioned previously, South Africa harbours approximately 26 000 legal refugees (UNHCR, 2004) and a further 140 000 undetermined asylum seekers, arriving from Angola, Burundi, Congo-Brazzaville, the Democratic Republic of the Congo, Ethiopia, Rwanda, Somalia and Sudan (Landau, 2006) and more recently Zimbabwe. It has been a struggle to find an appropriate supportive and protective system for refugees in South Africa (Handmaker, 2001; Landau, 2006; Palmary, 2005). This has made South Africa not as safe a haven for refugees as, for example, Europe or Canada. This research report argues that the relatively unsafe and unstable setting that refugees find themselves in impacts on the type of psychotherapeutic intervention appropriate for them. This in turn impacts on the therapist's preparedness for this task. Therapists in the South African context working with refugees have very little supporting evidence to base their practice on or suggestions from other literature to go by. This report is motivated by the argument that the unique situation that South Africa presents needs to be examined more closely in terms of effectiveness of therapy, what is required of therapists, issues faced by therapists and the impact of this work on therapists in South Africa. This hopefully will produce some knowledge to inform working with refugees in unsafe and largely uncontaining settings.

In order to gain an understanding of the above issues this review first reflects on understandings of psychological distress experienced by refugees as this in essence is the reason for contemplating psychotherapeutic support for refugees. The literature review then discusses in more depth the South African refugee context, arguing that this context plays a necessary understood foundation around which this research revolves. The third section discusses counselling approaches used to assist refugees around the world and the forth section explores the usefulness of these approaches for refugees in unsafe contexts. The last section of the literature review explores the difficulties confronting therapists

working with refugees that are mentioned in the literature. The literature review grounds this present study with established knowledge found in the literature. This study attempts to expand on some of this knowledge.

2.2 Refugees and psychological distress

Most refugees have suffered the direct and indirect effects of war and civil disruption (Kinzie, 2001). Along with having been witnesses or victims of war, refugees are also forced to flee their homeland. The consequences of forced migration are layered as it implicates a person's personal, social, economic and psychological areas of life (Ager, 1999; Miller, 1999). This total experience that a refugee undergoes including both the violence of war and forced migration has been labeled as the 'refugee experience' (Ager, 1999). The psychological implications of the refugee experience are diverse. Most commonly discussed is the impact of the psychological distress experienced because of being the victim and/or witness of the violence of war and civil disruption. There is a large amount of literature that relates exposure to violent events and psychological distress (Herman, 2001; Levy, 1999; Kinzie, 2001; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004) to posttraumatic stress disorder (PTSD). Many of these studies have also noted the high prevalence of major depressive disorder (MDD) amongst traumatized populations, including refugees (Miller, 1999). These studies adhere to the dominant Western biomedical model in formulating the impact of forced migration and related trauma.

Numerous studies demonstrate the high prevalence of PTSD and MDD (Mollica et al., 1998; Weine et al 1998; McSharry & Kinney, 1992; Miller, 1999, cited in Miller, 1999) in both clinical and non-clinical/community refugee samples. These studies depict that refugees constitute a population at risk of severe and persistent psychological distress. The biomedical and Western understanding of psychological distress is presently the most common model used by NGOs, clinics and Aid workers to address the problems faced by refugee populations world wide (Bracken, Giller, Summerfield, 1997; Palmary, 2005; Sideris, 2003). The biomedical model defines psychological distress; PTSD, as commonly occurring after a person has been the victim of an extremely traumatic event

(Sadock & Sadock, 2003). Identifiable symptoms are intrusive thoughts of the past event/s, avoidance of particular situations that function as reminders of the event and persistent symptoms of increase arousal that have been present for more then one month (Sadock & Sadock, 2003). These symptoms have an inhibiting impact on a person's social, personal and occupational areas of life (Sadock & Sadock, 2003). PTSD as a diagnostic tool has enabled psychiatrists and psychologists to understand patient's symptoms clinically; however, diagnosing is not a cure for the psychological distress that refugees experience (Ager, 1999).

Biomedical models of post-traumatic stress disorder appear to offer "a biologically universal causal model for anybody's reactions to stress no matter what the cultural background or nature of stress" (Eisenbruch, 1991, p. 676). Several authors (Bracken et al., 1997; Eisenbruch, 1991; Palmary, 2005; Sideris, 2003) argue that stress reactions of themselves are perhaps not universal, and symptoms known in the Western construct of stress might not be experienced in the same way by other people around the world and therefore might not be treatable by the same means. For example, Eisenbruch (1991) describes how the boat people from China's symptoms of insomnia and 'delusions' were cured by Buddhist rituals, rather than antipsychotic medication. Eisenbruch (1991) argues that sometimes Western 'symptoms' of distress can be seen in other cultural contexts as constructive, normal responses to presenting circumstances. However, the biomedical model treats cultural and emotional aspects as supplementary to the primary diagnosis.

Parallel to the biomedical model is the psychoanalytic or psychodynamic understanding of trauma. In broad terms this includes the understanding that a traumatic event impacts on the psyche (emotional and cognitive) protective barriers surrounding the sense of self (Garland, 2004; Lemma & Levy, 2004; Levy, 2004). When traumatizing event/s overwhelm an individual the person's established belief in goodness, trust, safety and predictability are influenced and decreased. The person is left feeling attacked, invaded and persecuted (Garland, 2004; Lemma & Levy, 2004; Levy, 2004). A sense of mistrust is dominant. In an attempt to deal with the traumatic event/s, the traumatized person may establish an emotional defense either by identifying with the aggressor or with the victim

(dead or damaged) role. Garland (2004) argues that at this point one's ability to conceptualize or think about the events without falling back into the emotional trauma of the event (flashback) is no longer possible. Present traumas are argued to trigger past painful childhood traumas of having to separate and individuate from parental figures. The process of healing from such intense trauma is parallel to the process of mourning (Lemma & Levy, 2004).

Lemma and Levy (2004) argue, however, that a mourning process is only truly possible when one is able to conceptualize, symbolize and think about the traumatic event. Often times with severe trauma there is a "breakdown or perversion of the capacity to mourn" (Lemma & Levy, 2004, p. 5). The loss, both external (of other people or past way of living) and internal (of a part of self), is often too much to bear, causing a breakdown, "where the individual identifies with the lost person [or lost life] in a particularly cruel or relentless way. We understand this as the perversion of loss" (Lemma & Levy, 2004, p. 5). Within the perversion of loss one replaces the extremely painful feelings with identifications, and these have to be understood, thought about and worked through in order for healthy mourning to take place. This process is not literally able to bring back what is lost or dead, whether that is another person, the sense of self before the trauma, and in the case of refugees, past sense of place, culture and social networks. The life of the survivor will never be the same again (Lemma & Levy, 2004). The process of mourning allows for the recovery of symbolic thought, letting the traumatic events become a part of the survivor's emotional world, which in turn allows for flexible and creative thinking rather then rigid split-off realities (Garland, 2004), and hopefully then the ability to engage with current life circumstances.

Although this is depicted as a very personal and individual process, social, contextual and cultural circumstances influence this process. Lemma and Levy (2004) state:

> *"No matter how 'equally' we experience an event, there is no uniform response to it. For each patient, the event has a specific, personal, meaning, which reflects aspects of how they engage with the world. As clinicians these idiosyncratic responses tell us something about the nature of the people's inner worlds and the quality of their attachments* (p.3)*".*

Although some argue that the psychoanalytic formulation moves away from the biomedical model, embracing the internal world of a person, it pivots around the

individual, and assumes a Western construct of the 'self'. This model also still sees the human response to trauma as largely universal. Although cultural and contextual elements surrounding the individual are recognized, they continue to play a supporting rather than central role in formulation. Sideris (2003) argues that because Western cosmology defines psychology as the study of individual behaviour and intra-psychic dynamics it is a difficult task to place the social into psychology as the social is seen to lie outside the individual. This makes using these constructs of psychological distress in non-western contexts challenging.

Many practitioners trying to use both the psychiatric and psychoanalytic models of trauma across diverse contexts have articulated various critiques. The main criticism is that traumatic stress as outlined in the DSM and in other psychological models, such as the psychoanalytic model described above, reflects an objective worldview, rather then appreciating that these models are of themselves a construct of a particular cultural context. "In making such claims, the model of PTSD (implicitly or explicitly) prescribes how people should act, how their distress should be expressed and what remedy should be applied in all contexts" (Palmary, 2005, p. 24). It also assumes that by adhering to the remedies prescribed, medical in the case of psychiatry, or in the case of psychoanalytic theory by gaining insight into their internal world, emotions and/or cognitions, people can change and thereby heal (Palmary, 2005). These assumptions place the individual outside or separate from their cultural/social context and do not allow for a diversity of meaning to be attached to specific symptoms (Bracken et al., 1995). In this way, suffering arising from war, domestic violence, or rape, all in a sense have to adhere to the same understanding of psychological distress, as according to the biomedical model, victim's symptoms are the same. Several authors (Bracken et al., 1997; Eisenbruch, 1991; Palmary, 2005; Sideris, 2003) argue that rather than all symptoms meaning the same thing, their meanings are diverse and appreciation of these diverse understandings may impact on the possible methods of the resolution of stress. By separating the individual from the social, one decreases recognition of the possible range of feeling-states constituted by one's cultural world and social relations (Sideris, 2003).

The clinical reification of refugee's experience in terms of 'symptoms' as discussed thus far seems to have led to research focusing on the relationship between exposure variables and symptoms of posttraumatic stress (Roth, Lebowitz & DeRosa, 1997). The danger of such clinical assessment and related research is that the layered traumatic experience of the refugee is lost, leading to a neglect of other less tangible aspects of the refugee experience which influence their present sense of well-being (Ager, 1999; Bracken, Giller & Summerfield, 1997; Eisenbruch, 1991; Palmary, 2005; Sideris, 2003). Models of intervention based on such constrained understandings in turn decrease the healing impact of therapy, disempowering both the refugee and the therapist alike.

One must not make the mistake however of throwing the baby out with the bathwater. PTSD is a useful diagnostic tool and an important consequence of one particular part of many refugees' experiences. It is however important to acknowledge the limitations of such concepts (Bracken, et al., 1995). It is also important to be critical and cautious about using these Western constructs in non-Western settings (Bracken et al., 1995; Eisenbruch, 1991; Palmary, 2005; Sideris, 2003). In conjunction with the repercussions of the impact of violence, in the case of refuge trauma survivors one must take into account the psychological implication of forced migration. Eisenbruch (1991) describes this implication as 'cultural bereavement', as the refugee parts with his/her known culturally imbued life. Uprooting oneself from a place previously known as safe and comfortable, where one had obtained a particular social role, to exist in a foreign context can be a particularly traumatic event, as known automatic schemas are disrupted (Horowitz, 1992). Thus in the case of refugee clients one is often dealing with dual, if not multiple traumatic stressors.

Palmary (2005) in her study exploring the varied experiences of trauma of female refugees in the South African setting, noted that most of the women emphasized the trauma of the loss of their old social networks and the disruption of their families, which left them feeling particularly isolated. Eisenbruch (1991) in his experience with refugees, noted that his concept of cultural bereavement came from repeatedly observing the nostalgia experienced by refugees as they faced the fact that they could not return to their

homeland, and experienced considerable social loss, causing them to feel displaced and uprooted. This in turn caused a great sense of grief. Sideris (2003), in her study of the experiences of Mozambican female refugees in South Africa, describes that the loss of social belonging was mentioned as one of the worst outcomes of war by these woman. This lack of social belonging left these women feeling different, misunderstood and alienated. Sideris (2003) argues that:

> *"For Mozambican women and other African women to whom individual well-being is in large part defined by having a social place, reconstituting links to community is critical to healing the injury done by rejection consequent to sexual violation"* (p.722).

Beiser and Hou (2006) argue that the process of resettling in a new country is psychologically distressing in and of itself as it challenges old and new definitions of self. Refugees have to choose whether to hold onto prior cultural constructs of self and ethnic identity or abandon their heritage and take on the host country's cultural understanding of self, and by doing so hopefully come regarded as a full member of the receiving society. Beiser and Hou (2006) argue:

> *"Economic difficulties, discrimination and language difficulties are among the most important resettlement challenges to wellbeing. Psychological and social resources help refugees respond to these challenges. The psychological literature suggests that ethnic identity— defined as identification with one's culture of origin— directly attenuates psychological distress and cushions the psyche against psychological assaults"* (p.138).

In relation to this understanding this sense many authors (Bracken et al., 1995; Eagle, 1998; Epstein, 1991, 1994; Horowitz, 1986, 1991; Janoff-Bulman, 1992; McCann & Pearlman, 1990, cited in Roth, Lebowitz & DeRosa, 1997; Sideris, 2003) argue that the essence of therapy lies in recovering the disrupted fundamental beliefs or schemas of the traumatized refugee. Presently several organizations working with refugees around the world are challenging Western models of psychological distress and are acknowledging contextual[2] accounts of people's understandings of trauma, encouraging agency by acknowledging clients' knowledge and choices. These organizations try to support people "in a way that works with their existing sources of support and within their own worldview" (Palmary, 2005, p. 62). In so doing it is important to keep the work fluid, creative and alive, as contexts are continuously changing from moment to moment.

[2] The term 'context' throughout this report does not assume a homogenous 'West' or 'Africa' but rather attempts to indicate broad differences and social inequalities that need to be acknowledged and understood.

Sideris (2003) warns against fixing or freezing certain moments of understanding as useful forever, thereby again falling into the trap of universal and timeless solutions.

It becomes clear that providing and facilitating a healing process for refugees is complex as one is faced with a multitude of traumatic features that all need to be acknowledged and effectively worked through in order for therapy to be beneficial. Alongside this, every refugee will have assigned different meanings to their present lives and their past experiences, which has been influenced by their cultural, social and political heritage (Bracken et al., 1997). Given that refugees by virtue of their relocation are likely to be culturally different from their therapists or counsellors, the therapeutic context also has to allow for multicultural sensitive practices. Having described some of the important elements of the complex trauma known by many refugees, it is important to add to this understanding an appreciation of the particularities of the South African refugee context.

2.3 Refugees in the South African context

Most of the literature concerning refugees is based on the experiences of refugees in Europe or the United States of America, although these countries host a minority of the world's refugees (Ager, 1999). The majority of the world's refugees are found in Africa and Asia (Westin, 1999). Both Europe and the United States of America can be seen as relatively safe and stable environments for refugees, as refugees are mostly provided with some form of social and financial support. The majority of refugees in Africa resettle in neighboring or other close by countries (Westin, 1999). These refugees often are forced to relocate to places that are far from stable or safe. The often complicated asylum procedures, the notion of 'temporary protection', xenophobia, poverty and lack of social support are more common to these refugees (Neuner et al., 2004; Vale, 2002). These additional stressors can cause the re-experiencing of war inflicted trauma and the sense of despair affiliated with it (Luebben, 2003). This in turn can cause a relapse or an increase in posttraumatic stress symptoms (Luebben, 2003). This is a large risk for traumatized refugees in South Africa.

In many respects the experience of refugee population in South Africa does not follow the same pattern as that of refugee populations in other African countries. In most African countries refugees are located in refugee camps. In these situations, refugees tend to arrive in big groups at a similar point in time, and according to Gotz (2003) are "predominantly from rural backgrounds, with 75% women and children" (p.33). South Africa has chosen to resettle refugees by integrating them into South African society as opposed to temporary refugee camps supported by humanitarian relief agencies (Spiegel, Qassim & UNHCR, 2003). As opposed to the camp populations, South Africa's refugee population is predominantly urban based as is the case in most Western countries (Groot, 2003; Gotz, 2003; Landau, 2003, 2006).

In general urban refugees are also better educated and more skilled than the majority of the refugee camp inmates (Gotz, 2003). For this reason alone, refugees finding refuge in South Africa tend to head for urban centers such as Johannesburg, rather than rural areas. Jacobsen (2006) argues that generally refugees are increasingly likely to seek out urban areas rather than camps. Presently approximately 18% of the worlds' refugee population lives in urban areas, compared to approximately 26% who live in camps, and the remainder spread through rural areas (Jacobsen, 2006). Urban refugees are defined by Jacobsen (2006) as refugees who reside in areas that governments have designated as urban. This population Jacobsen (2006) states includes:

> *"recognized refugees (i.e. those who have undergone determination procedures and have achieved official refugee status in the eyes of the government), asylum seekers (those who have applied and are yet to undergo determination procedures), those with temporary protection (for example, in the UK, this status is 'exceptional leave to remain'; in many African host countries, it is pram facie status), and those denied refugee status but who remain in the country"* (p.274).

Refugees living in urban areas generally face different livelihood problems than those in refugee camps (Jacobsen, 2006).

In 1996, after the fall of Apartheid which had caused many South Africans to find refuge in other countries, South Africa signed the United Nations 1951 Convention and 1967 Protocol Relating to the Status of Refugees and the 1969 OAU Convention Governing Specific Aspects of Refugee Problems in Africa (Palmary, 2005). The principles of these

international agreements influenced the 1998 Refugee Act (no. 130 of 1998) which became effective in 2000 (Palmary, 2005). South Africa's refugee policy on paper guarantees refugees: freedom of movement, access to social services, such as health care, schooling, and social assistance grants, and rights to compete in labour and housing markets (Landau, 2006). This is possible once refugees have applied for refugee status and a positive decision by the Department of Home Affairs (DHA) has been granted.

Research (Landau, 2003; 2006; Palmary, 2005) has shown that this process of gaining a positive decision by the DHA is lengthy and frustrating process and rife with corruption. Palmary (2005) states:

> *"The asylum system has become a significant challenge to South Africa's commitment to human rights and reports of ongoing abuse and violations of refugee rights have been rife"* (p.8).

Landau (2006) argues that interfacing with DHA is probably one of the biggest obstacles refugees face in legitimizing their stay and thereby being granted the support and protection they require. Firstly, the Johannesburg centre is one of the busiest refugee DHA centers in South Africa (Landau, 2006). Simply to get a turn inside the DHA office, refugees have to start queuing the night before (Gotz, 2003; Landau, 2006). This leaves them vulnerable to criminal activity and police harassment (Landau, 2006). Secondly, in order to simply file an asylum claim, many refugees were forced to pay a series of unofficial 'fees', starting with a fee to a private security guard who has been hired to keep order and make accessing the DHA facilities secure and possible (Gotz, 2003; Landau, 2006). For refugees who have fled and have often come with little financial resources these hidden fees can be unaffordable and prevent them from simply filing their case, leaving them without any chance of legality, social support and protection (Landau, 2006).

Those refugees that have been able to pass these two obstacles still face further hurdles as they wait for the DHA decision. Officially under the 1998 Refugee Act, the DHA should make their decision whether or not to grant refugee status within 6 months (Landau, 2006). In practice this process takes at least 18 months, some waiting as long as two years (Landau, 2006). In this time they at risk of being suspected by police of being illegal

immigrants and consequently often ill-treated by police and/or deported. At this point in time it is also difficult for refugees to legally protest against the often illegal actions taken against them (Sadie & Borger, 2003). The physical form of the asylum seekers' documentation (the Section 22 permit) also often acts as an obstacle. Groot (2003), Landau (2006) and Palmary (2003, 2005) explain that this single piece of paper, with hand-written amendments and conditions is not easily accepted or recognized by government agencies, police, healthcare workers or potential employers. Landau (2006) states: "A combination of inadequate documentation, ignorance and outright discrimination, ensures that many refugees are denied rights to critical social services" (p.319). Those who are lucky enough to acquire refugee status are supplied with a document that expires every two years, leaving the refugee trapped in a difficult and insecure cycle (Groot, 2003). The continuing process of acquiring legal status appears to be one of the biggest obstacles to refuge wellbeing.

In December 2001, there were 18,605 recognized refugees and 11,417 asylum seekers in South Africa (Landau, 2006; Palmary, 2005). In 2003, 31 600 new asylum applications were registered at the Department of Home Affairs (DHA), bringing the number of applications received since 1994 to 152 414 (Gotz, 2004; Palmary, 2005). The DHA are insufficiently prepared for this number of cases which has caused for a significant backlog in pending applications.

The basic needs standards that have been developed and adhered to in refugee camps are hard to equal in the urban refugee situation (Gotz, 2003). In fact determining basic rights and living conditions for refugees in urban conditions is relatively new for the UNHCR. At present, urban refugees do not generally have access to food aid, shelter, assistance with gaining free education or assistance in accessing resettlement programs (Jacobsen, 2006). The humanitarian assistance that is available is usually meager or irregular as it relies on funds and support outside the government system. Despite this, South Africa is known to other African nationals as a country where one is granted freedom of movement and the possibility of work, which for many seems worth the struggle. This has led to an influx of a relatively diverse group of refugees seeking a better life, often causing an

uncomfortable mingling of ethnic and political groups from the same country of origin (Spiegel, Qassim & UNHCR, 2003). Landau (2006) argues that this situation has not only created serious problems amongst urban South African refugee populations, but has also created problems for the entire host community in which these refugees have come to live. Having arrived in South Africa, refugees are therefore often confronted by economic, political and social hardships (Landau, 2006; Neuner et al., 2004; Palmary, 2005). They often find themselves again in relatively unsafe circumstances as conflicts from the country of their origin continue and material stability is uncommon (Neuner et al., 2004).

Refugees also struggle with access to social support systems. Asylum seekers and refugees who have acquired legal documentation for their status should have access to many public services. Although these rights are stipulated on paper, in practice they are not well implemented (Gotz, 2003). Section 27(1), (2) and (3) of the South African Constitution states that everyone has the right to health care services, that the state should do its best to provide at least emergency care to everyone in South Africa, regardless of nationality, documentation or residency status (Landau, 2006). Those with refugee status theoretically have the same right to health care access as other South African citizens. However, Landau (2006) states:

> *"The inability or unwillingness of many hospital staff members to distinguish between different classes of migrants (coupled with xenophobia) often means that migrants, including refugees, are denied access to basic health services or that hey are charged the fees levied on other non-citizens"* (p.320).

As refugees have often faced continuous obstacles in acquiring legal status paired with ignorance of their rights, many simply accept these violations (Landau, 2006).

Alongside the difficulties described thus far xenophobia seems to be on the increase (Vale, 2002). Many South Africans refer to foreign Africans as *amakwerekwere*, which is a derogatory term to describe migrants. Ramcharan, (2004, cited in Landau, 2006) South Africa's acting human rights commissioner stated:

> *"Refugees, asylum seekers, migrant workers, undocumented immigrants and so-called non-citizens are being stigmatized and vilified for seeking a better life. They are made scapegoats for all kinds of social ills, subjected to harassment and abuses by political parties, the media and society at large"* (p. 316).

The dominant perception is that African foreigners in Johannesburg are for the most part illegal immigrants, looking for better economic possibilities and consequently are a burden to Johannesburg as a whole (Landau, 2006; Palmary, 2003). Media accounts and political discourse often fail to distinguish between the different types of migrants who compromise this growing population, naming them all either 'refugees' or 'illegal migrants' (Gotz & Landau, 2003).

Xenophobic tendencies and beliefs are encouraged by police actions and expressed political views. In a survey of the Johannesburg metro-police department, 30% of new recruits believed that foreigners caused crime (Palmary, 2003). The overwhelmed asylum seeking system due to being under resourced and inefficient, does not help, as police are expected to distinguish between illegal immigrants and legitimate refugees. This is a complex task when legal documents are often inaccessible to refugees and illegible to police (Palmary, 2003). However police are generally seen by refugees as a dangerous rather than a protecting force (Segale, 2003). Refugees feared being confronted by police who did not accept their legality and therefore feared being deported, often despite valid documentation (Segale, 2003; Landau, 2006). Segale (2003) notes that police have even been known to go so far as to destroy legal documentation. Once arrested non-nationals are sent to Lindela Repatriation Centre in Krugersdorp. Reports of excessive human rights abuses such as sexual abuse, violence and extortion are common from this facility (Landau, 2006).

Refugees are also discussed in political circles as 'problems' creating a national negative discourse which allows South Africans to 'other' refugees (Vale, 2002). The xenophobic discourse subtly permits violent acts against refugees, increasing refugees' sense of insecurity. As a result, although on paper South African legislation is progressive and in keeping with international standards, proclamations from politicians, and media reporting on drug syndicates, prostitution and human trafficking all influence popular perception that all migrants are bad for South Africa, increasing xenophobic tendencies in many sectors of South African society, including those that are theoretically meant to safeguard and support refugees. Pursuing livelihoods in this unsupportive, unsafe context leaves

refugees reliant on their usually very meager social capital for material and emotional support, advice and potential employment connections (Jacobsen, 2006). As this is a very small network, most refugees are left vulnerable, unprotected and desperate. Despite the above described hardships, many refugees still consciously choose to remain in South Africa.

The refugee context in South Africa seems to be conflicted, with refugees carrying both hope and insecurity. This context differs significantly from the more stable and supported refugee context evident in most western countries, such as the Canada or Europe. Although all refugees face similar problems the degree of uncertainty of daily existence appears to be on a different scale in South Africa compared to that experienced by refugees in European and North American contexts. There also appear to be more threats to safety and less public protection.

It is therefore difficult to compare therapeutic literature concerning refugees around the world, as one must acknowledge the contextual impact on presentation and working styles. Palmary (2005) states that:

> *"Within this context [South African/Johannesburg] the possibilities of trauma interventions with refugees have been difficult and have been shaped by the barriers that refugees face in accessing their rights" (p.8).*

There is very little literature available concerning the usefulness of psychotherapy for traumatized refugees who find themselves in unsafe, non-Western contexts such as refugees face in South Africa (Neuner et al., 2004). The literature that does discuss working with refugees in unsafe or unstable situations suggests that mainstream models of trauma service delivery are not easily applied to contexts outside of which they were developed (Bracken et al., 1997; Eisenbruch, 1991; Palmary, 2005; Sideris, 2002). This literature stresses the importance of acknowledging the social and cultural context in which a therapeutic intervention is given, and holding this context at the core of the intervention model (Bracken et al., 1997; Eisenbruch, 1991; Palmary, 2005; Sideris, 2002). The literature also stresses the need for more research in this area as it requires mental health workers to adjust their services to take into account the present psychological pressures and distress experienced by many of their clients (Luebben,

2003; Neuner et al., 2004). In this regard, a central premise of this research project is that there is no universally appropriate trauma intervention and different social, political and cultural contexts will strongly influence the intervention given. In order to understand what needs to be offered and how conventional models may need to be adapted one must have a clear understanding of what therapeutic techniques are most commonly used when working with refugees.

2.4 Counselling approaches used to assist refugees

The literature speaks of a variety of therapy techniques that have been applied in working with refugees. These techniques include: Cognitive-Behavioural Therapy (CBT), Rational Emotive Behaviour Therapy (REBT), Testimony Therapy, Narrative Therapy, integrative models such as the Wits Trauma Model, and various forms of Psycho-dynamic therapy (Ager, 1999; Kinzie, 2001; Levy, 1999; Luebben, 2003; Neuner et al., 2004; Paunovic & Ost, 2001; Woodcock, 2001). Explaining in detail these various techniques is beyond the scope of this paper, however, a brief overview of the basic therapeutic framework informing therapeutic work with refugees is provided as a backdrop. What is important is what research has found to be effective in terms of working with refugees as this gives one a clearer understanding of the task and the efficacy of the tools available to therapists. Recent research has stressed the importance of a two-pronged approach, often termed a 'psycho-social' approach. This approach includes any of the above mentioned psychological techniques, in addition to a social supportive aspect. This section will end with a discussion of this approach.

2.4.1. The Therapeutic 'Frame'

Although most commonly seen as a fundamental aspect in psychoanalytic and psychodynamic therapy, all therapeutic styles adhere to a consistent frame. In psychoanalytic terms the core features of the analytic frame include: consistency, reliability, neutrality, anonymity and abstinence (Lemma, 2003). These terms translate into a framework that includes ethical considerations, and a contract around time, frequency of sessions, place and fees. For many therapists these framework aspects are often almost taken for granted (Weiner, 1998). Although this may be so, these aspects of

the therapeutic frame are not inconsequential for the course of psychotherapy, and therapist should keep these considerations in mind, regardless of the therapeutic technique that will be used (Lemma, 2003; Weiner, 1998).

Consistency in time, place and frequency of sessions allows for the creation of a safe, comfortable holding environment to be created (Lemma, 2003; Weiner, 1998). Creating this environment provides the client with a sense that it is safe to speak, therefore making it easier to open up and trust the therapeutic space and therapist (Weiner, 1998). Consistency with time means arranging an appointment time for psychotherapy at regular and fixed intervals. Although currently there is no indication of what particular length of session is most beneficial, maintaining a consistent time boundary allows for therapists to end sessions without communicating a dislike or disinterest for the patient. In terms of the frequency of sessions, Weiner (1998) states that clinical experience suggests that at least weekly sessions are necessary to sustain treatment and promote change. This weekly interval can be changed to twice weekly, for example, if the personality or situation of the client were to require it in order to allow therapeutic goals to be actualized (Weiner, 1998).

A consistent place allows clients to gain a sense of familiarity allowing them to feel more "at home" (Weiner, 1998). This comfort makes it easier for clients to talk about themselves. Lemma (2003) argues that the therapeutic room needs to be both homely and relatively neutral at the same time. For example photos of family members and important or special events of the therapists are inappropriate in this context (Lemma, 2003). It is also important that the place enables us to ensure confidentiality and minimize interruptions by others (Lemma, 2003). The frame creates a setting in which the struggles that clients are experiencing in life can be expressed and worked with. It provides a concrete expression of the containment the therapist can offer the client, "an indication of what the patient can expect from us and can therefore rely on" (Lemma, 2003: 101). This frame also helps therapists self-monitor, for example, if a therapist extends a session or deviates from the frame in any other way, it can act as a warning signal that something in

the therapeutic relationship or the therapist him/herself needs to be attended to (Lemma, 2003).

Having provided an explanation of the importance of the general framework for psychotherapy, it is important to remember that therapy does not happen in a vacuum and the social, political and cultural context in which therapy occurs will impact on therapy and also possibly on the framework of therapy. "This immediately raises the questions of cross-cultural validity of the frame as conceived of in the West" (Lemma, 2003, p.103). Every context will contain its own particular cultural/social rituals, imbued with specific meaning and emotional background and these rituals need to be understood and applied, in order to establish culturally meaningful boundaries, which in turn can then be interpreted and used whilst doing therapeutic work (Lemma, 2003). In this regard, an understanding of multi-cultural or cross-cultural counselling is essential in conducting therapy with refugees.

2.4.2. Multicultural Sensitivity

Bracken et al. (1995) argue that the cultural reality of their culture of origin should be seen as central to understanding the psychological distress of refugees, and should inform the application of appropriate culturally sensitive therapeutic techniques. They argue that:

> "*Social, political and cultural realities structure the context in which violence is experienced and determine to a greater or lesser degree: the subjective meaning of the violence or trauma; the way in which the distress associated with violence is experienced and reported; the type and extent of general support available to the individual; and what type of therapies are available and are appropriate*" (p.1077).

Techniques based solely on Western concepts, that ignore the political, social and cultural context in which the trauma and recovery take place are seen by many working in non-Western contexts to be inadequate. These techniques tend to emphasize what might be *universally* similar and ignore the often great cultural differences in response. As health and sickness are imbued with cultural meaning it is necessary to have a variety of culturally sensitive therapeutic approaches in working with trauma (Eisenbruch, 1991).

Western approaches applied to cross-cultural trauma work have the risk of isolating people's trauma experience from their political, social and/or religious struggles (Bracken

et al., 1997). Bracken et al. (1997) argue that the challenge for agencies dealing with refugees around the world, is “to establish ways of supporting people through times of suffering by listening and hearing their different voices in a way that does not impose an alien order” (p. 441). This challenge requires that practitioners welcome and engage with various understandings of trauma and recovery. In order to do this, an understanding of cross-cultural counselling is necessary.

Within the cross cultural counselling context counsellors need to acknowledge the ‘cultural noise’ in order to understand and empathize in alleviating subjective distress. In this context the counsellor plays an interactive role, not a unidirectional one. In this relationship the counsellor and client “require each other and dynamically, dialectically and jointly make each other up” (Shweder cited in Swartz, 1998, p. 8). In order for this kind of cultural sensitivity to be possible, Bracken et al. (1997) and Brems (2001) argue that a therapist must be able to constantly reflect on our own accepted ways of thinking about the world and be open to challenging the assumptions from which their therapeutic practice springs. This in turn helps counsellors to develop cultural awareness. Brems (2001) breaks cultural awareness down into cultural awareness, cultural knowledge and cultural skills. These three aspects influence each other and all need to be nurtured through engaging with other cultures, honest self-reflection and acquiring historical and present knowledge about the cultural contexts of clients with whom one works.

An important aspect of cross cultural counselling is being flexible around ones therapeutic frame and technique, and using the knowledge of someone’s cultural context to modify ones therapeutic approach appropriately, depending on the clients needs (Ponterotto, Casas, Suzuki & Alexander, 1995, cited in Brems, 2001). Having stated this, one must also be able to strike a balance between recognizing the role of culture in therapy and offering therapy as it is traditionally understood (Brems, 2001). Brems (2001) argues that by becoming a culturally competent clinician one automatically becomes an agent of social change, by taking a proactive advocacy stance against cultural discrimination.

In the context of therapeutic work with refugees, clients' traditional identities and ways of being have often been damaged by war and organized violence. Dealing with trauma can be experienced as more difficult as the cultural framework that helped individuals cope and provide meaning is no longer available (Bracken et al., 1995). It is for this reason that Eisenbruch (1991) suggests that much of trauma work with refugees could be named 'Cultural bereavement' work. This term centralizes refugee clients' cultural heritage and presents them with the space to mourn the loss of their past cultural, social and political networks in counselling. This loss of cultural context is usually paired with the atrocities of war and social disruption that refugees might have experienced and the two sets of experiences are often not clearly distinguishable (Bracken et al., 1997). Bracken et al. (1997) states: "Some refugees have told us that torture was not the worst thing that had happened to them" (p.437), suggesting that dislocation may be more profound. Bracken et al. (1997) argues that in treating trauma experiences as primary refugees might end up viewing themselves as victims who require special psychological care. In this respect, one might be taking away all sense of agency and resilience, whereas focusing on broader social displacement might prevent this. Western psychological discourse can increase the sense of 'otherness', and may involve "a loosening of one's ties to the home culture, the very culture whose myths or religious idiom may be important sustaining factors" for the individual (Bracken et al., 1997, p. 439). Having set the stage for thinking about therapeutic work in general, and more specifically about the cross cultural sensitivity that therapeutic work with refugees demands, several specific therapeutic techniques that have been applied to therapeutic work with refugees are elaborated on below.

2.4.3. Cognitive Behaviour Therapy

According to Foa and Meadows (1997, cited in Paunovic & Ost, 2001) CBT has been the most commonly studied form of therapy with regard to working with patients with PTSD. CBT approaches emphasize both cognitive restructuring and exposure and desensitization aspects in treating trauma. Comparing their results pertaining to the use of CBT and other therapy techniques in working with refugees with PTSD, Paunovic and Ost (2001) concluded that CBT was not significantly more effective and suggested that there were

various ways to treat refugees with PTSD. Other research (Kinzie, 2001) found that CBT seemed effective on a relatively short-term basis, but that relapses were common.

2.4.4. Psychodynamic Therapy

Psychological distress involves both dealing with the concept of a 'real' external stressor and physiological reaction (symptoms) and the internal psychological response to the threat of death, physical harm, destruction of one's entire meaningful life, or exposure to the grotesque. Psychodynamic therapy focuses on the later, arguing that this internal response will evoke some primitive responses linked to unconscious fears (as was discussed in detail in a previous section). Psychodynamic therapy focuses on the sense of loss that this extensive breach of the internal protective shield causes and the healthy process of mourning and thereby thinking of, and making meaning of these experienced losses (Eagle, 1998; Garland, 1998, Levy, 1998, 2004; Lemma & Levy, 2004). Treatment aims to prevent or gradually reduce the use of repression as a defense as this can lead to neurotic symptom formation (Eagle, 1998). In this way therapy aims to protect against further regression into more primitive personality structures and low ego strength. Psychodynamic treatment approaches tend to place emphasis on "locating the impact of the trauma within the person's historical context" (Eagle, 1998, p. 138).

2.4.5. Testimony Therapy

Another popular therapy method is Testimony Therapy. This method was initially used in Chile to treat survivors of the Pinochet regime (Luebben, 2003). Testimony therapy allows refugee to tell their stories and to use their stories as legal testimony. This provides them with a sense of social empowerment as well as a space to be heard (Ager, 1999; Luebben, 2003). Research concerning Bosnian refugees suffering from PTSD found that Testimony Therapy reduced symptoms by up to 50% at six month follow-up (Kulenovic, Pavkovic and Gibbons, 1998, cited in Paunovic, 2001). Luebben (2003) suggests using the testimony method as a foundation for therapy with refugees in unsafe contexts. However, Testimony Therapy on its own, without the option of other supportive therapy has the danger of making refugees aware of their struggles without providing them with the safety of longer-term support (Kinzie, 2001; Luebben, 2003).

2.4.6. Narrative Therapy

Similar to testimony therapy is narrative therapy. Narrative therapy makes use of the understanding of stories, dominant discourses and alternative discourses (Freedman & Combs, 1996; Neuner et al., 2004; Woodcock, 2001). Life stories are complex and entail tensions and conflicts between a multitude of personal, social and contextual layers (Freedman & Combs, 1996; Neuner et al., 2004). White (1991, cited in Freedman & Combs, 1996), one of the founders of narrative therapy, argues through a social constructionist world view that people come to therapy when dominant narratives are limiting their personal self expression (Freedman & Combs, 1996). By unravelling their multitude of stories through language, even the most marginalized and disempowered people's lived experiences can be placed in alternative or counter narratives, giving them new meaning. By putting these lived experiences on the map of social existence, people feel empowered, experiencing that they are again the authors and the arbiters of their realities and lives (Herman, 1992; Woodcock, 2001). The concept of narrative therapy tends to resonate with many cultures as most cultures hold oral traditions dear (Neuner et al., 2004). This makes Narrative Therapy accessible for refugees coming from different cultural contexts to that of the west (Neuner et al., 2004; Woodcock, 2001).

2.4.7. Integrative Therapeutic Approaches

Although the literature mentions these three specific therapy methods as discrete interventions, some therapists feel strongly that in terms of working with refugees one needs to be prepared to work more broadly or integrate specific models allowing the known strengths of different models (usually a combination of CBT and Psycho-dynamic models) to work together (Eagle, 1998; Kinzie, 1981, 2001; Roth et al., 1997). Specific therapeutic interventions are usually described in terms of treating PTSD symptoms. As mentioned earlier, conventional trauma interventions with refugees have a tendency to reduce the refugee experience to their experience of traumatic events as opposed to acknowledging the multidimensional aspects of their experience. In order to allow for therapeutic change these subjective experiences need to be validated (Roth et al., 1997). Refugees in a new cultural and social situation are in need of a social advisor and

sometimes even a mediator of sorts (Kinzie, 2001). In order to fully assist refugees Kinzie (1981, 2001) found it necessary to be prepared to take on a more open and dynamic role as a therapist. Kinzie (2001) argues that one must see the various therapeutic methods as tools that support the therapist, keeping the central role of importance to be that of providing a significant therapeutic relationship. A therapists ability to listen, to stay with the patient, to receive from the patient and to continue to believe in good, despite all evil that is so predominantly present in many refugees experiences is what is crucial (Kinzie, 1981, 2001).

Eagle (1998) suggests that an integrative approach allows for both the subjective experiences and internal phenomena to be acknowledged as well as providing space within the therapeutic process to focus on external stimuli and the need for more directive external support to be fulfilled. An integrative model suggested by Eagle (1998) named the Wits Trauma model incorporates both a psycho-dynamic framework as well as a Cognitive-Behavioural perspective. This model includes five components which can be used interchangeably throughout the therapeutic process depending on the needs that the Client is presenting with. These five components include: Telling/re-telling the story, normalizing the symptoms, addressing self-blame or survivor guilt, encouraging mastery, and facilitating creation of meaning (Eagle, 1998). The flexibility and greater scope for providing support that the integrative model allows resonates with the diverse and multitude of needs that refugees present with. Another more dynamic form of support mentioned in the literature which is gaining popularity in both Western and developing contexts is what is coined ‘the psycho-social approach’ in counselling refugees.

2.4.8. Psycho-Social Approach

Since the 1980s there has been an increasing interest in refugee mental health care (Palmary, 2005). Aid agencies have been lobbying for mental health approaches to take place as part of humanitarian interventions. As noted above, however, refugees affected by war seldom see mental health care as their primary need (Bracken et al., 1997; Miller, 1999; Palmary, 2005). Refugee’s main priority is often the meeting of basic needs such as food, shelter, employment opportunities and social support. This has been noted in both Western and developing contexts, as well as in the unsafe context of South Africa. There

is also more and more evidence that mental health care support on its own is not decreasing the incidence of PTSD or MDD (Miller, 1999; Misra, Connolly & Majeed, 2006; Palmary, 2005). For this reason many practitioner and Aid organizations are calling for bottom-up approaches, giving priority to basic needs initially, and later combing social support as well as mental health care.

The refugee experience of exile; the uncertainty and lack of control regarding legal status, the loss of community and social network, the loss of meaningful social roles, can make integration and adjustment in the host country difficult and may in turn marginalize refugees, through their sense of powerlessness (Miller, 1999; Webster & Robertson, 2007). In the UK, Misra et al. (2006) and Webster and Robertson (2007) found that many refugees were also reluctant to use formal psychological and psychiatric services due to the social stigma attached to using such services. Both these factors require an alternative or complementary approach that incorporated cultural understandings of mental health, as well as social support and aims to avoid the stigma attached to mental health care (Miller, 1999; Misra et al., 2006; Webster & Robertson, 2007).

The psycho-social model incorporates ideas and strategies from public health and the ecological model of community psychology (Miller, 1999). Psycho-social approaches allow health care services to be complemented by "a variety of culturally grounded, community based strategies that do not require attendance in formal mental health settings but are tailored specifically to helping people adapt to and master the numerous challenges of life in exile" (Miller, 1999, p. 285). An important aspect of the psycho-social approach is asking refugee communities to define their own needs and strengths and to incorporate these communities in the solution from the start (Miller, 1999; Misra et al., 2006: Webster & Robertson, 2007). Misra et al. (2006) argue that refugees present with a multitude of complex needs, which requires services to be broad based, "involving social services and advocacy groups, as well as primary care and specialist mental health services" (p. 247). According to Miller (1999) the success of psychotherapy depends on this. Having described several of the more prevalent therapy methods used in working

with refugees it is important to discuss the usefulness of such therapeutic approaches in the relatively unsafe South African context.

2.5 Usefulness of therapeutic approaches for refugees in unsafe contexts

The unstable context that refugees in South Africa often find themselves in brings into question whether the psychotherapeutic approaches used with refugees in 'safer settings' are applicable (Luebben, 2003; Neuner et al., 2004). Unfortunately available literature provides few working examples of how to support refugees in this specific setting. In 'Western' settings where refugees find themselves in more stable situations it seems more appropriate to delve into the traumatic events of the past, as refugees are in a safe space that allows for easier containment. This intense form of therapy is not a comfortable easy process, for example, Exposure Therapy (ET) and CBT are known to become overwhelming for refugees as the exposure to traumatic material confronts them intensely with inner psychic pain (Paunovic & Ost, 2001). Even refugees treated in more stable contexts find this exposure to psychic pain so distressing that this causes them to skip CBT and ET therapy sessions (Paunovic & Ost, 2001). One could argue then that for refugees that do not find themselves in stable or safe situations this type of therapy could possibly add to their sense of trauma, as 'sequential traumatization' (Keilson, 1979, cited in Luebben, 2003), rather than actually being experienced as healing. It is also not necessarily where these refugees most want support although these traumatic memories are continuously present (Luebben, 2003).

Taking the unsafe contextual situation into consideration Luebben (2003) found that using the testimony method as a foundation to therapy was beneficial to refugees. The testimony could be used as legal evidence and the process of creating it allowed for a good therapeutic relationship to develop (Luebben, 2003). This in turn encouraged the client to continue with a more 'supportive therapy', which decreased PTSD symptoms (Luebben, 2003). Another positive example of therapy with refugees in unsafe situations was demonstrated by Neuner et al. (2004). Using narrative exposure therapy with a group

of Somali refugees in Tanzania, they found that refugees felt empowered and took active control of their lives. These positive results allow one to keep in mind that appropriate therapy can positively influence refugees' lives despite their detrimental circumstances (Van der Veer, 1998, cited in Luebben, 2003). Having described the difficulties of applying clear cut therapeutic methods in work with refugees in the South African context and yet also having established importance of therapeutic support for refugees in unsafe settings, the usefulness of the psycho-social model, where therapeutic approaches are complimented with social support, is discussed.

As mentioned in the previous section, the psycho-social model, incorporating community based interventions supported by community knowledge, along side psychotherapeutic support has been encouraged in both Western settings as well as more unsafe contexts. Palmary (2005) concludes from her research with refugee women in the South African context that a broader psycho-social approach, stressing contextual cultural identity, is necessary. She argues that this approach allows for interventions that are more meaningful, integrating a whole range of peace-building, advocacy, support/counselling, spiritual and economic interventions. This approach would embrace and build on contextual meanings of psychological distress and healing. This approach allows the priorities of intervention to be named by the refugee community, rather than being imposed (Palmary, 2005). The challenge of this model is to integrate various interventions "in ways that address the range of needs that refugees have" (Palmary, 2005, p.10). Interestingly, Miller (1999) noted that these inventive and creative models were often found in contexts outside of Western countries, as these contexts often demanded more creative, low budget interventions that did not require the support of well organized government services.

Miller (1999) describes several projects in Angola, Mozambique, Mexico, Sri Lanka and Nicaragua that emphasized that the initial phase of exile demands support in linking refugees to new social resources and aiding them in developing new social support networks. For example he describes a project where Guatemalan refugee women were trained in basic mental health knowledge and active listening skills (Miller, 1999). These

women actively engaged with other community members in workshops where they used their skills and their own experiences of psychological distress to support other community members. Another project (CAFES) mentioned by Miller (1999) provided the opportunity for refugee families within their new refugee community setting to share their experiences in exile and to engage in collective problem solving. The facilitators of these groups were community members (Miller, 1999). “In this process, new social networks are formed and information is shared (often by the participants themselves) regarding important resources available in the community” (Miller, 1999, p. 295).

A similar project established in Sri Lanka (Family Rehabilitation Centre, FRC), brought widows from the civil war together for workshop lasting several days, that aimed at promoting a sense of shared experience, as well as helping the women “gain access to important educational, legal, health and employment related resources” (Tribe & De Silva, 1999, cited in Miller, 1999, p. 295). Another psycho-social project, using the ecological community psychology model was established by an organization named *Mama Maquin* (Light, 1992, cited in Miller, 1999). Light “documented the positive impact of newly acquired social activism on the mental health of Guatemalan refugee woman in southern Mexico” (p.299). *Mama Maquin* was founded by Guatemalan refugee woman, and provided women with the opportunity to share their experiences as well as to engage in social action. In this way women acquired new social roles and were able to demonstrate social agency.

These types of projects in non-Western and perhaps more unsafe contexts, demonstrate the usefulness of psycho-social projects with dual emphasis on promoting social support and providing mental health care. Miller (1999) argues that “it helps communities become better able to address their own needs in culturally congruent ways” (p. 288). Having described some of the strengths and limitations of various therapeutic approaches to working with refugees, some further discussion of observations about difficulties entailed in such work is warranted.

2.6 Difficulties confronting Therapists working with refugees

The complex trauma common to the refugee experience requires a sensitive and specific therapy style. Therapist have a relatively wide choice of therapeutic methods to choose from as there is still not one specific style that has been proven more beneficial then others. Especially in unsafe contexts, therapists are left to their own devices in terms of how to manage therapy as conventional approaches to working with PTSD are either not viable or sufficiently comprehensive. In order to support therapist more successfully it seems important to identify the most common issues that therapist working with refugees are presented with. Some such issues have been identified in the literature based on the work of therapists who work mainly with refugees in the Western contexts. From the literature four main issues have emerged as significant: therapist exposure to the horror stories described by refugees (Kinzie, 1981, 2001; Levy, 1999; Woodcock, 2001); the need to step out of the conventional therapist role and take on the role of social advisor and mediator (Kinzie, 1981, 2001; Luebben, 2003); assisting clients to deal with the cultural stigma of psychological illnesses (Kinzie, 1981, 2001, Luebben, 2003); and lastly, bridging the often present cultural divide between therapist and client and client and society (Kinzie, 1981, 2001; Neuner et al., 2004; Vale, 2001).

Therapists working with refugees are often confronted with a stream of horrific stories involving torture, degradation and multiple losses which they find difficult to contain (Kinzie, 1981, 2001; Levy, 1999; Woodcock, 2001). Levy (1999) describes the desire to replace these horrific stories with something more comforting. Not only are the memories of refugees very often unsettling, the feelings of hatred and anger that accompany these memories are often difficult to engage with (Levy, 1999). Levy (1999) describes managing and containing these feelings to be the most difficult aspect of working with refugees. Kinzie (1981) describes the existential quest that both refugee and therapist find themselves on as consequence of the human atrocities presented. This quest puts into question whether either therapist or refugee can continue to engage with life (Kinzie, 1981) and may confront therapists with profound existential issues.

The therapist can be so overwhelmed by the feelings of anger and hatred that accompany these traumatic events that it is not unusual for them to quit such work (Kinzie, 1981). Woodcock (2001) describes this therapeutic experience of having to manage and contain stories of war and violence as sinking deeply into the consciousness of therapist, often creating a sense of resistance which may be acted out in various ways. A common defense mechanism noted by therapist is that they place their client at the level of social hero or see them as a survivor of a dying culture which needs rescuing i.e., they may valorize the client or their struggle, placing them in the realm of the extraordinary and defending against their own anxiety or revulsion. Alternatively they may skirt around these horrific experiences by focusing on more abstract sociological understandings (Woodcock, 2001). Woodcock (2001) argues that idealization and intellectualization are defenses against realities that are too painful to be fully recognized. The ability to truly listen and stay with the patient by fully engaging with him/her demands that the therapist be a constant in a chaotic world (Kinzie, 1981, Levy, 1999, Woodcock, 2001). In order to remain this constant, Woodcock (2001) underlines the importance of supervision. Supervision according to Woodcock (2001), allows the therapist to discover and work through his/her own defenses, creating space for a good therapeutic relationship.

Another major issue that therapist working with refugees describe is having to step out of the conventional therapeutic role to encompass the role of social mediator. Often refugees find themselves in a social context foreign to them. This makes it difficult for them at times to act as social agents and leads to a sense of frustration, suspicion and lack of trust in the government of their new home country (Kinzie, 1981). As a therapist for these refugees it is important to be able to guide them through this new social/cultural world, at times acting as a social mediator (Kinzie, 1981). Many conventional therapists would not be comfortable with this extended, dynamic role. Luebben (2003) argues that in a social context where refugee are feeling unstable due to constricting and unhelpful or even persecutory state structures, it becomes impossible to convince refugees of the necessity to work through past traumas. These refugees need practical support in their present traumatic circumstances (Luebben, 2003). Luebben (2003) describes how a group of mental health professionals lobbied alongside human rights lawyers for better treatment

of psychologically affected refugees. This created a great sense of trust for the refugees involved, and provided for a good therapeutic relationship (Luebben, 2003). These examples portray how therapists in the field are forced sometimes to step out of the conventional therapeutic boundaries in order to truly support their clients. Overstepping therapeutic boundaries cannot be taken lightly, however, and represents an important issue that many therapists grapple with.

A third important issue described in the literature is dealing with the cultural and social stigma of psychological illnesses (Kinzie, 1981, 2001; Luebben, 2003). For many cultures psychological illness is shunned and shamed, making it a big and difficult step for those suffering from psychological pain to seek help (Kinzie, 1981). Having found help, it is then is often personally difficult to accept the help, as by accepting it one often has to accept the label of having a 'mental illness' (Kinzie, 1981, 2001; Luebben, 2003). As a defense patients often focus on physical symptoms (Kinzie, 1981). Taking these symptoms seriously by doing a thorough physical examination and alleviating some of the symptoms with psychotropic drugs may strengthen rapport and create a space to continue with therapy (Kinzie, 1981, 2001). Another suggested method of bridging this difficulty is initially using a therapeutic method that can play an important social function, for example the writing of one's testimony (Luebben, 2003). From this initial phase it is easier to continue with a more in-depth therapy. Although these suggested solutions seem to work, the issue of the stigma of mental illness remains a difficult and constricting factor in many therapeutic settings, particularly in those settings where it is not possible to do thorough physical examinations or to expand on therapeutic methods.

Another important issue that therapists working with refugees face is the issue of cultural differences (Kinzie, 1981, 2001; Neuner et al., 2004; Vale, 2002; Woodcock, 2001). There may be cultural differences between the therapist and his/her client and the therapist may have been exposed to social prejudices concerning refugees (Kinzie, 1981; Woodcock, 2001). Therapists need to be aware of and reflect on their personal cultural background and the social prejudices that they might carry with them concerning specific cultural groups or refugees as group. Commonly prejudices consist of the fear of

contracting contagious diseases, resentment of supporting people who are 'cheating the system', resentment surrounding the increased job competition that refugees create and resentment for the potential increase in criminal activity caused by the influx of poor refugees (Kinzie, 1981, 2001; Neuner et al., 2004; Vale, 2002; Woodcock, 2001). It is difficult to truly be present and supportive of a person who brings in an undertow of so many other subtle meanings that may cause an increase in resistance on the part of both therapist and client, and a subtle sabotaging of the therapeutic relationship (Woodcock, 2001). Language differences and other barriers to clear communication may also compound other aspects of cultural difference.

Although these issues have been described in several articles, it is not clear how such issues affect therapists working in the South African context or other unsafe contexts. There seems to be a definite need for more research or understanding in this area. It is important to identify what issues are significant for therapists in this context with the ultimate aim of improving understanding and service provision.

2.6 Conclusion

The literature review has described significant aspects of refugee experience and has highlighted the importance of clarifying the nature of different refugee contexts and how these contexts influence the appropriateness of methods employed in such work. In order to support therapists in South Africa with their work regarding the psychological support of refugees it seems important to explore the subjective experiences and views of people offering and receiving such psychotherapy or counselling. A fundamental aspect of this task is to explore the difficulties that therapists working with refugees in the less stable South African context experience and also to look at clients' experiences of strengths and weaknesses in this aspect of intervention. Having identified four issues that therapists in more Western settings and some in less stable settings have experienced, one is able to compare whether these issues are also present in the South African setting and whether similar solutions are useful. There appears to be no formal academic literature concerning therapeutic work with refugees in South Africa. Articles on working with refugees in unstable or developing country contexts all include a call for more elaborate research to

be done. The current study aims to make some contributions to addressing this apparent lacuna in the literature.

CHAPTER 3

Research Method

3.1 Introduction

> *"Qualitative methods have provided a promising response to the need for contextual social science that speaks from the perspective of those being researched, and constitute an effective antidote against hegemonic discourses which have tended to swallow up the voices of the excluded and marginalized in the quest for universal explanations"* (Kelly, 1999, p. 402).

Qualitative research provides the researcher with tools to gain a rich, in-depth understanding of individuals in a specific context. The ultimate goal of this research project was to derive guiding principles for therapists who are working with African refugees in an unstable or unsafe context for the refugee, such as that which South Africa generally represents. In order to do this, an in-depth understanding of what psychotherapy for some refugees in the South African context entailed was needed. To achieve this, a qualitative research approach was implemented, using semi-structured interviews in order to gain insight into the practical, subjective experiences of both psychotherapists dealing with refugees, and refugees who have undergone psychotherapy.

It was hoped that a qualitative approach would allow the researcher to get an in-depth understanding of the social inter-active process (Addison, 1989) that occurs between the therapist and the refugee client. Within the qualitative arena, an interpretive approach paradigm was adopted. The interpretive approach allows us to access 'local knowledge' through the use of language (Terre Blanche & Kelly, 1999). It allows us to take part in a journey through the experiences of both refugees and therapists. This journey is mapped and thought about through the analytic, hermeneutic spiral and seven supporting cannons (described more fully in a later section) (Kvale, 1996). Using the interpretive framework as the epistemological/ontological base (Kelly, 1999), the analytic method of thematic analysis, as described by Terre Blanche & Kelly (1999) and further elaborated by Boyatzis (1998) and Joffe & Yardley (2004), was followed.

3.2 Research Aims

The aim of this study was to derive guiding principles for therapists who are working with African refugees/asylum seekers (A.S.) in an unstable or unsafe context for the refugee, such as that which South Africa generally represents. In order to derive guiding principles for therapists it was important to understand what both therapists and clients perceive as important considerations in the provision of effective psychotherapy for African refugees in the South African context.

3.3 Research Questions

In order to support the research aim, four supporting questions were established:

Supporting questions:

1. What are the strengths and contributions of psychotherapy as identified by therapists and refugee clients?
2. What are specific dilemmas that arise in the context of psychotherapy for refugees?
3. What potential solutions or ideas are there to work through these dilemmas and other difficulties?
4. What are the guiding principles used by therapists in working with refugee clients?

3.4 Methodological Approach/Framework

A primary assumption of qualitative research is that people's subjective experiences are real and should be taken seriously (Terre Blanche & Kelly, 1999). Wanting to give room to these voices, as well as understanding and interpreting them, requires a theoretical framework that embraces a qualitative, interpretive approach (Kelly, 1999). Qualitative, interpretative research allows one to construct new ways of understanding by eliciting and exploring contextually grounded subjective experiences. This involves a journey that needs to be mapped rather than a mining expedition where 'pure quantifiable information' is measured (Kvale, 1998; Terre Blanche & Kelly, 1999).

In order to succeed in this journey it is important to be well equipped with prior knowledge about themes relating to the journey, as well as to be able to step cautiously

through new territory, thereby deducting new themes from that territory. Kelly (1999) argues that qualitative research is a dialogue between questions, data and prior contextual understandings. This is supported by Radnitsky's (cited in Kvale, 1996) fifth canon of the hermeneutic circle, which states that the researcher needs to have an extensive understanding of the questions being asked in order to pick up on nuances in the text. It is important to balance the contextual information that the research is presenting with theory. The notion that understanding is generated in a bottom up and top down interaction, seems appropriate for this study.

3.4.1 Interpretive Inquiry/Hermeneutics

The interpretive approach allows us to access 'local knowledge' through the use of language (Terre Blanche & Kelly, 1999). It combines the 'insider' or 'first person' perspectives with 'outsider' or 'third-person' perspectives (Kelly, 1999). This allows for a creative interpretive process to develop (Kelly, 1999). Interpretive research relies on first hand accounts which are rich in detail (Terre Blanche & Kelly, 1999). It is acknowledged that these accounts are constructed between the researcher and her participants. Schwandt (1998) argues that in order to engage in and with the world, or in research with participants' accounts, it is necessary to interpret. Interpretation, Swandt (1998) argues, is a human approach that allows us to engage with and be a part of our world. In interpretive research one initially negotiates meanings together with participants through the interviews. Then the researcher distances herself by re-engaging with the same interview as a separate text (Kvale, 1996). Distantiation allows one to acknowledge the "contextual and social limits of understanding" (Kelly, 1999, p. 400), as "no matter how thoroughly we understand a context from within, there are certain things about the context that are only going to become evident when we look at it from the outside" (Kelly, 1999, p. 400).

In order to guide this process *hermeneutics* supplies us with principles of circular inductive processing in order to interpret the interview text produced (Addison, 1989; Kelly, 1999; Kvale, 1996). Kvale (1996) suggests that hermeneutics is a method of reengaging in "dialogue or conversation with the text" (p. 46). The guiding circular

principles or ‘canons’ (Radnitzky, 1970, cited in Kvale, 1996) assume that in order to understand a text, the meaning of the separate parts is understood to be determined by the global meaning of the text (Kelly, 1999; Kvale, 1996). “In principle, such a hermeneutical explication of text is an infinite process, while it ends in practice when one has reached a sensible meaning, a valid unitary meaning, free of inner contradictions” (Kvale, 1996, p. 47).

There are seven suggested hermeneutical canons of interpretation to support the interpretive process (Radnitzky, 1970, cited in Kvale 1996). The first and most frequently cited canon suggest a ‘circulus fructosis’ (Kvale, 1996, p.50); that is, a spiral process entailing a back and forth between the parts of the text and the whole, allowing for a continuously deepened understanding of meaning. The second canon suggests that this spiral stops once a ‘Good Gestalt’; a sensible pattern and coherent unit is reached (Kvale, 1996). Thirdly, one can test the interpretations made against the greater global meaning of all the used texts (interviews) and other texts (Kvale, 1996). The fourth canon reminds the researcher that each text should initially be understood on the basis of its own frame. One needs knowledge about the themes of the text in order to be sensitive to nuances of meaning expressed in each text (Kvale, 1996).

The sixth canon follows on, emphasizing that therefore one’s interpretations are not presuppositionless (Kvale, 1996). “The interpreter cannot ‘jump outside’ the tradition of understanding he/she lives in” (Kvale, 1996, p. 49). As a researcher/interpreter it is therefore important to make these presumptions explicit, being reflective about the influence of one’s own set of cultural/social lenses (Kvale, 1996). The last canon adds to this, stating that if all the above are kept in mind, the researcher is involved in an innovative creative process (Kvale, 1996). This in turn, allows the interpretations to go “beyond the immediately given and enriches the understanding by bringing forth new differentiations and interrelations in the text, extending its meaning” (Kvale, 1996, p. 49).

Terre Blanche and Kelly (1999) argue that in order to succeed with interpretive analysis one must stay close to the data. It requires a back and forth movement on a number of

levels- between the part and the whole of each 'text' (interview), between knowledge arising from the text and background knowledge, between the strange and the familiar, as well as between description and interpretation (Boyatzis, 1998; Joffe & Yardley, 2004**;** Kvale, 1996). The goal is to reach a "good gestalt" (Kvale, 1996, p. 48); a unity or "compelling account of the phenomenon being studied" (Terre Blanche & Kelly, 1999, p. 140), which remains close enough to the context that other people familiar with the context will recognize it, but not so close that nothing new, no innovative creativity has been added. One hopes that a new perspective arises. Having described the analytic approach adopted in this research project, the process of such research is outlined in further detail.

3.5 Participants

With qualitative research the choice of research participants is preferably based on purposive sampling whereby the participants are selected according to criteria which are relevant to the specific research project (Willig, 2001). This allows for the selection of a reasonably homogenous group, in the sense that they all share particular characteristics, experience/s or situational exposure, which is necessary in terms of connecting the interviewees' different experiences to answer the research question (Willig, 2001). For this reason criteria for inclusion were set out.

Criteria for inclusion:

- <u>four therapists</u>
    1. Involved in conducting therapeutic work with refugees for at least 6 months, including having seen one or more clients for at least 8 sessions.
    2. Training or registered as a Counselling/Clinical psychologist or having several years of therapeutic/counselling experience in a professional capacity.

- <u>four African refugees</u>
    1. Above the age of 18
    2. Having the status of asylum seeker

3. Having been in psychotherapy for at least 8 sessions or 2 months.
4. Articulate in English, (making thick descriptive interviews possible and counteracting potential ethical difficulties in using an interpreter) (Willig, 2001).

In 2006, 8 research participants were interviewed. Generally, the minimum size of a qualitative research sample falls between 6 and 9 participants (Creswell, 1998). Participants (both counsellors and refugees) were sought through advertisement (see Appendix 2a.) put up at the trauma centre at The Centre of the Study of Violence and Reconciliation (CSVR) in Johannesburg. Interested refugees and therapists obtained a detailed information letter (See appendix 2b. & 2c.) from the receptionist of the centre or the researcher, outlining what participation would entail.

The process of accessing participants was supported by snowballing. For refugees this process happened in two phases. The first refugee client interested suggested another refugee client that he knew was interested in participating from his community (Rwandan). Although this second refugee client knew another potential candidate within this same refugee community, I choose to re-advertise at CSVR in the hope of gaining a more diverse account of the refugee experience. From the second round of advertising, a third refugee contacted me. He then suggested another refugee client from his community (Zimbabwean). In this way four refugee clients were interviewed. Therapist participants were found through purposive snowball sampling. The first therapist suggested the following therapists and upon approaching him, he was interested and agreed to participate. He suggested a third and so forth. All transportation costs were funded by the researcher and arrangements to interview participants were made at their convenience. Although this was not the intention at the outset the 8 participants interviewed were all either service providers or recipients of services offered by the Trauma Clinic of the CSVR or the closely associated Zimbabwe Torture Victims Project (ZTVP). It proved difficult to find participation outside of these service structures. It is therefore acknowledged that there may be some organizational specificity in the findings as will be discussed later in examining the limitations of the study.

3.5.1 Refugee Clients Brief Biographies

❖ *Refugee 1.*

Refugee 1 is a Rwandan man in his forties. He chose to go to therapy after partaking in a trauma workshop for refugees at the CSVR. In this workshop he recognized several trauma induced symptoms, most particularly 'flashbacks'. He went to therapy for a little less then a year, a few years ago. He fled to South Africa through several different countries, and saw in South Africa the potential of being able to live a relatively 'normal' type of life, where he could be a fully mobilized social agent, being able to make choices for himself and his family. This was different to being in a refugee camp where he felt his ability for personal development would be stagnant. Unfortunately he underestimated the difficulties and dangers of being a refugee in the South African context and at one point was desperate to be resettled elsewhere with his family. This did not happen and was experienced as a great disappointment.

❖ *Refugee 2.*

Refugee 2 is in her thirties and also originally from Rwanda. While in Rwanda she had been working as a teacher, married and had one child. While fleeing her child was killed. Her journey to South Africa was also through many countries, where she witnessed many other Rwandans being killed. Arriving in South Africa she experienced herself as depressed and struggling to have space in her mind to do the practical daily activities that were necessary. She also went to a workshop on trauma at the CSVR and recognized her symptoms to be symptoms of trauma. She chose to go to therapy, and went to see her therapist twice a week for 12 months. She has been in South Africa for over 5 years.

❖ *Refugee 3.*

Refugee 3 came to South Africa in early 2003 from Zimbabwe. He is part of the Ndebele ethnic group and worked as a school teacher in a rural area. He felt threatened there and choose to leave his wife and children and find refuge in South Africa. He had never been to South Africa before, but had a relative in Johannesburg who he found after a long and scary journey over the boarder. He struggled for over a year to obtain his asylum seeking

papers, and only after being referred to the CSVR did he eventually acquire them. Through the intake process that was set up for Zimbabwean refugees by ZTVP it was noted that he might benefit from psychiatric and psychological support. Taking this advice he commenced therapy. He was in therapy for about eight sessions he estimated.

- *Refugee 4.*

Refugee 4 is in his forties. He too came from Zimbabwe, where his wife and children still reside. He fled to South Africa illegally after having been a victim of torture by the political regime in Zimbabwe. Refugee 4 indicated that he felt himself to be a traumatized victim upon arrival in South Africa. He has been in South Africa for around two years and struggles with employment after leading a very financially secure and professional life in Zimbabwe. He came into contact with the ZTVP project in Johannesburg and was referred for medical, psychiatric and psychological support. He was still attending therapy at the time of the interview and had been in therapy for approximately half a year.

3.5.2 Summary of Therapists' Brief Biographies

Of the four therapists interviewed one was a registered social worker, one a psychiatric nurse and the other two were counselling psychologists. Three were female and one was male. Their work in the field of traumatic stress and or refugee care ranged between 18 months and 10 years. All four had reasonably extensive experience of conducting psychotherapy with refugee clients and 3 of them had also played other service provider roles with refugees, for example providing psycho-social services. Their therapeutic orientation tended to be integrative or eclectic with some emphasis on CBT, Narrative and Psychodynamic orientations.

Although generally there is a clear distinction between these forms of psychotherapy and 'trauma counselling', this research project will use the term therapy or psychotherapy to encompass all interventions used in this context, as all four therapists' psychotherapeutic experience with refugees was extensive but not homogenous. All four of the service providers are referred to interchangeably as 'therapists' in the rest of this study since this

was the area of their service provision that was of interest in the study. In order to protect confidentiality no statements quoted are referenced back to any particular participant. All refugees are referred to as *'he'* as they were predominantly men, and all therapists are referred to as *'she'* as they were predominantly women. This also aided confidentiality.

3.6 Data Collection

In 2006 interviews with the four above mentioned refugees and the four therapists were conducted. The interviews took place where it was convenient for each individual interviewee. This included a therapeutic room on the Witwatersrand University premises, my own office and the offices of the interviewees. The spaces allowed for comfort and confidentiality to remain intact. Generally the interviews were done after office hours which allowed for fewer distractions from other daily 'pressing issues'. Data collection started by interviewing refugee one and therapist one. These interviews were taped and later transcribed by me, the researcher. During transcription of the interviews I started making initial notes on themes or striking aspects of the interview. I then read through the transcript highlighting main themes and other questions that arose. My supervisor was given the same two interviews and she also highlighted themes. These were compared and discussed during supervision and notes were made as to what to keep in mind for the next interviews.

The same process was repeated once again during data collection. This allowed me to start immersing myself in the data and the spiral of interpretation at an early stage. After the last interview was transcribed a new phase of interpretation started which was supported by the thematic analysis framework mentioned earlier. This framework is described in more depth below. Terre Blanche and Kelly (1999) argue however, that in interpretive research there is no clear cut distinction between the different phases of research. "Rather, there is a gradual fading out of the one and a fading in of the other, so that at first you are mainly collecting data and towards the end you are mainly analyzing what you have collected" (Terre Blanche & Kelly, 1999, p.139).

3.6.1 Interviews

As interpretative research requires thick descriptive texts (interviews) for analysis, semi-structured interview schedule using open-ended and non-directive questioning, for both refugee clients and therapists, was developed. Willing (2001) argues that this type of interviewing structure allows one to generate highly rich and descriptive narratives. The interview structures for both refugee clients and therapists had a 'phase one' which was open-ended and non-directive (See Appendices 1.a & 1.b for interview schedules used). This allowed the interviewees room to share their experiences of therapy, and allowed for a dialogue where researcher and interviewee could negotiate definitions and understandings of the interviewees' 'life-world' (Kvale, 1996; Willig, 2001).

The questions which were of interest to the research, along with understandings derived from the literature review, were used to create guiding questions/probes for the interview schedule. As the interview was in principle semi-structured, not all the guiding questions or probes were used in each interview. The questions/probes were rather set out as a supportive structure to ensure that the aim of the research was kept in mind. Throughout the interviews care was taken to apply questions that encouraged descriptive answers such as using questions starting with when, what or how, as opposed to questions pertaining purely to the why. In order to confirm meanings between myself and the interviewee, I would seek clarification and reflect as much as possible on what I thought s/he was saying. This allowed us to negotiate and construct meanings together, and enabled me to check my understandings. The interviews over time became quite circular in nature, and the 'circulus fructosis' (Kvale, 1996, p. 50) process of interpretation began during the process of the interviews.

Different from the structure of the refugee clients' interview schedule, the therapists' interview schedule had an added second phase. In phase two of these interviews a more directive approach was used, including more questions pertaining to the 'why' in order to explore therapist rationales for making certain assertions. This phase also allowed us to look more specifically at difficult issues described by other therapist as identified in the

literature. Although delineated into two phases in the interview schedule, in practice the interviews moved between both types of reflection in a fluid process. Oftentimes many of the more directive questions were spontaneously answered in the first phase by the interviewee. The fluidity of the process also allowed for more unexpected areas of interest to arise, alongside material supporting themes noted in the literature review.

Officially, the interviews were planned to take 45-60 minutes maximum. The first interview with refugee client one and later refugee client two met this time frame. The interviews with the therapists' all took a minimum of an hour and a half. Therapists' seemed to enjoy the space granted to them to speak, and were eager to speak for as long as possible. In fact for interview 2 and 4, it was the researcher who had to terminate the interview after over two hours. This in itself indicated that there was little opportunity for therapists to reflect on their work or to be truly acknowledged for the depth, intensity and difficulty of their work. By the end of data collection approximately 15 hours of material had been recorded. This translated into thick descriptive text ready for a second more in-depth round of interpretation (analysis).

3.7 Data Analysis

In order for a new perspective to arise out of the collected data certain analytical steps need to be followed. This upholds the rigor of the research project. A summation of Terre Blanche and Kelly (1999), Boyatzis (1998) and Joffe and Yardley's (2004) description of the steps of thematic analysis suggests five steps. Although these steps were used to guide the analysis, Terre Blanche and Kelly's (1999) argument that "in reality, interpretive analysis rarely proceeds in as orderly a manner as may be suggested by a step-wise presentation" (p. 140) was also kept in mind. The five steps that guided the analysis are outlined as follows:

- *Step 1. Familiarization and immersion*

The first step in analysis was to familiarize myself with ideas and theories about the phenomenon being studied. Terre Blanche and Kelly (1999) state that data gathering in interpretive research cannot be a mindless exercise but demands prior knowledge and

understanding about the phenomenon in question. This is supported by Radnitzky's (1970, cited in Kvale, 1999) fifth canon, which states that extensive knowledge about the themes arising out of the data will allow for nuances of the themes to be understood and clarified when needed. For this reason I started this journey by reviewing relevant literature and drawing from themes in the literature to create my interview schedules. The literature review also allowed me to probe or gain a more in-depth understanding during the interviews. Discussing the first two interviews with my supervisor helped refine my understanding of different parts and the 'whole' of experiences of therapeutic work with refugees. Terre Blanche and Kelly (1999) suggest that in these initial stages it is important to make notes to oneself, draw diagrams of thought and brainstorm, which I made use of throughout my data collection and analysis process.

- *Step 2. Inducing themes*

The next three steps (inducing themes, coding and categorizing) are used quite freely and interchangeably in the literature. For this reason I will define each briefly and then discuss them in more depth. Inducing themes involves finding and noting patterns in the data, while coding is the labeling of these patterns, giving clarity to the thick descriptive text (Boyatzis, 1998; Joffe & Yardley, 2004; Terre Blanche & Kelly, 1999). This process is a bottom up or inductive approach (Terre Blanche & Kelly, 1999), although it is supported by prior knowledge (Boyatzis, 1998). The themes that are drawn out of the immensely detailed texts (interviews) are features that are salient for our research (Joffe & Yardley, 2004). This allows an inductive and deductive movement to be available at the same time (Boyatzis, 1998).

Boyatzis (1998) refines the description of a theme by adding that "at the minimum (a theme) describes and organizes possible observations or at the maximum interprets aspects of the phenomenon" (p. vii). Boyatzis (1998) continues: "A theme may be identified at a manifest level (directly observable in the information) or at the latent level (underlying the phenomenon)" (p. vii). Joffe and Yardley (2004) suggest that the manifest theme might initially be the focus, whereas latent themes are drawn from the manifest ones, and often require deeper interpretation of the data. Therefore, initially, one

must be open to all information present. In order for thick description to be available for further analysis an array of themes need to be created. These themes are then labeled, which is the process of coding.

❖ *Step 3. Coding and Categorizing*

"In thematic analysis codes can be used to describe verbal patterns" (Joffe & Yardley, 2004, p. 63). Terre Blanche and Kelly (1999) argue that generally speaking finding themes and coding blend together and support or influence one another. As one continues to code themes, ones understanding of the themes are refined, adapted and changed (Terre Blanche & Kelly, 1999). For this reason "codes should never be regarded as final and unchanging" (p. 143). Strauss (1998) refines the understanding of coding by suggesting that the initial phases of coding, is that of "open coding" (p. 102). Open coding allows us to "open up the text and expose the thoughts, meanings and ideas contained therein" (Strauss, 1998, p. 102).

The themes throughout the interview are all labeled into codes and these codes are then re-visited and the codes that are conceptually similar in nature or meaning are then grouped under more abstract concepts called 'categories' (Joffe & Yardley, 2004; Strauss, 1998). To help in this process the cut and paste options in a word document was used, and in this way codes were sorted "spliced and linked" (Joffe & Yardley, 2004, p. 61). Textual categories were then integrated into conceptual categories (Joffe & Yardley, 2004). To help with this task a mind mapping computer program was used to create a mind map of all textual themes (See Appendix 4).

❖ *Step 4. Elaboration*

The mind map allowed the categories to be viewed visually and helped to analyze the nature of the relationship between the various categories and their subcategories. Exploring themes, codes, categories and how they are inter-related more closely Terre Blanche and Kelly (1999) call elaboration. The goal is to establish a unified and logical whole (Kvale, 1996; Terre Blanche & Kelly, 1999). The result of this last step is demonstrated in the Analysis chapter of this research project.

❖ *Step 5. Interpretation and checking*

The final step of the analysis process of this study was putting together the emerging interpretations (Boyatzis, 1998; Terre Blanche & Kelly, 1999). Since the presentation and discussion of findings are integrally related in most qualitative research, they are explored together in chapters 4 and 5. It was also in this phase that I was able to re-visit my own role in the process, and I was able to observe the subtle but significant impact of my social positioning on the data collecting and analysis process.

3.7.1 Validation

There are a vast variety of different methods described in the literature to address the question of the validation of qualitative research (for example the suggested methods of: LeCompte & Goetz, 1982; Lincoln & Guba, 1985; Eisner, 1991; Lather, 1993; Richardson, 1990; Wolcott, 1994, cited in Creswell, 1998). The procedures for validation suggested by Creswell (1998) include eight verification procedures that summarize the most common methods of validation discussed in the literature. These include: prolonged engagement and persistent observation, triangulation, peer reviewing or debriefing, negative case analysis, clarifying researcher bias, member checks, rich, thick description and external audits. Of these eight procedures it is recommended to use at least two.

This research project used peer review to provide an external check on the research process, thereby supporting the reliability, validity and credibility of this research project (Creswell, 1998). Peer review through research supervision and allowed important questions to be debated and clarified, and allowed for discussion around tentative understandings that had emerged out of the individual interviews. The semi-structured interview also allowed for thick descriptive text to develop. I have also included a reflexive commentary which includes observations of possible researcher bias.

3.8 Reflexive Considerations

As the epistemology and thereby methodology adhered to in this research works under the fundamental assumption that meaning is mutually created, and our experiences and

understandings are confined by our thoughts and activities (Yardley & Marks, 2004), it is imperative that my position as the researcher is reflected on. Prior to each interview I disclosed my position to each participant. This brief summary of who I was did vary, depending on whether I was interacting with a refugee client or with a therapist. With the four refugee clients I explained that I was finishing my master's year here in South Africa, and I added that my home country was in actual fact Kenya. I noticed through subtle remarks that each refugee client compared themselves to me as I too was not in my country of origin. Yet I had my own means of transport, a roof over my head and social/financial connections. This part of the comparison was noted by my refugee participants as well. Prior to my interviews with the four therapists, I introduced myself as a trainee clinical psychologist at the University of the Witwatersrand. Being a 'Wits clinical psychology student' implies that my training has at its foundations a psychodynamic orientation. Asking questions around how therapists worked and what they found challenging was therefore coloured by their knowledge of who I was and possible assumptions about my therapeutic orientation. Therefore, I found that my position was kept in mind and thought about by both refugee clients and therapists, and I was incorporated or isolated respectively at different times.

3.9 Ethical Considerations

The following was ensured:

- Participants were recruited with full knowledge of the scope and context of the project as well as what their expected involvement would entail (See Appendix1c. for example of informed consent forms).
- Recruitment of both therapists and refugees was on a purely voluntary basis.
- Participants were made aware of their freedom to withdraw from the research at any time.
- The participant's confidentiality was guaranteed directly and no direct personally identifying information concerning the refugees has been included in the final report. Dealing with refugees, the issue of confidentiality is particularly important, given the nature of their past trauma and current status. Separate consent for tape recording the interviews was sought and granted.

- Inherent to qualitative research is the use of direct quotes for validation of argument or analysis. The quotes used were selected in such a way as to ensure that participants could not be individually identified.
- Feedback will be provided to the organisation by means of a discussion group or mini-workshop.
- The possibility of secondary/re-traumatisation was acknowledged from the start and participants were made aware of further free counselling services available to them. It did not prove necessary for any participants to pursue this option. Almost all the participants in fact indicated that they had found the interview process beneficial in terms of support and reflection.
- The tape recordings of each interview will be destroyed after examination of the research report. In the interim they will be kept in a safe place at the researcher's home.

CHAPTER 4
FINDINGS AND DISCUSSION: PART 1
The Lived South African Refugee Context

4.1 Introduction

In analyzing the data a clear picture was painted of the lived refugee experience in the South African context. As this 'lived experience' determines the nature of therapy required and shapes possibilities for intervention, this chapter discusses the South African refugee experience as depicted by the interviewed refugees and therapists working with refugees. As explored in the literature review, the 'refugee experience', (which includes the reason for fleeing and the experience of forced migration), has personal, social, economic and psychological implications. South Africa, and more specifically the context of Johannesburg colours the refugee experience in such a specific and intense way that one cannot fully understand the varied and complex implications of being a refugee without exploring the refugee experience in this particular setting in more depth.

The discussion first explores *the general refugee experience* in greater detail, including common themes such as: types of refugees, multiple losses, trauma and up-rooting. The second part of this section will explore *the urban South African refugee experience* more specifically. This section addresses the experiences of meeting basic needs, discrimination, living in fear, retraumatization and refugee resilience. Having outlined the lived experience, the second section outlines refugees' descriptions of their psychological distress. The last part of this chapter discusses refugees' experience of counselling.

4.2 The general refugee experience

4.2.1 Political refugee versus economic migrant

As mentioned in the literature review, post Apartheid South Africa prosperity has seen a rise in the number of migrants crossing the boarder, some of whom abused the system.

This unfortunately has made the process for 'actual', politically motivated refugees more difficult and open to discrimination and misunderstandings. As one refugee stated:

> *"In fact the number of refugees is very small. So it would be nice to be accepted as genuine refugees"*.

An interviewed therapist explains how this distinction plays an important role in the psychological impact of relocation, as the impact is very different for an economic refugee than for a persecuted/political refugee.

> *"And some, I mean we would need to make a distinction between economic refugees and political refugees. People that are feeling persecution. Because if I'm an economic refugee, obviously this is what I expect. Because at home this is what I was feeling, the starvation, the poverty. But if I was just staying at home living a normal life and all of a sudden I'm being accused of something that I do not know. And I don't even care…"*.

The reasons for seeking asylum in South Africa comprised an important part of the refugee experience, and coloured the context in which counselling took place.

All four of the interviewed refugees hoped that South Africa would offer them the freedom and stability to be able to continue with their lives, which had become impossible in their countries of origin. As one refugee explains:

> *"So I thought this was a place where I could be protected and carry on with my life. Because I don't even attempt to go back home. At any point. I don't have it in me, because what I saw is enough"*.

Another refugee explained:

> *"This was where I could get protection. Because elsewhere, even in my country, you know, people were on my neck. You know? And they found me even where I had taken refuge, you know, about three times. In Congo, in Tanzania, in Malawi, you know?"*

This is different to wanting to better one's life and hoping for more possibilities to do so in South Africa, as is the case with economic migrants. An essential psychological difference is the voluntarism of relocation and the sense of anxiety one carries (or not) as a consequence of persecution. Another noted difference between economic migrants and refugees, was that an economic migrant often has time to plan their move to a new country and may have acquired social networks that can support them in the country to which they are moving. Persecuted refugees generally have very little time to plan their escape and often find themselves in a new place of which they know very little. One of the refugees describes this experience:

> *"I went into South Africa. And actually it was the first time that I went into South Africa. So, now these guys that I was following were going to the Northern Province, and I wanted to get to Johannesburg. But I had no idea how to get there….So I waited for the train and got into*

the train and I was alone, the train wasn't full, until we got to, just before we got to Pretoria at Polokwane. There quite a few people got on the train, and one man sat next to me then I was able to talk to him in English. So he told me that Johannesburg is just nearby. I stayed in the train and got of the train at Park Station. Because I saw everyone in the train standing up. So I also stood and followed them up the stairs".

The distinction mentioned above was elaborated on by both refugees and therapists. Both sets of interviewees explained that one's initial social and economic placing also impacted on the refugee experience. Three of the refugees described how their lives used to be comfortable, as they held professional jobs in their country of origin. In South Africa they found themselves struggling to meet the most basic of human needs, such as food and shelter. The above distinction plays an important role in the magnitude of the social and cultural loss experienced.

4.2.2 Multiple losses

"I had a professional job. I could afford anything, such as medical aid. My children could go to school. My life was intact, until I decided that the undemocratic way that the government has… currently in the country there. I was tortured. And actually I went through horrible things there, which at times still affect my mind. To such an extent that I think that I did get some assistance in the form of counselling. In the form of trying to accept my new way of life".

As described in the literature review, a fundamental aspect of the refugee experience is the deep experience of loss. One of the refugees spoke with pride about his past job as a teacher. He had taught for many years and had enjoyed watching his pupils grow and prosper. On arrival in South Africa he found himself living amongst former pupils who had not finished school and had chosen to move to South Africa, mainly for economic purposes. He describes how being confronted with these pupils brought home an incredibly painful experience of loss: The loss of his former comfortable, meaningful and stable life.

"So most of them I had taught, they had actually fled the country and were here in Johannesburg. And they were leading better lives then I! And they were still living far much better then me even today. So at times you see, it really puts one off. Because those are my direct products and now they are wondering why someone who was saying he is learned, qualified for working, is walking down the streets of Johannesburg, like anyone. Like anyone who did not go to school. You see, they tend to have those kind of conceptions".

Although this depicts one refugee's specific experience, his experience paralleled the experiences of others. Another refugee spoke of his former life in his country of origin and how it compared to his life in South Africa.

> *"I was having a job. Jah. And most of the people we were not used to sell things. Yah. We were used to, like we go to school, we finished and you worked, that's all. And back home everyone was having his own house. We were not used to do those things like renting. Or when it comes to those things like sharing, it is something which is very bad. Because we find that you are a wife and husband you are staying in a room like this. And you are sharing with two of your children, it is not good. You find out that you don't have sugar to make tea. And back home it was not like that. Because you have something, like you have like your farm, yah. You can't be in the same poverty like here"*.

His life as a refugee forced him to live and do things that he had learnt in the past were 'wrong' or below his social status. His experience speaks of the loss of a job, the loss of resources, the loss of fulfillment of assumed basic needs (such as a place to stay and appropriate room for the entire family), and the foundational assumptions of his life. It speaks of the loss of a meaningful social role and social identity, a loss of existential purpose and social network. These narratives highlight the painful material, social, and psychological consequences of these experienced losses.

One of the therapists describes the intense transition of a refugee's former life to the life of a refugee in South Africa.

> *"He is a former MP in parliament. I mean like, if you were to think of a person who is a former MP, and obviously this person, before he came to South Africa, he was living a better life. He had almost everything: Owned a house, living, or leading what you would call like a normal life. And all of a sudden because of what is happening, he gets arrested, he is taken to jail, he has been tortured then taken out of the jail, and they left him, like in the bush. Then he decided, it is unsafe here, maybe what I need to do is come to South Africa. I come to South Africa and I don't have any place to live. I'm homeless. In fact I'm just destitute"*.

The impact of this sense of loss was sometimes so unbearable that, as one refugee said,:

> *"It's like, life is at a standstill*".

And this unbearable standstill provoked strong feelings of suicidal ideation for two of the interviewed refugees. As one stated:

> *"Ja, because in the end I was now thinking of taking my life. Because you know I was coming from the situation where you know, my life was intact"*.

Lemma & Levy (2004) argue that this sense of loss "can be experienced like a death of the self, a form of internal torture where life is attacked" (p. xv). The quotes demonstrate what Eisenbruch (1991) terms 'cultural bereavement', as they speak of the pain of losing ones social and cultural identity, and sense of social agency. As refugees in South Africa are forced to fend for themselves, from the moment they enter South Africa, the impact of their cultural bereavement seems magnified. The overwhelming psychological distress caused by these losses is tangible in these quotes and the psychological consequences,

such as a sense of deadness and serious ambivalence about life and death, relay the psychological struggle refugees are faced with.

4.2.3 Trauma

Refugees are often the survivors of multiple traumatic experiences, including indirect (such as losing loved ones or community members) and direct experiences (such as torture) of war. One refugee described some of the distressing past memories he carried with him and was burdened by:

> *"I actually witnessed a lot and I actually experienced that kind of brutality. That from the time I was doing my high school we were attacked and beaten up seriously. And I had some relatives dying. And some of them stolen at night and never come back. So when you see, it was very unsafe. And now our safety became a major concern"*.

Many refugees have not only experienced traumatic events, but these events have been compounded by experiences of torture. The act of directly inflicting severe pain as a means of punishment or persuasion can break protective psychological barriers in such a fundamental way that survivors are left unable to trust in basic human assumptions of safety and continuity. One of the refugee clients confides his experience of torture:

> *"Because now this, actually, this depression was also affecting me, because I had been beaten on the back, you see. So with that pain again, so I was tortured there, on the bottom of my feet, I was beaten on the back, you know. I was electrocuted"*.

Refugees noted that these experiences caused psychological distress. It is important to acknowledge this distress and its cultural, social, political and personal meanings, as an important aspect of many refugees experience. In South Africa refugees are left struggling with both day to day survival, and living through the often times distressing memories and experiences of the past. This is compounded by another common aspect of a refugee's experience, which is that of social uprooting or alienation.

4.2.4 Social uprooting: The experience of alienation

As mentioned previously, an aspect of the refugee experience is social, family and environmental uprooting (Bracken et al., 1997; Eisenbruch, 1991; Kinzie, 2001; Lemma & Levy, 2004; Miller, 1999; Misra et al., 2006; Neuner et al., 2004). One refugee client describes:

> *"Especially after, you know I would stay with people, and people chased me away at times. You know, you are not working, you don't bring any income here. Of course you cannot survive without food, but, I mean those people had things together to get a place to sleep.*

Where you know you that you are going to put on for the night".

This experience is highlighted in refugees who have exiled to countries where integration into the existing social structure of the country is left up to them. Refugees are often left with a strong feeling of not belonging to the social system they are presented with upon arrival in South Africa. This leaves them with the bitter pain of a lost sense of belonging within their communities of origin, and of fearing that they will never again experience quite the same past sense of belonging. This runs parallel to the fear and lack of trust that they feel for the society they are presently confronted with. One Refugee explained:

> *"And any time here, I cannot have it done, because I'm not part and parcel of this country. And if I were to go back, I, I, I, would be killed"*.

Another adds:

> *"And you didn't know the necessary people to advise you on where to get the facilities such as the soup kitchen, the shelters"*.

An interviewed therapist reflects:

> *"Refugees are so ripped out of their social support, and that is where it becomes very difficult. There are those refugees that are connected, that have those extended family networks here. And I think they fare better"*.

This therapist suggests that the implications of this lack of social support complicates the refugee experience and is a great hurdle to healing. The lack of containment that an assumed material and social support network provides exacerbates the difficulty of dealing with past and present emotional stressors.

Many therapists (Herman, 2001; Kinzie, 2001; Levy, 2004; Rees, Blackbrun & Lab, 2007; Webster & Robertson, 2007) who have worked with refugees in other contexts (out of South Africa) argue that the initial step of healing is to establish a safe, trusting and containing environment. Although all the refugees interviewed spoke of some access to people from communities of their countries of origin in South Africa, their narratives stressed an ambivalent relationship with these communities, with a strong underlying thread of mistrust. Part of this mistrust is a fear that other refugees may compete with them or damage certain opportunities, spoiling that which is potentially good. This is portrayed in a quote of a refugee speaking about the complicated and mostly disappointing process of asking the UNHCR for resettlement.

> *"So they found out that many people were coming there and then they go with that referral letter for UNHCR. Some of them were giving the information which was not true.*

> *And after that UNHCR found out that they are referring people who are not telling the truth"*.

A therapist remembered an occasion when she was looking for community support for one of her refugee clients. At the time she suggested to her colleagues:

> "*Let's ask one of the refugees who is a nurse to do it. They said: "No, they don't trust one another." They will think that this other refugee is poisoning them*".

This reflects the underlying sense of mistrust that is common amongst refugee communities in general and seems to be amplified in the South African urban context. Some argue that this mistrust is part and parcel of the psychological distress caused by the entire refugee experience. The interviews suggest that refugees' community links and social relationships are tenuous and volatile. Thus again, part of the background fabric that generally allows for good therapeutic work is lacking in refugees' lives. This may preclude exploratory work in psychotherapy but also may place added burdens on therapists to meet a range of relational and containment needs because of the absence of close relational networks outside of therapy, as will be discussed later.

4.3 The South African urban refugee experience

This section will focus on five key areas of *the South African urban refugee experience* that emerged from the interviews. These include: A struggle for basic needs, living with discrimination, living in fear, retraumatization and refugee resilience. These themes reflected similar themes found in the literature. The goal of this section is to root the discussion of the nature of therapeutic work with refugees in the unique context that the South African urban setting presents.

4.3.1 Basic needs and support

Refugees in South Africa face severe challenges in meeting basic needs. These basic needs include: food, shelter, safety, accessing asylum seeker permits and refugee status, jobs, social services (such as health care or education), and community support. All four of the refugees interviewed spoke of the process of day to day living in South Africa as simply trying to survive.

> *"On the other hand the society feels that this person has come to look for greener pastures, yet I'm trying to survive. I know how bad it is at, behind me. So basically there are no basics that are given to the refugee"*.

The ordeals of resettling were experienced to be so difficult that all four refugees had at times wished that they could return to their country of origin. Knowing that they could not, left them in a state of despair, contributing to depression.

> *"Coming to South Africa was not a good experience I would say, because besides that I was a victim in my own country, a traumatized person one could say. And when I arrived in South Africa, the load became bigger, because I had to actually, it was like the problem which I had when I left, it was like the problem that I was carrying from my own country was compounded by other problems. Because it was difficult to adjust to the South African way of life"*.

The process of attaining either a Section 22 Permit or refugee status, as highlighted in the literature review, was riddled with obstacles that left refugees feeling humiliated, frustrated, hopeless and helpless. One refugee reflected:

> *"So you don't know, how, they tend to handle issues. But, I have come to realize that maybe they just make it hard for you, so that one point you will just give up and say, 'No I cannot achieve this. Let me leave."*

> *"But where we used to go to get our ID's stamped, it was really horrible. When you approached you knew, you would undergo some kind of ridicule"*.

Although in theory, asylum seekers in the process of legalizing their refugee status should be able to access social support as they wait (Landau, 2006) in practice they struggle to survive and are left having to acquire basic sustenance on their own. One refugee explains:

> *"So they* (asylum seekers) *are subjected to quite a lot of difficulties: Can't find a job, you can't find a place to sleep, you can't find something to eat, the weather is bad. It is now raining, there is nowhere to sleep and there is nothing to eat. All this, cold, cold weather. No proper clothing, no food to eat"*.

Although there are shelters that provide temporary accommodation while a refugee finds his/her feet, the time span that they are able to stay at these shelters is brief and does not correlate with the time it takes for the Department of Home Affairs (DHA) to process applications (Landau, 2006). Often refugees are left without shelter and without money as they are not welcome on the job market. A therapist reflects on how one of her client's desperation for accommodation led to a temporary solution:

> *"Because they are sleeping in someone's hairdresser, on the floor, you know, like hiding out, you know"*.

Not having a place to stay often forces refugees to sleep in unsafe places. All four therapists explain how this justifiably increases refugees' sense of being unsafe. The

supposed ‘freedom to integrate’ combined with the inadequate and corrupt asylum seeking process leaves the refugee with very little effective protection.

Due to the theoretical freedom to access the local job market, refugees are given little to no financial or material assistance from the South African government or UNHCR. Part of the problem is that there is little social understanding of refugee rights and many possible employers refuse refugees point blank.

> *“They don’t think it is something genuine. It is not the case of it is not a legal document. It is a legal document. But uh, those companies that don’t accept the document as legal, ahhhhh, they don’t know how it works. There is a lot of ignorance. Some can’t even read what is tabulated on the paper, you know”.*

Another obstacle is the social discrimination and xenophobia that refugees become victim of. A therapist explains:

> *“And yes, the mother is trying to do piece jobs. But you get paid R30 a day washing a whole mountain of clothes. And that is the reality, that people are not paid the minimum wage in this country, because they are foreigners, because they don’t have rights. And, whoever wants to employ them goes: “Okay you don’t want the money, then just go. I will find somebody else”.*

The fact that many refugees are exploited and forced to work for very little in turn places nationals at a disadvantage and increases xenophobia. Discrimination and exploitation leave refugees struggling to meet critical basic needs.

> *“Because with work, I thought I would forget a lot. Two, I would get some form of income. With an income I would be able to cover a lot because it would allow me to get some shelter and some food. That is major. Shelter, food and other basics”.*

The interviewed refugees described both the subtle and more blatant forms of discrimination that refugees in South Africa are confronted with. Below the nature of this discrimination is elaborated.

4.3.2 Living with discrimination

> *“They are completely discriminated against. I don’t have one client who has not experienced massive discrimination, repeated discrimination by any type of public service; clinics, police... That family who had these terrible attacks had phoned 10111 and were told to: ‘Fuck off Kwerikweri! Go back to your country!’ They don’t have a service open to them”.*

The interviewed refugees describe how they are seen as villains by their adopted societies. Nationals are convinced that a refugee’s primary goal is to take away South African peoples’ precious livelihood. One refugee says:

> **"***So people think, especially the locals, that you come here to take their jobs. To steal their wealth. But, what I wanted to say, is that they shouldn't, maybe there are some people who come with such motives. But I for one ended up being here. In fact, it just took me unawares! I never dreamt that I would be here in South Africa"*.

The discrimination and xenophobia felt by asylum seekers in South Africa is widespread and arises from many different corners of a refugee's social world. The refugees described feeling discriminated against by society as a whole, by their own countrymen and women in South Africa and by the police. One refugee explains:

> *"Here they have the embassy. The embassy is in fact creating hatred amongst ourselves, because they come and recruit you, and when they recruit you they tell you things to do for them. To spy on other refugees, you give them information. You know they can label you with anything, accuse you of anything you have never done in your life"*.

Thus there is a fairly pervasive sense of mistrust, fear of hostility and lack of protection against this. The voice of discrimination is most clearly heard and feared through the actions of patrolling police. One refugee relates a situation where he was walking with his friend through Joubert Park, a central park in downtown Johannesburg, and a random police raid took place. Thinking they had nothing to fear, as they both carried legal refugee papers with them, they spoke to the police. The response they got made them realize that despite their acquired legality, they were in a situation of danger as the police personnel's' view of them became clear:

> *"The attitude was that: 'There is no war in Zimbabwe, so you are lying! You bought these papers from the streets!' I felt it was so abusive and just being rude of the police officers. And we were interrogated there, and we were forced into the truck driven to the police camp"*.

This leaves many refugees in South Africa fearful of many potential sources of attack. In addition, there is profound disillusionment that the so-called possible forces of law and order, including the South African Police Services (SAPS) and government officials are often the worst perpetrators of abuses rather than being the protectors of their rights. This is another area in which the reality of refugees' experiences in South Africa belies the supposedly liberal policies encouraging social integration. It also adds force to the incredible need for containment that refugees present with. This powerful need is often expressed in therapy. The capricious and dangerous context within which many refugees in South Africa find themselves often sets the stage for retraumatization. Rather than providing a secure temporary heaven where healing is able to take place the opposite is often true.

4.3.3 Retraumatization

Luebben (2003) argues that additional stressors, such as those described thus far, can cause the re-experiencing of war inflicted trauma for refugees and heighten the sense of despair and deep depression affiliated with such memories and experiences. Alongside this risk of re-opening of old wounds to which refugees in South Africa are prone, they are also at risk of new experiences of traumatization, as refugees in the city of Johannesburg. One therapist explains:

> *"A mom, who lost her whole family in Burundi. Married at 14, had 3 children on the run between different refugee camps in conflict ridden areas. Arrived in South Africa, both her children were raped. I mean just the compounded trauma. In the 6 or 8 months that I have seen them, every week, literally, there is another trauma; being evicted; just on and on and on"*.

Speaking of another client she portrays how therapy is strongly affected by these new traumas, such that it becomes impossible to work with the original or historical traumatic material that brought about refugee status in the first place.

> "*They start on it in the first session, but by the second session they have been raped, and by the third session they have been mugged and by the fourth session they have been thrown out of their house*".

That many refugees survive these ordeals and are able to support themselves speaks to their levels of resilience. It is important to balance the discussions of refugee victimization with some reference to evidence of positive coping capacities lest refugees be seen as completely passive in the face of such difficulties.

4.3.5 Refugee resilience

Therapists working with refugees who listen to narratives of survival week in and week out are impressed by the determination and resilience that some portray. One therapist said:

> *"In the time I have seen her she has been raped twice, she's, all her possessions have been stolen by the police. Her roadside stall; her stuff have been taken and she just never fails to demand human treatment. Like she still conducts herself like a person with self respect. You know. She goes and she follows procedures to get her things back. And doesn't lose her cool. And just suffers repeated degradation in the way that people respond to her. But she never loses the, the belief about herself, as a human being who deserves the respect. I just think that's amazing resilience, where people maintain a sense of normality; routine. They survive without assistance"*.

Korac (2003, cited in Landau, 2006) argues that Italy's policy (similar to that of South Africa) pushes refugees to engage actively in reconstructing their lives, suggesting that

this in itself functions as a healing process. Landau (2006) engages with this assertion suggesting that despite having a similar will to integrate and heal, refugees in South Africa face so many debilitating hurdles on this journey, that their willpower might not be enough for them to gain the protection they initially sought. Despite the trials and tribulations that they face, some refugees are able to hold onto hope; hope for life to continue 'normally'; hope for a better future. Levy (2004) argues that it is this hope that a therapist helps a refugee to hold. By holding this hope, alongside the trauma and stress, the horror and the anger, a therapist opens up the possibility for healing, for rekindling a sense of the ideal and of the good.

These articulated experiences point to the prevalence of psychological distress within the refugee community. The following section presents the lived experiences of refugees' distress, and some of the correlating Western understandings or diagnoses of these experiences.

4.4 Mental health of Refugees

The refugee clients' description of their experiences of psychological distress often seemed to be appropriate responses to their presently extraordinary situations (albeit possibly appearing 'abnormal'). As noted in the literature review, the dominant discourse concerning psychological distress is based on Western understandings and therefore imbued with Western meaning. The danger of the clinical reification of the refugee experience is that the entirety of the individual and layered nature of refugee experience may be lost, decreasing the value of related therapeutic work. For this reason this section first describes psychological distress as depicted by the refugees and then draws upon therapists' understanding of these descriptions to portray a more generalized, yet also important, description of common symptoms. The prevalence of these symptoms as spontaneously raised by the interviewees stresses the importance of psychological intervention, as it was clear that refugees in South Africa are a population at risk of being socially and emotionally paralyzed by severe and persistent psychological distress. This does not however, deny the importance of understanding psychological distress using the socio-cultural and political framework of each refugee.

The main descriptions of psychological distress discussed by the refugee clients included those that were caused by past trauma and those that were a response to current experience. The refugees described the psychological distress caused by past trauma as including: bad memories, difficulty concentrating, inability to sleep and fear of social situations as well as preoccupation with the past. The following quotes illustrate some of these conditions.

> *"Once you have trauma, you still have images of the incidences that happened, what ever you saw in front of your eyes. And the remaining memory is back. And once you get something to remind you of them, they automatically come".*

> *"Like the time when I was going through counselling it was when it was too much for me. Maybe it was because all the things were coming back into my mind and it was worse for me. I was only concentrating on what had happened to me".*

> *"No, no, no it was not easy. My mind was always concentrated on what has happened to me. And there was, as I told you earlier, I was not having any interest in my life".*

> ***"**There was a lot on my shoulders. I couldn't think properly. And you know with your thinking capabilities, if they are not proper, everything is dead. You don't know what to do next, you know?"*

It appeared that the persistent and uncontrollable memories of what had happened in the past were the main source of distress experienced and significantly affected thinking capacities. The psychological distress experienced due to present circumstances included: not being able to adjust to new environment, depression, lack of self esteem, general sense of apathy, hopelessness, helplessness and a lack of sexual desire.

> ***"**So at that time it was very difficult, it was very difficult. I could not adjust; you see if you get used to maybe live with your family and that kind of comfort now, you get to an environment where you cannot even control the place where you sleep".*

> *"I became very depressed. Especially after, you know I could stay with people, and people chased me away at times. You know, you are not working; you don't bring any income here. Of course you cannot survive without food, but, I mean those people had things together to get a place to sleep".*

> *"I had even lost confidence. You know maybe if you would be called for an interview, you couldn't really answer properly… I was, I couldn't think that they would maybe accept me to contribute. Even now, I think I am not at my best today. Maybe I am leaving things out. I am sorry for that".*

> *"Where you start feeling, the fear of hopelessness creeps in now. You are afraid, you know. That fear at times becomes very depressive. Lack of sleep sometimes also compounds that fear. Then at times you feel suicidal, you feel like taking your life away".*

> **"….***especially my other desires which I felt before, I couldn't feel them. It was like my whole body was dead".*

Their distress appeared to be primarily due to a lack of satisfaction at basic needs and the absence of social support networks, leaving them feeling very alone, isolated and desperate. These feelings fuelled a sense of helplessness which at times led to wanting to alleviate themselves from the despair and feelings of 'deadness', or not being alive any more. Their bodies felt numb and unresponsive. This seemed to be emotionally a very painful and frightening experience.

Some of the descriptions of their experiences could be categorized as symptoms falling within the DSM-IV syndromes of PTSD, Mood Disorders, Adjustment Disorder or Disorders of Extreme Stress Not Otherwise Specified (DESNOS). This was supported by therapists' understandings of their clients' distress. They described the traumatic distress to often fall within the classic PTSD diagnosis or suggested that the symptoms were more complicated and could be constructed as falling under the nascent diagnostic category of complex trauma or DESNOS. In the latter case they felt that the diagnosis captured the inability to connect, excessive mistrust and fragmentation of self associated with multiple traumatization.

Therapists also noted the presence of depressive symptoms and observed that these symptoms were often related to present refugee circumstances. It was understood that some symptoms, for example mistrust of people in general, might be more compound in causality, possibly stemming from both past trauma and present circumstance. The overwhelming nature of distress was portrayed often in the pervasive sense of apathy. One therapist describes this as a consequence of multiple traumatization:

> *"The problem is when somebody has been so traumatized that there is a sense of apathy. "I can't do anything. I am so helpless, I am so powerless".*

Another therapist described how present circumstances could cause a sense of apathy and depression.

> *"The inactivity, they can't find work, and they are **hard** workers. I mean they have been activists, they are people who were community leaders, doers, involved, and they come here and their life just shrinks. It's terrible depression. It is also very hard to even work through the depression".*

Although the PTSD and depression symptoms were the most prevalent, therapist also noted psychotic symptoms in some cases for example delusions and hallucinations. These symptoms were less commonly noted. As stated earlier most symptoms noted were not simply placed under the construct of one diagnosis. According to the descriptions of all of the therapists most refugee clients presented with co-morbid mental ill health conditions.

> ***"****An understanding of comorbidity, I think therapists or psychiatrist need to understand…uh, the assumption is that one would present with PTSD, because it is a reaction to an event. But in the case of refugees it's ongoing traumatization, it is not just one event. And the majority of the clients present with depression rather then PTSD. So one needs to understand that, and look for symptoms of depression as well"*.

The self identified psychological distress described above, was often validated for refugees through the psychosocial workshops held at CSVR. The workshops provided them with a reflective space where they were able to contemplate the possibility of therapy as a supportive measure and seemed a useful first step in inviting them to consider engaging in psychotherapy. Interestingly, the psycho-educational part of the workshops adhered to Western concepts of psychological distress, explaining PTSD and distress symptoms. All four refugees noted that they recognized aspects of their distress experiences within this explanation, and they were encouraged by the possibility of 'being healed' of these symptoms through counselling. All four refugees indicated that counselling had provided some form of relief and healing, thereby improving their general sense of wellbeing.

4.5 The Refugee Counselling Experience

The main reasons for partaking in therapy noted by the interviewed refugees were: recognition of symptoms after a psycho-educational workshop on the effects of trauma and/or an overpowering sense of hopelessness and disempowerment. Counselling appeared to be one of the social support structures that was easily available to refugees. There seemed to be an underlying hope that the counselling experience would be able to offer them help in a broad range of areas; such as meeting basic needs and accessing social networks and emotional support. Although the reasons for seeking counselling included recognition of psychological distress, which is similar to the reasons Ager

(1999), Herman (2001), Levy (1999), Kinzie (2001); Neuner, Schauer, Klaschik, Karunakara, & Elbert (2004) had found, the hope for general support in basic needs and social networking appeared to be unique. Refugee responses supported Miller (1999) and Misra et al.'s (2006) findings that general social support was an essential aspect to refugee wellbeing.

One refugee explained:

> *"The single reason why I chose to go for counselling, because it came to my awareness that it could help in some circumstances as well as those ones that I was in. And I looked forward to going for counselling, and I was hoping that everything would go fine"*.

This refugee client explained that he had come to that 'awareness' through a psycho-social workshop. All of the refugees had the opportunity to partake in a psycho-social workshop organized by CSVR. These workshops generally seemed to include information on refugee rights in South Africa, paralegal advice and psycho-education based on Western concepts of the effects of trauma. The workshops were held in positive regard by all four refugees. As one of the main reasons that refugees choose counselling was general social support, it seemed the workshop on its own provided them with possible social networks of support that might be available to them. Another unspoken factor that might have contributed both to the positive feedback on the workshops as well as choosing to partake in the counselling experience was that the organization as a whole through the thoughtfulness of the workshop, demonstrated empathy, caring and concern about refugees' wellbeing. This might have been experienced as a unique situation in their South African context and the holding of the workshop in itself provided a sense of mental and physical containment that refugees crave.

From the introduction to therapy through the psycho-social workshops it appeared that therapy became a beacon of hope that struggling refugees could hold onto. One refugee client explained that having felt that he had hit rock bottom, he needed something to boost him and support him on his way back to health and happiness.

> **"***Ja, I couldn't adjust. Actually at times I could even get to the extent of regretting why I left, I thought maybe I should have agreed to persuade any how, as long as I could be keeping close to my family. That would be good. But already that it was too late for me. The decision I had taken was now irreversible. So now, basically that made counselling important"*.

This quote indicates the tremendous impact of forced migration and the refugee experience. It portrays a sense of helplessness, as all has become unfamiliar, alien and inescapable. The situation is 'irreversible'.

Another refugee describes a similar sense of desperation:

> ***"****So that is when I decided to attend therapy. I couldn't sleep, I became depressed, I just felt dizzy sometimes when I was walking. I just had this fear when I came to a group of people. I was just afraid you know? And I felt hopeless. So I decided to seek therapy"*.

The considerable distress expressed in general by these refugees appeared to be mainly associated with a refugees' experience of life in exile and their sense of loss of all positive aspects of their past life. This supports Eisenbruch (1991) concept of cultural bereavement. All three quotes depict the levels of hopelessness that was experienced by all four refugees before choosing to start with therapy. Although refugees experienced the option of therapy as a beacon of hope, their actual presenting problem were vaguely defined, as their needs were far broader then simply trauma work.

Refugees chose to go to therapy due to their high levels of material, social and emotional needs. As therapy is presented to these refugees as one of the few possibilities of any form of support, refugees chose to partake in the counselling experience simply to address their intense need for containment, validation, connection and basic needs. Perhaps there is also an unconscious hope to be rescued from their dire situation. The described refugee context in South Africa notes the high sense of mistrust of people that has developed due to their refugee experience. This context may set up a complex therapeutic dynamic regarding dependency and resentment. The following section discusses the strengths and contributions of psychotherapy for refugees. In doing so it answers the first of the four research questions that this study set out to answer.

CHAPTER 5

FINDINGS AND DISCUSSION: PART 2

Psychotherapeutic work with refugees in South Africa

5.1 Introduction

Having conveyed some key aspects of refugee experiences and their related mental health problems, this chapter now moves to focus on the core questions of the research relating to delivering and receiving therapy in this context. In analyzing the data numerous themes were elicited and these have been categorized into three main groups. These three groups center around the research questions and focus on:

- What are the strengths and contributions of psychotherapy as identified by therapists and refugee clients;
- What are specific dilemmas that arise in the context of psychotherapy;
- What potential solutions or ideas are there to work through these dilemmas and other difficulties;
- What are the guiding principles used by therapists in working with refugee clients?

These four questions will be addressed in the order outlined above.

5.2 Strengths and contributions of therapy with refugees

5.2.1 Psychotherapy for refugees

Most of the refugees described counselling to be an intense process as well as an experience that brought about relief. It was intense as traumatic or distressing experiences were revisited, and most of the refugees noticed that after the session they caught themselves thinking of all the other parts of their story that still needed to be told. One refugee explains:

> *"Ya it was difficult because when I was going through that, I also I remember that time when I was going to counselling. After when we finished, I would go home and all the way I couldn't remember who I had meet. I was concentrating on what I was had said that time".*

At the same time the possibility to speak of all the things on his mind allowed for a sense of relief.

> *"I felt I had a bit of relief because the very person who was administering that therapy to me, actually allowed me to speak about my concerns. So, he actually gave me time to open up. You see, I personally liked the environment and I felt that it was so accommodating"*.

Important about the experience was that it provided refugee clients with a space to speak about their daily and past worries. This space was possible in their minds due to the professionalism of the therapists. Although the framework of professionalism will be discussed in more detail further on, it provided a corner stone to the counselling experience for refugees. Professionalism included the concept of confidentiality and the offering of time. This gave the refugee clients a sense of a respectful space, where time was set aside especially for them. For a refugee who had fled from danger to an insecure and uncontrollable space this was essential.

> *"No one would actually care to listen to that. So that time there was someone to listen to me, to listen to my concerns, to listen to my fears and allay them"*.

To have a space where they could be heard, not judged and feel safe was one of the important contributions that therapy had to offer.

This research project found that generic aspects of therapy were noted to be beneficial by refugees in their healing processes. These included the containing aspects of the therapeutic space and the therapeutic relationship. This allowed for some healing to take place in all four refugees. Other positive outcomes that refugees noted included: a decrease in negative symptoms, feeling more normal, gaining a new perspective on life and their circumstances, gaining mental space to attend to basic needs, increased hope, increased self confidence and courage, ability to trust and an increased sense of social agency. These positive outcomes will be discussed in further detail below.

A decrease in negative symptoms was noted by all four refugees. The most commonly noted alleviation of symptoms was in those relating to depression. One refugee describes:

> *"Ok, I will tell you what I have realized is that once you start going for counselling, of course you are under depression, all these things, they are symptoms of your disease. Ok. And as time goes on, you start feeling better, because you have somebody to talk to about your problems. And I remember from the beginning of my sessions, up to the end, the way*

I had started, I could end up with at least you know, some good indicators. I have gained something out of what I have told the counsellor".

Another refugee mentioned:

"So I went there and those people saw that I was very depressed. Because they were not funded, they didn't have the proper facilities and all that, so they referred me to CSVR. But when I got CSVR I think it took me two months to actually access a therapist because they also had a back log of people. And all that time I was very depressed. It was, ja, it was I think it was the worse time in my life…[He had described throughout the earlier part of the interview how in the period before he was introduced to CSVR he had struggled to sleep, had at times thought of taking his life and had had days where he would simply sit alone and feel incapacitated and isolated] *Ja, through therapy, from therapy there was some form of assistance"* [He continues further in the interview] "*Actually, I mean my therapist I would say, in January up until now, there is a vast difference. The only thing with which I'm yet to achieve now is to settle down".*

Refugee clients as well as therapists noted that having a respectful space available where refugee clients were listened to, emphasized with and thought about, appeared to provide an important healing function. Lemma (2003) argues that the framework of the therapeutic space allows patients to feel received and contained and that this provides patients with an increased mental or emotional capacity where the ability to think about and manage feelings becomes increasingly possible.

Another positive outcome of therapy that was described by refugees was the feeling of regaining a sense of normality.

"It's normal, because [those] *other times when I met some people, I was using to tell what has happened to me and crying often, often. Everyday I was crying. That is what I can tell you. Even when I was away. But in the end it was better".*

"It was it really helped me because all those memories have gone back out. Uh, before I went to the counsel, I couldn't concentrate. And the time when, I was, if I was with other people, I was not trusting anybody. And, after that, I found out it's something normal. Maybe because it was because I had talken about my story".

"That is what I'm saying that load which I felt before… Because I think my body wasn't functioning, before therapy. I was really, I think it was stress. Those are conditions, I needed to be helped. And after therapy, with those healing sessions, I began to feel myself again".

A sense of feeling better, more functional and more able to cope with life at hand, were strengths of the therapeutic experience. Again this positive outcome does not specifically relate to any therapeutic technique. These quotes also touch on the (positive) influence of psycho-education, as by understanding that other refugees also felt the intensity of past memories and uncontrollable, intense emotions (causing crying), refugee clients could

understand and place these ‘distress symptoms’. This on its own appeared to provide the ability to regain a sense of normality. Another important healing aspect to therapy noted in these quotes was that providing refugee clients with a safe space in which they could learn to trust the therapist provided them with the possibility of trusting other people in their’ social contexts. Providing the general possibility to trust again could in turn allow refugees to expand their social network, which Miller (1999) and Misra et al. (2006) argued could increase refugee wellbeing. Again these quotes seem to imply how important the therapeutic space can intrinsically be.

The sense of gaining a new perspective on life and one’s circumstance was noted by refugees to be another positive therapeutic outcome.

> *“I knew that sometimes he would come up with a solution, but uh, saying that out, that would put me into a better perspective”.*

According to this refugee, this new perspective came from advice or solutions that the therapist had to offer. Some of the therapists that were interviewed interwove a problem-solving aspect to their therapy as they noted that refugees’ primary presenting problems often related to negotiating the new, unknown and often rather threatening environment. One therapist describes this process:

> ***“****So I think this populations needs are quite particular. So your role, your role is broader…you do skills transfer. There is transparency. The community members must be involved in every stage of the decision making process in terms of solving what every problem they have. So it really focuses on power a lot and being aware of your own power and making sure that you are meeting with your community or client on equal terms… And I have found that very useful practically, because you are seated with a person who has problems of the mind. But those problems can’t be explained outside of the context and outside of the political structures and oppressive structures that they are experiencing. And you can map that out with them. Sort of map the influences of their circumstances”.*

Although the therapists struggled with the responsibility of adopting this approach and the fear that they would be judged by their own psychotherapeutic community for doing unconventional or perhaps even inappropriate therapy, their vision is backed up by Miller, (1999), Misra et al. (2006), Rees, Blackburn, Lab and Herlihy (2007), Tribe and Patel, (2007) and Webster & Robertson (2007), as they argue that interventions with refugee should be psycho-social in nature. The combination of social with psychological interventions was depicted as a strength and positive contribution by refugees. The quotes below demonstrate this.

"He actually supported me very much, by that after therapy I could realize my major weaknesses. And if I had no shelter he would maybe provide me with that. Because at times he would pay for my shelter. Times he will keep me a food voucher to keep me going. The other days I would look for myself".

"Oh yes, my counsellor was helping me by identifying some kind of jobs that I could do. Especially in the paper. And uh, encouraged me to respond to those. And during that process the counsellor would maybe ask me that, uh have I maybe made some applications here and there? And he would, at times he would even have some newspapers, with some jobs being advertised. …Yes, during the time I was undergoing the counselling, I had become a client to CSVR so they, every time they made sure that I got my transport fares and they even went out of their way I think, to give some vouchers, to, to buy myself food. Yes".

In quite a real and concrete sense, therapists at times had the power to change refugee clients' material and social circumstances. Although the need for social support sometimes created tension between therapists and refugees due to misunderstandings concerning the extent of therapists' social power, therapists' active attempts in contributing social support on the whole resonated with most of refugee expectations.

A refugee describes the new perspective gained from the therapeutic experience.

"*I used to have those kinds of tensions, even when I met some Zimbabwean teachers, those old memories of when I was still at home, they were still haunting me. But now, after those sessions, I had a new approach. I am a different person altogether. And people who knew who I was some 10 years back or 5 years back, they would be amazed to see a different someone".*

Although community and psycho-social intervention is encouraged it does not negate the important role in the healing process that more classic aspects of psychotherapy hold (Miller, 1999). The new perspective gained by this refugee, transcends coming to terms with his present circumstances or his recently acquired 'refugee' label/social role, as it reaches further back, alleviating him from worries or life patterns present from before his forced exile. He suggests that therapy has allowed him to develop a powerful new sense of identity against the background of his circumstances.

One of the major setbacks caused by symptoms of depression, PTSD, and psychological/ emotional distress in general is that it can overpower the ability to think and function in the world. A major contribution of psychotherapeutic work according to refugees is that it increases the shrunken mental capacity and allows them to think, act and function again.

"*I'm saying this from my experience. Okay. At the very first time I didn't even know where to begin, because I had sooo many things inside my mind. And they are not letting*

me do anything better for myself. Instead they were pulling me down. Now, what is very important with mental health, the moment you start reducing those problems, all the charges that you have in your mental bank or memory bank. Once they start to be discharged and uh, you have less problems that you think about, then, that is when you can focus on other things. Because everything of you, everything that you think about is on this bad side of memories. Once you get them out, then you start seeing also another side of good things. Then you can choose and you see your way and you say oh! Maybe I should do this and see if it works".

"*Yes. There was a lot on my shoulders. I couldn't think properly. And you know with your thinking capabilities, if they are not proper, everything is dead. You don't know what to do next, you know?"*

Bion (1962) suggested that the capacity for tolerance of frustration enables the psyche to develop thoughts, which in turn are themselves a means by which frustration is made more tolerable. If the capacity for toleration of frustration is inadequate, the psyche feels the need to evade the frustration, resulting in the eviction of these bad thoughts (Bion, 1962). If intolerance of frustration continues, a vicious cycle of evacuating 'bad thoughts' continues, and soon the individual is unable to distinguish good thoughts from bad thoughts, making all thoughts bad and therefore intolerable (Bion, 1962). In this way the thinking apparatus (as Bion (1962) named it) is disturbed. One could argue, that the therapeutic process allowed refugees' tolerance of frustration to increase, thereby allowing thoughts to develop, which in turn increased their ability to tolerate frustration and continue thinking.

Increasing refugee clients' capacity to think in turn increases resilience and a sense of social empowerment and self confidence.

"Like as it is now, now I still, I got to the position, that I have the courage to apply or respond directly to advertisements. I am really optimistic".

"I think I found that I regained my confidence. I found that I could speak to people again. That is when I decided even to get involved with meeting people, you know. Because when you meet people, your mind opens up, you get new ideas, you get new this and that. I could attend workshops, I could interact with people. That was after therapy".

Therapists' ability to be the container, holding refugees intolerable feelings and slowly feeding them back in sizeable chunks, along with a good dose of affirmation, validation and hope seemed to encourage this healing cycle. As refugees' resilience, courage and empowerment increased, their sense of hope increased.

> *"Yes it gave me a good experience. That is why I'm saying actually that I started having some new hopes, some sense of revival. And as it is now I am seeing every possibility of starting my life here as it is now, in South Africa".*

Alongside increased hope another surprising contribution of therapy that one of the refugees noted was that it opened up the possibility of becoming part of a South African community network.

> ***"****And I'm not even able to interact with the South Africans and that was well, a breakthrough on my side…Because counselling really changes attitudes. You see you tend, you get to have a different view of the situation, from what you had right at inception. You have a different view. You now look at people around you, the environment around you, as part of you. Yes you feel like you are belonging to the new environment, to the new system".*

Having a sense of being a part of a social network, allows one to gain new social roles and schemas, which Horowiz (1992), Miller (1999) and Misra et al.(1999) argue to be fundamental to any healing process.

It appeared however, that simply supplying refugee clients with social support and access to new social networks would not go far without helping refugees regain their ability to think. The latter then allowed them to expand themselves and integrate into newly acquired social networks. Refugee clients noted that through the support provided by therapists on several levels; emotional, practical and existential, they were set on a healing journey to gain a more empowered sense of self.

> *"The support is actually to be self reliant. If I can be self reliant I can always be in contact. Even phoning your kids, speaking to them".*

The positive outcomes of psychotherapeutic work that refugees noted were supported by therapists' reflections on their sense of the positive impact of therapy for refugee clients. Generally it was felt that refugee clients' sense of wellbeing was increased, as one therapist describes:

> *"He just reports more of a sense of wellbeing. Like when he came his life had sort of hit rock bottom on his lifeline, the way he drew it. He was really down, but he feels step by step he is starting to build things".*

Another therapist acknowledged the importance, particularly with refugees, of the respectful and professional therapeutic stance that one needs to adopt.

> *"I think another thing they get here is respect. And that is something I have really been like obsessive compulsive about. I make sure that every interaction I have with them is respectful. That I give them choice. And I think they respond to that. This is one of the few*

> *places where the receptionist greets them, where they are offered tea, where they are treated like a legitimate citizen. And I think that is what keeps them here".*

This stance is essential as refugees have had to endure social discrimination both in their countries of origin and in South Africa, leaving them feeling disregarded, misunderstood and of little value (Miller, 1999; Misra et al., 1999). The professionalism of the therapists allows them to be certain that they will be treated with respect and genuine interest and empathetic understanding. The experience of being treated as significant appeared to bolster self-esteem and self-efficacy, again pointing to the importance of the relational aspects of the therapeutic process and setting.

What appears unique to therapy with refugees is that they are not presenting to therapy with a desire to grow or delve into a journey of self-exploration or self-discovery. Refugees' main hope for therapy is to be materially, physically, mentally and emotionally supported thereby experiencing containment, both practically and emotionally. This expectation in itself calls for a more supportive style of therapy. In this context challenging beliefs or cognitions does not necessarily seem useful. In fact, the strengths and contributions of psychotherapy as described by refugees point more to the significance of foundational elements of therapeutic work than of any specific therapeutic techniques.

Alongside the therapeutic frame, refugees were encouraged by practical problem solving solutions that their therapists volunteered. This more psycho-social approach has been noted to be an important cornerstone to working with refugee clients (Miller, 1999; Misra et al., 2006; Rees, Blackburn, Lab & Herlihy, 2007; Tribe & Patel, 2007; Webster & Robertson, 2007). From the interviews the dialectic relationship between emotional, mental and practical support was highlighted. The importance of the 'containing therapeutic space', which allowed unpalatable feelings and experiences to be digested, thereby increasing refugee clients' capacity to think, seemed to be considered another pivotal aspect of therapeutic work with refugees.

5.3 Dilemmas arising from therapeutic work with refugees

The narratives of the refugees and therapists in this research project acknowledge that psychological distress is pervasive within refugee communities, which was in accordance with much of the psychological research concerning refugees. That psychological services need to be available for refugees is therefore a given. Within the environmentally uncontaining and unsafe context that refugees in South Africa find themselves, therapists struggle to work solely within traditional therapeutic frameworks. They are often left to fall back on their own devices in terms of how to manage therapy as little is known about essential/beneficial aspects. In order to support therapists more successfully one of the goals of this research project was to identify common issues/dilemmas that therapists in this context struggle with.

This research project found four salient dilemmas noted by therapists, two of which resonated with issues identified in the literature review. The latter two issues were having to step out of the conventional therapist role to take on the role of social advisor and mediator; and having to deal with the impact of the horror stories described by refugees. Thus, therapists had difficulty with role definitions, role expectations and therapeutic boundaries, as well as with what could broadly be termed the countertransference or emotional impact of the work. In addition, two further thematic dilemmas that were identified from the interviews which did not specifically resonate with dilemmas previously identified in the literature, were: therapists' struggle to identify the appropriate therapeutic approach to use, and therapists' struggle to determine whether refugees' narratives were truthful or fabricated in part or whole.

These pressures of refugee work pervaded the discussions in the interviews and were implicit in some of the more specific core dilemmas or difficulties that therapists' identified. Some of the difficulties identified were evident in mirror image concerns of refugees, for example, the maintenance of boundaries, as will be discussed further. Once a better understanding of these dilemmas is gained, possible solutions, or thoughts on a way forward will be discussed in the last section of the chapter (part three).

5.3.1 Therapist role conflict

> *"And obviously there is an ethical dilemma, as this person is saying I need a job, you know? And on the other hand, that is not my role as a therapist. And it comes back time and again. Yes, we might make an interpretation, you might reflect on it, but this is my* [refugee] *main, main concern. Because yes, I can come for my sessions but when I leave this room, I don't know where I will be going, I don't know what I will be eating".*
>
> *"Then the person comes, and it is all about "I want to get a job". Do you then say, hang on, let's go back to that torture. So that is what I mean about the nature of the presenting problem".*
>
> ***"****Yes, I did it all together. It was very difficult. It was difficult to be a therapist, to be a social worker, to be a nurse, to be a doctor, all those various roles rolled up into one. It was very difficult".*

Because of the psycho-social stressors that refugees face in the South African context, it is important for therapists to support refugees through this new social/cultural world. At times this forces therapists to reconsider working in a conventional therapeutic frame and adopting a conventional role, almost compelling them to extend their engagement into more instrumental roles. As one therapist states:

> ***"****So I think this populations needs are quite particular. So your role is broader".*

A sense of environmental, emotional and mental containment, are the foundations to a working therapeutic alliance. The interviewed therapists identified this as an issue, noting that refugees themselves desired to be supported on all the above levels, as they cannot get this type of support from any other source. One therapist describes:

> *"And when they come to CSVR, these are the things that they expect to deal with. And obviously when they come, this is not what we do. We are not an employment agency, we provide counselling. So in a way when we see them for counselling, these are the problems that we can encounter. Where, consistently the person is asking, where can I get a job? Or, I did not get anything to eat. Then obviously as a therapist you would feel helpless, you would feel that you wanted to rescue this person".*

In South Africa where the material and social support for refugees is sparse therapists are often forced to play many different roles at once. A therapist explains:

> *"So that is the challenge. That, yes, the counselling work is done here. But there is a lot of hard work that needs to be done out there to sustain it. Because without that holding supportive structure, remember one of the priorities in trauma work is to build trust".*

In more conventional psychotherapeutic terms, taking on such multiple roles (such as those of facilitator, advocate or mediator) can have an influence on maintaining the 'ideal therapeutic relationship'. Overstepping therapeutic boundaries cannot be taken lightly

(Brems, 2001; Corey, 2005; Lemma, 2003; Weiner, 1998) and demonstrates an important issue that many therapists are confronted with. Clients' idealized expectations of therapists may be reinforced and client autonomy compromised. Issues of dependency become complicated and therapist stamina and availability may be tested. It may be difficult to establish a good, and more particularly stable or consistent, working alliance in the context of such complex role expectations.

The main dilemmas concerning their role that were discussed by therapists included: the multiple roles a therapist has to negotiate and the consequences of this, the therapeutic boundaries that are brought into question, the type of help (practical or psychological) a therapist is able or willing to offer and lastly and linked to the previous issue, the role a therapist plays in response to a refugee's wish for resettlement. Each aspect will be discussed in further detail.

5.3.1.1 Multiple roles

The types of roles a therapist has to negotiate can roughly be divided into three categories: Organizational roles, case management roles and therapeutic roles (as identified by the researcher). What is important about this is that therapists are officially considered to play one type of role, which is the therapeutic role. Therapists are understood to give therapy and to work primarily in therapy with psychological distress and symptoms caused by trauma. Their domain is understood to be that of the 'psychological' and their role to assist in healing psychological distress. The two other categories are less commonly thought about or heard of in the context of 'the therapist'. Therapists therefore find themselves often negotiating privately and in their own time how to deal with their occupation of these less familiar and formally unacknowledged roles.

The organizational roles that therapists find themselves having to negotiate are perhaps better understood. Organizational roles include: giving training, doing research and supervising. In many clinics these roles are common and understood as part of one's job outline. However, there is often less official time allocated to these roles. These roles

appeared to come with a certain amount of stress for the therapists interviewed, as they were confronted with the problems of the sustainability of refugee services. Service providers in Johannesburg who they encountered in training, supervision and debriefing complained of struggling to cope with their work, especially within the unsupporting South African context. The organizational role thus is not only about training, but also about managing a range of strong emotions evidenced by other service providers. One therapist explains:

> *I felt that part of my task was to help them cope, help them cope with their own helplessness and powerlessness feelings".*

Thus the already stretched containment capacities of therapists working directly with refugee clients often becomes further compromised by needing to address the emotional strain of a community of service providers who are encountered as part of everyday service delivery. There was a sense of a number of frustrated and struggling refugee assistants who all needed to lean on each other and on therapists in particular.

The third broad category was the most difficult for practitioners to pin down. Case management included roles and tasks such as advocacy, social mediation, social work, writing referral letters and organizing appropriate referrals, needs assessment, medical and psychological assessment, networking, encouraging refugee support systems, and trying to create a sense of community amongst refugees. These role demands present within therapy sessions, as one therapist describes:

> *"In a therapy session one is required to be more of a case manager then a therapist. That you are dealing with practical issues, that you don't go into more in-depth psychological stuff with clients".*

These roles appeared to be poorly recognized as legitimate and were often negotiated individually by each therapist in a sense 'in secret' or even covertly. One therapist commented:

> *"You know there are these like, no, no things that, uhm, ja, that you feel like you would hang your head in shame that you did that. So sometimes I feel reluctant to mention some of the stuff I'm doing, because it is sort of devalued or seen as stepping outside the bounds of psychology and acting out".*

> *"That secrecy is perpetuated because of different therapists that are offering you a different service and maybe you don't want to show up your colleague who is not doing the advocacy or what ever so you rather just shut up. And in a way her or his position has more legitimacy because it is more theoretically correct. Shouldn't be doing all these things, you are a counsellor, you are a therapist".*

Most conventional therapeutic paradigms adhere to explicit and implicit rules of boundary maintenance, as therapists argue that these rules concerning boundaries provide a unique and safe framework that allows clients to feel more free to talk about themselves and their often private struggles. Transgressing these boundaries can set up internal conflicts in therapists, as they have been taught to maintain these boundaries as a code of conduct. However, in the specific circumstances that refugee clients present with, maintaining these boundaries can often mean that one is not supporting them in the manner that is needed to maintain and improve refugee wellbeing. For example, does one as a therapist solicit services or money from acquaintances to assist people in dire circumstances? Does one disclose to an angry shelter manager that one's client has some psychotic symptoms that cannot be ameliorated until they can access a doctor or psychiatrist? In some respects these dilemmas are of an ethical nature, as therapists struggle between moral principles of beneficence and fidelity. Challenges to make these kinds of decisions or judgment calls are frequent in refugee work and therefore cannot always be taken to supervision or debated with others. Having to make these difficult principled choices, as well as to occupy less conventional roles can take up a lot of time and energy. The fact that there is very little acknowledgement for taking on this challenge and the multiple tasks it involves can make this process even more difficult.

> *"You write reports and you really advocating, you are taking a stand. You are not writing a neutral psychological report, you're recommending: this person will benefit from going to a place where they can be safe. So you cannot be neutral, you can't, …well, you can if you want to, but I don't want to. It is not the way that I see my role".*

Not only is this role unfamiliar it is also conflictual, because many therapists feel that they have to maintain a neutral stance and that it is inappropriate to in a sense 'take the side' of the patient (Brems, 2001; Corey, 2005; Lemma, 2003, Weiner, 1998). This may become problematic at many levels, for example in creating potential dependency, antagonism or feelings of obligation, depending on the outcome of one's 'advocacy'. Such interventions may thus 'contaminate' therapy. In keeping with the stance of the therapists interviewed in this study, some practitioners and authors (Luebben, 2003; Rees et al., 2007; Webster & Robertson, 2007) argue that a neutral stance is not useful when

working with refugees. These theorists suggest that the advocacy stance is important in developing trust and a good therapeutic alliance.

Refugees often present with problems of basic needs, danger and discrimination in the South African context. Social mediation and support is often necessary. The following quotes relay this:

> *"Write a referral letter, phone up the local food, whatever, distribution. Find the person that sponsors, like. You know, to me it is not outside the realm of possibilities".*

> *"I had a client who had stitches in her face, beaten up! And she is forced into these relationships. So what do we do? So if we can help them get going, and start them with something to get going, why not"?*

Organizational, case management and therapeutic roles are all negotiated simultaneously, making for taxing engagement. The departure from a known or accepted therapeutic stance presented the therapists with a personal and ethical struggle:

> *"So I have had to really grapple with that on an ethical level, on my own sort of personal, moral level, and just theoretically or work experience wise, because, how do I see who I am? So at times it has been, it has been like that".*

Not only did it leave therapists with a personal and often unarticulated struggles, the sense of transgressing therapeutic conventions was cause for frustration and stress. One therapist said:

> ***"****In relation to the roles, prioritizing, you know what the client's needs were. And meeting those needs. Obviously one was not able to meet those needs as a therapist and even as a case manager. One was able to only provide limited support. So that was a huge frustration".*

This pertinent dilemma of multiple role occupation was not lost on refugee clients. In fact, the confusion of being seen by therapists occupying multiple and sometimes conflicting roles, as well as some awareness of the therapists' silent struggle to negotiate these potential roles, often left the refugee confused, angry and at times unable to trust the therapeutic space. One of the ways that this dilemma was noticed by refugees was that they observed that different therapists from the same clinic took on different sets of roles and set different boundaries. As one refugee put it:

> *"There, the people who wants to study. Because I know somebody who has gone also to counselling. The counsellor who has counseled him, he took his file to people who are funding, yah. So it depends on the counsellor".*

The vague role boundaries and the therapists internal conflict left refugee clients unable to fully trust their therapists. It fed into their tendency to lean towards mistrust, sometimes leaving them feeling manipulated and used. This is portrayed in the following quote:

> *"If you can make up, if you can draw some project proposals, we put them forward and see if we can get some funding for you." They have done that several times, but still there is nothing which has been done like putting them together, and giving them what had been collected for them! You see? So, I may say that, there might have been other hidden agendas, to, use the community to, to, meet their own ends you know"?*

In this client's case, it seemed that attempts by therapists to raise funds to materially assist refugees was constructed as discriminatory, ineffectual or self-serving and left him with questions about the therapists' bona fides and motivation. Such a break in trust in his case led to premature therapy termination.

5.3.1.2 Therapeutic boundaries

Having described the multiple roles that therapists have to negotiate, it is important to look at the related issue of the boundaries that are generally prescribed for therapy and the dilemmas that therapists struggle with in terms of keeping to these boundaries. The most commonly spoken about boundaries that had to continuously be renegotiated included: money boundaries, time boundaries, boundaries surrounding emergency care and boundaries around the provision of basic needs. It is clear that most of these boundaries related to the particularly precarious position that South African refugees face where there is no state sponsored material or welfare support (as discussed earlier).Often boundary issues had to be confronted when refugees presented with considerable desperation. This is noted by the following quotes:

> *"The father was beaten up in the street and he went to the clinic and the clinic turned him away and he came here, bleeding. Ok, so what do you do? Do you say, oh, well here is a referral letter, off you go? And it was just one of those scenarios where I asked my supervisor, I will just be taking this guy to the clinic is that ok? Drove him to the clinic, dropped him there".*

> *"Those are some of the challenges because they are no job opportunities. Because if you were to be realistic about the whole situation, I mean even South Africans struggle to find jobs. And maybe this is the difference as compared to refugees in Canada, where the mere fact that you are a refugee, you are entitled to certain basic needs, like water, shelter, food, transfer and clothes. But here in South Africa we do not have that. It is just a survival of the fittest. For them, if they come for their sessions we only concentrate on therapeutic related issues. But in this context you cannot. You cannot be saying to this*

> *person, you cannot be talking about that. It is out of this context. For me then that would be fairly unethical. It would be very unethical to say that to your client, to say: "No, it is not therapy related".*

These quotes demonstrate the desperation that refugees bring alongside the therapists' continuous struggle to negotiate appropriate therapeutic boundaries in the Johannesburg context. The continuous negotiating of boundaries appears to often take place individually and tacitly, as the therapeutic taboo of breaking conventional therapeutic boundaries feels almost shameful. There is also concern that one's sense of 'doing what is right' might be challenged. Because this is difficult territory full disclosure and robust discussion of holding and transgression of boundaries tends to be inhibited. As therapists work within a system, other staff members become involved in this struggle, sometimes inadvertently.

At CSVR, refugees are entitled to be reimbursed for transport costs. This gives refugees the possibility of getting to therapy. As one refugee explains:

> *"By then I was living down in Yeoville, close to Bellevue East. So I wouldn't have been able to attend the sessions. And it would be even more difficult because I would be looking around to get some jobs in order to sustain myself. So the financial support that I got, and the moral support that I got, made me really, took me to a different height".*

The therapist involved with the particular refugee is required to give a written authorization to administrative staff to give the money. This process is rife with anger, suspicion and contradictions as there is some concern about potential client 'abuse' of the system, largely from administrative staff. This potentially conflictual situation is then dealt with in different ways by different therapists. One therapist notes:

> *"That has been interesting seeing that play out. Some just can't be bothered to fight the admin staff and they just give a top up out of their own money. And I have not done that, because I can't be handing money to a client as a psychologist. But totally different service being offered to different clients".*

Lemma (2003) argues that the exchange of money in the therapeutic context brings to the surface themes relating to subjective inequities between therapist and client (needy versus knowing), themes concerning indebtedness, and therapist issues of identifying with a client's neediness and needing to be a 'saviour', who sacrifices their own self for the benefit of others. "How we calibrate emotionally what we feel we owe to another, what we feel the other might expect of us and what we feel we want to give him or take from

him are important questions that hover in the background of the reality of the fee" (Lemma, 2003, p.110). She suggests that health care organizations as a whole need to reflect on the meaning of money and how it is used by both therapist and client, as the entire organization plays a role in this interaction or agreement. One technique used by one of the therapists to reflect on this boundary issue is portrayed below:

> *"It is a difficult one to be able to manage, in terms of the client's motivation! Obviously, it would present itself in the session, whether the client is working at particular issues or not. And you as a therapist should be able to track that client's process".*

Unfortunately this often silently negotiated boundary issue is noted by refugee clients, and the discrepancy in actions between different therapists becomes apparent. The dialogue below speaks of this.

A: *Yah, it could help, because I know, some of them they know some people who can find them. There, the people who wants to study. Because I know some body who has gone also to counselling. The counsellor who has counseled him, he took his file to people who are funding, yah. So it depends on the counsellor.*
Kieke: *oh. Really*
A: *and some counsellors they give money to their clients*
Kieke: *really?*
A: *Yah.*
Kieke: *so it is very different*
A: *yes it is different*

Another refugee comments on his frustration concerning this inconsistency.

> *"So unless people be consistent and are delivering the real purpose why they are doing that. Let them be more conscious. More, you know, having ways of approach. Of tackling problems of individuals"*

The refugee is often left wondering why identical treatment is not meted out and wishing for a therapist who apparently would give them more. Thus some envy and jealousy between clients may be evoked. One could argue that this interaction and struggle of negotiating boundaries is on some level a powerful transference and countertransference interaction. Perhaps it touches on the transference of strong feelings of desperation, helplessness and neediness, which in turn can invoke a strong parenting need to support and protect, both materially, practically, emotionally and mentally. Lemma's suggestion that these interactions need to be engaged with both on a personal as well as an organizational level might be of use as this interaction at times threatens the therapeutic space and causes acting out on both sides. This first main dilemma relating to therapeutic

roles and boundaries was the most spoken about and seemed to interweave into the other dilemmas that were identified.

5.3.2 Dealing with the emotional stress of refugee trauma work

Although feeling overwhelmed by the horror of what refugees present with, (in keeping with the literature such as Kinzie, 1981) therapists in this research project were more specifically overwhelmed by the multitude of presenting problems, rather then the content of the horror stories. Bober, Regehr, Zhou (2006) and Woodcock (2001) recognize that trauma workers face a high risk of vicarious traumatization due to the overwhelming emotions that they empathetically hold for their clients. Therapists built coping strategies both consciously through self care and unconsciously through acting out or acting on the pervasive sense of helplessness. One of the conscious coping strategies noted by therapists was the importance of reflecting on this spiraling process of exposure to overwhelming presenting problems, feeling helpless and overwhelmed oneself, and then having to reflect upon whether offering practical support was a form of acting out or a necessary intervention, or both. This process of continuous self reflection was experienced as hard work.

The intensity and the variety of issues that refugees present with often leave therapists feeling underprepared, helpless, tired and overwhelmed.

> *"And that, as I mention in the absence of other places to refer people to, you feel ethically bound to do a lot. So it's hard work".*

> *"Ja, time and again, I ask myself all these questions. Especially, like I mean when I have had a session and I write process notes, and I'm making all these notations. But on the other hand there are all these issues. You know. And a question that I have is it helpful for me to sit with this person, to sit and reflect about their frustrations. And they tell if I get this everything will be solved. And you feel helpless".*

The lack of parallel social support provision in the South African context, despite the immense and increasing need of refugees leaves the therapist feeling both responsible and impotent on a multitude of levels. The unsafe and uncontaining environment often brings to the therapeutic space distressing and sometimes shocking stories of the refugee clients present life, filled with degradation, brutality and exploitation. Dealing with these stories in the context of the refugee clients' situation demands that the therapist be a container in an uncontaining environment, which in itself can be an impossible task. Subsequently this

leaves the therapists at times feeling indirectly responsible when refugees are further victimized. Therapists are often left feeling quite isolated and emotionally taxed in fulfilling the tasks of therapy. Working in such an unsupported environment puts these therapists at a high risk for burnout and vicarious traumatization. Bober et al. (2006) suggest that, particularly with trauma work, where the situation is often presented as urgent and highly emotional, counsellors quickly question their own competence, feeling helpless to relieve the suffering of the presenting client. Bober et al.'s (2006) understanding is reflected in the experience of the therapists who took part in this study.

The sense of helplessness and loneliness that can arise from conducting therapy in such a context are just a few of the emotions that therapists have to cope with. Therapists also struggled with emotions such as anger and with a need to sometimes act out the emotions and internal struggles that refugee clients present with:

> ***"****I remember the first time I gave your class a presentation, last year. I said: "I wish that someone would kill Mugabe!" I was very angry. Ok. And after I said that, I thought, gosh, these M1 students that have come in, and it's the first time they are here and I said that! So I think dealing with anger is an important aspect. Understanding why one is feeling that, or reacting in that particular way, because that is very important".*
>
> *"I read, you know Judith Herman, the book on trauma. She talks about that, how people who work with trauma, uhm, they often go, things go underground and secret. And I really try to keep that in mind, the whole year, not to fall into that trap. And not to be acting out because the person's trauma is so overwhelming that you start to do these things".*
>
> *"Like whatever they tell you, like this person is washing himself with Omo* [a detergent powder]*, and your feeling them and this is too much, let me get down and do some problem solving with them, or refer them. You know? So, in that way, it could, yes I could see a lot of my behaviour as being interpreted as like a rescue, you know reaching out in a rescue act".*

In order to defend against these highly emotionally charged circumstances counsellors use conscious and unconscious defenses. Common defense mechanisms noted by therapists in the literature are, that they either place their client at the level of social hero, see them as a survivor of a dying culture which needs rescuing, or skirt around these horrific experiences by focusing on more distanced, sociological understandings (Woodcock, 2001). Some of the quotes cited already could be seen to demonstrate these tendencies.

In order to maintain their capacity for empathy and helpful intervention, therapists noted immense self discipline was required and the ability to continuously reflect on thoughts and actions. This process on its own was experienced as tiring:

> *"You need like amazing self awareness, and, and its draining to always be questioning what you are doing. And to not have a set role. Because it shifts, depending on the client, depending on the situation".*

Although these consciously cultivated coping mechanisms, can increase therapists' capacity to cope and maintain their ability to truly listen and stay with the clients allowing them to remain a constant in a chaotic world (Kinzie, 1981; Levy, 1999, Woodcock, 2001), they were noted to be very taxing, particularly as this self reflection was mainly done alone, outside of supervision.

5.3.3 Therapeutic style and goals

Multiple traumatization and stress, poor social support structures, and the unsafe circumstances that refugees in South Africa find themselves in, challenges therapists in terms of the type of therapeutic models of psychotherapy that are appropriate to draw upon. Therapists struggle at times to know whether it is appropriate to consider in-depth and more exploratory interventions, or whether therapeutic work should simply be supportive in nature. As one therapist describes her/his struggle in relation to some pull to do more challenging/interpretive or analytic work:

> *"You know I find it really hard, although I can see the usefulness of that type of understanding, and I'm not denying its validity. I just find it really ethically jarring to try and implement that with a person whose circumstances have colluded to make them like that".*

They also feel conflicted as to whether they should be working with present stressors and traumas, or past events, particularly those which precipitated forced migration.

> *"Other clients don't need that much practical stuff. But, when they come, their daily experiences, how they found food, they got mugged, they didn't eat, they have a hole in their shoe, like, the one client, really speaks about that all the time".*

Therapist notice that often sessions fluctuate between crisis management and in-depth interpretive therapy. The dilemma here is whether this oscillation in itself is sustainable or even useful for the refugee clients. This dilemma is aptly described in the quote below:

> *"…it would really free me up to do the more in-depth work that trauma asks for. Where at the moment I feel that I am just, just holding people while they keep their heads above the water. And I'm just sort of one arm that is holding them there. And I think if all of that were in place, peoples basics needs would be met much more quickly and they would be able to really process their losses and their trauma and start building their life. Where it*

feels to me that most of my clients, there is no building, there is just maintaining, and trying to prevent back sliding and deterioration. It is really hard for me to say that I'm moving forward with my clients, in terms of their mental health. So ja, it would be great to really be able to focus".

A further difficulty in operating within conventional therapeutic models is that most therapies tend to have an interior understanding of pathology, i.e., it is located in a sense within the individual or the family. Models of intervention employed by therapists and supervision within the clinic system often continue to locate the problems within the refugee client, ignoring the overwhelmingly dysfunctional social system within which they are located.

"I have found a tension there, because traditional therapeutic understandings look for, how can this person change, like inside themselves, like in attitudes and beliefs and emotions. And sometimes I have had to sit and say, this person is having a very normal reaction to their circumstance. And my role is simply to witness that".

"Like that mom who I was saying just keeps her family going. When she comes, it's very hard for her to look at the internal dynamics of her family and how she might do things differently, because she perceives all the assault coming from outside her family, through rape, through eviction, through the police. And I find it is almost like, it is almost like invalidating their experience".

This also raises diagnostic questions, which in turn impact on the manner in which one works in the room.

"Like I have to say to him, he says he avoids certain areas for fear of this man. He has been attacked about three times, I think by the same man. So he avoids certain areas. You can't interpret that as pathological, sort of PTSD symptoms. Ja, I think it is really great that he avoids certain areas that are not safe for him".

"Is this person paranoid? Or is he really being chased. Initially with that client I was not sure. You know, are these panic attacks pathological or are they just a normal reaction to a very scary situation".

The understanding that external circumstances have played and play a major part in the distress and symptoms that clients present with, suggests that a more supportive and validating approach is often appropriate with this population. However, this may leave important issues buried and some aspects of pathology unchallenged.

5.3.4 Dilemma of dealing with client fabrication

In the South African context where many refugees are hoping for the promise of resettlement and very few are actually granted such by the UNHCR (Landau, 2007), the challenge to make oneself eligible for resettlement is considerable. The stressful context

which South Africa presents makes that limited possibility even more attractive for many refugees. These three quotes below depict three different understandings of how to engage with refugees' narratives and the degree to which they reflect truth or fabrication. The quotes suggest that a concern about the veracity of accounts features at the back of each therapist's mind and influences the way they are able to listen to refugee narratives. In this sense therapy and therapists' possible social power has a very real political connotation. While in most other therapeutic context truth and fabrication are primarily interesting on a psychological level, portraying aspects of one's internal world and personality structure, in the context of therapy with refugees, the consequences are not only symbolic but concrete and practical, possibly influencing one's survival.

> *"With the Zimbabwean crisis, a lot of the clients are desperate ok. And it is a huge issue, in that, we have had clients give false narratives to us. Ok. So, this is an ethical dilemma that I face as a clinician in relation to taking a persons history, as well as documenting their reactions to those experiences. At the back of my mind, constantly having to think is this person telling me the truth or not"?*

> *"You know, people don't really lie, people become creative with the truth. People try to hide the truth. And the person is actually trying to cope with life. Yes, you know they lie, because they have learnt that I don't say this, I don't really get what I want in my life. As a counselor that is something that I try to teach myself, not to use the word lie".*

Certain characteristics or life circumstances make refugees more or less eligible for resettlement and the embellishment or fabrication in refugee accounts is understood to arise from needing to present oneself as 'eligible'. In addition, mistrust and the need to secure resources in general may sometimes lead to perversion of the truth. However, for therapists wishing to engage in authentic ways with clients, any suspicion that the client is misleading or lying in their accounts poses problems for establishing a good working relationship. Even if one appreciates the motivation behind such behaviour it is difficult to work therapeutically when one cannot distinguish between truth and fiction and is being related to strategically by a client. The sense of being used, manipulated and devalued by refugees seems to simmer subtly in the back of therapists' minds. Engaging with this dilemma it appears somewhat unique to the South African context and poses yet another set of problems for therapists in this situation. This subtle dilemma evokes powerful feelings at times both for refugees and therapists. This aspect of therapeutic interaction again speaks to transference and counter-transference of feelings, judgements

and needs. Again, this demands intensive self reflection and thoughtfulness on the part of therapists.

5.4 Some guiding principles proposed for engaging with therapeutic dilemmas and difficulties

This and the previous chapter have outlined the refugee experience in South Africa, the therapeutic experiences of refugees, refugee expectations of therapy, therapist goals/expectations of therapy, the strengths of present therapeutic experience, and four of the main dilemmas that therapists face in their therapeutic work with refugees. This section engages with these issues and therapists' and refugee clients' suggestions (arising from the interviews) concerning possible solutions or guiding principles to better inform such work. It is important to acknowledge that these suggestions are contextually based and arise from data from a small sample. The consequence of this is that the suggestions may be primarily applicable for the Johannesburg context.

This final section of the chapter is divided into two main parts. The first part focuses specifically on therapeutic work within a supportive organization. It will discuss therapeutic framework, assessment of refugee client, two phases of therapy, the therapeutic process and the importance of reflexivity and organizational/therapist self care. The second part provides a brief psychodynamic interpretation highlighting some of the main aspects of the therapeutic process and the psychological impact of refugees' distress on both refugees and therapists in this specific context.

5.4.1 Guidelines for therapeutic work with refugees in the Johannesburg context

The lack of safety for refugees in the South African urban context, the multiple needs of refugees and the limited strained social services available to refugee clients, left therapists struggling to find a containing framework appropriate for this context. Although several conventional psychotherapeutic frameworks were referenced by therapists, in terms of informing their therapeutic work, they were noted as more of background issues than as a primary concern. What was generally important were aspects of what was called by both refugee clients and therapists 'professionalism', or working within a professional framework. The 'professionalism' they referred to included:

positive human regard, keeping one's word, confidentiality, working within an agreed upon time frame, transparency and a good understanding of refugee life, trauma, torture and refugee rights. Several of these aspects represent common therapeutic objectives and therapeutic stances held by all psychological frameworks. This section will discuss a holistic flexible framework to working with refugees in unsafe contexts resting on these pillars of professionalism. All four refugees stressed that aspects associated with 'professionalism' were the most important foundations to therapy.

5.4.1.1 The therapeutic frame and therapeutic alliance

One of the foundational pillars noted by several of the refugee clients was that therapists needed to maintain positive human regard, or as one refugee called it 'love', for them.

> *"The most important thing, when you are a counsellor you have to show love to the person you are counselling. Because if you are not showing love, she won't trust you, she won't be able to speak to you and tell you what she has gone through. But also it is not, it is something which is necessary, which you can say".*

This love one could argue is the foundation of trust. Trust according to most psychotherapeutic understandings is the cornerstone to being able to do therapeutic work as it encourages a strong therapeutic alliance (Corey, 2005; Lemma, 2003; Weiner, 1998). Another important foundation is that therapists should keep in mind and adhere to ethical principles and considerations. As one refugee reflected:

> ***"****I don't know what your ethics, do tell you, but, in any profession, you will find that there are certain conduct that you cannot go beyond".*

This refugee had a bad experience in therapy, as his therapist seemed to be unable to bare the discomfort in the therapeutic process and had acted out his own discomfort inappropriately.

> ***"****Whatever he had on his mind I think he meant it but he didn't know what to do. Because he kept on laughing…But instead, because that very person I think was not professional enough, caused me, caused more harm, you know. Because I could see him in front of me, instead of in fact being at the same level, or the same you know, I can't, I don't know how I can express it, but seeing in front of you someone who you are narrating your story to and he is laughing at it or at you! So it doesn't make any sense to me".*

This had made the refugee reflect on ethical principles that needed to stay in place and the importance of maintaining a stance of positive human regard and respect.

A third foundation of professionalism noted by both refugee clients and therapists was that of confidentiality. As one refugee client explained:

"By allowing, giving the client, that kind of a freedom, that kind of assurance that what you are saying is between you and me. You see that confidentiality. Now you make the person to come out. And by enabling him to come out, you are bringing in some form of relief to him or her".

For all refugee clients interviewed, the relationship with their therapist was of utmost importance and a good therapeutic alliance had a cathartic power to it in and of itself. This suggests some advantage to adopting a person-centered therapeutic approach, where the real therapeutic relationship is of primary importance, as this relationship is used to work through the pain of other relationships (Corey, 2005).

5.4.1.2 Content and context understandings

A second general aspect of therapeutic professionalism that was noted by both refugees and therapists alike, comprised having knowledge and understanding of the general refugee experience, understandings of the impact of trauma and torture and having a good working knowledge of the general rights of refugees and more specifically, the rights of refugees in the South African context. As one therapist suggests:

"Just to know, in DRC people are fleeing because this is what is happening and people are fleeing Zimbabwe because this is what is happening. And when they come to South Africa these are the problems that they encounter, and this is how they come to CSVR".

This suggestion is supported by refugee reflections, cited below:

"*I think, really the counsellors really need to know the background of the refugee".*

"I think the major thing is that they should know that refugees, are people that have problems from where they are coming from and secondly, they have encountered other problems within the South African community. Ja, it is an extra load actually to the refugees. They might, it might increase a ten fold".

Having these understandings possibly allows refugee clients to feel more validated within the therapeutic space. This in turn supports the therapeutic frame in building a good, trusting therapeutic alliance. According to Cardemil and Battle (2003, cited in Corey, 2005), within a multicultural framework, the importance of being willing to learn, adapt and engage in conversations about contextual issues enhances the therapeutic alliance.

5.4.1.3 Usefulness of conventional therapeutic models

Apart from adopting a therapeutic model similar to that identified in the Client Centred Approach to psychotherapy the three conventional models of which aspects were found to be useful by therapists were the psychodynamic model, the cognitive behavioural model and the Wits trauma model. The psychodynamic model was noted to be useful to

work through past traumas and conflicts with refugees who presented with good ego strength, a desire or inclination to reflect on themselves and their pasts and who were not presenting with extreme distress due to present social circumstances. One therapist reflected on a case where the psychodynamic model seemed to fit.

> *"With him, losing his father is very traumatic, when he was 6. Then to him, I mean the whole experience having been forced to leave his country of origin, has opened up, all other traumas. So obviously you cannot say, no, be like others, why are you not thinking about getting a job? Why not worry about people back home? To him, I would need to take the psychodynamic route"*.

The main concerns regarding the psychodynamic model that were mentioned included the tendency to stress individual psychopathology and underplay social circumstances, the relatively long term commitment that was needed from the refugee clients and the inability within this model to address and support refugee clients presenting with extreme distress due to unmet basic needs and lack of social support. Therapists also noted that a fair amount of ego strength was necessary for working psychodynamically, which many refugee clients initially did not demonstrate.

Aspects of the cognitive behavioural model were implemented by therapists when symptoms of PTSD were clearly present. All therapists noted that in the trauma literature CBT had been demonstrated to be useful with PTSD. One of the aspects noted by a therapist that she had found useful was using the technique of visualization as a way to decrease anxiety and irritation. She noted that in her practical experience this method had been useful.

> *"He used to be very angry and very irritable with his wife and he has reported that that is reduced. And I have done CBT stuff with him a lot, like visualizations"*.

The beneficial impact of CBT is supported by the literature (Paunovic & Ost, 2001). The last model that was mentioned of which aspects were noted to have been useful was the Wits Trauma Intervention Model (Eagle, 1998). Although aspects were often mentioned separately, all the different aspects that this model is comprised of were mentioned in most therapists' interviews. These aspects included: telling the story, normalizing symptoms through psycho-education optimizing coping mechanisms and making meaning of what had occurred. One therapist noted the usefulness of the entire model for working therapeutically, specifically with experiences of trauma.

> **"***You know it was, it was very useful in relation to telling the story, normalizing the symptoms, looking at coping strategies and making meaning of one's experiences. And given clients, I think anybody who understands the phases of traumatization, like the impact phase, the reaction phase and the reintegration phase. That was very helpful to clients. That they better understood their reactions and how to deal with that".*

Mostly aspects of the Wits Trauma Model were used interchangeably following the refugee client's lead, when working on past trauma specifically. When daily life stressors were discussed, the model did not feature, although aspects of supporting coping were applicable.

The above discussion has noted the importance of being grounded in a professional framework and from this stance having the flexibility to work with several different therapeutic models. All therapists felt that working holistically with an integrated or eclectic approach was essential. The flexibility that the integrated or eclectic approaches offer was important. The ability to work with different therapeutic models within an integrated and eclectic framework is supported by what was coined a two-phase therapeutic approach.

5.4.2 Two phase approach to therapy

A useful supportive framework noted by therapists was what one therapist coined "a two phased approach".

> *"I see it in those phases, where your basic needs are not met, and there is no safety, and maybe there is a stage where there is safety and space to reflect really on its own and for now they are just managing to stay alive, every week".*

One could argue that this approach is both integrative and eclectic in nature; integrative in that it integrates both supportive counselling techniques alongside a more in-depth and interpretive approach; eclectic in that a mix and match of useful techniques, depending on the presenting client and the presenting problems, is used, primarily in the first phase of the approach. The first phase of the two phased approach could be called the 'basic needs' phase. The type of therapy that is appropriate in phase one is more supportive in nature. This is the most common phase of therapy with refugees in South Africa and therapists noted that one doesn't often pass this phase entirely. This phase also includes psycho-social interventions and building community links. The necessary containment in this phase is primarily on an environmental and material level. Levy (1999) argues that

this containment is an essential primary step in the healing process for refugees. The second phase could be described as a more reflective counselling phase.

This phase requires more in-depth interpretive therapeutic techniques. In order to work in this phase a refugee client needs ego strength. As far as possible ego strength is built in the first phase. Therapists noted that common themes addressed in the second phase include: life review, bereavement, depression, loss of previous life, and trauma and torture witnessed or experienced. Therapists noted that these themes all included aspects of making meaning. Here containment is primarily on an emotional and mental level. Although these phases are split apart and described separately, often times therapists noted that both types of work may take place concurrently, "dipping in and out" as one therapist said, sometimes even in the same session. Although described as if a recognized model in practice, the notion of a two phase approach is not clearly recognized or articulated within the clinical setting. It seems useful for therapists to more mindfully and communally adopt a working model that explicitly allows for both kinds of phases of intervention.

Ideally speaking a multidisciplinary team would be beneficial, however realistically therapists have taken on several psycho-social roles. The two phase framework could possibly legitimize and support these various roles. Legitimizing both more practical and conventional psychotherapeutic roles of therapists working with refugees, might address the 'secrecy' that has been described in the dilemmas section previously. It provides the possibility for an open forum for discussion and support for therapists and allows therapists to tap each others' strengths, combining them into a network of resources. This in turn could help therapists to cope with the multitude of presenting problems, another dilemma, and it could also give refugees a clearer sense of what possible support each therapist could give them. It could clear up the discrepancy in the service provision that some refugee clients have been witness to and disappointed by. Combined, these two aspects encourage ego strength, building of internal and external resources, and regaining a sense of social agency and identity. One could argue that these are important foundations for wellbeing, and more specifically, refugee wellbeing.

5.4.3. The Importance of the Therapeutic relationship

An important therapeutic goal of phase one is to establish a strong therapeutic alliance. This goal is common to all forms of therapy. Establishing a trusting and safe space with refugees who have been a witness to or victim of trauma/torture is of utmost importance. As one refugee stated:

> **"***The most important thing, when you are a counsellor you have to show love to the person you are counselling because if you are not showing love, she won't trust you, she won't be able to speak to you and tell you what she has gone through. But also it is not, it is something which is necessary, which you can say".*

A therapist describes how this trust is essential in the therapeutic process, because it is this trust that helps establish a sense of safety within the therapeutic relationship. This trust and safety encourages refugee clients to expand that newly found trust outward towards other possibly supporting people.

> *"The client feels good. That's when they go for treatment there is somebody who understands them. So that circle of trust widens then. You know, so having more committed people helping out at various levels".*

This section briefly discusses aspects of the therapeutic relationship that both refugee clients and therapists noticed were important in order to establish a strong therapeutic alliance. It then will briefly discuss what roles were projected onto the therapists by refugee clients. Important is how these roles, as well as the fact that therapists were South African, allowed for the development of a trusting relationship. This trusting relationship in turn helped refugee clients gain trust in the possibility of helpfulness from South African citizens as a whole.

Two refugees noted that the mere fact that a confidential talking space was provided to them and the care this suggested was an important aspect in their healing process and their ability to cope.

> *"And I feel that is very important as far as counselling is concerned, because uh, what really destroys people in my position, is for them not having the opportunity to confide in someone".*

One refugee reflected:

> *"I'm much safer now. Because I know that I cannot just fall anyhow or anywhere".*

Another aspect that refugees found to be an important base for establishing a good therapeutic relationship was having the sense that one's therapist had a genuine interest in what you had to say. Thoughtful guiding questions in therapy supported a sense of

genuine interest. It seems that in order to feel comfortable and safe a more interactive conversation style was useful. One refugee compares a good therapeutic experience he had to one that had felt less supportive:

> ***"****She was very lovely, she was, the way she was talking, she made me tell her everything that was happening to me. Like if you were asking questions, like you see, the way we are doing it. Not just listening only. Like if you come to the counselling, I don't know if, because I'm not a counsellor, but not only sitting and listening"*.

Sensitive questions appeared to provide a needed structure to the therapeutic space. All refugee clients reflected that having a space in which they could speak of anything they wished felt very supportive and seemed to serve a cathartic function. One refugee client explained:

> " …[My therapists would] *allow all his subjects to say out all that they have. Because by so doing, the, the person feels relieved. Now if you keep something in you, you are not relieved until you say it out. So I would like to really commend my counsellor for that*".

Relating to a South African therapist in a caring and respectful relationship encouraged the possibility of trusting other South African citizens. This in turn allowed refugees to become more confident in asking other service providers for help, as the task of interacting with other citizens felt less daunting. One refugee describes:

> *"Ja. Particularly that the counsellor was South African. Because I used to have the sense that South Africans were more hostile. But the fact that he was a South African giving the South African view of the problem doesn't mean that all South Africans are have that kind of xenophobia. There are some that appreciate our problems and are prepared to assist us as much as possible"*.

In this way the role that the therapist plays within the therapeutic context expands from within the room to establishing the possibility of trusting other people within refugee clients' new social environment and thereby increases the ability to integrate and establish other supportive social networks.

One of the important aspects of gaining trust and establishing a trusting relationship was testing whether the therapist was able to handle and stay with the distress that the refugee client experienced. Both refugee clients and therapists reflected on how this dynamic could play itself out within the therapeutic context. Therapists reflected that there was a subtle line between aiding refugee clients with practical issues and acting on or acting out the desperation and helplessness that the refugee client was presenting with. This subtle process is reflected on by one therapist.

> *"Like whatever they tell you, like this person is washing himself with Omo, and your feeling then and this is too much, let me get down and do some problem solving with them, or refer them. You know? Uhm, so, in that way, it could, yes I could see a lot of my behaviour as being interpreted as like a rescue, you know reaching out in a rescue act. My understanding is that then the client would feel that their pain is intolerable or overwhelming for the therapist and they might not come back or disclose fully. I think the other implication is that you reinforce their sense of helplessness. And that I have been really aware of".*

One refugee describes his fear of simply being discarded as another unimportant powerless, worthless, useless and invisible beggar.

> *"You see always people, would like to, to, to, speak to people maybe who are well to do not as such, but who are, who are, who have got a standing of some kind. It is always apparent. You see if you meet people on the street, beggars, you don't have time for them. Likewise, she don't have time for, somebody who is… you know? That is what I think".*

The choice to act practically on the distress and when to stay at the level of reflection and containment appeared to require a high level of self awareness on the part of the therapist.

The role of the therapist was described by most refugees as being similar to that of a family member or a friend. As one refugee acknowledged:

> ***"****Ja, he is like a friend, someone out there who you didn't know but who is prepared to help you in your process in life".*

Another refugee described:

> ***"****Ja, because I took my therapist as my savior. He was actually my best friend. And somebody whom I could actually tell, tell everything. I knew that sometimes he would come up with a solution, but uh, saying that out, that would put me into a better perspective".*

Once this nurturing and trusting relationship is established refugee clients described mentally holding onto the therapeutic space and relationship outside of the therapeutic hour.

> *"And you really hope. Because many times you will go and visit your therapist and speak about your problems now or which you have experienced in the course of the period between your last therapy and next therapy. And you find that you say let me tell my therapist about the events that have transpired; that you had a nightmare about the past".*

Being able to hold therapy in mind between sessions appeared to be related to the clients' ability to nurture and hold their own sense of hope. This sense of hope seems to be a powerful catalyst in refugee clients' recovery or re-discovery of their social agency and wellbeing. Therapists' ability to hold a sense of hope when refugees were feeling desperate and hopeless encouraged refugee clients to trust again and in so doing seemed to open up possible avenues of renewed hope and courage.

Holding onto this sense of hope appeared to play a big therapeutic role within the first phase of therapeutic work with refugees. One therapist describes her sense of anxiety at the thought of possibly breaking this sense of hope.

> *"I said: wait, wait, wait, wait, please, because the mom is so fragile right now, that to take the child away could mean that she might just tip and go psychotic".*

This also indicates the strength of the transference and countertransference. Therapists often have a strong parental kind of feeling towards their clients in the sense of feeling responsible and protective. It seems that the strength of this reaction might well be somewhat particular to the South African/Johannesburg context, as the demand for a containing mother/parent (for environmental, material, emotional and mental containment) seems intense. Once a strong therapeutic alliance is established, practical social issues are usually being dealt with simultaneous to therapy and refugee clients' sense of hope and connection is increased. At this point, therapists were able to move towards a more reflective and interpretive phase of therapy. In order to commence on a more in-depth and interpretive therapeutic journey a fair amount of ego strength is needed. With some sense of external security, stability and support, therapists noted that it was possible to encourage a more in-depth reflection upon the experiences that refugee clients had had.

One therapist describes how after a year of therapy with one of her clients, she felt is was possible to challenge her client to reconsider what up until then had been felt by the refugee client to be an important life enforcing factor from which she continued to gain the strength and resilience to keep going. This factor was her relationship with her son. The therapist describes the importance of finding new and different types of meaning in the life of this refugee client:

> *"Now a year into therapy, because I got scared. If something were to happen to this child this woman would kill herself. So I said is there any other reason for your existence other then this child? Because you know, this child will eventually get married and have his own family. And you won't be able to, it is not fair to expect that this child will live with you. So, how do you, set up your own life? And preparing for that, so that her whole world is not centered around this child. So that she has her own life and her own identity. So yah, creating meaning".*

The process of making meaning and sometimes creating new meaning in ones' life could be experienced as quite challenging and confronting at times, as the previous quote demonstrates.

One of the common defenses that therapists noted was an inclination to speak about present circumstances.

> *"They know they are coming to counselling because of their torture. But for a lot of them, they don't go into their torture".*

It may be difficult to distinguish between whether this is a defensive avoidance or a resistance related to real external intrusions.

> *"Ok we can say, ok is a job then an escape from thinking about that other experience? And if it is an escape is it negative? Or is it positive? But the subjective, their subjective meanings that they attach to that, is that if they find a job, I'm able to support my family. I might then regain my sense as a person or maybe my manhood as a person. That I can still claim, that active role of being a father, a father who manages to support his family back at home. So I do not know, it is an escape, but is it negative?".*

Although deflection into current problems can disengage the refugee from the intense and often very painful process of making meaning and healing, in the South African context this defense also needs to be respected and noted as a healthy reaction indicative of agency, resilience and psychological wellbeing despite the concurrent suppression of traumatic material.

5.4.4 An extended therapy process

The therapeutic process with refugee clients in the South African context demands considerable time and patience from the therapist. All four therapists as well as three of the refugee clients described the therapeutic process as long. Two refugee clients explained:

> *"No, it went step by step. Step by step. Because at times, you know, even with therapy, you know, you can be ok today but then tomorrow things might change, you might go back to your mood again. It happens. So there were times when I would, because I would come every week, I would come for therapy. But then, at times I would come there, with a very low esteem, very depressed".*

> *"And it is not an overnight thing, so that is why it needs a long time. I think it would be better for therapist to motivate that person to have more sessions and to pin point that this is not a short process. It is really going to take time, you have to accept that".*

A Therapist states:

> **"…***That dealing with torture survivors, refugees who have been exposed to ongoing traumatization, that it is a long process".*

Both the South African context and the harrowing war/torture/social disruption experiences that many African refugees have had make this a therapeutic group that demands longer term therapeutic intervention. As the refugee client above mentioned, it might be useful to let refugee clients understand from the beginning of therapy that oftentimes the process will be long and dynamic, requiring different interventions at different times and a process of revisiting certain themes, depending on what internal and external contexts are present and need to be attended to.

Once basic needs are met, several therapeutic interventions are possible and useful, however one must keep in mind that the external context continuously influences the more interpretive, or in-depth work.

> *"And in between that we have had breaks of "I have got attacked this weekend" and ok let's bring in his wife and do a debriefing. And then we like get back on track. And then there is another, labour dispute at work and I'm referring him to a lawyer. But in between we manage".*

This external context needs to be acknowledged time and time again. This allows for the psychological healing process to continue and a healthy sense of trust and social agency to develop. Many of the dilemmas discussed in the previous sections appear soluble in the explicit adoption of an extended two phase or element form of therapy.

5.4.4 Therapist reflexivity

The interviews with therapists all suggested that an important aspect of being able to deal with conflicting therapeutic roles, horror stories and the overwhelming volume of presenting problems that refugee clients come with, is personal reflection.

> *"When you take the social worker role, what are the implications for therapy, reflect on it, take it to supervision. You know? Look at yourself, is it like a defense? Is it like the rescue complex".*

It became clear that working with refugees in the South African context required a heightened level of reflexivity. This in turn could be taxing and stressful as a multitude of difficult and conflicting issues are dealt with on a day to day basis, requiring therapists to engage continuously in self reflection and most often without the support of supervision. As mentioned earlier in the dilemmas section, therapist felt highly burdened by having to constantly make choices in terms of boundaries and type of help they would offer. As one therapist reiterated:

> *"Where do I find leadership and guidance in this? If someone says to me you are not allowed to organize a sponsor for this person. I would have gone, 'You know what, you are right'. But because there wasn't a strict rule or policy, I have had to rely on my internal sense and to take it to supervision".*

All therapists felt that supervision played an important supportive role in this context. Alongside supervision, three therapists noted that self care measures, such as setting clear boundaries were important, as well as finding internal and external appreciation for their work and seeing improvement in their clients' wellbeing. Self care measures and supervision (as emphasized by Bober, Regehr & Zhou, 2006 and Rothchild & Rand, 2006) were important in helping therapists 'hold the hope' for refugee clients, allowing them to deal with the overwhelming despair that was again and again projected into them. As one therapist states:

> *"And also in terms of debriefing... Just feeling someone else knows about what is happening with these people because sometimes it's all very heavy".*

> *"I think the main thing about that is the containment that you need in supervision. That when you come to your supervisor and they are overwhelmed with what you have brought, you think what am I going to do now? It is so hard for me, if it's hard for her, you know? You need someone to just, even if they don't know what the right answer is, you need them to pretend that they know what the right answer is. So that you can move forward. That containment I have found, like when you walk out of supervision, I think ok, this work is not so bad, this person is going recover, you know? Because when you are with the client you sometimes don't feel that. You feel overwhelmed".*

Group supervision seemed particularly useful in that it provided therapists with a forum where common struggles could be discussed and useful tools to approach these problems could be debated. One therapist reflected:

> *"And we have that* [group supervision] *here and I, for me it has been so helpful to hear* [other] *therapists talk about their mistakes, and also talk about where they have done unconventional things but where it has been what the client needed".*

> *"I don't think, I think even if it is not, if you are an experienced therapist, I think it would still be about doing group supervision and sharing your cases. Because I think this work presents ethical dilemmas and that whole secrecy thing that I spoke about that you need a group of trusted colleagues where you can really say, this is what I have faced. And I think that is really, really important".*

Having the support of a group allowed for reflection on unconventional interventions, their consequences and related boundary concerns. This lightens the work burden and opens up the possibility for a collective consciousness to develop between therapists working with refugees in South Africa, which strengthens the possibility of better

formulating contextually sensitive therapeutic interventions. It is also important to note that in addition to supervision and self-care, organizational support was also crucial in the provision of good services. However, due to length constraints recommendations for organizational structuring cannot be addressed in any depth. It was evident that respect for multidisciplinary, networking and clear policy formulation would all be organizationally beneficial. The next section offers a somewhat more interpretive reflection on aspects of the data presented thus far.

5.5 Interpretive reflections

In this final section an attempt is made to apply psychodynamic thinking to the process of therapeutic work with refugee clients in the South African context. Without negating previous aspects of the discussion an attempt is made to reflect upon some prominent aspects of the therapeutic process and the psychological impact of refugees' distress on both refugees and therapists at a somewhat more symbolic level. This section of the discussion will reflect more deeply on the importance of containment and the possible impact of the powerful transference and countertransference dynamics arising within therapeutic work with refugee clients and therapists.

As discussed previously in the literature review, psychoanalytic thought argues that trauma, and especially recurrent trauma and torture such as that which many refugees have experienced in their countries of origin, during their exodus and in South Africa, can diminish mental resilience, causing a withdrawal of libidinal or life energy from the demands of daily living to focus on supporting a person's core or ego (Solomons, 1988). This regression due to severe and deep narcissistic injury can cause a profound personality breakdown, interpersonal disconnection, psychosomatic illness or depression (Levy, 1999). This depends on the severity of the traumatic distress and the individual's prior personality structure. The defensive responses to massive traumatization are often 'primitive', including splitting, identification with the victim or aggressor, repetition compulsion, denial and the inability to think (as mentioned previously) (Levy, 1999; Solomon, 1988). Such protective mechanisms are employed in an attempt to defend the ego or personal core against the deeply disturbing, powerful and traumatic emotional

material. These defenses alongside the strong feelings of anxiety, helplessness, hopelessness, rage, shame and internal deadness are transferred onto therapists working with refugee clients. One can imagine that this can at times be experienced as an incredibly powerful and perhaps even overwhelming kind of transference.

As described previously, therapists' primary role is to create a place of containment. Levy (1999) discusses two concepts central to containment, the first being the provision of a holding environment on a physically real and tangible level. As refugees' "external reality has been massively and brutally interfered with in ongoing and intentional ways" (Levy, 1999, p. 239) a healing step is to alter this continual unsafe space by the provision of physical security and containment. This process should take place parallel with mental containment, which is established through the therapeutic environment where a therapist actively listens to and validates the refugee's experiences. Validating refugees' experiences means acknowledging their suffering, and the impact of their past socio-political and cultural worlds on their present lives. In some respects one could understand the enablement of physical safety and the setting up of a trustworthy therapeutic relationship as encompassed by Phase 1 of the two phase model of intervention proposed earlier.

The second central concept relevant to containment is the therapist's capacity to manage the disturbed and distressed feelings that the client puts into him/her in the course of their work and to translate these toxic feelings into a more manageable and less poisonous form which the refugee client can digest (Bion, 1962; Levy, 1999). Bion (1962) describes such a function as a vital aspect of the relationship between mother and infant. In working with refugees therapists are required to take on this mothering/containing role. In this containing role the therapist needs to bear witness to refugees' testimony and to in a sense become the container of their testimony. This entails absorbing the emotional impact of the material and demonstrating that one is not overwhelmed by this, as well as helping the refugee client to make sense of and think about their experiences, to make their experiences 'digestible'. In the South African context therapists not only bear witness in this way but also attempt to take on a multi-layered parenting role as they aim

to establish both external and internal containment. The intense demands required in occupying such a role can be experienced as overwhelming and often also deeply disturbing as therapists are continuously confronted with and have to bare the injustices that refugees in South Africa continue to face. In this sense the contextually loaded client transference can provoke a very powerful countertransference reaction of needing to take on and immerse oneself fully into a parenting role for the client. This may sometimes manifest in interventions which are over-active and provide material containment at the expense of psychological containment. However, it is very difficult to determine whether therapists are manifesting a kind of 'manic defense' at times or whether they are very much in touch with real situated demands.

In conducting the research I was struck by my strong feelings of injustice and anger towards politicians and government officials who promoted these injustices and subtle acts of violence. I had a strong need to write this story, to validate and acknowledge refugees' experiences and make sure that tangible physical and concrete changes would occur or be encouraged. On reflecting on my powerful responses I wondered whether overwhelming and overpowering desperation and horror that refugee clients and therapists spoke of had also been transferred to me, and whether I too was inclined to want to tangibly act on and change this context.

Containment and validation happen on various levels, both concrete and tangible, as well as symbolic, mental and emotional. In performing these functions therapists are confronted by an often overwhelmingly powerful transference of a desperate need for containment and the supply of real and psychological resources. Although containment on this level is absolutely necessary for healing to occur, the therapeutic task requires expansion from working at the manifest or surface level to working with latent causes of intense feelings. Simply containing and being busy on the surface level might risk a continuation (repetition compulsion) of some of the internal dramas of the event and may also be played out in organizational tensions and dramas. It is therefore very important to create occasions for thinking about the work.

On reflecting on my own ambivalence, I wonder if therapists' full hearted engagement with the practical tangible parenting role (organizing safe place to sleep, food, etc.), might at some points represent a manic defense that had the danger of causing a sense of stuckness and repetition. Perhaps an initially relieving and containing experience for both refugee client and therapist, engaging practically with manifest needs and symptoms, may at some points become a repetitive representation of a situation in which the 'parent' is unable to truly make sense of and translate all the chaos s/he is presented with and in turn translates and gives back only part of the chaos in digestible pieces. There is possibly a danger here of denying the dialectic between manifest and latent content, resulting in some mis-attention to the latent content, possibly leaving the refugee constantly seeking out practical support but never feeling their needs are fully assuaged and continuing to feel the deep rage, hurt, helplessness and hopelessness that they initially felt when they were unjustifiably ripped from their home and social network. With this in mind it is important that therapists are open to acknowledging the disappointment, rage and despair that may come up in the course of therapy and also that they are able to tolerate the limitations on their capacity to respond in this most difficult therapeutic context. They need to be able to bear the fact that what they provide may be flawed, and to trust that it has value.

CHAPTER 6
Conclusion

The final chapter of this research report is comprised of three sections: a summary of the central findings; limitations of the study; and, implications for future research.

6.1 Central findings

In accordance with the literature describing the general refugee experience and more specifically the South African refugee experience, this study found that the general experiences of multiple losses, trauma and up-rooting, as well as more specific experiences related to the urban South African context such as meeting basic needs, discrimination, living in fear, retraumatization and refugee resilience influenced and impacted on the lived experiences of the interviewed refugee clients. These multiple aspects of the South African refugee experience had complex implications for working therapeutically with refugee clients. Refugees in South Africa face a contextual situation that continues to be extremely distressing leaving refugees in a physical and psychological state of insecurity where they are forced to physically and emotionally defend themselves. That many refugees survive these ordeals and are able to support themselves speaks to their levels of resilience.

In accordance with the literature, the main descriptions of psychological distress discussed by the refugee clients included those that were caused by past trauma and those that were a response to current experiences. The persistent and uncontrollable memories of what had happened in the past were the main source of distress experienced due to past trauma. The psychological distress experienced due to present circumstances included: not being able to adjust to new the environment, depression, lack of self esteem, general sense of apathy, hopelessness, helplessness and a lack of sexual desire. Some of these descriptions could be categorized as symptoms of DSM-IV syndromes such as PTSD or Major Mood Disorders such as depression. The prevalence of these descriptions and symptoms of distress stresses the importance of psychological intervention, as it was

clear that refugees in South Africa are a population at risk of being socially and emotionally paralyzed by severe and persistent psychological distress.

This research study noted that social support and access to new social networks would not go far without helping refugees regain their ability to think, thereby increasing their resilience, sense of hope and courage. The dialectic relationship between emotional, mental and practical support, as well as the importance of the 'containing therapeutic space' which allowed unpalatable feelings and experiences to be digested was highlighted. Refugee clients noted that increasing their capacity to think, act and function was an important contribution that therapy had to offer. Other important contributions of therapeutic work noted by refugees included: a decrease in negative symptoms, feeling more normal, gaining a new perspective on one's life and circumstances, gaining mental space to attend to basic needs, increased hope, increased self confidence and courage, regaining the ability to trust and an increased sense of social agency.

This study found that the containing therapeutic space was possible due to what refugees coined 'the professionalism of the therapists'. Professionalism included: The concept of positive human regard; keeping ones word; confidentiality; transparency; a good understanding of refugee life, trauma, torture and refugee rights; a respectful and trusting relationship; and working within an agreed upon time frame. Therapists' professionalism created a sense of a respectful space, where time was set aside especially for the refugee client. This study found that being grounded in a professional framework and from this stance having the flexibility to work with several different therapeutic models was important.

Four salient dilemmas were noted by therapists in terms of working therapeutically with refugee clients. Two of these dilemmas were similar to findings in related studies and included having to step out of the conventional therapist role and having to deal with the impact of the horror stories described by refugees. Unique to this study, were two further dilemmas, namely, therapists' struggle to identify the appropriate therapeutic approach to use and therapists' struggle to determine whether refugees' narratives were truthful or

fabricated in part or whole. This study found that these dilemmas were also in part reflected in refugee concerns and observations about psychotherapy. The confusion of being seen by therapists occupying multiple and sometimes conflicting roles at times left them confused, angry and unable to trust the therapeutic space.

Arising out of material garnered in the study was the possible solution of working within the supportive framework of a two phased approach. Such an approach could be both integrative, and eclectic in nature. Integrative in integrating supportive counselling techniques with a more in-depth and interpretive approach; eclectic in that a mix and match of useful techniques depending on the presenting client and the presenting problems can be flexibly implemented. The first phase, or 'basic needs phase' would involve supportive counselling alongside the support of psycho-social workshops, building a strong and trusting therapeutic relationship and helping to build community and supportive social structures. The second or 'reflective phase' would allow for more in-depth interpretive therapeutic techniques. In order to work in this phase a refugee client needs ego strength which is bolstered in the basic needs phase. Therapists noted that common themes addressed in the second phase of interventions included issues such as life review, bereavement and working with trauma and torture witnessed or experienced.

In accordance with the literature, this study found that the therapeutic relationship was important and held cathartic power. This study found that in order to establish a strong therapeutic alliance refugee clients need to have a sense that they were both supported externally and emotionally and that the therapists demonstrated a sense of genuine interest. Contrary to the literature, it was noted that a more interactive conversation style with supportive questioning was useful to provide a sense of structure, containment and interest. A third important aspect of the therapeutic relationship was establishing trust, and refugee clients often tested their trust by seeing whether their therapist was able to hold their sense of distress. A subtle line was noted between aiding refugee clients with practical issues and acting on or acting out the desperation and helplessness that the refugee client was presenting with.

This study found that an important aspect for therapists dealing with the continuous negotiation of therapeutic dilemmas was self-reflection. In accordance with the literature this process could be taxing and stressful, leaving therapists at high risk of vicarious traumatization. All therapists found that supervision supported them in dealing with and managing the affects of the therapeutic work. Both individual and group supervision was seen as essential. Group supervision was viewed as particularly important in negotiating multiple roles, boundary stretching and novel interventions.

6.2 Limitations of the study

The relatively small number of participants is the principle limitation of this study. It is apparent that the participating refugee clients represented a particular sub-group of the population of refugees in the South African context, as they were all proficient English speakers and had the resilience to find CSVR and engage in therapy. However, rich data was gathered and the sample appeared sufficient for a research study of limited scope. Although it was not the intention to study a particular organizational setting, therapist participants were all part of CSVR's therapeutic team, or had been a part of the team in the past. It was noted that the opportunity for refugees to acquire therapeutic support was limited and the CSVR appeared to be one of the only organizations providing such treatment. The study thus centred on the intervention strategies of therapists at the CSVR. The data that arose out of this research project that seemed particular to CSVR's organizational circumstances was not appropriate to include in this study. However, the bulk of material that emerged from the interviews appeared to have some general applicability in terms of understanding therapeutic interventions with refugees in non supportive contexts.

Despite the relatively small number of participants, the amount of data that was generated was extensive, as is common with in-depth interviews. Although this allowed for a thorough exploration of the guiding research questions, it was difficult to do justice to the entire volume of the data. Related to this, it was noticed that despite the usefulness of having both refugee clients and therapists' understandings and experiences to work with,

these two groups' narratives were very different in style. It was also somewhat difficult to integrate the two sets of findings, although each group could speak in greater depth about some aspects of interest in the study, contributing to greater richness. Refugees were able to speak at length and in-depth about their experiences in the South African context but could only speak from a lay perspective about their therapeutic experiences. This meant that they could often only describe the impact of therapy rather than having an awareness of the process. This made it difficult at times to access the research questions from the refugee clients' perspective. Therapists' in-depth knowledge of the process of therapy made it easier to incorporate their experiences into the analysis. As the primary goal of the study was to outline dilemmas and principles of psycho-therapeutic work with refugees in unsafe contexts, this imbalance in the use of the narratives, focusing at times mainly on therapists' experiences, was perhaps appropriate.

5.3 Implications for Future Research

As there appeared to be no formal literature concerning psychotherapeutic work with refugees in South Africa and very little literature concerning psychotherapy in similar situations internationally, this study attempted to open up a space where knowledge and research based ideas on working with refugees in non-supportive settings could be produced. In general, further research concerning this specific field of psychotherapeutic work would be useful as there is little concerning its usefulness in non-Western and unsafe contexts. In order to support mental health workers as well as refugee clients in this context more literature concerning methods of adjusting conventional psychotherapeutic services would be useful.

This study has noted that although there is a definite place for psychotherapeutic work with refugees there is also a dire need for complementary or integrated psycho-social intervention in order for refugees to achieve both the environmental and emotional containment that they require. It appears that these aspects of containment are in a dialectic relationship and further research exploring this relationship would be beneficial. The study has suggested the possible benefits of a two-phased approach. An evaluation of the implementation of such a two-phased approach would be beneficial. Alongside this

and in accordance with the literature, an in-depth assessment of mental health within the Johannesburg refugee community would also be useful. This needs assessment could influence future psychotherapeutic work within the Johannesburg context and could be the foundations for more interactive and community based mental health projects.

The study found that the foundations of therapy such as professionalism and the therapeutic relationship are of central importance to refugees in their experience of psychotherapeutic work. Further research focusing on the therapeutic relationship in more depth and more specifically on the transference and countertransference dynamics within such therapeutic relationship would be beneficial.

All of the above topics for possible further research could carry benefit for both refugee clients and therapists working with refugees in the South African or other similar unsafe contexts. As the refugee population continues to grow world wide, challenging host countries and demanding a solid foundational understanding of how best to support such individuals socially, mentally and emotionally, establishing better knowledge and research based intervention principles is of utmost importance.

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APPENDIX 1a: Interview schedule for therapists

Phase one **Open-ended**

1. Could you tell me a bit about how you work as a therapist and how you work with refugee clients?
    a. *Probes*
        i. *Therapeutic framework*
        ii. *Specialized in specific area*
        iii. *Do refugees fit into this area of psychotherapeutic work*
        iv. *Therapeutic framework in terms of working with refugees*
2. What has your experience of working with refugees been like?
    a. *Probes*
        i. *Rewarding and frustrating aspects*
        ii. *What aspects complicates working with refugees*
        iii. *Own growth or development in the area*
        iv. *How you feel about working with refugees*
        v. *Examples*
3. In your view, how do you think refugees experience therapy?
    a. *Probes*
        i. *Feedback you have gotten from refugees specifically*
        ii. *With your experience what you imagine it would be like*
        iii. *Rewarding and frustrating aspects for refugees*
        iv. *Reflect on the refugee experience and psychological implications*
4. What would you like to see happen in the future for therapists and refugee clients alike, in terms of psychotherapy?
    a. *Probes*
        i. *Any questions you have about therapy that you would like to see answered*
        ii. *What do you feel every therapist working with African refugees in South Africa needs to know or be aware of*

Phase two **Directive**

1. What are the key issues that refugees present with to psychotherapists here in South Africa?
    - PTSD
    - Uprooting
    - Disrupted identity
    - Social issues (financial and social support, food, employment, rights, legal status, political credibility, xenophobia)
    - Unsafe/hostile environment

2. What do you consider to be the strengths of the model or way in which you work with African refugee and why?
    - If you were to advise a therapist or an organization just starting to work with African refugees what would you tell them?
3. What are the main difficulties experienced by psychotherapists working with refugees here in South Africa?
    - Having to deal with the horror stories described by refugees
    - Having to step out of conventional therapist role and take on the role of social advisor and mediator
    - Having to deal with imposing the cultural stigma of psychological illnesses
    - Bridging cultural divide between therapist and client and client and society
    - Use of interpreters
    - Political division imported into South Africa
    - Veracity of clients accounts
    - Other
4. What models and aspects of existing approaches have you found useful and why?
    - Cognitive behavioural therapy
    - Narrative therapy
    - Psychodynamic therapy
    - Rational emotive behavioural therapy
    - Testimony therapy
    - Group therapy
    - Others
5. What modifications have you felt compelled to make in working with African refugees and why?
    - E.g.: Testimony therapy to initiate therapeutic alliance, rapport and to contribute a document that increases social empowerment (Luebben, 2003)
6. What is the impact of this work on you and other psychotherapists in South Africa?
7. What were the main difficulties experienced by refugees in terms of psychotherapy?
8. What role do you see supervision playing in assisting you to work with refugee clients?

APPENDIX 1b: Interview schedule for refugees

Phase one **Open-ended**

1. Could you tell me about your experience of being in psychotherapy/counselling?
    a. *Probes*
        i. *What made you choose to go for psychotherapy/counselling?*
        ii. *How long did you go for therapy/counselling?*
        iii. *What was useful?*
        iv. *What was frustrating?*
2. If you could give your therapist/counsellor feedback on psychotherapy/counselling what would you tell him or her?
    a. *Probes*
        i. *Did you feel supported by therapy/counselling?*
        ii. *Are there aspects to therapy/counselling that you feel need to change?*
        iii. *Did anything in your life change because of therapy/counselling?*
        iv. *Were there important aspects of your life that you could not bring to therapy/counselling? Please elaborate.*
3. What do you feel every therapist/counsellor should know or do if they are to work with refugees/asylum seekers?
    a. *Probes*
        i. *Aspects about being an African refugee/asylum seeker in South Africa?*
        ii. *Aspects about cultural issues?*
        iii. *Aspects about primary refugee/asylum seeker needs?*
        iv. *Aspects about the appropriateness of disclosure of life events?*
4. Is there anything else I need to know or understand about refugees/asylum seekers and therapy/counselling in South Africa that you feel would benefit refugees who will be seeking therapy/counselling in the future?

APPENDIX 1c: Informed consent forms

Consent form therapists

I _____ consent to being interviewed by Kieke Grootenhuis and to partaking in a focus group with other therapists and supervisors for her study on Guiding principles and dilemmas concerning psychotherapeutic work with African refugees.

I understand that:

- Participation in this interview and the focus group are voluntary.
- That I may refuse to answer any question I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me will be included in the research report and my responses will remain confidential. However, I also understand that confidentiality in the focus group is dependant on the actions of other focus group participants who will be asked by the interviewer to commit to confidentiality.
- Direct quotes might be used in the research report, but these will be selected making sure that they cannot identify anyone personally.
- That all interview material will be destroyed after examination of the research report.

Signed _____

Date _____

Consent form refugees (Interview)

I _____ consent to being interviewed by Kieke Grootenhuis for her study on Guiding principles and dilemmas concerning psychotherapeutic work with African refugees.

I understand that:

- Participation in this interview is voluntary and therefore my own choice.
- That I may refuse to answer any question I would prefer not to.
- I may withdraw from the study at any time.
- No information that may identify me will be included in the research report and my responses will remain confidential.
- My words might be used in the research report, but they will be used in a way that makes sure that they cannot identify me.
- I understand that there are limitations to confidentiality. If I report any involvement in illegal activities by myself or anyone else that may be identified this will have to be reported to the necessary authorities.
- I understand that all interview material will be destroyed after examination of the research report.

Signed _____

Date _____

Consent Form Therapists (Recording)

I _____ consent to my interview and the focus group with Kieke Grootenhuis for her study on Guiding principles and dilemmas concerning psychotherapeutic work with African refugees being tape-recorded. I understand that:

- The tapes will not be heard by any person in this organization at any time, and will only be processed by the researcher. Tapes will be kept in a safe place by the researcher.
- All tape recordings will be destroyed after the research is complete and has been examined (or at most within 3 years).
- No identifying information will be used in the transcript or the research project.

Signed_____

Date _____

Consent Form Refugees (Recording)

I _____ consent to my interview with Kieke Grootenhuis for her study on Emerging Dilemmas concerning psychotherapeutic work with African refugees being tape-recorded. I understand that:

- The tapes will only be processed by the researcher. Tapes will be kept in a safe place by the researcher.
- All tape recordings will be destroyed after the research is complete and has been examined (or at most within 3 years).
- No identifying information will be used in the transcript or the research project.

Signed_____

Date _____

APPENDIX 2a: Posters advertising for therapists and refugees

Would You Be Willing

To Help Us Understand

What Refugees Need or Want

From Counselling?

- **If you are a refugee with asylum status, over the age of 18, comfortable to speak in English and have had counselling for at least 8 weeks or sessions**

OR

- **If you are a registered professional mental health practitioner working with refugees or other helping profession and have counselled refugees for a considerable amount of time, I would very much like to speak to you about helping me by taking part in a research project.**

- **For more information please contact:**
  Kieke at 072 291 3668
  Or get information from reception at _____

APPENDIX 2b: Information letter for therapists

Dear Sir/Madam
My name is Kieke Grootenhuis, and I am conducting research for the purpose of obtaining a Masters degree in clinical psychology at the University of the Witwatersrand. My area of focus is the benefits and difficulties of counselling African refugees or asylum seekers, and I am working under the supervision of Professor Gill Eagle. The aim of this project it to create guiding principles for therapists who are working with African refugees in an unstable or unsafe context for the refugee, such as the context that South Africa presents. Therapists have little literature specifically concerning how to work with African refugees/asylum seekers in South Africa to draw on, which sometimes can make it difficult to know what is especially important for such refugees during therapy. In order to support therapists in South Africa with their therapeutic work, thereby also allowing refugees effective and appropriate psychotherapeutic support, it seems important to hear what both therapists and refugee clients have to say about their experiences of therapy. We are looking for counsellors who are either registered counselling or clinical psychologists or are professionals who have several years of therapeutic/counselling experience. If this includes you, then we would like to invite you to participate in this study.

Participation in this research will involve being interviewed by myself, at a time and place that is convenient for you and later partaking in a focus group with other therapists and supervisors in the same field. The interview will last for approximately one hour and the focus group for 90 minutes. Participation is voluntary. All of your responses will be kept confidential, and no information that could identify you would be included in the research report. The interview material will not be available to any other person in this organization and will only be transcribed by myself and analysed by me and my research supervisor who will not be aware of any interviewee's identity. You may refuse to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point.

If you choose to participate in this study please will you contact me via email (kiekeg@ananzi.co.za) or telephone (072 2913668).

Your participation in this study would be greatly appreciated. This research will contribute both to the body of knowledge on therapeutic interventions concerning refugees in general, as well as to specific knowledge of effective therapeutic interventions concerning refugees in the South African context. The general trends emerging out of the research will be fed back to your organization in either written or verbal form. If useful, the organization is welcome to request a full copy of the final research report coming out of the study.

Kieke Grootenhuis
072 2913668

APPENDIX 2c: Information letter for refugees

Dear Sir/Madam,

My name is Kieke Grootenhuis, and I doing research for the purpose of getting a Masters degree in clinical psychology at the University of the Witwatersrand. My research is on the benefits and difficulties of counselling African refugees or asylum seekers. The aim of this project is to gain a better understanding of what is needed to support refugees in a counselling context here in South Africa. This will support counsellors here with their work and other refugees seeking counselling in the future.

For this I need to speak with refugee about their experiences of counselling. I am looking for African refugees/asylum seekers, with asylum status, over the age of 18, who have been in counselling/therapy for at least 8 sessions and can speak English. If this includes you, then I would like to invite you to participate in this study.

Participation means being interviewed by myself, at a time and place that is convenient for you. The interview will last for approximately 1 hour. I will pay 60 rand towards your transport and the cost of food. Participation is voluntary. All of your responses will be kept confidential, and no information that could identify you would be included in the research report. I and my Supervisor are the only ones who will hear or read your interview. You may choose to withdraw from the study at any point. Taking part in this study will not help your legal status and there will be no personal benefits for you. Your participation in this study would be greatly appreciated and if you would like to hear what comes out of the report you are welcome to contact me.
If you choose to participate in this study please will you contact me via email (kiekeg@ananzi.co.za), telephone (072 2913668) or through your therapist.

Thank you,
Kieke Grootenhuis
072 291 3668

APPENDIX 3: Mind map of emerging themes in analytic process