Psychology of the refugee, the immigrant and their children

Development of a conceptual framework and application to psychotherapeutic and related support work

Kristal-Andersson, Binnie

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PSYCHOLOGY OF THE REFUGEE, THE IMMIGRANT AND THEIR CHILDREN

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DEVELOPMENT OF A CONCEPTUAL FRAMEWORK AND APPLICATION TO PSYCHOTHERAPEUTIC AND RELATED SUPPORT WORK

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SUMMARY

Psychology of the refugee, the immigrant and their children – development of a conceptual framework and application to psychotherapeutic and related support work

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In recent years, awareness has grown of the necessity of understanding the inner world of refugees (in particular traumatized refugees), immigrants, and their children. These groups have come in increasing numbers to Scandinavia, and otherwise confident and capable professionals in all arenas of mental health, social work and other fields have often felt inadequate when working with them.

After many years of clinical and supervisory work, Kristal-Andersson realized that there was an acute need for a treatment model that considers the specific psychology of these groups. In her view, specialized process-related training in psychotherapy and its related fields, and also in support work, is necessary to obtain psychological understanding of their difficulties, and also to build up the knowledge, insight and confidence of professionals and others in working with them. Formulating a framework and organizing a specialist form of education for various categories of professionals have been the principal goals of her research work and this subsequent doctoral dissertation. The relevance of the framework (part I of the dissertation) is evaluated through experiences of a course of practical training based upon it (part II).

Part I provides a summation of over twenty-five years of Kristal-Andersson's and others' clinical and support work with refugees and immigrants. First, it describes the commonly occurring psychological and other difficulties that the individual/family faces in the new country. Second, it presents a conceptual framework or treatment model evolved over many years of clinical work, supervision and consultation. The model was derived through interaction between literature study, empirical research and clinical evaluation.

Part II describes and evaluates a year-long process of training for caring professionals based on the framework, and summarizes and evaluates particular items of casework. The training was designed to expand the psychological understanding and confidence of the carers involved. Its primary purpose here is to validate the use of the conceptual framework in treatment and support work. Method, documentation and evaluation include tape recordings of the theoretical education and supervision and evaluations of these; participants' continuous oral and

written evaluations; summations and reports of casework sessions; and data from three written questionnaires administered at and after the final seminar.

At a scientific level, the primary purpose of this dissertation is to provide further knowledge and understanding of the specific psychological and outer difficulties of refugee and immigrant groups, and promote increased interest in this area of psychology. A further purpose is to describe a practical approach and mode of working in psychotherapy and support work with refugees and immigrants. In practical terms, it is hoped that the dissertation can assist in the development of educational, curative and preventive programs for assuring good mental health and improved social conditions for refugees, immigrants and their children. In turn, this might lead to improved adaptation and an improved social situation for them in their new country. Finally, it is hoped that the psychological knowledge obtained can help prevent and counteract discrimination, prejudice and tension, and lead to more open and sensitive attitudes towards these groups in the societies to which they now belong.

To the refugee
To the immigrant
To their children

PREFACE

There has always been an acute need for understanding of and insight into the inner difficulties of refugees, immigrants and their children. These difficulties are caused, affected or complicated by fleeing from or leaving a native land, and the changes and conflicts experienced in living in and adapting to a new country.

The purpose of this dissertation is to present and attempt to validate a conceptual framework of understanding for psychotherapeutic and related support work. In terms of subject area, the work might be regarded as lying at the interface between clinical psychology and empirical pedagogics.

It is the hope of the author that the results of this research can be used to continue to treat, supervise and educate others. I hope to have added to knowledge of the psychology of the refugee, the immigrant, and their children, and look forward to further research in the arena.

It would be impossible to acknowledge everyone who has supported me – in different ways – in this endeavor. I will name just a few.

First, I want to mention Professor Alf Nilsson, Department of Psychology at Lund University, the supervisor of the research project and dissertation; the refugees and immigrants, and their children, for sharing their inner and outer worlds; my parents, who were both of refugee background, and residents of the Flatbush neighborhood of Brooklyn, New York, where I grew up; my colleagues, teachers and supervisors, in particular Gunnela Westlander, Carl Martin Allwood, Carl Otto Jonsson, Björn af Forselles, Inga Sylvander, Merit Hertzman-Ericsson (now deceased), Ulla Bertling and Stina Thyberg, and especially Alice Breuer, Per Stenfelt and Imre Scezsödy, for their belief and encouragement; and, the people – both inside and outside Sweden – who have encouraged me to believe in what I am doing. My special thanks go to Kjell Jönsson, Kjell Öberg, the now-deceased Hans Göran Franck and Arne Trankell, Robert Vargás, and John Giordiano.

The process-training program based on the framework, organized in Finland by Åbo Akademi University's Center for Extension Studies, would never have come about without the steadfast determination of my colleague, Kristina Saraneva. We benefited from the constant involvement of Kerstin Sundman. Margita Vaino authorized and supported the project. By the time of writing, two other training programs have been completed. I want to thank all

the professionals participating, and also the individuals with whom they worked. Without their efforts, this part of the project would never have been completed.

I thank Kerstin Hallén, Jason Andersson, Jerrold Baldwin and Jon Kimber for their assistance with the manuscript.

I also wish to express my gratitude to the island of Lefkada, Greece, where much of this dissertation was written – for the inner peace I found there, and to Sweden – for giving me the security and the opportunity further to develop my work.

Finally, I want to thank my sons, Jason and Danjel, for giving me the meaning, will and determination to attempt to make their world and mine more understandable and humane.

My thanks to all I have mentioned and those I have not.

Binnie Kristal-Andersson

TABLE OF CONTENTS

1. INTRODUCTION

This chapter offers an introduction to the dissertation. It describes the development of a conceptual framework designed to aid caring professionals in their work with refugees (especially traumatized and tortured refugees) and immigrants. The framework is based on over 25 years of the author's experience in the field. The cases on which the framework is based are described in a wide variety of respects.

Leaving one country for another, by will or by force, has gone on throughout the ages. People have fled from persecution, poverty and famine, or have emigrated with a dream of a new and better life for themselves, their family, or any group to which they might belong.

How does such change affect the inner and outer world of the refugee, the immigrant and their children?

Can the experiences of the refugee and immigrant be systematized in a manner that will provide guidelines for therapeutic treatment and support?

Is it possible to evaluate and validate any set of guidelines arrived at?

The primary aim of this dissertation is to attempt to approach an answer to these questions. To do so, it describes a conceptual framework that has been developed and systematized by the author to facilitate understanding of the inner and outer worlds of refugees, traumatized and tortured refugees, immigrants, and their children. The framework has evolved in stages, and is based on the accumulated clinical experience of the author.

A secondary aim is to address the question: "What common and specific problems are faced by refugees and immigrants respectively?"

The purpose of the conceptual framework is to allow psychotherapists and other support workers more efficiently to be able to apply their experience and theoretical knowledge in helping these groups.

The validity of the approach is tested through the process evaluation of a one-year training program, based on the framework, for psychotherapists, mental-health carers and support workers.

THE NEED FOR RESEARCH

The psychological difficulties of the refugee/immigrant have not always been considered or understood, nor are the problems of children born in the new country. Most refugees, immigrants and their children do not seek psychological support before finding themselves in deep or acute crisis.

Those who receive psychotherapy, mental-health care and other support seldom stay on to complete it. The psychotherapist, mental-health carer or support worker then feels inadequate, and the refugee/immigrant dissatisfied. Over the years, the author has met many people working with and trying to support these groups, and also many refugees and immigrants who recognize their need.

Currently, it is of the utmost importance to achieve greater understanding of the outer (economic, cultural, environmental, and social) and inner (specific psychological) difficulties of refugees and immigrants. Broadly speaking, outer difficulties are regarded as being with matters such as adaptation to a new way of life, possibly even simply the climate, inner difficulties with particular psychic states of being, e.g. the experience of being a stranger or loneliness. Many countries that were once largely homogeneous are now more diverse. Accordingly, there is an acute need for clinically based, structured knowledge of the specific psychological and outer difficulties and problems of the refugee and immigrant. Ways of working with these groups in psychotherapy and support work, and in preventive and educational programs, might then be developed accordingly.

Outline of the dissertation

Part I (chapters 3-11) describes and illustrates the conceptual framework. Part II (chapters 12-15) evaluates and discusses the conceptual framework in the light of a training program based upon it.

Part I describes the development and systematization of the conceptual framework, and its background and utilization in individual and family clinical treatment of the refugee, the immigrant and their children. There is a particular emphasis on traumatized and tortured refugees. Each component of the framework is described in a separate chapter and exemplified with excerpts from 69 cases (of men, women and children of different ages, backgrounds and cultures). All cases are drawn from the author's clinical and supervisory work. Documentation for part I comprises written notes and tape-recorded sessions, and oral and written reports (of the author, and of psychotherapists/support workers she has supervised).

Part II is offered as support of the conceptual framework's validity and utility by considering the processes undergone by other clinicians. It consists of a description and evaluation of a year-long specialized program of training, based on the framework, for mental-health and other

support workers. The training program took place 1992-93 in Finland, and was organized by Åbo Akademi University Center for Extension Studies. It involved fifteen participants (from a variety of professions), two supervisors, and several guest lecturers. It consisted of 100 hours of classwork and 70 hours of case supervision. Twenty-two cases were supervised, encompassing work with adults, children, families, and groups. Ten were short or long-term psychotherapies, and twelve supportive casework. Methods of documentation and evaluation included tape-recorded reports and written evaluations of the training, supervision and casework, both during and after their conclusion.

By chapter, the dissertation breaks down as follows. Each chapter is introduced by a brief summary in italics.

Chapter 1 is an introduction to the dissertation.

Chapter 2 describes the experiences of the author and the methodological foundations on which the dissertation is based.

Chapter 3 is an introduction to part 1, the conceptual framework, its background and goals. The terminology used in the dissertation is explained. Relevant studies and literature are recounted, and methods of data collection and documentation presented. The purpose and utilization of the case-study material are clarified.

Chapter 4 explains the concept of the *refugee/immigrant* situation.

Chapter 5 describes the first aspect of the conceptual framework, the *states of being*.

Chapter 6 illustrates the second aspect of the framework, the *adaptation cycle*.

Chapter 7 considers the third aspect of the framework, the *childhood experiences*.

Chapter 8 explains the fourth aspect of the framework, the *relevant background conditions*.

Chapter 9 illustrates the fifth aspect of the framework, the *reason* that the individual or family was forced to flee or chose to migrate to the new country.

Chapter 10 reviews the sixth aspect of the framework, the *transition-related conditions* that can influence the individual or family in the new country.

Chapter 11 summarizes and discusses the results of part I.

Chapter 12 serves as an introduction to part II and to the training program, its background, planning and realization. The goals, methods, documentation and evaluation of the training program are described.

Chapter 13 describes the casework in the training program, and illustrative examples are provided.

Chapter 14 documents evaluations of the training program.

Chapter 15 discusses methodology for the human sciences, and scientific verification and applied research methods, in relation to the evaluation of the framework and the training program.

References and appendices follow.

Casework material

A casework sample is chosen from the entire population from which the framework was derived (see tables 2.1 – 2.3). The selection was made so as well as possible to illustrate the concepts encompassed by the framework, and the ways in which they are utilized.

Cases are numbered by chapter. For example, case number 1 in chapter 4 is denoted as “4.1”, case number 2 as “4.2”, and so on.

2. RESEARCH PLATFORM

This work is based on both practical clinical experience and a specific methodological approach. This brief chapter is divided into three sections. First, it provides an account of the author's personal background and clinical experiences. Second, it presents what is described as a "qualitative-clinical approach" to the analysis of these experiences. Third, it offers background to how experiences of application of the framework are evaluated.

EXPERIENCE AND FAMILIARITY WITH THE PROBLEM AREA

The author has worked as a psychologist/psychotherapist and supervisor with refugees (many traumatized and tortured), immigrants and their children since 1975. She has worked clinically with people from 104 countries all over the world, all of whom have sought asylum or emigrated to Sweden or other parts of Scandinavia (see Appendix 1).

The people receiving therapy or support have been of varying ages, genders, religions and nationalities, and cultural, political, socioeconomic and educational backgrounds. They speak a wide variety of different languages. They have had varying reasons for seeking political, religious, ethnic or racial asylum or entrance, and emigrated at different stages of their life (see table 2.1).

Table 2.1. Refugees (without trauma or torture), traumatized refugees, tortured refugees, and immigrants treated over the years 1975-1998 by type of casework.

Type of casework	Refugees	Traumatized refugees	Tortured refugees	Immigrants	Total
1. Individual	74	132	110	129	445
2. Family	28	40	39	44	151
3. Group	3	5	4	3	15

From 1975 to 1998, the author allotted 920 weeks (approx. 40 weeks a year), and 18,920 hours, to work with refugees and immigrants (treatment or supervision of others). This involved approximately 14,720 sessions in psychotherapy and other modes of treatment and support work; 2,760 hours as an individual and group supervisor; and 1,440 hours acting as an educator of different categories of professionals working in treatment and support work with these groups.

In her clinical practice and supervision, 903 refugees (some traumatized and/or tortured) and immigrants have received treatment –

individually, in families, or in groups. Some were seen on just a few occasions, others on a continuous basis for several months or years. Over 500 persons received treatment for two years or more, usually on the basis of 40 sessions a year. Some had been in their new country for only a few weeks or months, others for many years, while still others had been born in the new country (of refugee or immigrant parents). See table 2.2.

Table 2.2. Casework by type and duration (1975-1998).

Type of casework	Number of persons	No. of sessions	Duration range
1. Individual	445	11,911	1 wk – 5 yrs
2. Family	360 (151 families)	2,145	1 wk – 2 yrs
3. Group	98 (15 groups)	664	6 mths – 2 yrs
In total	903	14,720	1 wk – 5 yrs

The reasons for these persons seeking psychological support have varied widely, ranging from inner emotional and existential conflicts, through individual and family problems, to neurotic and psychotic feelings or states of mind. Most sought, or were referred for, help because of some difficult or crisis situation – either psychological or based on the actual reality they were encountering in their lives, in particular as a refugee or immigrant. The work was carried out both privately and under the auspices of government, municipal and voluntary organizations and institutions in Scandinavia.

A CLINICAL APPROACH

Throughout the development of the framework, a qualitative-clinical approach was employed. Berg Brodén (1992) has defined the term "clinical approach" as follows:

> *'The term "clinical approach" describes a specific research methodology which aims to arrive at a profound understanding of individuals and organizational situations through direct contact and interaction with the subject(s) and through the psychobiographical study of other data pertaining to those individuals (Berg Brodén, 1992, p. 23, author's translation).'*

The conceptual framework presented in this dissertation evolved through the interaction between literature study, empirical research (based on clinical practice), and clinical evaluation. These were the three elements in a parallel process that developed over more than 25 years, and ultimately resulted in the research described here.

Patton (1980) explains that with nominal-scale data, the researcher identifies, codes and categorizes the primary patterns in the data, analyzing the content of the material inductively, so that patterns, themes, and categories emerge from the data rather than being imposed on them prior to collection and analysis. What Patton calls the qualitative synthesis is a way to build theory through description and induction. He states that the purpose of the synthesis is to identify and extrapolate lessons learned, and synthesize these from a number of cases to generate generic factors that contribute to the effectiveness of research (in this context into psychotherapy).

Franke-Wikberg and Lundgren (1979) explain that, following a program's development, its goal is further to understand the ways in which educational programs are effectively built-up.

Evaluation according to a transaction model

A transaction model, as described by Stake (1974, 1978; cf. House, 1980; MacDonald, 1975; Parlett and Hamilton, 1973) was utilized in an attempt to validate the framework. This took place in the form of an evaluation of a training program of which the framework formed the core. House describes the transaction model as follows:

> *'A transaction model concentrates on the educational (or program) processes themselves… . It uses various informal methods of investigation and has been drawn increasingly to the case study as the major methodology' (House, 1978:5, cited in Patton, 1980, pp. 118-119).*

Evaluation of the training program adheres to a theory-directed design as described by Franke-Wikberg and Lundgren (1979):

> *'The purpose of theory-directed evaluations is to know what occurs during an educational program… . Theory-directed evaluations are directed at critically describing and explaining what occurs during an educational program' (author's translation from Franke-Wikberg and Lundgren, 1979, pp. 147-148).*

In this dissertation a case-study approach to evaluation is adopted. House (1980) maintains that such an approach is one of the most promising and worth developing. If it is credible to its intended audience, a well-constructed case study is a most powerful evaluation tool. It allows the representation of diverse views in complex situations. In this sense, it can be

one of the most democratic approaches. On the other hand, it entails a distinctive set of problems of its own. Portraying events so personally results in problems of confidentiality, fairness and justice. In the presentation of cases, to protect individuals and ensure confidentiality and anonymity, certain ancillary information has been altered in or omitted from the case histories, and composites made of some of them. A related issue is whether an evaluator should make explicit recommendations on the basis of such a study, or whether this should be reserved for the reader; i.e. the evaluator should draw no conclusions of his/her own. House contends that either position is permissible, and that which is preferable depends on the audience. The latter position is adopted here.

Part II of this dissertation describes use of the framework in practical terms. It depicts and evaluates a year-long training program based on the framework for psychotherapists, psychoanalysts and support workers. It describes how the framework is applied in different types of treatment, and taught to a group of people in various professions and with differing clinical experience. A transaction model is applied in this process assessment, since quantitative outcomes are difficult, if not impossible, to achieve in this area of research (Stake, 1974, 1978; cf. MacDonald, 1975; Parlett and Hamilton, 1973). House describes it as follows:

> *'This approach concentrates on the program processes themselves and on how people view the program. The major question asked is, "What does the program look like to various people who are familiar with it?"... The qualitative case study is so prevalent as a methodology that I have used this term, along with "transaction", to refer to the approach. ...*
>
> *The aim of the approach is to improve the understanding of the reader or audience of the evaluation, primarily by showing them how others perceive the program being evaluated. ...' (House, 1980, pp. 39-40).*

Following presentation of the conceptual framework and the evaluation of the training program based upon it, issues of methodology are further considered in the concluding chapter (chapter 15).

PART I – A CONCEPTUAL FRAMEWORK

Part I describes a theoretical framework for practical application in psychotherapeutic and related support work of the refugee, the traumatized and/or tortured refugee, immigrant and their children; its background, and the key dimensions in its formulation; its practical application, areas of utilization and goals. Each component of the framework is explained and illustrated with three cases. Part I concludes with a discussion in relation to 1) conceptualization and formulation of the framework; 2) and cases selected to describe and illustrate each component and its practical application.

3. INTRODUCTION TO THE CONCEPTUAL FRAMEWORK

This chapter consists in an introduction to the conceptual framework – its background, and the key dimensions in its formulation and utilization. An overview of relevant literature is presented, and definitions of terminology are provided. Modes of data collection and documentation are described.

From reports in the case-study material and in the literature that will be presented, it appears that the refugee and the immigrant – whether child, adolescent or adult – living in a new country, enters into a process of questioning prompted by the changes he/she is experiencing. Such questioning applies to both simple and complicated aspects of life and behavior, from how to adapt to a different climate to understanding the inner workings of a new society and culture. Regardless of homeland or the reason why the individual migrated or sought refuge, the questioning seems to begin. It begins irrespective of sex or age, color or ethnicity, or of landscape, environment, culture and religion of origin. Whatever the person's language or education, socioeconomic or political background or what he/she has endured, a process seems to begin of inwardly and outwardly questioning new circumstances. This may be done consciously or unconsciously, and may or may not find explicit expression.

The refugee/immigrant seems to live between two worlds. He/she has changed countries and cultures. The language and customs are different. Values, religions and moral codes, even modes of thinking, may differ. He/she may have a different appearance than inhabitants of the new country. Within the individual, a process seems to begin of comparing homeland childhood and adult experiences with those of the new country. He/she seems to be forced to see, remember, question and compare the old with the new. A long, difficult and sometimes painful psychological process of questioning oneself and one's life, life style and values begins, which may be experienced differently. This conscious or unconscious state of questioning can lead to positive development and change, and integration of the two worlds. However, if the worlds cannot be combined, it can lead to an identity ridden by conflict and incongruity.

The framework presented here suggests a way of looking at and gaining insight into the world of the individual within this process. It offers a method for structuring and systematizing the inner and outer worlds of the refugee, the traumatized/tortured refugee or immigrant by considering his/her past life experiences in the homeland, present ones in the new country, and how the combination of the two may influence his/her current symptoms or problems (see figure 3.1).

The framework

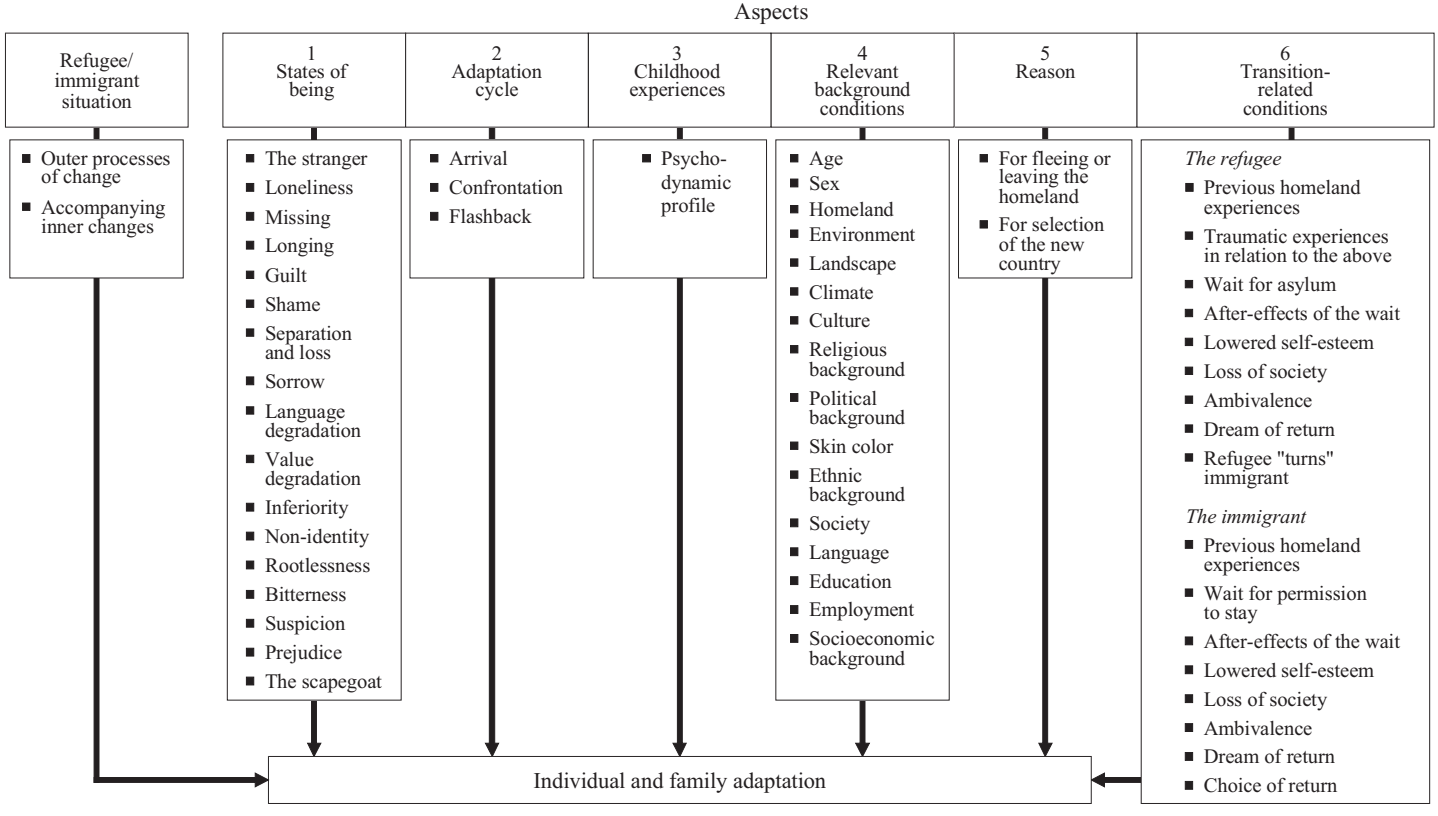

Figure 3.1. A schematic model, derived from extensive clinical experience, for understanding the refugee/immigrant and for application in psychotherapy and support work.

The fundamental difference between the refugee and the immigrant is that the refugee was forced to, while the immigrant chose to, leave the homeland. Clearly, there are differences between the situations of the refugee and immigrant (as pointed out throughout this dissertation), but the distinction between the two categories is not as clear-cut as might be initially supposed. For example, within refugee families, there may be adults or children who came to the new country because of other members of the family, and were not themselves forced to flee the homeland. Children and adolescents of refugees/immigrants can be born and/or raised in the homeland or the new country. The inner consequences of these essential distinctions are pointed out throughout this dissertation.

Identification of significant key dimensions

The key dimensions of the framework became gradually apparent, and were formulated in stages, over the author's years of clinical work, supervision and training, related to the refugee (including the traumatized and/or tortured refugee), the immigrant, and their children. An overview of the framework is provided in figure 3.1.

The framework consists of a number of significant key dimensions defined in terms of the *refugee/immigrant situation* and six *aspects.* The aspects are: 1. the *states of being*; 2. the *adaptation cycle;* 3. *childhood experiences*; 4. *relevant background conditions;* 5. the *reason* the individual/family sought asylum or immigrated; 6. and *transition-related conditions*. Each aspect has several components, and each component of any particular aspect describes a different factor. The aspects and their components have inner and outer consequences for the *refugee/immigrant situation*, and the individual's life situation. One or all of these may cause, influence or complicate inner and outer difficulties, and the ways in which problems, conflicts, life crises or life changes are endured and handled in the new country. The *refugee/immigrant situation* and the aspects of the framework influence the individual's and family's adaptation to and social circumstances in the new country.

Development of the conceptual framework

The conceptual framework developed in interaction between clinical work and study of literature on the refugee and immigrant. The author's experiences found echoes in the works of many writers, both past and present. Accordingly, the aspects of the framework and the relevant

literature are presented in tandem. In the early 1970s, when the framework began to be formulated, large numbers (at least by historical standards) of both refugees and immigrants were entering Scandinavia. Refugees from many parts of the world were fleeing from political and religious oppression. Immigrants sought improved employment opportunities.

When persons from these groups were in need of treatment for various symptoms and difficulties, most professionals working in mental health and providing support services did not realize, nor consider, the differences there might be between refugees, immigrants and the majority population with regard to the causes of and reasons for their symptoms and difficulties. The key dimensions of the framework focus on these differences, but also on similarities between people. It seemed essential that the clinician and support worker learned to consider these key dimensions in order better to understand how they caused, influenced or complicated the symptoms and problems for which the refugee/immigrant and/or family sought assistance.

For example, the outer changes that the refugee/immigrant had gone through in coming to the new country and in what ways he/she may have been influenced by these, were not usually considered. The term, the *refugee/immigrant situation*, was constructed by the author to highlight these outer changes and the inner ones by which they may have been accompanied. It highlights the two in combination. Outer changes include such variables as climate, landscape, environment, culture, ethnic/racial differences, religion, language, employment, politics, society, socioeconomic conditions, education and the way the new country functions.

At the same time as the concept of the *refugee/immigrant situation* was formulated, it became apparent that many refugees, immigrants and their children were in one or several commonly occurring states of mind (which anyone can go through, but seemed to be more prevalent among them). The term, *states of being,* the first aspect of the framework, was formulated to illustrate seventeen such conditions: feeling like *a stranger, loneliness, missing, longing, guilt, shame, separation and loss, sorrow, language degradation, value degradation, inferiority,* a sense of *non-identity, rootlessness, bitterness, suspicion, prejudice – to be prejudiced, to feel prejudice,* and *the scapegoat syndrome – to be the scapegoat, to feel like the scapegoat.*

Adaptation to a new country is unique to each individual and family. At the start of the author's clinical work, this dimension of the refugee/immigrant's life-situation was investigated, despite it not being considered in most of the treatment and support work offered to these groups. The second aspect, the *adaptation cycle,* was inserted into the framework to emphasize this process and its difficulties. It considers the length of time the individual/family has been in the new country and how he/she and the family have adapted to it.

From the start of its formulation, the third aspect, *childhood experiences*, was a key dimension. The early experiences of an individual have proved to be of great significance in the comprehension of human behavior. These experiences are common, but take on a form that is unique to each one of us.

As the framework evolved, it became apparent that there were many other background variables that had to be considered in order to understand the full range of influences on presented symptoms and problems. The fourth aspect, *relevant background conditions*, includes such components as age on arrival in the new country and now, gender and gender roles, country of origin, environment, climate, landscape, and cultural, racial/ethnic, political, educational and socioeconomic factors in the home country and in the new one.

Early in the formulation of the framework, it was noticed that the *reason* an individual/family seeks asylum or emigrates to another country, and how and why the new country was selected (or not), influences the *refugee/immigrant situation* and the four aspects; and even the current symptoms and problems. A fifth aspect, the *reason*, became an important dimension to include.

The final key dimension, the sixth aspect of the framework – defined as *transition-related conditions,* was formulated to highlight the necessity of considering several significant components of the life of the refugee, the immigrant, and their children. There are many *transition-related conditions*, but they break down into three categories:

- *Previous homeland experiences* of oppression and violence – atrocities of war; the loss, death and/or disappearance of family, friends, colleagues; imprisonment and torture; loss of possessions; catastrophes of nature.

- *Traumatic experiences* in relation to any of these homeland experiences.
- *Experiences in the new country* – waiting for permission to stay; loss of society and political or religious place within it; lowered self-esteem; ambivalence to the new country; dream of returning to the homeland; refugee turning immigrant when the situation changes in the homeland and he/she can return without risk; the choice of returning to the homeland.

Any one factor may cause, influence or complicate symptoms and problems.

Suggested applications of the conceptual framework

When the framework is applied in work with the refugee or immigrant child/adolescent and parents, their difficulties can be systematized, so that the most severe ones obstructing development and well-being are more effectively dealt with. When applied in treatment and support work, the framework seemed to facilitate treatment and improve treatment outcome.

The *refugee/immigrant situation* and the aspects allow most essential parts of past and present life experiences to be studied systematically. Mapping out each part of the framework in relation to the individual facilitated understanding of the life experiences that may have caused, influenced or complicated current symptoms and problems.

For example, the ways in which the *refugee/immigrant situation* has influenced the individual in the new country may relate to why the individual/family sought help. Each *state of being* may be affected by the *refugee/immigrant situation* and the other aspects, such as the *adaptation cycle,* the *reason* or any of the components within *transition-related conditions.* Similarly, the individual's *childhood experiences* and the *adaptation cycle* may affect the ways he/she deals with the *states of being* (such as feeling like *the stranger*, *loneliness*, and *inferiority*). Each *relevant background condition*, e.g. age on arrival in the new country or ethnic and political background, can impact on the *refugee/immigrant situation,* the *states of being* and the *adaptation cycle* and complicate present symptoms and problems. The *reason* may affect the *refugee/immigrant situation,* the *states of being,* and the *adaptation cycle*. *Transition-related conditions*, such as previous homeland experiences of oppression and violence, may influence the *refugee/immigrant situation,*

the *states of being,* and the *adaptation cycle.* The framework and the inter-relations between its components is thoroughly investigated. Its most significant parts become known, especially those that may relate to the current problem. This enables the problem to be worked through more efficiently.

It should be possible to integrate the framework into different methods of individual, family and group therapies, into short or long-term psychotherapy, psychoanalysis and support work, and into play, art and drama therapies. It may also be utilizable on a larger scale in institutions and out in society for the setting up of preventive, curative and educational programs.

The framework was constructed primarily for utilization in treatment and support work with refugees (including traumatic and/or tortured refugees), immigrants and their children. However, it can also be applied to individuals who do not stem from these backgrounds, e.g. those who have moved from one area to another within their native country; those who have made significant outer changes within their country; or those who have lived or worked in another country for a lengthy period of time and then returned to their native country.

The *refugee/immigrant situation* considers outer processes of change and accompanying inner changes. Many of these changes can also occur within a country. The *states of being* are conditions that anyone can experience. The *adaptation cycle* can be utilized to study the individual who has changed areas and life styles within a country. *Childhood experiences* are, of course, applicable to all. The components of the fourth aspect, *relevant background conditions*, can be studied to aid comprehension of certain native inhabitants, e.g. with regard to racial/ethnic origins, or change in dialect, environment, and religious or socioeconomic background. The *reason* a person moves voluntarily or is forced to leave one area of the country to live in another, or leave the homeland and return to it, can also be considered. Several components of the final aspect, *transition-related conditions*, are also relevant to these other groups, e.g. previous home area experiences, traumas in relation to these, ambivalence to the new area of the native country, and the dream of and/or choice of return to the home environment.

Intended aims and functions of the framework

Practical application of the conceptual framework in psychotherapy and related support work is intended to facilitate attainment of the following goals:

- The refugee/immigrant – adult, child, adolescent – is enabled to accept him/herself and his/her cultural, religious and ethnic identity in the new country.
- The refugee/immigrant – adult, child or adolescent – is enabled to live a satisfying and fulfilling life in the new country, despite adverse homeland experiences (endured by him/her or any members of the family).
- The refugee/immigrant – adult, child or adolescent – is, if he/she wants to, enabled to reject the attitudes, customs, values, religion and life style of the new country that he/she disapproves of or cannot accept or integrate within him/herself.
- The refugee/immigrant – adult, child or adolescent – is enabled to free him/herself, if he/she wants to, from the attitudes, customs, values, religion and life style of the homeland and culture.
- The refugee/immigrant – adult, child or adolescent – is enabled to integrate past and present cultures, languages, attitudes, customs, values and life styles into a harmonic whole and a broader identity that encompasses both the past and present.

Relevant studies and literature

Migration and exile and their consequences have been studied extensively throughout the century. Sociologists, historians and anthropologists have all conducted prominent investigations in the arena. However, at the start of the formulation of the framework, there were few systematic research studies in the fields of psychology and psychiatry concerned with the specific inner difficulties of the refugee, the traumatized and/or tortured refugee, the immigrant, and their children. There follows an illustrative review of the literature most relevant to the development of the framework. The general principle for inclusion in the review is that a work bears upon one or several components and/or aspects of the conceptual framework as it developed, and how it came to be applied to psychotherapeutic and related support work with adults, adolescents and children.

First, some examples of important studies in the fields of sociology, anthropology and philosophy are presented, followed by literature in the fields of psychiatry and psychology.

Definitions of the refugee, the traumatized and/or tortured refugee, and the immigrant and their children are provided before undertaking an illustrative review of the specific literature that applies to them.

Several specific studies of the refugee and immigrant are discussed, including those concerned with mental disorders and cultural conflicts. Various aspects of migration and exile are considered. Mental-health issues concerning both adults and children, particularly related to the conceptual framework, including those concerned with torture and trauma, are discussed. Some examples of the relevant literature on individual and group psychotherapy and support work with these groups are reviewed. Recent significant literature, published after construction of the framework, is also reviewed.

Studies in the fields of sociology, anthropology and philosophy

A number of studies in the fields of sociology, anthropology and philosophy, which appeared to be important in the psychology of the refugee and immigrant, bear upon the components and aspects of the framework. Here follows a few illustrative examples.

Basic view of the framework

The basic philosophical view of the framework was conceptualized from the ideas and the studies of many writers. Tillich (1972), for example, spoke of the "courage to be" (p. 2) in the face of anxiety, despair, longing – the trials and dilemmas of being human. He believed it necessary for the individual to learn to live constructively "in spite of" (p. 4) the trials and tribulations of life. The goal of psychotherapeutic and support work with the framework is to attempt to create an atmosphere where the refugee or immigrant finds that he/she can share past homeland experiences, to be able finally to learn to accept these experiences as part of his/her life, and to be able to continue to live on "in spite of" them. At the same time, he/she is also encouraged to encounter and overcome the problems of life in the new country "in spite of" its complications. Up to the present, in the treatment and care of these groups, Tillich's position still appears to be the most relevant.

Common human conditions become states of being

In clinical work, certain general human conditions, such as loneliness, missing, longing, sorrow and feeling like a stranger or outsider, are repeatedly expressed by refugees and immigrants, regardless of their homelands, ages, genders or backgrounds. At times, these common human conditions appear to become states of mind or "states of being". The person's existence in the new country and his/her psychological and other difficulties appear to be dominated by these specific human conditions or states. Over the years, many writers have discussed common or universal states of mind.

Heidegger (1949) formulated and elucidated the expression "Dasein" (p. 12), that of "being-in-the-world" (p. 26). May (1983) referred to "Dasein as the essential attribute of the person who 'is there' "(pp. 96-97), who is conscious of and therefore responsible for his existence. These philosophical ideas influenced the conceptualization of the *states of being*, the first aspect of the framework.

Each *state of being* has, at least in part, roots in the literature of one discipline or another (see below). For example, Wilson's (1956) study of the personality of the outsider in society described this person as feeling alienated, alone and unable to feel as if he/she is a participant in society. Wilson's research offers an example of the studies that led to the conceptualization of the *state of being: the stranger.*

As early as in 1872, Darwin postulated the universality of emotional expression. More recently, Ekman and his colleagues (1972, 1982; Ekman and Friesen, 1975; Ekman et al., 1987) studied the ways in which facial expression convey emotions, such as surprise, fear, anger, disgust, happiness, and sadness. Ekman and others, in support of Darwin's early theory, have also shown that members of very different cultural groups demonstrate consistency in associating facial expressions with emotions (Deaux et al., 1993, p. 122). These recent studies seem to confirm the view expressed in this dissertation that there are certain specific human conditions.

Social identity

In clinical and support work, it became apparent that the social identity of the refugee, immigrant and their children seems to influence their psychological difficulties. During the formation of the framework, several studies suggested that social identity can affect the individual's

well-being. Cooley (1902) and Mead (1934) were among the first to recognize the self as a product of social interaction and that we see ourselves as others see us. Cooley used the terms "self-concept" and the "looking-glass self" to convey the idea that self-concepts reflect the evaluations of other people in the environment. Jenkins (1996) presented sociological and social anthropological approaches to social identity and argued that this key concept should be seen as both individual and collective. Jenkin's view, and those of others investigating this concept, are incorporated within the framework. The individual's/family's social identities in the country of origin, and also in the new one, are taken into consideration within several aspects of the framework: the *states of being*; the *adaptation cycle*; *relevant background conditions*; the *reason*; and *transition-related conditions.*

Culture

When a carer has knowledge of the refugee's and/or immigrant's culture, it appears to facilitate their treatment and care. Early in the formulation of the framework, the literature on culture was reviewed. There are many and diverse definitions of culture. For some researchers, culture consists of the values, motives, and moral/ethical rules and meanings that form part of a social system. For others, culture comprises not only values and ideas, but the complete set of institutions within which humans live. Some perceive culture as consisting of learned ways of thinking and behaving, while others emphasize genetic influences on the repertory of cultural traits. Finally, some researchers see culture as consisting exclusively of thoughts or ideas, while others maintain that culture consists of thoughts and ideas, plus associated activities (Harris, 1999). Durham (1991), along with a majority of contemporary anthropologists, insists that a distinction must be drawn between culture and human behavior. Culture consists exclusively of shared and socially transmitted ideational or mental entities, such as values, ideas, beliefs and the like "in the minds of human beings" (op. cit., p. 3). Culture is "the fabric of meaning in terms of which human beings interpret their experience and guide their action" (Geertz, 1973, pp. 144-5). However, Harris's own view "that a culture is the socially learned ways of living found in human societies and that it embraces all aspects of social life, including both thought and behavior" (1999, p. 19) reflects the definition of culture used in this dissertation. In the development of the framework, culture became a component of its fourth aspect, *relevant background conditions.*

Culture change

In clinical and support work, it became apparent that a change in culture could cause psychological dissonance within the adult and child. Mead (1947), in an anthropological study, discussed the implications of culture change for personality development, and suggested that the migrant is a culturally disoriented person, subject to special strains that intensify psychic conflicts. At the same time, he/she is bereft of the cultural means for reducing these tensions. In clinical work with refugees and immigrants, Mead's observations seem to coincide with the reality expressed by persons forced to flee to, and/or to reside in, a new culture. Cultural disorientation appears to be temporary, but is sometimes permanently experienced by each individual, of different ages, in unique and specific ways during different times in his/her life in the new country. Cultural disorientation also seems to complicate and intensify other psychological conflicts. Through the years, and up to the present, in the specific studies of refugees and immigrants reviewed later on in this chapter, and also, in clinical work with these groups, Mead's research findings tend to be reaffirmed. Culture change became an important factor to consider in the use of the framework in psychotherapy and related support work with these groups. Besides being a component of the *relevant background conditions,* culture change is also considered in the *refugee/immigrant situation,* the *adaptation cycle,* and in several components of the *states of being*, and *transition-related conditions.*

Cultural and ethnic identity

Several sociological studies appear to confirm the importance of considering and respecting the cultural and ethnic background of the individual/family in psychotherapeutic and support work. Novak (1971), for example, investigated what he called "unmeltable ethnics" (p. 2) in the United States, i.e. the persistence of ethnic patterns in white groups and their social, economic, psychological and philosophical consequences. He concluded that in order to create tolerance and avoid resentment and conflict between different ethnic groups, it is of utmost importance to understand and respect individual and group ethnic identity.

More recently, Jenkins (1997) discussed the cultural content of ethnicity, and concluded that culture is a significant construct in understanding ethnic identification. However, Barth (1994) and Hughes (1994) concluded that cultural traits do not constitute ethnic difference. In

contrast, however, Cornell (1996) and Handelman (1977), argued that in considering ethnic identification, the cultural aspect is not irrelevant. In this dissertation, the view of Jenkins is adopted: "Our culture – language, non-verbals, dress, food, the structure of space, etc. – as we encounter it and live it during socialization and subsequently, is for us simply something that is. When identity is problematized during interaction across the boundary, we have to make explicit – to ourselves every bit as much as to others – that which we have hitherto known without knowing about" (Jenkins, 1997, pp. 76-77).

These, and other similar studies, have led to and seemed to confirm the importance of the inclusion of cultural and ethnic background as components of the fourth aspect of the framework, *relevant background conditions.*

Language

Difficulties with the new language and its consequences in complicating the problems of the refugee and immigrant became apparent in clinical work and led to the study of the literature on language. To illustrate, Henle (1972) surveyed several studies of the ways in which language and its use influence thought and culture, and concluded that – on conscious and unconscious levels – it has affects on both. Condon and Fathi (1975) analyzed verbal and non-verbal interpersonal communication between cultures, and concluded that a human complex, based on many variables – such as values and background – must always be considered. The linguist, Searle (1965) proposed five general items that people intend to convey through their language: (1) to describe something, (2) to influence someone, (3) to express feelings and attitudes, (4) to make a commitment, and (5) to accomplish something directly. To accomplish any task, people rely on a variety of implicit rules and agreements that are shared in the society – a common ground. Participants must share certain beliefs and suppositions that will enable them to coordinate their communicative efforts (Deaux et al., 1993, p. 118).

These studies and others on the effects of language on the individual and his/her family were utilized to define and formulate specific factors to consider as to the individual's language of origin and his/her second language. These factors are considered in several aspects and components of the framework, including the *refugee/immigrant situation,* the *states of*

being – especially, *language degradation*, the *adaptation cycle*, *childhood experiences, relevant background conditions*, and *transition-related conditions.*

Psychiatry and psychology

General theories and the framework

The conceptualization and construction of the framework were inspired by the theories of numerous psychologists and psychoanalysts. The account presented here was chosen to focus on several of the specific theories used, and which may be of significance in furthering psychological understanding of the refugee/immigrant.

The basic clinical viewpoint of the framework was formed to allow the carer to be able to guide the refugee/immigrant to accept and to learn to live a constructive life for him/herself and others in spite of the painful, sometimes horrendous, past experiences, he/she has endured, and even to be able to further develop as an individual because of these experiences. The following examples illustrate some of the writings which influenced this point of view. Frankl (1959, 1963, 1976) was the originator of logotherapy, an existential psychotherapy that stresses man's capacity to transcend suffering and find meaning in life. Bettelheim (1960) studied concentration-camp victims and survivors, and came to the conclusion that the people who were best able to survive horrendous situations were those with a core identity and set of beliefs. May (1967, 1969, 1972, 1977), throughout his writings on psychology and psychotherapy, emphasizes the opportunity for an individual to use the inner pain that he/she experiences in constructive ways.

One of the purposes of the framework is more effectively to be able to identify the circumstances that have caused suffering to the refugee/immigrant – so that he/she can work these through, and be able to utilize past experiences in constructive ways for both him/herself and others. The aspects and components of the framework were in part inspired by these illustrative examples.

The first aspect of the framework, especially the *states of being*, *inferiority, separation and loss* and *language degradation,* has been influenced not only by the writers above, but also the following illustrative studies.

Adler (1927) discussed sadness and sorrow as an affect occurring when one cannot console oneself over a loss or deprivation. He stated that

feelings of inferiority, inadequacy and insecurity determine the goals of an individual's existence. The degree and quality of the social feeling helps to determine the "goal of dominance" (p. 25). Bibring (1953) examined the mechanism of depression and discusses separation and loss as a component of it. So too does Bowlby (1969, 1973, 1980), who pointed out that separation and loss are also causes of anxiety, anger and sadness. Greenson (1950) studied the mother tongue and the mother, and Erikson (1950) the process and consequences of growing up in a variety of cultural and social settings. All these studies had an indirect influence on conceptualization of the *states of being,* and the *refugee/immigration situation*.

The framework is primarily based on a psychoanalytic view of the human being. The third aspect considers *childhood experiences*. In the formulation of this aspect, the works of Freud (1917) were obviously important. But many others have stressed the significance of early childhood experiences to the personality of the individual (among them Bibring, 1953; Bowlby, 1969, 1973; Erikson, 1950, 1968; Fairbairn, 1943; Fenichel, 1946; Fromm, 1959, 1973; Jung, 1917; Kernberg, 1972, 1976, 1984; Klein, 1932; Kohut, 1977; Mahler et al., 1975; Mitchell and Black, 1995; Piaget, 1929; Sullivan, 1953; Winnicott, 1958, 1965, 1971).

For the framework's development in treatment, besides the aforementioned general studies, particular attention was paid to the following: the work of Jacobson (1943), and her studies of depression and the effect of disappointment on ego and superego formation (1964, 1971); Guntrip's (1961) studies of personality structure and human interaction; Laing's (1961) writings about the self and others; Searle's (1965) collected papers on schizophrenia; McDougall's (1969, 1989) examinations of the mind and body; Kernberg's (1976) object-relations theory; Blanck and Blanck (1974) and their study of object-relation psychology; the works of Kohut, especially his examination of the restoration of the self (1977); Bollas's (1987, 1989) analyses of the shadow of the object and the forces of destiny in psychoanalysis and psychotherapy; and Cullberg's (1990) description of crisis and development.

More recently, studies such as those of McWilliams (1994) confirmed the effectiveness of the psychoanalytic view and modes of treatment. However, Bucci's (1997) psychoanalysis and cognitive science, and

Ryle's (1997) presentation of cognitive-analytic therapy argue that the psychoanalytic point of view can well be combined with cognitive psychology for more effective treatment and care of the individual/family. The framework presented in this dissertation was designed to be utilized in all modes of treatment and care. At present, it is even being utilized in cognitive-analytic therapy.

Studies of childhood and adolescence

As well as by the aforementioned theories and studies the formulation of the framework was influenced by the following authors and others with regard to its view on children and adolescence. Klein's (1932) research into the psychoanalysis of children and the writings of Anna Freud (1937, 1965) were particularly influential in the conceptualization and utilization of the components and aspects of the framework in regard to children. The latter's study, performed with Burlingham (1943), of war and children was used in the formation of the components of the sixth aspect, *transition-related conditions,* in particular, previous homeland experiences; and traumatic experiences in relation to these.

Erikson (1950, 1968) studied the influence of society and culture, and various religious and economic factors on the child's and youth's personality and identity. He stressed that a broad range of factors must be considered and understood. Several of the components of the fourth aspect of the framework, *relevant background conditions,* were structured along the lines of Erikson's theories. More specifically, Piaget and Weil (1951) discussed the development in children of the idea of the homeland and of relations with other countries.

Several studies influenced the view on adolescence presented in the framework. Particularly important were Jacobson's (1961) study of adolescent moods, Blos's (1962) psychoanalytical interpretation of these years, Masterson's (1967) study of the psychiatric dilemma of this phase of life, Offer's study (1973) of the psychological world of the teenager, and Esman's (1975) studies of adolescence, and Coles's (1964, 1986a, 1986b) examinations of the dilemmas of children in society and how they are influenced by childhood experiences in building up moral and political attitudes. He analyzed by interview and questionnaire how children in grade schools across the United States are influenced by family, religion, culture and other factors, and concluded that a person's basic moral and political attitudes are formed during the first decade of

childhood. Sylvander (1982) examined the identity development of adolescents in the risk zone and the reasons why youths can become destructive to themselves and others. She described the specific difficulties of refugee and immigrant youth through a presentation and discussion of the components and aspects of the presented framework. Sylvander concluded, in accord with the view of this dissertation, that youths from these groups must be able to choose, and finally to be able to integrate, the values and life-styles of both cultures in their own identity. If they are not allowed to, or cannot do this, they can remain in the risk zone.

Family and couple studies

The framework appears to have a specific application in family and couple therapy and support work. Several aspects of the framework were strongly influenced by Ackerman's (1958) study of the psychodynamics of family life, Haley and Hoffman's (1967) outline of practical technics in family therapy, Luthman and Kirschenbaum's (1974) study of the family's dynamic aspects, Richter's (1974) examination of the family in treatment, and – in particular – by the work of Minuchin et al. (1967) with families of the slums (who were often of refugee/immigrant background). The structure and treatment of these families were analyzed, and it was concluded that new approaches and strategies must be tried. Minuchin and Fishman introduced their concept of family-therapy technics in 1981. The concept of family therapy seems to be more effective when utilized within the framework. It becomes possible to systematize each family member's background and present problems, and also the ones that therapists should prioritize to alleviate the family's difficulties. The modes of treatment and evaluation of marital conflict presented by Guerin et al. (1987) were utilized within the framework and seem to facilitate therapists' work.

Only in recent years have the social and political contexts of family therapy been discussed. Mirkin (1990) concluded that social and political contexts must be considered in the treatment and care of the family, which is also the view presented in this dissertation. Also, the subject of rape of women and men (in wars and conflicts) and its effects has only currently been openly discussed and researched. The need is most significant for developing models of treatment in family and individual therapy for rape victims. Cwik (1996) discussed the effects of rape on the victim, his/her family and significant others, and offered suggestions for a family therapy that could be integrated into the various family-therapy models. Cwik

explored the myths about and reactions to and treatment of trauma due to rape, the need for social support of rape victims and their families and significant others, and the implications for family therapists. Cwik's suggestions for family therapy for rape victims has been woven into the supervision and training of the framework.

Ruszczynski (1993) reported on various theoretical approaches being used in couple and family psychotherapy at the Tavistock Institute of Marital Studies. However, the common elements of the different approaches are stressed. These include: transference and counter-transference; the importance of the unconscious mind in determining current experiences and behavior; the importance of object-relationships both from the past and in the present; the use of current opportunities and relationships to re-work problems unresolved from the past, and the view that marriage is an arena where these phenomena are experienced and can or must be worked on. These, more recent and adapted couple and family psychotherapeutic techniques, applied with the carer's knowledge of the framework, appear to be most effective. This also seems to be confirmed in the framework's application to the more recent family-therapy concepts and methods presented by Nichols and Schwartz (1995). Ryle (1997) described the application of cognitive-analytic therapy (CAT) to work with couples and presented a Procedure Sequence Model (PSM) "which emphazises how the sequence is constituted of inner mental events, of anticipations, of acts and of the perception of the consequences of acts. In describing the interaction between a couple one is identifying the interlocking of two sets of role procedures (in psychoanalytic terms, identifying the mutual projective identifications)" (p.177). Ryle concluded that the application of CAT to work with couples involved a straightforward extension of its underlying principles and methods.

Self-concept and identity

Early in the evolution of the framework, it became apparent in clinical and support work with the refugee, the immigrant and their children that there seemed to be a relationship between self-concept, identity and well-being. A confused self-concept and dissonant identity were often reported. Psychological difficulties appeared to become complicated by the various facets of the person's self-concept, and also individual and group identity specific to the process of migration and exile. It seemed important to

understand and to consider the reasons for these incongruences and how the individual's self-concept and identity complicated his/her psychological difficulties. James (1890) for example, believed that any reference to one's self affects one's sense of well-being and self-worth. He also believed that self-concept is very much a social experience, and described the identity-threatening consequences that we would suffer if our relationships with other people were greatly changed or eliminated. Deaux et al. (1993) contended that most contemporary psychologists agree that the self includes many elements, and that almost any experience can affect our self-concept. Proshansky (1978) and, with colleagues Fabian and Kaminoff (Proshansky et al., 1983), proposed that part of one's sense of self includes physical environments that have meaning for each of us – home, neighborhood, and workplace, etc.

Cognitive psychologists, such as Markus and Zajonc (1985), describe mental representation as how an event or an experience is represented in the mind. A schema is an organized body of knowledge about past experiences that is used to interpret present ones. From a social-cognition perspective, Kihlström and Kantor (1984) recognized the self-concept as one of many types of cognitive structure. Markus (1977) defined self-schematas as "cognitive generalizations about the self, derived from experience, that organize and guide the processing of self-related information contained in the individual's social experiences" (p. 64). In 1986, Markus and Nurius used the term "working self-concept" (p. 954) to denote the specific aspects of one's identity that are activated by the role one is playing at any particular moment.

These studies seemed to relate to the experiences of self-concepts of refugees and immigrants, and their children, which they then conveyed in clinical and support work. Assessment and treatment of the individual/family became more effective following consideration of the individual's/family's self-concept alongside the aspects of the framework.

Tajfel (1978, 1981) submitted a theory of social identity, and (in 1982) contended that belonging to the group becomes a salient characteristic of our self-concept. The individual's/family's experiences of group identity was converted to clinical work and utilized in the formulation and application of the aspects of the framework. Tyler et al. (1999) studied the research on the psychology of the social self and explained that the desire to enhance the social self motivates people's attitudes and behaviors in intergroup situations. People want to maximize the value of the groups to

which they belong because that value influences their social selves. The social self, in turn, influences feelings of self-worth and self-esteem.

Consideration of the individual and group identity of the individual is included in several aspects of the framework as a prerequisite for a fuller understanding of the person or family. Identity, or feeling the lack of it, is one of the *states of being* and is considered in the second and third aspects, the *adaptation cycle* and *childhood experiences.* The fourth aspect, *relevant background conditions* considers several components that may cause identity confusion.

Trauma and torture

The framework is designed to be particularly applicable to treatment and support work with the individual and family that has experienced trauma or torture. From the pioneers of psychoanalytic and psychological thought, there is comparatively little literature on the effects of trauma and torture caused by external violence. However, through the conception and development of the framework, the works of many of these have been studied – and somewhat amended – to relate to trauma and torture caused by organized violence. Key items include Freud's writings in general, and his analysis of repression (1915) and mourning and melancholia (1917); the work of Jacobson, in general, and on the self and the object world (1964); Fairbairn's (1943) studies of repression; Klein's work, especially (1948) on anxiety and guilt; Bowlby's writings (1969, 1973, 1980) on attachment, separation and loss; Kernberg's (1975) account of borderline conditions and pathological narcissism, and in 1979, his examination of the internal world and external reality; Miller's (1983) study of cruelty in child-rearing and the roots of violence; and Winnicott's writings, especially his examinations of playing and reality (1971) and human nature (1988).

One of the purposes of the framework is to make the carer aware of the effects of trauma/torture on the individual/family and his/her collective and enable understanding of how these may complicate presented difficulties. This is considered in several aspects and components of the framework, and was influenced by Bettelheim's (1943) study of individual and mass behavior in extreme situations, Reich's (1946) study of fascism, Bion's writings (1961) on group behavior, and Fromm's (1973) study of the anatomy of human destructiveness.

The framework's approach to treatment of torture and trauma survivors was built up though the years with the afore-mentioned authors in mind, and

also Frankl's (1959) approach to existentialism and its use in clinical work, and Casement's (1982) paper on the analyst's role in working with trauma. From a psychoanalytic perspective, Krystal's (1988) analysis of psychic trauma and its consequences on developmental, dynamic, biological and clinical dimensions were extremely important. He compiled an extensive review of the key contributions in the area and reported his own experiences with 1, 000 survivors of Nazi persecution. He established the significance of the concept of psychic reality to the psychoanalytic understanding of trauma, and also various ways of dealing therapeutically with trauma. Ochberg (1988) gathered together studies on post-traumatic therapy (PTT) with victims of violence. He concluded that PTT is not just a series of techniques, but rather a clinical philosophy that requires empathic understanding of the victim, collaboration between therapist and client, and recognition of empowerment as a therapeutic tool. Five critical aspects of the victim's experience are taken into account: bereavement, victimization, autonomic arousal, death imagery, and negative intimacy. Ochberg's five aspects have been used in the application of the framework and appear to offer an effective way of working with the traumas experienced by refugees and immigrants. In 1992, Herman suggested a model for psychotherapy with traumatized people, based on two decades of research and clinical work in the United States with victims of sexual and domestic violence, combat veterans, and victims of political terror. She suggested that the syndromes of traumatized people have certain basic features in common, and that recovery processes also follow a common pathway.

In psychotherapy, the healing process has several fundamental stages: to establish safety; to reconstruct the trauma story; and, to restore the connection between survivors and their community. However, Herman's research did not account for the trauma and torture experiences of people living in exile. Herman's model was integrated into the application of the components and aspects of the conceptual framework. The individual's difficulties caused by life in exile, childhood and traumatic experiences, and the present psychological problems could be distinguished. Combined with the framework, Herman's clinical model seemed effective in the treatment of trauma and torture survivors living in another country.

Other writers, such as Aberbach (1989), examined trauma and bereavement, and also their integration, and suggested that working through the consequences of trauma can lead to creativity. Caruth (1995) described various types of traumas and treatment approaches from a

psychoanalytic and contemporary theoretical point of view. She concluded that there is no single approach to listening to traumatic experiences. Horowitz (1997) presented theory and research and case histories on stress-response syndromes: posttraumatic stress disorder (PTSD), grief, and adjustment disorders. Horowitz concluded that personality factors and preexisting conflicts form a patient's reaction to a stressful life event.

In clinical work with refugees and immigrants based on the framework, these views appear to be confirmed. This seemed to facilitate the understanding of the ways in which the individual's reaction to a current life event is influenced. A significant goal of work with the framework is to guide the individual/family towards integration of past traumatic experiences and open the possibility for the individual/family to live a constructive and creative life. Aberbach's proposition that trauma can lead to creativity, and Caruth's conclusion that traumatic experiences may be shared and listened to in many ways appeared to be confirmed in the treatment and care of the traumatized refugee/immigrant.

Trauma experienced by children was studied by Anthony (1986) and presented in a description of children's reactions to severe stress. Terr (1988, 1991) studied the early memories of trauma and, in 1989, discussed treatment of psychic trauma in children. Terr divides traumatic conditions in children into the following categories: traumatic experiences that come as a single sudden and unexpected blow (type I); traumatic experiences that consist of long-standing, repeated and therefore anticipated ordeals (type II); and traumas that appear to settle between the afore-mentioned major types (e.g. one blow creates a long-standing series of childhood adversities). Regardless of the age at which they become victims, traumatized children have the following characteristics: strongly visualized or otherwise repeatedly perceived memories, repetitive behaviors, trauma-specific fears, and changed attitudes about people, aspects of life and future. Terr concluded that children who suffered from unanticipated single traumatic events (type I) have symptoms that differ from the children who suffered from more enduring traumatization, and these different symptoms should be considered in treatment and care. These illustrative studies on trauma experienced by children coincide with the views and application of the treatment framework presented in this dissertation.

Osofsky and Fenichel (1994) presented studies of infants and toddlers in violent environments, and suggested that children from 0-3 years old react to trauma with reactions of hurt, healing and hope. It seems that the

infants and toddlers studied did not develop the same locked patterns and symptoms that traumas can cause in older children and adults. Osofsky and Fenichel argued that the positive abilities of infants and toddlers to reparation have not been considered in treatment and care of trauma victims. This view has been integrated into the utilization of the framework and its application to the individual/family.

Psychotherapy and support work

The conceptual framework is designed for utilization in psychotherapy, its related fields and support work, and also in supervision. Here follow some illustrative examples of the literature reviewed, which were of significance to the practical application of the framework in treatment and care.

The structure and technics of the psychotherapy, support and supervision provided were especially influenced by: Sullivan's (1947, 1953) views on the psychiatric interview in assessment and diagnosis; Fromm-Reichman's (1959) outline of the principles of intensive psychotherapy; Dewald's (1964) approaches to psychotherapy and, in 1987, to supervision; Searle's (1962, 1965) papers on the supervisory process; Bion's studies of groups (1961), learning from experience in the treatment situation (1962), and attention and interpretation (1970); Greenson's (1967) explanation of the technique and practice of psychoanalysis; Langs' (1978) examination of the listening process and in 1979, the supervisory experience; Ullman and Zimmerman's (1979) conception of the mode of dreamwork; Malan's (1979) study of individual psychotherapy; Luborsky's (1984) examination of the principles of psychoanalytic psychotherapy; Casement's (1985) exploration of learning from the patient; and, Meissner's (1991) study of "current thinking in psychoanalysis about the nature of personality change in the psychoanalytic process, linking it predominantly to the role of the analyst and his interpretive activity, which lead to authentic insight on the part of the patient" (p. 4).

More recent research has enhanced the utilization of the framework, and the training and supervisory process in context to it. These studies include Sandler et al.'s (1992) examination of the new knowledge of the clinical concepts of psychoanalysis, the psychoanalytic process and the clinical situation, and McWilliams' (1994) development of a psychoanalytic diagnostic that facilitates the understanding of the personality structure in the clinical process.

During the 1990s there was a tendency to combine different psychotherapy technics. During the formation of the framework, and in clinical and support work with the refugee and immigrant, it appeared to be sometimes necessary for the carer to adopt a more eclectic mode of treatment so as to be able to achieve the individual's/family's well being. In 1993, Horowitz discussed the development of a general theory for an integrated psychotherapy, drawing on the states of minds theory, the person schemas theory, and the control process theory and the implications for both theory and intervention. He argued that each of these successively deeper formulations included issues of emotionality, relationships, self-control, and development. Horowitz concluded that attention to these three domains may lead to the development of a common language and a movement away from "brand names" (p. 85) for psychotherapy. Bucci (1997) examined recent work on emotions, child development, and neuroscience, and integrated these diverse areas of research and theory into a multiple code theory linking psychoanalytic theory to cognitive science.

In support work, the application of the framework to social work was influenced by Reynolds' (1942) explanations of learning and teaching in the practice of social work, Hollis's (1964) description of casework as psychosocial therapy, and May's (1967) art of counseling.

The dissertation stresses the necessity and goal of seeking improved ways to support people for whom welfare services provide, such as refugees and immigrants. This seemed to be confirmed in a recent overview presented by Cameron et al. (1997) of support programs and research for working with disadvantaged children and families in the United States. Cameron and his colleagues confirmed the need for an open discussion of the issues and organizational realities that could lead to incorporating more promising ways, in a support perspective, of working with child welfare and in other settings.

Time-limited and crisis work

Several sources were utilized to adapt the framework to treatment and supervision in time-limited and crisis work. They include Sifneos' (1972) study of the use of short-term psychotherapy in emotional crisis; Mann's (1973) description of time-limited psychotherapy; Malan's (1976) study and explanation of brief psychotherapy; Bellak and Small's (1978) emergency psychotherapy and brief psychotherapy; Budman's (1981) description of the varied forms of brief therapy; Bauer and Kobos' (1987)

examination of brief therapy and short-term psychodynamic intervention; Crits-Christoph and Barber's (1991) review of short-term dynamic psychotherapy, and Messer and Warren's (1995) review of current theory, research, and their proposal for a comparative approach to the practice of psychodynamically oriented brief therapy.

Currently, even in time-limited and crisis work, the consolidation of theoretical and treatment models is being discussed and taking place. Ryle (1997) integrated cognitive-analytic therapy in brief psychotherapy. Donovan (1998) discussed the controversies facing the varied models of brief couples therapy. He concluded that current brief couples therapy faces important theoretical and technical dilemmas, but argued that from these dilemmas can be gained the knowledge that brief couples therapy can progress into a consolidation phase. Nonetheless, the aspects and components of the framework can be woven into combined models of treatment.

Supervision

Other literature relevant to the teaching and supervision of the framework includes that of Ekstein and Wallerstein (1958), and their explanation of the training of the psychotherapist; Fleming and Benedek's (1966) method of psychoanalytic supervision; Bibring's (1968) explanations of teaching of dynamic psychiatry; Szecsödy's (1974, 1981, 1990) papers and research on the process in psychotherapy supervision; and, Mead's (1990) suggestions on effective supervision.

Studies, such as Grinberg's (1990) discussion of the goals of psychoanalysis and the difficulties of projective identification and projective counter-identification, identity and supervision, appear to confirm the necessity of the training and supervisory processes involved in carers' working with the framework with refugees/immigrants. More recently, there have been numerous writers proposing a combined model of supervision that can integrate the various modes of supervision. One of the studies that has been significant to supervision and training in relation to the framework has been that of Holloway (1995). Her presentation of a new model of clinical supervision embraces different theoretical approaches to counseling, moving away from models limited to only one approach.

Currently, in the United States, Altfeld (1999) has presented an experiential group model of supervision constructed for both group and individual therapy presentation, emphasizing concepts from object-relations

theory and group-as-a-whole dynamics. It focuses on intrapsychic, interpersonal and systems processes, and stresses the group aspect of the supervisory process. Its central thesis is that material presented in a supervisory setting stimulates conscious and unconscious parallel processes in group members. Through here-and-now responses, associations, and interactions among the supervisory members, counter-transference issues that have eluded the presenter might make themselves known and be worked through on emotional as well as cognitive levels. Note that the training program and the casework supervision of the framework presented in this dissertation include a group model constructed for both group and individual therapy and support-work presentations. Altfeld's observations and conclusions seem to be a confirmation of the training and supervisory experiences submitted in this dissertation.

Ladany et al. (1999) presented a review of the salient ethical guidelines related to the practice of supervision, and discussed the results of a study of 151 supervisors examining supervisor ethical practices. They concluded that the most frequently violated guidelines involved adequate performance evaluation, confidentiality issues relevant to supervision, and ability to work with alternative perspectives. Greater nonadherence to ethical guidelines was significantly related to a weaker supervisory alliance and lower supervisee satisfaction. This study was important in the understanding of the ways in which the supervisor (and the supervisee) may react to the ethical issues with which they are constantly faced in clinical and supportive work with the refugee/immigrant.

Burnout

In the training and supervision of carers working with refugee/immigrants, burnout was reported frequently. A review of the literature confirmed that burnout is a common phenomenon in helping professions. Many authors have attempted to define, study and describe the burnout syndrome. Cherniss' (1995) study of human-service professionals in the United States and her antidotes to burnout have allowed for a deeper understanding of the syndrome, and have been useful in training and supervision in relation to the framework. Brown and O'Brien's (1998) examination of stress and burnout in crisis intervention workers and other front-line mental health workers is also important. Their conclusion that workers with high job-related stress and low social support tend to be most vulnerable to experiencing burnout symptoms appears to be confirmed through the

supervision of carers working with refugees and immigrants. Brown and O'Brien suggest that psychologists providing clinical or consultation services to these groups should emphasize the importance of creating a supportive work environment, developing a sense of personal accomplishment related to their work, and teaching and modeling helpful coping strategies. Brown and O'Brien's suggestions have been most useful in the training and supervision of carers working with the framework.

In Spain, Gonzales-Roma et al. (1998) studied factors associated with burnout among 209 male and female nurses and physicians. It was concluded that varied factors lead to burnout, such as lack of job and personal autonomy, or social support. Work stress, depersonalization, emotional drain, personal competence and intention to abandon the job were also factors that cause burnout.

These factors also appeared to be prevalent in carers working with refugees and immigrants, and are currently taken into account in the training and supervision of the application of the framework.

DEFINITIONS OF TERMINOLOGY – THE REFUGEE AND THE IMMIGRANT

There are several different ways of defining the refugee, the traumatized and/or the tortured refugee. And some other terms relating to migration and exile can sometimes have an unclear usage. Accordingly, some definitions of terminology are presented before giving an overview of the literature specifically pertaining to these groups.

The refugee

The refugee is defined as a person with a well-founded fear of persecution – because of, say, racial or ethnic background and/or religious or political beliefs. The refugee is *forced* to leave or flee because of the fear or reality of persecution, oppression, imprisonment, torture or annihilation, or due to war and its atrocities.

Family members may be forced to leave or flee with the person, or before or afterwards. The refugee and family do not want to leave their homeland, and cannot return to it. Sometimes, family members can return, but it would mean separation from each other.

When the refugee arrives in a new country, he/she seeks protection, refuge and asylum. A *quota refugee* is an individual who has *received refugee status* in the country of exile *before* or *on arrival.* An *asylum seeker* is an individual who first *seeks* permission to stay in the country *on arrival.*

The *traumatized/tortured refugee* is forced to leave/flee for the same reasons as the refugee, but has also had severe traumatic experiences (generally caused by human evil). *Trauma* comes from the Greek word meaning "wound". It is defined in Webster's New World Dictionary (1984) as a "bodily injury caused by violence, and/or emotional shock or injury often leaving a lasting psychic effect" (p. 636). The *traumatized or tortured refugee*, as defined within the context of this dissertation, has endured one/several of the following:

- a psychological shock that is intense and often unforeseeable, and breaks through the person's psychological defenses, e.g. assassination attempt, rape, abduction;
- repeated psychic and physical stress going beyond the individual's tolerance level, e.g. war, terrorism, other pressures caused by organized violence;
- an extreme situation surpassing the individual's ability to cope either physically or psychologically, e.g. torture, imprisonment, deportation (Roche, 1987, p. 232).

All forms of individual trauma (torture, rape, abduction, etc.) and collective trauma (war, terrorism, etc.) are destructive of human integrity. The persons causing the outer traumas deliberately deny or ignore basic human rights and conditions. The individuals forced to endure these traumas must live through periods of being denied basic human rights and conditions, experiences which can cause a loss of "sense of self", or of belonging to humanity and life.

The immigrant

The immigrant has left his/her native land *voluntarily* to come to another country, and can return to it. The reasons may be personal or economic, or result from natural disasters. He/she can be escaping from severe poverty, oppression and abuse within the family or society. The immigrant is an individual in search of an improved life.

The refugee "turns" immigrant

When the situation changes in the homeland and the refugee can return without risk, he/she becomes or "turns" immigrant. In the context of the framework, the refugee is now regarded as being in the inner and outer world of the immigrant.

The homeland, the home country, the native country, the native land

The homeland, the home country, the native country, the native land, fatherland or mother country are words used in this dissertation to denote the country in which the refugee or immigrant was born or has roots (Webster, 1974, p. 372).

The new country

For the refugee, the new country – the host country, the country of resettlement – is the country in which he/she has sought asylum and lives in exile. *For the immigrant,* the new country is the country to which he/she migrated or moved in search of a better life.

The outer and inner world of the refugee and immigrant

The outer world

In the context of the framework, *the outer world* is regarded as containing all the factors in the individual's outer life in the homeland and in the new country, such as people, culture, religion, language, way of life, and environment (Altman and Rogoff, 1987; Erikson, 1950; Lewin, 1936, 1938; Saegert and Winkel, 1990).

The inner world

Within *the inner world* is the individual's thoughts, ideas, daydreams, fantasies and dream life, which can be both conscious and unconscious. Also within the inner world is the "self", which is regarded as being "composed" of childhood experiences, culture and values, religion and moral codes, and also a mode of thinking and language (Abrams and Hogg, 1999; Deaux et al., 1993; Erikson, 1950; Markus and Nurius, 1986; Tajfel, 1982).

Mental states

The inner world of the refugee and the immigrant may encompass experiences of inner difficulties, problems, an inner and/or existential conflict, confusion, neurotic or psychotic feelings, neurosis or psychosis, a life crisis or life change. These are endured in the same way as by anyone else (Kristal-Andersson, 1976). The expressions for *mental states,* such as *inner difficulties, problems, feeling confusion, having neurotic* or *psychotic feelings,* or *neurosis* or *psychosis* are meant to be understood as ones that can vary in connotation, degree, intensity and scope. *Existential conflict* is a term used to refer to the questioning of life's meaning that can awake within a person during different periods of life (May, 1967). A *life*

change is defined here as a transition between different natural phases of life, e.g. from childhood to puberty, or from the adult years, through the middle years, to old age. It can also refer to such life passages as marriage, pregnancy and childbirth, menopause, or to changes in school, work, or environment, etc. A *life crisis* is defined here as separation, divorce, unexpected or sudden death, accident, or an outer change in life or the environment (Cullberg, 1990). In most instances, unless a specific mental state is referred to, the expression "inner difficulties" is utilized to denote the above mental states.

Becoming a *refugee* may be a *life change* or a *life crisis,* or a *combination of both,* depending on the circumstances surrounding being forced to leave or flee the homeland. Usually, however, it is a life crisis and/or a combination of life change and crisis. Becoming an *immigrant* is usually a *life change* but can, for some, be a life crisis, depending on the circumstances surrounding immigration, and also the age of and other background conditions affecting the individual.

Commonly occurring feelings, such as fear, sadness, anger, disgust, happiness and surprise, appear to go beyond the boundaries and barriers of culture. They are experienced regardless of a person's background, in terms of sex, age, country, landscape, climate, environment, culture, ethnic/racial origins, religion, society, class, economics, politics and language (Darwin, 1872; Ekman, 1972, 1982; Ekman and Friesen, 1975; Ekman et al., 1987; May, 1969).

"Based on reality", "exaggerated experience of reality", and *"fantasy"* are expressions used throughout the dissertation. *Based on reality* may be a feeling or condition that is founded on a real event in the homeland or the new country. An *exaggerated experience of reality* is something founded on a real event in the homeland or the new country that becomes magnified and at times distorted. A *fantasy* is formed by the illusion or fabrication of an event in the homeland or in the new country.

Expressions of time in the new country

Each person is unique, and goes through feelings, experiences and phases of life in a different and individual way. Specific phases or periods of time in the new country that the refugee or immigrant passes through, and the changes that follow because of these, are deliberately not defined in this dissertation. However, certain expressions of time are employed: *on arrival* – the period of time when the individual arrives in the new

country; *a short time afterwards* – the period of time after arrival and briefly afterwards; *after a time* – the period of time after arrival, settlement and start of establishment of life in the new country; *after some time* – the period of time after settlement and when life is established; and, *after a long time* or *many years* – the period of time long after settlement and establishment in the new country.

Specific studies of refugees and immigrants

Up to recently, most of the literature has not differentiated between the difficulties of these groups. Accordingly, the overview that follows includes illustrative examples of some of the research that relates to this dissertation on cross-cultural psychology, mental disorders and culture conflicts, mental disorders that can be caused or complicated by both migration and exile, and culturally-specific mental health care and treatment methods. For the most part, the studies and literature submitted relate to the refugee, the traumatized and/or tortured refugee, the immigrant and their children. It is pointed out when a study is specific to a certain subgroup.

From the late 1980s, literature on these groups has increased substantially – especially in fields such as psychology, psychiatry, sociology, ethnography and education. Besides the above issues, the treatment of torture and trauma – especially post-traumatic stress disorder (PTSD) – and refugee and immigrant children has been paid particular attention. But, even in recent years, the studies tend to consider the groups together. In some of the literature, various modes of treatment are reported on. However, there seems to be no single model that can be compared with the framework in terms of its purposes with regard to treatment and care.

There follows an illustrative presentation of examples particularly relevant to the dissertation.

Cross-cultural psychology

During the conceptualization of the treatment framework, culture was not considered a significant component in the understanding of human behavior. For the most part, the role of culture and cultural differences was not discussed in the treatment and care of individuals with a refugee/immigrant background. Interest in cross-culture psychology began in the 1960s, with several articles in diverse journals.

Segal et al. (1998) define cross-cultural psychology in general as comprising “many ways of studying culture as an important context for

human psychological development and behavior. … Cross-cultural psychology consists mostly of diverse forms of comparative research (often explicitly and always at least implicitly) in order to discern the influence of various cultural factors, many of them related to ethnicity, on those forms of development and behavior" (p. 1102).

Berry and Dasen (1974) discussed three complementary goals that were proposed for cross-cultural psychology: 1) to transport and test current psychological knowledge and perspectives by using them in other cultures; 2) to explore and discover new aspects of the phenomenon being studied in local cultural terms; and to integrate what has been learned from these first two approaches in order to generate more nearly universal psychology, one that has pan-human validity. Up to the present, these goals are the ones that remain the most considered (pp. 12-20). Recently, Allwood (in press) discussed various definitions of cultural and social influences on the individual in a multicultural society, and argued that the possibility of integration towards a universal psychology is a question without an obvious answer.

Some other examples of terms to which cross-cultural psychology can be referred are "cultural psychology" (Shweder & Sullivan, 1993, p. 497), "ethno-psychology", (Diaz-Guerrero, 1975, p. 3), "intercultural psychology" (Camilleri and Vinsonneau, 1996, p. 10), and "transcultural psychiatry" (Al-Issa, 1995, p. 54).

Research in cross-cultural psychology has focused on phenomena of fundamental importance in general psychology, with particular emphasis on abnormal psychology, cognitive psychology, developmental psychology, and social psychology (Segal et al., 1998).

A relevant illustrative example of the literature in the field is Triandis et al.'s (1980) six-volume handbook of cross-cultural psychology. More recently, Bleichrodt and Drenth (1991) collected papers on contemporary issues in cross-cultural psychology. The mental-health issues taken up were as follows: work in psychotherapy with maladjustment, definition and occurrence of mental illness in different cultures, assessment and diagnostics, and psychometric and measurement problems in cross-cultural comparisons. The authors concluded that cross-cultural psychology has become a significant independent subdiscipline, which is also the view of this dissertation. However, it is most important to continue research in this field, and especially to define its goals and methods.

Mental disorders and culture conflicts

Among early writers, Hallowell (1934, 1936) studied the influence of culture on mental disorder and concluded that it plays a significant role in how the individual experiences and deals with that phenomenon. Beaglehole (1939) looked at culture and psychosis in New Zealand, and concluded that the severity and duration of psychosis may be influenced by conflicts of culture. Edgerton and Karno (1971) investigated Mexican-American bilingualism and its relation to perception of mental illness. It was concluded that the influence of the individual's cultural identification affected perception of mental disorders. Vahia (1962) discussed cultural differences in clinical schizophrenia and hysteria in India, and also in the United States. He concluded that cultural differences must be considered in the understanding and diagnosis of the patient.

Kiev (1972) attempted to formulate the concept of transcultural psychiatry, and maintained that culture determines the specific ways in which individuals perceive and conceive of the environment, and strongly influence the forms of conflict, behavior and psychopathology that occur among members of any one culture. More recently, Florsheim (1990) compared Eastern and Western concepts of self in the treatment of mental illness. He proposed that cultural variances in the way that illness is expressed and treated related to differences in culturally determined myths of the self. For example, in India, the self is conceived as fluid and interdependent; in the West, the self is conceived as more solid and autonomous. Florsheim concluded that the therapeutic methods employed by the Western-trained psychoanalyst and psychotherapist made use of the Western myth of self, while in India, the healing process in mental illness was in accordance with the myths of self available there. Further, the cultural construction of the self in relation to both cognition and emotion has been elaborated on by Marcus and Kitayama (1991, 1994).

Florsheim's comparisons and Marcus and Kitayama's cultural construction of the self coincide with the treatment view of this dissertation and the framework's application to different forms of treatment, which consider the individual's/family's conscious/ unconscious culturally linked ways of perceiving and dealing with mental illness.

Al-Issa (1995) collected papers concerned with an international perspective on culture and mental illness to provide researchers with information on sociocultural differences both within and outside the

boundaries of their own countries. Al-Issa argued that "Western concepts and theories of mental illness, whether sociocultural or biological cannot be valid unless they are based on evidence from all humanity, and historical and contemporary psychiatric information with a sociocultural framework from different regions of the world" (p. 2). Al-Issa's goal was, as was the goal of this dissertation, to "demonstrate the biological unity of mankind" (ibid.).

As previously explained, culture became a significant component of the framework, and is especially considered in the *refugee/immigrant situation,* the *states of being,* the *adaptation cycle,* and *relevant background conditions.* In the utilization of the framework, the individual's mental difficulties are studied and diagnosed with respect for, and in context of, the influence of the individual's culture on these. The ways in which the culture he/she is presently living and may have influenced the disorders are also considered.

Extent of mental disorder

Early on in the clinical work with refugees and immigrants on which the dissertation is based, it appeared that culture dissonance seemed to cause and/or to augment mental disorders in refugees and immigrants.

Jaco (1939) reported, in an early study of the mental health of Spanish Americans in Texas, that this group had more psychological difficulties than the non-Hispanic population. Tsung-Yi (1953) studied the incidence of mental disorder in Chinese and other people who had recently immigrated to the United States, and concluded that this group had a higher frequency of mental disorders. In France, Devereux (1956) collected literature on culture and mental disorders, and specified the varied ways in which different cultures experience and deal with mental disorders. He also discussed the terms "normal and abnormal" (pp. 3-48) in a cultural perspective and concluded that what may be deemed as abnormal in one culture could be considered normal in another one. Haavio-Mannila and Stenius (1973), in a study of Finnish immigrants in Sweden, found that the mental-health status of this group is worse than that of the Swedish population as a whole. Mostwin (1976) discussed uprootment and how it causes different degrees of anxiety. Epstein (1979) interviewed children of survivors of the holocaust and depicted the sensitivities and mental difficulties of the second-generation.

Nesdale et al. (1997) presented a model of migrant psychological distress in which ethnic identity was predicted to influence personal coping resources (i.e. self-esteem, self-mastery, interpersonal trust) and external coping resources (i.e. tangible, appraisal, esteem, and a sense of belonging, social support) that were predicted to influence migrants' psychological well-being. The model was tested on 270 male and female Vietnamese migrants to Australia through questionnaires. Results showed that ethnic identity was a significant predictor of migrant distress, via self-esteem.

The afore-mentioned illustrative examples of studies (and also the ones that follow) appear to support the view that there seems to be a necessity to consider specific variables when working with the refugee and immigrant. The conceptualization and setting up of the framework was in part motivated by these type of studies, especially with regard to the *refugee/immigrant situation*, some aspects of the *states of being* (especially *the stranger; separation and loss; guilt; shame; value degradation; language degradation; inferiority; non-identity; rootlessness; suspicion;* and *prejudice*), and *relevant background conditions* (such as *ethnicity; culture; values; socioeconomic changes*), the *reason* and *transition-related conditions*.

Culture-specific needs in treatment and care

During the clinical work that led to the formulation of the framework, it seemed apparent that there were culture-specific needs that should be considered in the treatment and care of the refugee and immigrant.

In the 1970s, Hartog (1971) illustrated transcultural aspects of community psychiatry, and stressed that these aspects must be considered in work with different cultures. Giordano (1973) described the necessity of considering the ethno-cultural factor in the delivery of mental-health services. Gaw (1976) studied mental-health care for the Boston Chinese community, and concluded that the culture and values of this group must be considered to improve treatment results. Vargás (1977) studied the mental-health needs of Hispanic communities in the United States. Besides consideration of ethnic background, the individual's reason for leaving the native land, and also separations and losses, must be taken into account. Gelfand (1976) studied ethnicity, aging and mental health. He concluded that ethnicity must be considered in mental-health care of the aged.

More recent studies, such as Markus et al. (1996) present a cultural perspective on emotion, and the argument that "psychological disorders must be reconceptualized in terms of culturally shared idioms and practices, and psychotherapists must place their clients and their problems in a wider context of culture" (p. 226). Markus and her colleagues proposed that "emotions are an assortment of socially shared and collectively enacted scripts that are composed of physiological, subjective, and behavior components, and are embedded in the immediate sociocultural, semiotically constituted environment. They are socially mediated, and the unconscious self-defenses are actually culture's ways of socially and collectively regulating emotional responses" (p. 225). Such a cultural view of emotion implies that emotion provided one mode of experiencing inner sensations by integrating them with external situations. Markus et al. (1996) concluded that emotion is shaped and enabled by cultural practices, ideas and institutions. Therefore, in working with the mental disorders of refugees and immigrants, carers and mental health programs must take consideration of culture and cultural differences. This view coincides with the one proposed in this dissertation.

Tabora and Flaskerud's (1997) study confirmed the importance of culture in determining the pathway to mental-health care. The purpose of the study was to describe the mental-health beliefs and practices of Chinese American immigrant women. A two-part design using both qualitative and quantitative techniques was employed. Focus group and key informant interviews were used to discover beliefs, practices and knowledge about the mental health of 86 women (aged 25-65 years). Content analysis of the qualitative data found that the cultural value placed on the avoidance of shame, a pragmatism that results in the use of both Western and traditional Chinese practitioners and treatments, and the inadequacy of Western-type services to meet the needs of the Chinese American immigrant population act as barriers to utilization of these services. The authors concluded that the importance of culture in determining the ways to build up adequate mental-health care was supported by the finding that higher levels of acculturation were related to greater use of mental-health services.

The framework was designed to be applied to therapy and support work. However, since its formulation, the framework has also been utilized to help to build up mental-health care programs for refugees and

immigrants in several countries. The framework appears to facilitate the mapping out of culturally specific needs in treatment and care.

Mental disorders and migration and exile

The framework was in part conceptualized on ground of the belief that there may be links between migration/exile and the onset of mental disorders. This belief was in part confirmed in the study of the relevant literature.

In the United States, Malzberg and Lee (1956), in a paper on migration and mental disease, studied first admissions to several hospitals. There was a significantly higher proportion of first admissions among the recent immigrant population. Seguin (1956) discussed the effects of migration on psychosomatic maladaptation of Peruvian Indians. The first year of migration was characterized by depression and anxiety, and also by a number of circulatory, respiratory, neurological and gastrointestinal symptoms. Murphy (1934) discussed the effects on mental disorder of culture and adaptation to the new society. Deutsch and Won (1956) discussed some factors in the adjustment of foreign nationals. Such factors as alienation, isolation and confusion were examined. Garza-Guerro (1974) explored the consequences of culture shock – in particular, mourning and the vicissitudes of identity.

Fitzpatrick (1975) examined the role of white ethnic communities in the urban adjustment of newcomers and concluded that acceptance of newcomers into the community seemed to facilitate their adjustment.

Weinberg (1949) investigated the problems of adjustment of Jewish immigrants to Israel. In 1961, he studied migration in relation to mental health and personal adjustment. In both of Weinberg's studies, his conclusions based on research from Israel, even coincided with Fitzpatrick's study from the United States.

Eitinger (1960) depicted the symptomatology of mental disease among Jewish refugees in Norway and concluded that there was a connection between their past experiences and the presented disorder. With Grünfeld, Eitinger (1966) studied psychoses among refugees. In their studies they found that the incidence of functional psychoses is higher in refugees than in the settled population, and that the paranoid syndrome is one of its most common manifestations.

In Spain, the Grinbergs (1989) published a psychoanalytic study of normal and pathological reactions to migration and exile in terms of three

types of anxieties: persecutory anxieties in the face of change, depressive anxieties in which one mourns for others left behind and for the lost parts of the self, and confusional anxieties over the inability to distinguish between the old and the new. These anxieties, together with the symptoms and defense mechanisms they may produce, are part of what the Grinbergs designated as, "a psychopathology of migration" (p.1). The Grinbergs also studied the relationship between migration and the language and age of the individual; its effects on the person's sense of identity; and the special problems of exile. They concluded that the ability to overcome these anxieties and problems and recover promotes an enrichment of the ego and the consolidation of a more evolved sense of identity. The Grinbergs published their studies several years after the conceptualization of the framework. Many of their conclusions seem to coincide with the formulation of the components and aspects of the framework, the goals of treatment of the framework, and the clinical research results of this dissertation.

More recently, Marlin (1994), as did the Grinbergs, explicated special issues in the analytic treatment of immigrants, such as the psychological problems faced by immigrants, and the tendency for therapists to consider the expression of cultural differences as pathology. The immigrant faces crises of overload and loss. Mourning the loss of the old culture is seen as a necessary step in genuinely adapting to the new environment, rather than making a quick and superficial adjustment. Unsuccessful adaptation may be marked by prolonged depression. A successful outcome of immigration is one where consolidation and transformation of identity are accomplished. Marlin's view of unsuccessful adaptation seems to be confirmed in the data presented in this research.

In contrast to the above-mentioned studies, Roth and Ekblad (1993) presented several research issues in migration and mental health. They explained that many studies in the arena have demonstrated increased rates of psychopathology among migrants, but the results are not clear-cut. The authors took the view that the ambiguities have to do with methodological problems, including definitions and key concepts, and/or complexity of the relation between migration and mental health. Suggestions for further research in the area include development of valid cross-cultural assessment instruments; studies with relevant control groups and more baseline data; and prospective, longitudinal studies in which psychopathology and its interaction with variables measuring the

adjustment process are utilized. Also, in the United States, Gaines (1998) explored mental illness and immigration. He argued that a large number of disorders, seen as psychiatric from the perspective of the United States, may appear in the context of immigration – problems such as, stress, certain psychological disorders, stigmatization, acculturation, physical deprivation and trauma, and poor communication. Gaines has shown how Western psychiatry (mis)perceived causes of mental disorders in immigrant populations.

In Sweden, Sundquist (1994) compared the differences in psychological distress of refugees and immigrants, and demonstrated the strength and influence of ethnicity on mental health in comparison with material factors and lifestyle. The author focused on health differences between Latin-American refugees, Finnish and southern European labor migrants, and matched Swedish controls. They were studied via questionnaire (Swedish Annual Level-of-Living Survey). Sundquist concluded that the strongest independent risk indicator of self-reported psychological distress was being a non-European, i.e. Latin American, refugee.

Postero (1992) described the processes refugees seeking political asylum must go through and the emotional obstacles they encounter. She concluded that refugees face a legal system insensitive to the emotional problems they commonly experience. They are often treated more like criminals than victims of political violence. Many experience renewed terror, and become unable to reveal the facts necessary to gain asylum. The author concluded that mental-health practitioners can help to explain the psychological symptoms of trauma to lawyers, judges and other government officials by providing a concise written evaluation of the refugee's mental condition.

Hulewat (1996) viewed resettlement as a cultural and psychological life crisis. She described the issues necessary to address when trying to help families cope with the stresses of resettlement as the stages of resettlement, the cultural styles and psychological dynamics of the population being resettled, and the individual dynamics of the family. The Soviet Jewish resettlement experience in the United States is used to demonstrate how understanding and identifying these elements as they operate influence how services can be designed that help clients handle personal crises as they adjust to their new lives. The task of the social worker should be to address the practical and emotional issues quickly

and effectively. Hulewat identified the groups of immigrants as “help me get started”, the “take care of me” and the “you must do it my way” groups (p. 129).

Hulewat’s opinion that the social worker should address the practical and emotional issues of resettlement quickly and effectively is also the view of this dissertation. However, resettlement can be considered either a crisis or a life-change. The issues that Hulewat considered are also utilized in casework with the framework. For example, the *refugee/immigrant situation* considers the outer processes of change and the accompanying inner changes; the second aspect, the *adaptation cycle* considers how the refugee/immigrant has resettled the society; the third aspect, *childhood experiences* considers the individual dynamics of each family member; the fourth aspect, *relative background conditions* considers the culture and many other components; as does the sixth aspect, *transition-related conditions* Moreover, the application of the framework seems to prevent the usage of the generalizations of the resettlement experience which are made by Hulewat in this paper.

Allotey (1999) explored the problems that refugee women faced during resettlement in Western Australia and concluded that these are often worse than those faced by voluntary migrants. Allotey pointed out that though these problems are generally thought to be related to previous traumatic experiences, this may not always be the case. There are many refugee women who may not have personally experienced torture or trauma but who nonetheless express needs that suggest a perception of marginalization from the mainstream society. Allotey summarized the health problems identified in a needs assessment of 67 adult refugee women from Latin America resident in Perth, Western Australia. The subjects reported suffering from insomnia, depression, social isolation and other health problems. Similar symptoms were reported in the data upon which formulation of the framework was based.

Haasen et al. (1999) studied the impact of ethnicity on the prevalence of psychiatric disorders among migrants in Germany. Admission records of 408 migrants (8.1% of total admissions) admitted to a psychiatric clinic from 1993 to 1995 were assessed for diagnosis, symptomatology and treatment. Of these, 38.7% received a diagnosis of a schizophrenic disorder, significantly more than other clinic patients. Language problems correlated with the diagnosis of a schizophrenic disorder. Haasen and his colleagues argued that the results of this study

posed questions for further research concerning the utilization of psychiatric services by migrants and the diagnostic validity of psychopathological phenomena in relation to ethnic factors. They concluded that the higher rate of schizophrenia in migrants may well be due to an interplay of etiological factors and misdiagnosis of affective disorders. In fact, the framework was conceptualized in order to make the professional carer aware of the numerous variables, including ethnic factors, that must be considered in the diagnosis and treatment of the refugee and immigrant.

Psychotherapy and support work

In the construction and utilization of the framework, the following literature was significant to try to understand the specific factors and modes of treatment that could be important to consider in treatment and support work with the refugee, the traumatized and/or tortured refugee, the immigrant and their children.

Hsu and Tseng (1972) illustrated the many facets of intercultural psychotherapy and the prescribed modes in which a therapist and a patient of another culture can function. By respecting cultural differences, the therapist gains the trust of the patient and can build up the necessary working alliance. Abel (1956) depicted the ways in which cultural patterns affect psychotherapeutic procedures. He explained that if these are not considered, the process may be disrupted. Carrillo (1976) defined differences in psychotherapy with individuals of Chicano background. She pointed out that it is necessary to take culture, socioeconomic background and language abilities into account as well as attitude to life and circumstances.

In a paper from the early 1950s, Devereux (1953) discussed cultural factors in psychoanalytic therapy and stressed that the psychotherapist must always take these into consideration. The most significant influence upon psychoanalytic psychotherapy of cultural factors is the therapist's own interest in these. The patient is usually sensitive to the therapist's interest, and will either gratify it by means of discussion or else use it as a means for more overt kinds of resistance. Devereux stressed that the psychotherapist must be genuinely interested in the cultural background of the patient and seek to understand the patient's productions in terms of it by acquiring knowledge of the individual's culture. Devereux's contention that the therapist must show interest and respect for the

patient's culture seems to be confirmed in the clinical work and supervision that formed the basis of this research.

Thomas (1961) discussed pseudotransference reactions due to cultural stereotyping, and came to the conclusion that a therapist's culturally determined, derogatory, stereotyped attitudes towards a patient – based on sex, race, religion, or socioeconomic status – may create disturbed, negative reactions that may be incorrectly interpreted by the therapist as a neurotic transference phenomenon. Significant distortions of the diagnostic and therapeutic processes can occur when neither therapist nor patient is aware of the nature of these reactions. In therapy, a patient's disturbed, unhealthy responses may be due to these distortions, and therefore not an indicator of neurosis. Patients may be especially sensitive to such attitudes in the therapist since they come across as repetitions of innumerable similar experiences in the outside world.

Vontress (1969, 1970) examined cultural barriers in the counseling relationship, pointing out that these may be aware or unaware, and must be dealt with openly in therapeutic work. He stated that it may be difficult for the therapist to establish empathy with persons unlike him/herself. The therapist who brings to the therapeutic encounter his/her own personal bias against ethnic minorities will not be able to empathize. Racial attitudes will directly or indirectly prevent the therapist from using professional skills to aid the clients. The native therapist can overly identify with the patient and feel too sympathetic to be of assistance. On the other hand, the therapist may retain some remnants of the majority's prejudices, feel guilty, and be incapable of helping the individual.

Milliken (1965) studied prejudice and counseling effectiveness. He pointed out that the therapist or patient may have consciously or unconsciously prejudiced attitudes to the other person, which affect the effectiveness of the situation. Ticho (1971) studied the cultural aspects of transference and counter-transference and concluded that these aspects must always be considered by the therapist and, if necessary, taken up and dealt with. Davidson (1987) examined what she called the "cross-cultural therapeutic dyad" (p. 659), and suggested that the presence of unrecognized cultural factors may slow down, stalemate, or end therapy if not analyzed. In l988, she pointed out that there has been an apparent lack of attention paid to cross-cultural and subcultural factors in

psychoanalytic work. Dahl (1989) reported on various problems of cross-cultural psychotherapy. Topics discussed included the working alliance, transference, therapeutic neutrality, communication, somatization, and treatment goals. Dahl concluded that if a working alliance on the basis of a trusting relationship can be established, and if the therapist can develop a cultural empathy (e.g. an acceptance of the patient's cultural self-image), then he/she can work therapeutically within the paradigms of psychoanalysis, and of psychoanalytic psychotherapy, regardless of cultural orientation.

The conclusions of the above-mentioned illustrative examples of studies in psychotherapic treatment modes appeared to coincide with the results of the clinical work and the research on which this dissertation is based. There follow some examples of more recent studies.

Kareem and Littlewood (1992) identified some of the key problems of working psychotherapeutically across cultures; they provided a compilation of the theories and techniques of intercultural therapy, as developed by several specialists.

Altman (1995) studied the treatment work of the psychoanalytically oriented clinician in New York public clinics and in what ways the patient's and clinician's skin-color, culture and social class may influence the therapeutic process. Altman concluded that when these variables are taken into consideration in psychoanalysis and its related modes of treatment, these modes of treatment can be relevant and useful to our increasingly diverse and multicultural society.

Eleftheriadou (1997) explored an existential approach to cross-cultural counseling and illustrated the complexities of adjusting to a different country to one's origin, and also, how some people lose a sense of self when they have moved from their familiar familial or cultural frame of reference. Eleftheriadou concluded that this created an inner confusion which needed careful exploration during the counseling encounter before a person can feel able to relate to the new context and, indeed, him/herself again. The views of this dissertation coincided with Eleftheriadou's observations. The utilization of the framework in the application of the existential approach to therapy and support work appeared to give effective treatment results.

Opaku et al. (1998) compiled current clinical methods in transcultural psychiatry and psychotherapy. The overview described various methods

of assessment, diagnostic and psychotherapeutic treatments for refugees and immigrants, including specialized diagnostic and treatment approaches for men, women and children, especially those who have experienced trauma and torture. The framework presented in this dissertation appeared to be able to be integrated into these most current clinical approaches.

Family therapy

McGoldrik et al. (1982, 1996) compiled studies on ethnicity and family therapy in the United States. Technics utilized by therapists in the treatment of refugee/immigrant families of diverse ethnic background were explored and discussed. McGoldrik and her colleagues concluded that ethnicity was a social reality requiring the therapist to be more culturally competent as we enter the 21st century. "Race, gender, religion, class, immigration status, age, sexual orientation, and disability are also critical identity issues that we must consider in order to understand our clients. Add to this the rapidly changing nature of family life, and it becomes clear that we need to reexamine our therapy approach in a larger multicultural context" (p. 25).

Daneshpour (1998) examined the applicability of the Anglo-American models of family therapy to Muslim immigrant families in the United States. The most significant differences reported were in value systems, between the Muslim and Anglo-American cultures, Muslim families' preference for greater connectedness, a less flexible and more hierarchical family structure, and an implicit communication style. Daneshpour concluded that the systems theory of family therapy, which deals with the pattern of relationships, seemed valid for all families regardless of cultural differences. However, the preferred direction of change for Muslim families needs to be integrated into the assessment and goals for family therapy. Similar conclusions were reached by McGoldrik and her colleagues. However, they include the possibility of using several of the actual modes of family therapy, such as psychodynamic family therapy, structural family therapy, narrative family therapy, etc.

Group psychotherapy and support work

Various elements discussed in studies of group psychotherapy – culture, language difficulties, socioeconomic background, class, culture and psychopathology, and treatment – can be related to the refugee, the refugee/immigrant and their children. In the different modes of group

psychotherapy and group support work presented in the material for this research, the application of the framework seemed to be a useful instrument for assessing and working through the difficulties of each group member. Here follow illustrative examples of the relevant studies in modes of group treatment in which the afore-mentioned elements are considered.

In the United States, Maas (1956) discussed the influence of cultural elements in group psychotherapy. He concluded that these must always be considered in understanding group dynamics and tensions. Dinnen (1977) reported on group therapy with Greek immigrant patients of low socioeconomic status and with chronic psychiatric illness conducted over three years, and on how barriers of language, culture and class were overcome. An analysis of these barriers is provided. Various claims concerning the effects of culture on psychopathology and treatment are also discussed. They concluded that it is possible to work in group psychotherapy if the language, culture and class differences of the group members and the therapists are considered. Kinzie et al. (1988) described their one-year experience of group therapy with south-east Asian refugees and also concluded that group psychotherapy with south-east Asian refugees can function when the culture is considered and respected.

Cultural influences, socioeconomic background, language and class are components considered in the fourth aspect of the framework, *relative background conditions*. Culture and language are also considered in the first aspect, the *states of being,* especially *value degradation, language degradation,* and *non-identity.*

In Germany, Roeder and Opalic (1997) reported on a psychotherapy group for Turkish patients using an existential analytic approach to overcome language and cultural barriers. The two main factors in the setting of this psychotherapy group were continuous cooperation with the interpreter and creative versatility in handling with regard to the therapeutic conditions and the search for better solutions. Also, and in accord with the view of this dissertation, Roeder and Opalic concluded that psychotherapy in the intercultural field is not only possible, but also enriching.

In the United States, Feinberg (1996) conducted an exploratory study to observe the impact of collective reminiscence on individual adaptation and restoration of identity. Eight elderly Russian Jewish immigrants

(aged 70-83 years) participated in a screening interview and attended 4-6 group discussions. Findings revealed four emergent themes in the reported experiences of the subjects: loss, oppression, struggle with identity, and reminiscence. The group members became aware of a lack of continuity of sense of self due to being uprooted through immigration late in life and also of a need to consolidate identity within the overall effort to integrate one's life as a whole at the final psychosocial stage. This awareness was fostered by group interaction. Feinberg concluded that the group model potentiated the activity of reminiscence and offered an important context for group members to synthesize their life stories and make meaning of their present lives. Feinberg's, and Roeder and Opalic's, conclusion that group therapy and support work are helpful therapeutic instruments in work with the refugee and immigrant coincided with the research results in this dissertation on group work with men, women and children of various ages.

Battegay and Yilmaz (see Husemann, 1997) described the psychodynamics and psychopathological aspects of Turkish immigrants in Switzerland who were members of psychotherapy groups. A group of 29 men (aged 29-58 years) and a group of 28 women (aged 24-47 years) were treated between 1991 and 1994. All of the patients were either depressive or had psychosomatic symptoms. Battegay and Yilmaz reported that the Turkish patients often showed basic resistance to change from the collective living characteristic of their culture to individual-centered living and, consequently, an unwillingness or inability to adapt to the habits of the new surroundings. Over time, the therapy groups were reported to appear to become a substitute embodiment of the former family and community. The co-presence of equally concerned people seemed to encourage the patients to continue beyond a regressive phase of life in the new country and learn more adaptive behavior without feelings of guilt or shame from loyalty conflicts.

Husemann (1997) criticized Battegay and Yilmaz's report and argued that they ignored the fact that their patients' immigrations were preceded by traumatic experiences which and could have been concealed from consciousness, and then projected onto the trauma of crossing cultural barriers. Husemann also contended that Battegay and Yilmaz also failed to realize that the cultural confrontation at hand may not be one between North and South, but rather, one between extremely

poor, medieval, lower-class culture and middle-class urban culture. Husemann's arguments coincide with the view of this dissertation. The traumatic experiences that the individual/family may be able to openly share or may find too difficult to speak of, or to think about or remember must always be carefully considered by the carer. These experiences, together with other variables, such as socioeconomic background, the culture and the environment in the homeland and the new country are examined in application of the framework to the individual/family member.

Torture and trauma

The following studies and literature present the subject of trauma and torture in context of the refugee and immigrant, and the necessity for specialized medical and psychological treatment of victims of organized violence. The overview was significant to the establishment of a more comprehensive understanding of the psychic consequences of trauma and torture and the various treatment methods to which the framework of this dissertation might be applicable.

Treatment and research methods

Amnesty International (1984, 1987) reported on torture in the 1980s, and described methods for examining torture victims. After the basic construction of the framework, and in corroboration with these and other reports and the author's clinical experience in the treatment of torture victims living in exile, trauma and torture was emphasized as a significant component of *transition-related conditions* in the framework.

Several other studies and literature on torture and trauma caused by external violence became available in the mid-l980s and onwards.

Miserez (1987) collected papers on the trauma of exile and its affects on mental health. The issues examined were disruption, uprooting, and flight; reaching the host country and the problems of asylum seekers; methods of support; adaptation and integration; and also the difficulties of children, women and the elderly. Scarry (1985) examined torture and its consequences. Westin (1989) studied the impact of torture on identity and psychological, existential and social existence, and also its significance as a societal phenomenon. Among the concepts and issues discussed were definitions of torture, its history, pain and its meaning, the structure of power, will, integrity and knowledge. Westermeyer (1989) presented a guide to psychiatric care of migrants, and – with Wahmenholm (1989) –

examined the assessment of the victimized psychiatric patient. Van der Veer (1992, 1998) defined the psychological problems of victims of war, torture and repression, and described varied methods of counseling and therapy.

After construction of the framework and its use in clinical work, supervision and training, literature and studies started to appear on the treatment of victims of torture and trauma caused by external violence. The illustrative selection that follows comprises some relevant examples of clinical and empirical research in the field. The aspects and components of the framework presented in the dissertation seemed to be applicable to these specialized modes of treatment.

Relevant works include Stover and Nightingale's (1985) studies of mental and physical torture, its background, consequences and treatment; Figley's (1985) studies of traumatic stress theory, research and intervention; Suedfeld's (1990) collected studies on the psychology and treatment of torture; and Peterson et al.'s (1991) clinician's guide to post-traumatic stress disorder (PTSD). The authors presented various theoretical explanations for the development of PTSD, its major symptoms and the course of the disorder, and also procedures for diagnosis and assessment and treatment. Also, in this field, there are Basoglu's (1992) description of treatment approaches to torture and its consequences; Kleber et al.'s (1995) collected material on work in counseling and psychotherapy with trauma, and its cultural and societal dynamics; and Klain's (1992) compiled papers on the psychology and psychiatry of the victims of the war in former Yugoslavia. Among the issues discussed are the behaviors of people in war, combat stress reaction, post-traumatic stress disorder, psychosomatic reactions, induced psychoses and deceptive behaviors, group behavior in war, alcoholism and drug addiction in war, and the wounded soldier.

Since the mid-1980s, there have been many reports on treatment work with torture survivors from institutions all over the world. Some of these relevant to the dissertation are as follows.

Lindblom-Jakobson (1987) reported on a year's experience of clinical work with tortured refugees at the Red Cross Center in Stockholm, the patient's silence over traumatic experiences (1990), and using an interpreter in clinical work with tortured refugees (1990, 1991). Jakobsson and Brandell-Forsberg (1991) examined the medical and

psychological aspects of fleeing, exile and torture in their description of the mental and physical difficulties of refugees living in exile in Sweden. Hjern (1995) surveyed various methods for diagnosis and treatment of traumatized refugees in Sweden. Malmström et al's. (1997) reported on torture and trauma treatment work at the Center for Treatment of Torture Victims in Stockholm.

Lavik et al. (1994) compiled papers on the clinical work of the Psychosocial Center for Refugees in Oslo. A historical/psychological perspective on organized violence and mental health, human-rights violations, and torture and its treatment are described.

Cunningham and Cunningham (1997) reported on the incidence of psychological and medical symptomatology, torture and related trauma in 191 refugee clients (aged 15-75 years) at the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) in New South Wales, Australia. Analysis of STARTTS client records permitted the coding of the presence/absence of 41 medical and psychological symptoms and of 33 torture and trauma experiences. The first symptom factor extracted for both the symptoms and trauma experiences was labeled "core PTSD" (p. 555), with regard to which relation to threats and humiliation, and being forced to watch others being tortured, best predicted scores on this factor. Although core PTSD is the dominant factor in symptomatolgy, comorbidity was also high. Cunningham and Cunningham's patterns of symptomatology and patterns of torture seemed to correspond with the case reports of torture victims related to in this dissertation.

The subject of torture and trauma and its treatment have led to many papers. Apitzsch (1985) examined the effects of extreme trauma on second-generation refugees in Sweden, the nature of torture (1987), and post-trauma and dreamwork (1995). Apitzsch concluded that dreamwork is an important psychotherapic tool in working through post-traumatic experiences. His conclusion concurred with the findings of this dissertation in regard to dreamwork. Cernovsky (1997) argued that recurring nightmares are an important diagnostic marker in assessment of PTSD. Statistical research is reviewed on the content and emotional aspects of the escape nightmares of Czechoslovak refugees (aged 17-71 years) from the part of Europe once controlled by the former Soviet Union, now living in exile. In these studies on refugees, within the first two years after escape, more than 50% reported escape

nightmares. After ten years in the host country, more than 80% reported having experienced the escape nightmare at least once. The peak incidence was within the first four years following escape, with a subsequent gradual decrease to very low levels. Cernovsky's argument that recurring nightmares are an important diagnostic tool is further confirmed in research on dreamwork such as the afore-mentioned study on PTSD and dreamwork by Apitzsch (1995). The findings of these studies seem to be confirmed in the reports documented in the casework of this dissertation.

With Ramos-Ruggiero, Apitzsch (1994) described a method for evaluating psychological trauma in an investigation of 45 asylum seekers to Sweden, and concluded that PTSD was frequent. Also depicted were problems encountered in assessment and treatment.

Bustos (1987) discussed psychic traumatization in refugees, reactions of the therapist and therapeutic institutions to victims of torture (1989), and psychodynamic approaches to the treatment of torture survivors (1992). In the latter article, Bustos presented a psychodynamic formulation of psychological responses to torture, a description of a psychodynamic therapy model, and a discussion of issues in treatment, especially counter-transference.

In Denmark, Agger et al. (1985), and Somnier and Genefke (1986) discussed the psychotherapy of refugees who had been submitted to torture. Agger and Jensen (1989) analyzed the encounter of trauma, and its meaning and significant concepts in transcultural psychotherapy for political refugees. The authors concluded that many of these refugees suffer from PTSD, and can be helped by post-traumatic therapy. It is important for patient and therapist to find explanations that give meaning to the traumatic experiences of the patient.

Weine et al. (1998) described the use of the testimony method of psychotherapy in a group of 20 traumatized (aged 23-62) refugees from genocide in Bosnia-Herzegovina. All subjects received an average of six sessions of testimony psychotherapy, and received standardized instruments for PTSD, depression, traumatic events, global functioning, and prior psychiatric history. The instruments were administered before and at the conclusion of the treatment, and at two- and six-month follow-ups. The post-treatment assessment demonstrated significant decreases in the rate of PTSD diagnosis, PTSD symptom severity, and the severity of

reexperiencing, avoidance, and hyperarousal symptom clusters. Depressive symptoms demonstrated a significant decrease, and there was a significant increase in scores on the Global Assessment of Function Scale. The two- and six-month follow-up assessments demonstrated further significant decreases in all symptoms and increase in scores on the Global Assessment of Functioning Scale. This pilot study provides preliminary evidence that testimony psychotherapy may lead to improvements in PTSD and depressive symptoms, as well as to improvement of function, in survivors of state-sponsored violence.

The above-mentioned authors, and especially Agger and Jensen's findings and their suggestions for treatment, seemed to coincide with the research material presented in the dissertation. Various approaches to treatment have been considered, and in some instances applied to the application of the framework in the casework material presented in the dissertation.

Religious beliefs

Shrestha et al. (1998) examined the impact of torture on 526 Bhutanese refugees (age 21-87) in Nepal. Interviews were conducted by local physicians and included demographics, questions related to the torture experienced, a checklist of 40 medical complaints, and measures of PTSD, anxiety, and depression as assessed by the Hopkins Symptom Checklist-25 (HSCL-25) for depression and anxiety. Results showed that the tortured refugees, as a group, suffered more on l5 of l7 Mental Disorders-III-Revised (DSM-III-R) PTSD symptoms and higher HSCL-25 anxiety and depression scores than non-tortured control refugees. Logistic regression analysis showed that history of torture predicted symptoms of PTSD, depression, and anxiety. Torture survivors who were Buddhist were less likely to experience anxiety. Tortured refugees also presented more musculoskeletal and respiratory system-related complaints than the control group.

Shrestha's conclusion that Buddhist torture survivors suffered the least anxiety seemed to be confirmed in the case reports in this dissertation. It appeared to be that persons with religious convictions seemed able to endure and overcome the psychological and physical consequences of trauma, torture and exile to a greater extent than those who did not have such religious convictions.

Women and treatment

Axelsen and Sveaass (1994) dealt with psychotherapeutic understanding of women exposed to sexual violence in political detention, now living in exile in Norway. The psychological reaction to sexual torture, including participation, powerlessness, guilt, meaninglessness, disassociation, negative self-image, and psychological symptoms (as coping mechanisms) are identified. Eight goals and principles of therapy are described: (1) work with self-esteem, (2) guilt, (3) body perception, (4) finish unfinished experiences and give new meaning to the trauma, (5) see the trauma in new life span perspective, (6) clarify the meaning in the reactions, (7) strengthen self-control, and (8) work with motivation through the therapeutic relation. The authors concluded that the therapist must allow the woman to proceed at her own speed and to direct her own process of change.

In the United States, Chester (1992) described therapy with women refugee survivors of political torture, and presented an overview and combination of approaches to examine treatment implications for the culturally diverse group of female torture victims currently living in exile. Chester concluded that support groups composed of women refugee survivors offer a promising means for empowering them to reconnect with their own inner strength. The group setting enables them to draw on the strength of other women who have undergone similar experiences. Young (1998) described the characteristic physical and psychological sequelae seen in women survivors of torture, and examined current clinical methods in assessment, diagnostic and treatment approaches to the rehabilitation of women survivors of torture. An overview of the current methods and aims of torture practices was provided, and thereby the sociopolitical context of torture. Potential burnout in therapists working with women survivors of torture was discussed. Young concluded that improved methods in empirical and clinical research are necessary.

Family

Chambon (1989) discussed refugee families' experiences with regard to three family themes in treatment work: disruption, violent trauma and acculturation. She concluded that institutional responses to refugee families contribute to family fragmentation and trauma, and also to acculturation conflicts in the family. Chambon's conclusions about

refugee families in the United States seemed to concur with casework material in this dissertation gathered in Scandinavia.

Seeking treatment

Priebe and Esmaili (1997) studied the differences between 34 Iranian victims of torture (aged 28-47 years) suffering from long-term mental sequelae of torture and living in Germany, and those who sought treatment and those who did not. Twelve were in the treatment seeking group and the remaining 22 were in the non-treatment group. According to the DSM-III-R, depressive, anxiety, and somatoform disorders were diagnosed with a high degree of comorbidity and with PTSD. Treatment seekers had a higher level of psychopathology, particularly PTSD symptoms of intrusion and increased arousal, and a poorer knowledge of German. It was concluded that the differences found between the two groups may reflect more or less successful adaptation to conditions in the host country and may contribute to the motivation to seek treatment. Piebe and Esmaili's conclusion that adaptation to the host country may be of influence in seeking treatment seemed to be in accord with the treatment seekers in the clinical work and supervision for the research in this dissertation. Those victims of torture or traumas due to war or political upheavals who have been able to constructively restart their lives in the host country seemed to less-frequently seek professional help to work through these experiences.

Validity of research

In the United States, Mollica and Caspi-Yavin (1996) examined the assessment of events and their related symptoms in torture and refugee trauma. They argued that in the field of torture rehabilitation, until recently, scientific investigations of the psychological symptoms of torture survivors consisted primarily of the reporting of symptoms without any systematic reference to the standardization related to psychiatric diagnosis. Mollica and Caspi-Yavin concluded that the problem of establishing reliable and valid measurements which capture the realities of the torture and trauma experience and related disease processes reveals the complex relationship between a concept of traumatization and the indicators of stressful life experiences and symptoms. Mollica and Caspi-Yavin, as well as Young in her study of women survivors of torture, point to a most important factor in the field of torture rehabilitation, i.e. the problem of creating reliable and valid

measurements in clinical and empirical research. Improved methods of assessment, diagnosis, treatment and care of torture and trauma victims are other factors that must continue to be studied and refined in this relatively new field of research.

Refugee and immigrant children

During the 1980s and onwards, the literature and studies on mental difficulties and refugee and immigrant children have concentrated mostly on the refugee child and adolescent.

In 1986, Westermeyer and Williams compiled papers on refugee-child and adolescent mental health in resettlement countries to emphasize their specific difficulties. Gustafsson and Lindkvist (1987, 1989) studied children who experienced war and their treatment, and described their own experiences and methods in working with them. Bustos and Ruggiero (1984) examined youth in exile and its effects on the emancipation process. Bendler-Lindqvist and Palm (1988) described psychotherapeutic work with refugee children and their families. The issues examined were small children's and adolescents' post-traumatic reactions; using play, art and other therapy technics; utilizing an interpreter; and, the unaccompanied child/adolescent in therapy.

Ahearn and Athey (1991) compiled an anthology of theory, research and services provided to refugee children. In a chapter of this book, Berry described an overview of refugee children's adaptation in settlement countries and primary-prevention methods. Boyd Webb (1991) collected papers for practitioners on play therapy with children in crisis. Angel and Hjern (1992) illustrated treatment methods of refugee children and their families from different countries in exile in Sweden.

Obradovic et al. (1993) collected data on the mental status of 102 children (aged 8-19) who were refugees from Bosnia, Herzegovina and Croatia, living in refugee centers. It was indicated that these children experienced sadness, worry, tension and loss of pleasure, with neurovegetative symptoms, such as lack of appetite, disturbed sleep, excessive perspiration, headaches and cardiac and respiratory complaints.

Weine et al. (1995) observed adolescent survivors of "ethnic cleansing" (p. 1153) in their first year in America. PTSD was diagnosed in 25% of cases, and 17% suffered from depressive disorders. It was concluded that the low rate of PTSD may be attributed to normal prior development, time-limited adversity, and lack of physical and sexual traumas.

Grundin (1994) interviewed 20 refugee children and adolescents from eight countries, and also their foster families, living in a suburb outside Stockholm. She mapped out the function of foster-home placement of the unaccompanied refugee child and its problems. She reported that the foster homes became extensions of the children's parents and culture patterns. She noted that all children interviewed were disappointed with their biological parents for sending them into exile, and suffered from severe fears of abandonment.

Almqvist and Brandell-Forsberg (1995) studied 50 Iranian refugee children living in Sweden and the effects of organized violence and forced migration on these children. A comparison of children's play performances and parental descriptions of organized violence revealed considerable similarities, thus suggesting that children were re-enacting traumatic experiences.

Similar conclusions were established in Gruenbaum's (1998) case example of a six-year old refugee female whose mother had been tortured and whose father had been executed. Gruenbaum's argued "that children of refugee families who have survived torture often have emotional, psychosomatic and behavior problems as well as problems with learning. In order to understand the difficulties of these children, we have to recognize the complicated interaction of accumulative traumatic strain and recurring exposure to shocking violence. The traumatic experiences of the child in the country of origin take place in the broader context of chronic danger and persecution, often to be followed in the country of exile both by recurrent family strain and social estrangement. In the transference this complicated mixture of repeated trauma and chronic strain may show as a pervasive tendency to retreat to defensive survival strategies combined with continual repetition of more specific traces of the impact of the trauma on the individual" (p. 442). This paper focused on how the enacted survival strategies in behavior and play can be contained and understood in the transference. "In due course the compulsive repetition can be given meaning as a precondition for better integration through symbolic thought and self-understanding" (op. cit., p. 451).

Ajdukovic and Ajdukovic (1998) examined the impact of war-induced displacement on children's well-being. Three indicators of children's mental health status are discussed: (1) mother's assessment of children's stress reactions; (2) the past traumatic stress reactions of

children; and (3) the level of depression of children during displacement. Data were gathered from a program that provided psychosocial assistance to families with children in a collective refugee center in Zagreb, Croatia. Displaced mothers and children were interviewed three times, over a period of three years. Findings reaffirmed the importance of the family and the support it provides to a child in coping with the prolonged stressful situation of displacement. Data also revealed that even in such situations where multiple stressors have accumulative effect over time, the incidence of stress-related reactions in children decreases. "Nevertheless it must be kept in mind that the child's exposure to extremely intense stressors can have delayed effects and can cause difficulties in psychosocial function in adulthood" (op. cit., p. 194).

Montgomery (1998) interviewed asylum-seeking Middle-Eastern refugee parents and children in Denmark to map out the prevalence of torture victims among parents, and the prevalence of experiences of war and other forms of organized violence. She found that the children frequently showed anxiety and other symptoms of emotional instability. Prevalent anxiety symptoms correlated with both previous living conditions and present family situation. Living under the prolonged influence of war and other forms of organized violence was found to be a stronger indicator of anxiety than specific events or changes in life conditions.

Almqvist and Broberg (1999) studied the importance of various risk and protective factors for mental health and social adjustment in 50 pre-school Iranian refugee children (mean age 5.2 years) who were evaluated 12 months after arrival to Sweden. Of these, 39 were re-evaluated in a follow-up study 2.5 years later. The effect to exposure to organized violence, age, gender, individual vulnerability, parental functioning, and peer relationships on the children's well being and adjustment was investigated using multiple and logistic regression analyses. The authors concluded that exposure to war and political violence and individual vulnerability before traumatic stress exposure were important risk factors for long-lasting post traumatic stress symptomatology in the subjects. Also, the emotional well-being of the mother predicted emotional well-being in children, whereas the children's social adjustment and self-worth were mainly predicted by the quality of their peer relationships.

The findings of Adjukovic and Adjukovic, Montgomery and Almqvist and Broberg seemed to be similar to reports from the case material presented herewith. It appears that the mental-health development and well-being of the child and adolescent who have experienced war and political violence, and are now living in exile, seemed to depend on the family, and especially the mother. Moreover, from the material gathered in this dissertation, it appeared that the emotional well-being of the child seemed also to be influenced by the father, the siblings and also, other support systems in the neighborhood, the community and the society. These factors may also be important to consider. Further research into the factors that create emotional well-being in children and adolescents living in exile is most necessary.

Berger (1996) described a program in Garden City, New York designed to provide group work services to immigrant adolescents from the former Soviet Union. She contended that these youngsters experience special needs because they are caught in a unique situation of simultaneous developmental and sociocultural transitions. Berger, a group supervisor in the program, argued that group work is an efficient modality for helping adolescent immigrants. In group work with refugees and immigrants in which the framework has been applied, Berger's arguments are in agreement with the research study presented in this dissertation.

The use of art therapy was studied by Kalmanowitz and Lloyd (1999) in two pilot art therapy programs in the refugee centers of Hrastnik in Slovenia and Prvic in Croatia. The description of the program in Slovenia outlined how art took as many forms as necessary to approach different age groups in different ways. The focus was primarily on the children, the largest group in the camp. In Croatia, with a time frame of three weeks with no future visits intended, maintaining a regular structure was difficult, yet it was possible to offer art daily in which individuals were encouraged to explore their own themes. Implications of the programs included the responsibility to bear witness and share the traumatic war experiences with others, and how the act of witnessing becomes an active intervention, and the development of the portable studio in which the internal structure of the art therapist can allow for work to take place inside and outside. The study concluded that at both programs art played a role as a subtle intervention. In the supervision, consultation and training

of art therapists, the framework appears to be able to be applied effectively to this mode of treatment.

Rousseau et al. (1998) explored the special case of unaccompanied refugee children, traditionally considered to be a high mental-health risk. The collective mechanisms of a specific culture, the pastoral society of northern Somalia, are analyzed. Using ethnographic data from unstructured and semi-structured interviews with young male Somali refugees (aged 13-18 years) and key informants (representatives of the host community in Canada), the authors showed how young Somali refugees are relatively protected by the collective meanings attributed to separations within their own nomadic culture, and by the establishment of continuity through lineage and age-group structures. This continuity is based not only on the potential substitution of ascendants by a vast social network, but also on a very strong process of identification with the age-group of peers. How the adoption of traditional nomadic strategies can be considered both an attribute within the social Somali structure and deviant or delinquent behavior by the host country is demonstrated. Rousseau and colleagues' research considers the positive elements of a specific culture in the resiliency in unaccompanied minors from the north of Somalia.

Also, the study of Coll and Magnuson (1997) focused on the positive psychological effects of migration on children. In the past, clinical and empirical research have concentrated on the negative impact of migration. The purpose of this study was to present a more balanced and thorough view. The authors have tried to take into account the possible positive benefits of migration, the influence of the developmental stage on the adjustment process, the complexity of the processes involved, and the crucial influence of present historical, political, economic and educational contexts. Children's reactions to stress, and the stressors of the migration experiences and PTSD, are discussed. Coll and Magnuson concluded that migration could lead to positive psychological effects in the child, such as the development of a dual frame of reference, which included biculturalism and bilingualism, and a widened identity and self. In the application of the treatment framework of this dissertation, Coll and Magnuson's conclusion is the final goal in the clinical use of the framework with both adults and children, i.e. a widened identity and self.

Rousseau and colleagues' examination of the resiliency in unaccompanied minors from the north of Somalia, due to certain specific mechanisms of their culture, and Coll and Magnuson's studies of the positive psychological effects of migration are promising research directions in the study of refugee/immigrant children. As the authors pointed out, clinical and empirical research has mostly been concentrated on the negative psychological consequences of migration and exile. By contrast, in the research and in the application of the framework in different modes of therapy and support work with the refugee/immigrant child/adolescent/parents, their constructive resources can be considered, as well as their difficulties, which can be systematized, so that the most severe ones obstructing development and well-being are more effectively dealt with.

Treatment models and frameworks

In studies of the literature before and during the conceptualization of the framework, there were no specific clinical models or frameworks for the treatment or care of refugees and immigrants reported. In more recent studies, after the formation of the framework of this dissertation, a few specific models relating to the psychology of, and/or the treatment and care of these groups have been presented. However, there appears to be no similar framework for the treatment and care of the refugee and immigrant as given in this dissertation. One of the possible reasons for this could be that the clinicians at work with these groups have not gathered or published their material. Here follows a review of the models of treatment.

Bemak et al. (1996) presented a multilevel model (MLM) of psychotherapy specifically designed for refugee populations, which included issues relevant to the refugee experience that are critical to consider in therapeutic interventions. The authors contended that "the cultural dynamics and history of each refugee present unique characteristics that are traceable to cultures of origin and cultures of resettlement respectively. These differences must be clearly understood and incorporated into therapeutic relationships at multiple levels, including individual, family, group, and community" (p. 243). An intervention approach that integrated Western with indigenous methods was incorporated in the model. Further, a holistic framework is also presented as an integrated strategy to meet the complex needs of

refugees. Six topics were considered: (1) cultural-belief systems; (2) utilization of mainstream mental health services; (3) acculturation and mental health; (4) psychosocial adjustment and adaptation; (5) the implications of resettlement policies for mental health; and (6) a multilevel model approach to counseling and psychotherapy with refugees (p. 261).

Bernak and his colleagues' intervention approach, which integrates Western with indigenous methods, is considered and commented on below, along with Street's (1998) study of Nathan's ethnopsychoanalytic therapy. In Bernak et al.'s multilevel model of treatment and care and holistic framework, both the individual and society are considered. The person's difficulties are studied, together with the relevant issues in society that must be considered. The view of this dissertation is in agreement with the idea of the specific model of treatment and a framework that attempts to integrate the societal and cultural issues to consider in work with the refugee and immigrant. While the otherwise-qualified psychotherapist and counselor could be supervised in the application of a specific treatment model for the refugee and immigrant, he/she may not have knowledge of the specific societal and cultural issues mentioned.

Ramirez (1999) presented a multicultural model of psychotherapy and counseling. "The techniques and strategies of the multicultural model reflect an eclecticism, ranging from the intensive study of the client's life history and the use of insight, to the employment of cognitive behavioral as well as humanistic and cross-cultural approaches. Multicultural therapy, however, is unique in its theoretical concepts and goals of change" (Ramirez, p. xi). The theoretical concepts include "a cultural and cognitive flex theory of personality which is sensitive to the traditional and modern cultural styles of cognition. These concepts are useful to understanding multicultural personality development and functioning" (p. 31). The goals of the multicultural model of psychotherapy are achieved in stages.

The goals are: (1) to reduce alienation and feelings of helplessness and despair; (2) to recognize and accept the unique self; (3) to achieve cognitive and cultural flex by recognizing the advantages of a multicultural society to personal development and help in the development of cultural and cognitive flexibility, which facilitates the development and expression of the self; (4) to empower clients to

become change agents, peer counselors and multicultural ambassadors. These goals are dependent on the accomplishment of a series of subgoals: (1) identifying the relationships of pressures to conform and assimilate to choice of cultural and cognitive styles; and (2) identifying possible attitudes and values associated with ethnocentrism and the development of negative stereotypes, which have prevented clients from participating in and learning from diversity. The therapeutic process generally consists of 16 sessions and follow-up. Each session focuses on specific goals (p. 50). Ramirez's ambitious multicultural model of short-term psychotherapy and counseling attempts to consider and deal with all the personal, societal and political factors involved in living as a refugee or immigrant in the United States in just 16 sessions.

The treatment framework and the over 25 years of casework research presented in this dissertation weighs heavily against Ramirez's belief that the goals of the multicultural model of psychotherapy can be achieved in so short a time. The framework presented here can be used in short-term therapy. The goal would be to ease or alleviate the presented symptoms and problems.

Streit (1998) and Freeman (1998) described ethnopsychoanalytic psychotherapy and ethnically oriented psychiatric consultation for immigrant families in France based on the work of a group led by the psychoanalytic psychologist Tobie Nathan's clinical work with migrants (which has gained increasing recognition in France over the last l5 years). Based on the theoretical work of George Devereux (1953, 1956) on the relation of culture to psychiatry, a group led by Tobie Nathan has developed large group multicultural consultations to make sense of the complex problems presented by patients from non-Western societies. Their work in clinical settings has evolved into the Centre George Devereux at the University of Paris Nord, where training in methods of consultation and mediation for immigrant communities take place. Their thinking has often challenged established psychiatric theories and practices based on Western society norms.

"The main premises and therapeutic implications of this plurithеoretical approach attempt to integrate therapeutic techniques used in non-Western cultures and psychodynamic therapy by introducing three main parameters: (1) the patient's mother tongue, (2) traditional etiologic theories (explanatory models) specific to the patient's culture of origin and, (3) a group setting with a multicultural

group of therapists. Nathan's focus on technique makes it possible to identify important elements of the therapeutic process; the material arrangement of the therapeutic setting (illustrating the main therapeutic idea) and specific logical processes such as analogical thinking, mediation, and reversal" (p. 1363).

Nathan's and also Bernak et al.'s model of combining therapeutic techniques used in "non-Western" cultures and psychotherapy seems interesting. However, this could lead to difficulties and complications in the therapeutic process and treatment without skilled therapists from the different cultures.

Silove (1999) questioned whether contemporary notions of trauma, and especially a focus on the category of PTSD, are adequate in assessing the multiple effects of refugee experiences. He presented an integrated conceptual framework to comprehend and treat the psychosocial effects of torture, mass human rights violations, and refugee trauma. A framework was proposed which suggests that torture and related abuses may challenge five core adaptive systems subserving the functions of "safety", "attachment", "justice", "identity-role" and "existential-meaning" (p. 200). It is argued that a clearer delineation of such adaptive systems may provide a point of convergence that may link treatment and research endeavors more closely to the subjective experience of survivors and clarify the types of clinical interventions that should be offered in trauma treatment.

Silove's questioning of the current assumptions of trauma, and especially PTSD, as sufficient for the assessment of the effects of refugee experiences coincides with the view of this dissertation. Each individual is unique. Therefore, it may be impossible to assess efficiently all the patient's symptoms and problems and be able to differentiate those caused by the refugee experience. Many and careful interviews are essential in order to be able to do this. Silove's core adaptive systems, considered in his framework, appear to be possible to apply within the framework presented in this dissertation. In other words, the one framework does not have to repudiate the other.

Berry (1997) outlined a conceptual framework for investigation of acculturation and adaptation of the refugee and immigrant, which considered the influences of social and personal variables that reside in the society of origin, the society of settlement, and phenomena that both

exist prior to, and arise during, the course of acculturation. He discussed the links between cultural context, individual behavioral development, and the long-term psychological consequences of the process of acculturation. General findings and conclusions based on a sample of empirical studies were presented. Applications to public policy and programs were proposed, along with a consideration of the social and psychological costs and benefits of adopting a pluralist and integrationist orientation to these issues.

Berry's model was criticized by several authors. Lazarus (see Berry, 1997) argued that Berry's analysis of acculturation, while impressive, is too broad and abstract, and should also incorporate the influences of the more specific factors of stress, emotion, and coping. Lazarus also addressed some limitations of the concept of acculturation as the main framework within which to examine the relocation process. Also, Schoenpflug (1997) questioned the usefulness of Berry's stress-coping paradigm and its neglect of identity changes. Schoenpflug proposed: (1) acculturation as a migration-induced process of individual development in various developmental domains, and (2) acculturation as identity change, to fulfill a need for assimilation or a need for differentiation from own or host group (p. 54).

Further, Triandis (1997) questioned the adequacy of Berry's terminology and contended that Berry's model would be more complete if most of the known dimensions of cultural variation were included. Horeneczyk (1997) argued that while Berry does examine the importance of contextual societal factors and their effects on individual adaptation, a more differentiated look at these majority attitudes is needed fully to understand their effects on immigrants' acculturation and adaptation. "The assumption implicit in Berry's model, regarding a single monolithic majority society to which immigrants acculturate and about which they develop acculturation attitudes, may fail to take into account the social complexity of many modern societies" (p. 34).

Kagitcibasi (1997) doubted Berry claims that integration is the best acculturation strategy and pointed out that multiculturalism, by itself, is no guarantee of tolerance. This issue is discussed by the author with regard to international migrants, especially the ethnic minorities from Europe. Pick (1997) contended that a potential limitation of Berry's theoretical model is that each part fits perfectly with the other parts in a functional relationship, like the pieces of a "Lego" (p. 49) structure, resulting in a model that

ignores the diversity of immigrant populations. Pick proposed "an approach integrating the concept of the social actor and the bidirectional impact of acculturation at the individual and group level" (p. 51).

Lazarus' questioning of the concept of acculturation as the main framework to investigate the inner and outer consequences of migration and exile seemed to affirm the formation and the application of several aspects and components of the conceptual framework presented in this dissertation. Pick's comments coincide with the view of the dissertation, especially pertaining to the varied refugee/immigrant populations and the necessity to study the bidirectional impact of acculturation on the individual and group. Berry (1997) replied to the above authors' comments contending that although many of the comments suggested emphasis, elaboration, or addition to the original text and figures, "no text or figure can be completely representative" (p. 363). What he intended was "an acculturation framework to which new developments can be added, rather than an inclusive model" (p. 68).

The above authors' criticism of Berry's model of adaptation and acculturation, as a means to understanding the psychological and social consequences of migration, only emphasizes the need for a conceptual framework that is flexible and makes no previous assumptions.

Throughout the process of developing the conceptual framework and its subsequent application, the literature described above had a considerable impact. As mentioned above, the framework developed in what can be described as "interaction" between clinical practice and literature study. The literature input can be regarded as largely conceptual. In general, it enabled the author to make the key distinctions between inner and outer worlds, between the separate situations of refugees and immigrants, and between different processes of change on which the framework is founded (see the goals of the dissertation as listed in the introduction to chapter 1).

Data and documentation

The data upon which formulation of the framework was based consisted of casework from a total of 903 refugees, traumatized refugees, tortured refugees, immigrants – adults, adolescents, children, families and groups – in long-term and short-term individual, family and group psychotherapy and support work, with a duration of treatment from

1 week to 5 years. This population is described in a variety of respects in chapter 2.

Data were collected from written notes and reports, and tape-recorded sessions and reports or summaries carried out during and/or directly after the sessions. The tape recordings were transcribed and the written material categorized and summarized.

Because it would have been impossible within the scope of this publication to submit case descriptions of the total population (903 persons and 619 treatments), excerpts from 69 cases (64 individual and 5 family) were selected by the author as best as possible to illustrate all aspects and subaspects of the framework. Since nearly two-thirds of the population were refugees, the components and aspects of the framework are illustrated with two refugee cases and one immigrant case. With the exception of an aspect and a component, where one is presented with only refugee cases, and one with two immigrant cases and a refugee case, because of their greater illustrative value. Each case description indicates the individual's age, gender, country of origin, length of time in the new country and the type of treatment, duration, and number of sessions. An overview of background characteristics of the illustrative sample is provided in table 3.1.

Table 3.1. Some basic characteristics of the illustrative sample.

Refugee or immigrant	44 refugees (plus 1 second generation), of which 20 traumatized/ tortured, and 20 immigrants (plus 1 second generation),
Gender	35 males and 29 females
Age	17 under 30, 25 aged 30-40, 21 aged 40 or over (1 age unknown)
Employment status (homeland)	41 professionals (including students) and 23 others (manual workers, etc.)
Employment status (new country)	39 professionals (including students) and 25 others (manual workers, unemployed. etc.)
Country of origin	Europe 15; Latin America 14; Middle East 16; Africa 7; Asia 7; Other countries 5

Reasons for seeking treatment (as reported by the individuals involved) were extremely varied (see table 3.2). In the case of five families in the sample, reference was made to intra-family violence, physical abuse, and concentration difficulties, aggressivity and family conflict.

Table 3.2. Reasons for treatment.

Aggressivity – criminal behavior	1	Insomnia – concentration difficulties	2
Aggressivity – depression	1	Insomnia – nightmares, isolation	1
Alienation	1	Manic depressive personality disorder	1
Anxiety	1	Mental exhaustion	1
Apathy	1	Obsession – death thoughts	1
Back/shoulder pain (psychosomatic)	2	Obsession – insomnia, concentration difficulties	1
Concentration difficulties – relationship problems	1	Panic – unable to work	1
Concentration difficulties – aggressivity, missing homeland	1	Panic – morbid brooding, concentration difficulties, insomnia, depression	1
Confusion, unhappiness, restlessness	1	Physical abuse	3
Constant melancholy, nightmares	1	Psychosis – feelings	1
Depression – general	4	Psychosis – behaviors	1
Depression – insomnia	2	Severe depression	8
Depression – nightmares	2	Severe depression with psychotic feelings	1
Depression – suicidal thoughts	6	Suicide – actual attempt	3
Drug/alcohol abuse	2	Suicide – thoughts, confusion, nightmares	1
Fatigue, indifferent to work and life	2	To try to understand myself	1
Hysteria	1	Unhappiness, feelings of loneliness	1
I don’t know who I am	1	Violent aggressivity	4

4. THE REFUGEE/IMMIGRANT SITUATION

This chapter explains the terminology "refugee/immigrant situation", i.e. the outer processes of change and the accompanying inner changes that the refugee, the traumatized and/or tortured refugee, the immigrant and their children may go through. It describes how the refugee/immigrant situation can cause, influence or complicate presented symptoms and difficulties.

Throughout the presentation of the framework, the expression *refugee/immigrant situation* is used to describe how the outer processes of change that the person goes through in moving to a new country may affect the inner world. Within the terminology is included the outer processes of change and the accompanying inner changes.

Outer processes of change

In leaving or fleeing a country and coming to another, the person experiences many outer changes, such as country, climate, landscape, environment, culture, ethnic/racial differences, religion, language, employment, politics. He/she may have come from a certain level of society, socioeconomic conditions and education in the country of origin, and have or be offered different ones in the new country. The way the new country functions and the people in it are also outer differences encountered by the individual (Garza-Guerro, 1974; Kristal-Andersson, l976; Mostwin, l976). Within the terminology, the *refugee/immigrant situation* also encompasses:

- the outer reasons the person came to the new country (gradual or sudden, planned or not), and their influences on the inner world;
- how the person meets and deals with the outer changes he/she is confronted with in the new country;
- how the person is received in the new country.

Accompanying inner changes

Accompanying inner changes are defined as the conscious and unconscious effects of these outer processes on the inner world and how they influence the person's life. In starting out in the new country, the *refugee/immigrant situation* is based on each person's unique and different experiences of the reality of the outer changes. At first, these can be based on reality, the person's experience of that reality, or even an exaggerated experience of reality or fantasy. How the individual contends

with the *refugee/immigrant situation* can also be based on other aspects of the framework.

The following case excerpts describe how the *refugee/immigrant situation* can cause or complicate presented symptoms and difficulties. In Case 4.1, the conflicts between mother and daughter are influenced by the mother's *refugee/immigrant situation.*

Case 4.1

An immigrant family, 21 years in Sweden, from a Middle East country with a warm climate; the mother, age 42, is a housewife; the father, age 49, a factory worker; they have 2 children, a daughter, 19 years old, and a son, 17 years old. Reason for treatment: violent conflicts between the teenage daughter and her mother. Form of treatment: family therapy, once a week. Duration: 3 months.

Case excerpt (from session 1, beginning of treatment):

The daughter explains to the therapist when asked why she gets so angry with her mother: "I fight with my mother because I have to help her with almost everything, I do all the shopping." T: "Why do you have to do all the shopping?" P: "She won't go out 7 months of the year. It's too cold for her, she says, and she is afraid of slipping on the ice. It's always been like this. I can't be who I want to be. My friends feel sorry for me. I am my mother's carer…and I don't want to be." T: "Do you feel you have to be?" P: "What will happen to my mother without me?" T: "Let's talk about that…"

In Case 4.2, the symptoms for which the individual sought treatment are complicated by the *refugee/immigrant situation.*

Case 4.2

A male refugee, age 55, 15 years in Sweden, a businessman, married; his wife, age 45, is a secretary; they have 2 children, 13 and 17 years old. Reason for treatment: aggressivity. Form of treatment: individual support work, once a week. Duration: 6 months.

Case excerpt (from session 4, after one month of treatment):

P: "I decided to take the bus today and leave my car. But on my way here, I just got angry at the bus driver. He asked me where I was going. I told him, and he said he didn't understand. Could I repeat my destination? I got angry. Don't you understand Swedish? I screamed. An old lady sitting there looked scared. I said the street name again. I paid, but I felt myself shaking inside. I have been in this country 15 years. I am a successful businessman and the bus driver doesn't understand a simple phrase I say in Swedish. All right, maybe I have a slight accent, but so what. No one usually complains about it. Then, is it me or him?" T: "Does it matter?" P: "Yes, I know I speak Swedish well." T: "Then why does it matter so much?" P: "Why do I constantly have to be reminded that I am a foreigner…should I show everyone my Swedish passport?" T: "Do you

think you have to?" P: "Sometimes I feel that way." T: "When do you feel you that way?" P: "I'll have to think." T: "Take your time, it could be important for you to understand what brings your anger on."

Case 4.3 describes how the *refugee/immigrant situation* can complicate the reason for which the individual is in treatment, especially when he/she has not yet worked through traumas experienced in the homeland.

Case 4.3

A female traumatized refugee, age 41, 12 years in Sweden, a home-language teacher, lives in a small city in the north, married; her husband, age 45, is an engineer; they have 2 children, 18 and 20 years old. Homeland traumas: her husband was imprisoned and tortured on several occasions before they fled. She experienced severe physical abuse the last time her husband was seized. Reason for treatment: severe depression, unable to continue her work. Form of treatment: individual psychotherapy, once a week. Duration: 2 years.

Case excerpt (from session 12, after 4 months of treatment):

During the first month of psychotherapy, she returned to her teaching job, but three months afterwards she went into a severe depression once again and could not cope with her home or work life. She explained that she became depressed again when she saw the television news reports on the recent series of threats and violence directed at refugees by a small group of neo-Nazis in Stockholm She explained to her therapist:

P: "The people here have always been friendly and kind to me and my family. But I am afraid that it could happen here, too." T: "What has happened in Stockholm is terrible, but it has not happened here. Throughout the years you have been here, has anyone showed racist attitudes towards you or your family?" P: "No, we are accepted here by everyone." T: "Then could it be your own fear inside you, rather than the reality of life here, that could have brought back the depression?" P: "But if it happened in Stockholm, it can happen here too." T: "Perhaps, but don't you think your friends and neighbors would stand up for you, if someone said or did something like that?" P: "Yes, I think so." T: "I am not trying to convince you that it can't happen here, too. Just as anyone could get hit by a car in Sweden. But most people don't, because the drivers are careful, despite all the cars." P: "You mean that most people are not racists, in spite of the recent events?" T: "I believe so." P: "I hope so." T: "Me, too…but worrying about it does not help you or anyone else." P: "No…my children are angry with me." T: "Can you tell me more about that?" P: "They tell me that we went through a lot worse in our own country and that we have nothing to be afraid of here. They can't stand seeing me depressed." T: "You told me that after they seized your husband the last time, you were so severely abused yourself, that you were hospitalized, then deeply depressed until you and the family could

flee your country." P: "Yes." T: "Could the recent events in Sweden be reminding you of everything that happened to you before you fled?" P: "Yes…" T: "You were abused just like the people on the television news." P: "Yes. I was in hospital two weeks because of it." T: "What did they do to you?" P: "They came into the house…" (The woman continues with a detailed description of the event, and finally realizes that it is the memory of this and other atrocities endured in the homeland, rather than her life now in Sweden, that brought on the depression.)

The cases above provide some examples of how the *refugee/immigrant situation* seems to influence the individual's symptoms, problems and difficulties, and the various aspects of the framework.

5. ASPECT ONE – THE STATES OF BEING

This chapter presents the first aspect of the framework, the "states of being". The expression states of being attempts to define the feelings, thoughts or conditions that may surround the person's life or existence in the new country and cause, influence or complicate his/her inner and outer difficulties. The states of being are: the stranger, loneliness, missing, longing, guilt, shame, separation and loss, sorrow, language degradation, value degradation, inferiority, non-identity, rootlessness, bitterness, suspicion, prejudice – to be prejudiced, to feel prejudice, the scapegoat – a syndrome: to be the scapegoat, to feel like a scapegoat. Each state of being is defined and illustrated by three cases chosen from the casework population.

The word *state* is intended to define a certain set of feelings, thoughts or conditions. It is defined in The New Shorter Oxford English Dictionary on Historical Principles (Brown, 1993) as "a combination of circumstances or attributes belonging for the time to a person or thing; a particular way of existing, as defined by certain circumstances or attributes; a condition especially of mind or body…" (p. 3036). The word *being* is used to encapsulate the ideas of life and existence (Frankl, 1976; Heidegger, 1949; May, 1967). Werner Brock, in his foreword to Heidegger's "Existence and Being", states the following: "According to Heidegger, the concept of 'Being' is the most universal one. …We make use of it in all knowledge, in all our statements, in all our behavior towards anything that 'is' in our attitude towards ourselves" (Heidegger, 1949, pp. 12-13). The expression as a whole attempts to approach a definition of the feelings, thoughts or conditions that seem to surround the person's life or existence in the new country and cause, influence or complicate his/her inner and outer difficulties. The *states of being* are *the stranger, loneliness, missing, longing, guilt, shame, separation and loss, sorrow, language degradation, value degradation, inferiority, non-identity, rootlessness, bitterness, suspicion, prejudice – to be prejudiced, to feel prejudice, the scapegoat – to be the scapegoat, to feel like a scapegoat.*

Naturally, not only refugees and immigrants experience such negative states of being, and it is also logically possible for a person never to experience any one of them. Nevertheless, the cases that follow show that they seem particularly to characterize certain experiences of the refugee and immigrant. This is not to deny that that there may be positive aspects of living in a new country, but these are not the central concern of this dissertation.

At some time in life, most anyone goes through the feelings, thoughts and experiences that can lead to a radically changed *state of being.* For example, almost everyone – at one time or another – has experienced the feeling of the stranger or the outsider (Josephson and Josephson, 1962). We have all had feelings of loneliness, of missing a loved one or a place. We may have had feelings of inferiority, or not had the words to express something we want to say or feel or believe, and felt stupid and inferior, humiliated or degraded. We may have felt at times suspicious or prejudiced, even against our will, or felt that someone has been discriminating or is prejudiced against us. Perhaps we may have, at one time or another felt that we were a scapegoat for another person, in a group or institution or out in society.

However, when someone's existence becomes dominated by one or several of these states on a conscious and/or unconscious level – to an extent that it *dominates* his/her inner and outer world – the person is in a *state of being*. The individual experiences life as controlled by the *state of being*. For example, the feeling of being a stranger grows – finally to form the *state of being*, *the stranger* (Wilson, 1956). Such *states of being* are experienced regardless of homeland, age, sex, culture, religion, color, racial or ethnic origin; language or socioeconomic, educational, vocational or political background; or for whatever reason or however long ago the individual came to the country.

Each state of being may:

- be conscious or unconscious;
- be based on reality, or the exaggerated experience of reality or fantasy;
- cause, influence or complicate current symptoms or inner and outer difficulties;
- be more apparent during emotional and/or existential questioning, conflicts or a life crisis or life change;
- affect current symptoms and difficulties and how these are endured, depending on the *refugee/immigrant situation*, and also other aspects in the framework;
- be experienced at the same time as other *state(s) of being*;
- cause different degrees of suffering – from confusion and inner and outer conflicts, through neurotic and psychotic feelings, to neurosis and psychosis;

- represent a fusion between current symptoms and difficulties, the *state(s) of being* and aspects of the framework making these difficult to differentiate and diagnose and treat;
- be caused and further complicated by other factors, such as –

in the refugee:

- past home experiences of oppression, war and its atrocities, torture, natural and man-made catastrophes;
- traumatic experiences in relation to the above;
- inability to visit or return to live in the homeland;

in the immigrant:

- past homeland experiences – personal, socioeconomic, or due to natural and man-made catastrophes;
- traumatic experiences in relation to the above;
- ability to return at any time to the homeland;

in the child:

- identification with the *state(s) of being* of parents and siblings, and going-through these in similar ways.

Each *state of being* is explained separately, and depicted by three cases selected from the total refugee/immigrant population so as best to illustrate the particular *state of being.*

STATE OF BEING: THE STRANGER

The refugee and the immigrant and their children are "strangers" when they arrive in the new country. At first, based on reality, almost everything and everyone is unknown and different. Often the individual/family must learn anew much of what was taken for granted in the homeland, from the simple to the complicated: basic tasks, habits, the language, the physical environment – the outer conditions of the new country. It can be even more difficult to learn the inner characteristics of the new country, such as psychological and sociocultural attitudes, rights and wrongs, the way of life. The refugee and immigrant is, in reality, a stranger or outsider. Everyday, he/she is reminded of it – from small unimportant happenings to larger events that affect his/her future in the new country.

Feeling like a stranger was reported to come on either suddenly or gradually, and last a few seconds, minutes or longer periods of time –

depending on what the refugee or immigrant is going through in his/her present life. Its onset has widely varying outer reasons – from the seemingly banal to the serious – such as a switchboard operator who may not understand his/her accent, or not getting a job he/she is qualified for. These are reminders that may be constant over the first months and years, or at certain specific times in life, or for the rest of life – according to how the person has adapted to the new country. Whether he/she remains a stranger and these feelings become the *state of being* does not appear to be based on how long the person is in the new country, but on how he/she encounters (and is encountered by) the new country. Is the person isolated? Does he/she have contact with the inhabitants of the new country? Has he/she learned the language, the customs, the life style of the new country? Many refugees and immigrants spend years in the new country, and still have only stereotyped ideas about the majority population. This may lead to remaining *the stranger*. The outward situation is reflected inwardly; he/she feels like a stranger and becomes encompassed by it. It becomes part of the individual and a permanent *state of being*. He/she is *the stranger*, the outsider.

Past experiences, such as war and its atrocities, torture and oppression, seem to cause severe feelings of alienation and suspicion toward people and, at times, life itself (Fanon, 1967; Miserez, 1987). Due to experiences in the homeland, the traumatized and/or tortured refugee seems to suffer more deeply because of the feeling of, or the *state of being*, *the stranger.*

Cases – state of being: the stranger

This first case exemplifies the *state of being: the stranger* when it is triggered off by a concrete or real happening or event.

Case 5.1

A female refugee, age 50, 20 years in Sweden, a saleswoman (an accountant in her native country), divorced; she has 2 children, 15 and 18 years old. Reason for treatment: severe depression. Form of treatment: psychotherapy, once a week. Duration: 1 year.

Case excerpt (from session 3, after 3 weeks of treatment):

She describes herself as feeling like a stranger in society. She has had this feeling for many years, she explained, but it was revived by a form she received in the mail which she could not understand. It was written in difficult, bureaucratic Swedish. She had to ask her teenage daughter, born in Sweden, to help her decipher it, which she did willingly. Shortly afterwards, she went into a severe depression. She could not work or take

care of her children, and found life without meaning. She then started psychotherapy.

By eventually becoming aware of her feelings of being *the stranger* and how they started, but realizing that she did in fact belong to society, with her family and friends, the depression began to lift. The actual inner difficulty was then revealed, a life crisis (menopause). She could look at, gain insight into and understand her feelings of being *the stranger* in Swedish society, along with her ambivalent feelings towards her "more Swedish than homeland" teenager (as she expressed it). Finally, she could come to terms with the temporary dependency on her daughter she had shown (even though this, she felt, was against both the cultural attitudes of her homeland and Sweden) and free herself from her feelings of guilt and envy towards her daughter. Her depression lifted when she could distinguish the *state of being: the stranger*, from the current psychological difficulties she was going through plus the life crisis, for which we could then continue psychotherapy.

The following case describes the *state of being: the stranger* when it is based on an exaggeration of reality of the person's life in the new country.

Case 5.2

A male immigrant, age 25, 6 years in Sweden, he came to the country to find work; currently unemployed. Reason for treatment: hashish abuse. Form of treatment: motivation support work with a social worker, twice monthly. Duration: 2 months.

Case summary (after termination):

He was 19 when he came to Stockholm, from a poor rural background. He worked at odd jobs for a while, but is now unemployed and lives in a rented room. He has a poor knowledge of the Swedish language. He started smoking hashish with some acquaintances from his own country when he first came. He continued to do so alone "to forget the loneliness". He now sits in his room smoking hashish all day. He has lived outside the new society since he came. He describes himself as "strange" and "alien" to everything and everyone in Sweden. He hates the people and the way of life, but now that he is on hashish, he can't go home, he says. He won't talk about his situation and refuses help for treatment of his abuse.

Feelings of alienation may not always be based on concrete reality, and can be painful and difficult for the person and others to comprehend. These feelings may be the result of something repressed in the past. Case 5.3 provides an example of the *state of being: the stranger* when not based on reality.

Case 5.3

A tortured refugee, age 36, 13 years in Sweden, a social worker, married; he has 2 children, 8 and 12 years old. Homeland trauma: at 20 years of age he was imprisoned and tortured for 6 months. Reason for

treatment: severe feelings of alienation. Form of treatment: supportive psychological conversations, once a week. Duration: 6 months.

Case summary:

A university student when he came to Sweden, now a social worker working with teenagers from his homeland who have serious asocial behaviors. He seeks professional help for feelings of alienation, for feeling like an outsider. He doesn't want to tell his friends or family, as they would worry. He has no real reason to feel this way, he explains. He has a family he loves and work he is satisfied with. The feelings of alienation have been with him several months. He cannot sleep and has nightmares when he does. He is intellectual and astute with words, but after a few sessions, it is evident that he has very few words for his feelings, nor does he take his feelings seriously. The psychologist tries to cut through the barrier of intellectuality. He is provoked and refuses to come to 2 sessions.

Case excerpt (from session 5, after 5 weeks of treatment):

He comes into the office with a threatening and aggressive attitude.

P: "I'm reminded of prison." T: "Prison? You've been in prison?" P: "Six months of hard mental and physical torture. I was 20 years old."

He went back to that period describing the inhuman conditions he was faced with and the mental and physical torture he endured. We worked through this verbally in session after session. Finally, tears and gut feelings came out, as if they would never stop. Then, one day he came in and said that "they" didn't understand.

T: "Who?" P: "My own children, and the kids I work with. They don't know why they are in Sweden. Why their parents are forced to live in exile. I wasn't much older than the kids I work with when I was tortured. I was about 12 years old, my son's age, when I started working politically. All my son does is listen to his stereo." T: "Do they know that you have been imprisoned and tortured for your political views?" P: "No!" T: "Why not?" P: "I wanted to forget." T: "But you couldn't…And now you are here…" P: "You mean I should tell them about it?" T: "It is an important part of who you are. Why do you have to deny it? Why do you have to hide it?"

A few sessions later, he didn't need my help any longer, he said. He slept now, without nightmares and he didn't feel alienated.

P: "I told it all to the kids I work with. One of them said I knew. You are so tough on yourself and on us, he said. Then I told my own children. My 8 year old daughter said, 'Daddy, I can kiss the pain away'. My son wanted me to help him to read my books in our language on the political history of our country."

STATE OF BEING: LONELINESS

The refugee and the immigrant may feel a sense of great loneliness during different periods of life in the new country, based on all that is not there (Deutsch and Won, 1956). Such feelings can overwhelm the individual,

and finally lead to the *state of being*: *loneliness.* Loneliness may be based on the concrete reality of life in the new country (Feldstein and Costello, 1974; Malzberg and Lee, 1956). The refugee or immigrant lives in the isolated world of the family, if they have one, or alone. This can become more serious as time passes. He/she may become even more isolated to avoid being reminded of the loneliness.

With the traumatized and/or tortured refugee, the feelings and the *state of being* can be caused or further deepened by trauma. He/she may have been forced to flee the homeland suddenly or under difficult circumstances. He/she has usually had past homeland experiences of sudden and violent separation and loss of close relationships. The *state of being* seems to be more severe when the person experiences it combined with the trauma, as described below in Case 5.4.

Cases – state of being: loneliness

The following case illustrates the *state of being: loneliness* based on the reality of the individual's life situation.

> Case 5.4
>
> A traumatized female refugee, age 59, 39 years in Sweden, a librarian, unmarried. Homeland trauma: World War II concentration camp survivor. She came to Sweden alone when she was 20 years old. Her family had perished in German concentration camps. Reason for treatment: severe depression. Form of treatment: medication; support work, once a week. Duration: 7 weeks.
>
> Case summary:
>
> The woman had worked at the same library for l5 years. She spoke with a heavy accent. She was polite and worked well, but kept to herself and bothered no one. Only one person there had asked why she had come to Sweden. She lived in a one-room apartment in an old area of a large city. She had no friends or social life. While in treatment, she committed suicide by hanging herself. She had been dead for 3 days when she was found. Someone she worked with wondered why she had not come to the office or called. It was so unlike her, she said.

Even if there is a network of family and friends, the refugee/immigrant can sometimes feel a sense of great loneliness. Such loneliness can be a consequence of the *refugee/immigrant situation* – all that is not, or does not seem to be there. Case 5.5 illustrates the *state of being: loneliness* based on exaggerated feelings of reality.

> Case 5.5
>
> A male refugee, age 57, 37 years in Sweden, a businessman, married with 3 adult children, 1 son and 2 daughters, 27, 25 and 22 years old.

Reason for treatment: severe depression, unable to work for over 2 months. Form of treatment: psychotherapy, once a week. Duration: 8 months.

Case excerpt (from session 1):

He described the depression as a "feeling of loneliness that came over him". He felt he could not cope with life any longer. He did not want to go out of his house, and felt indifferent to everything and everyone around him. His son had just christened his infant child and named him after his father according to the tradition of his country. It was an occasion of great joy for him and his family. There had been lots of celebrations, and a brother whom he had not seen for many years traveled from another country for the christening. It was soon after his brother's departure that he became depressed, he explained. He had gone into a process of remembering, longing and feeling lonely. Remembering his dead parents and brothers, sisters and relatives, now scattered all over the world, and the war and poverty that had separated them. He was unconsciously longing for his family and his country, and therefore feeling lonely. During this time of great joy for him, and on reunion with his brother, he went into an unconscious mourning process, which he had not been through in the past – being a busy and successful businessman. He had everything now, which produced more unconscious guilt and self-anger and finally led to a depression, even more difficult because he felt he had no right to be sad and depressed.

Case summary:

After several psychotherapy sessions he became aware of his longings and feelings of loneliness. He could finally accept without guilt that he could feel longing, feel lonely and depressed, things he had never allowed himself to do – and that these feelings could even be experienced in moments of joy. When he could accept that he could still, after 35 years in Sweden, long for his family and his country and feel pain because of being forced to separate from his relatives and country, his *loneliness* disappeared.

Feelings of loneliness and the *state of being* in the refugee and the immigrant can be complicated by commonly occurring feelings of existential loneliness – in part due to the inner and outer reality of the *refugee/immigrant situation*. Case 5.6 offers an illustration of the *state of being: loneliness* founded on feelings of existential loneliness.

Case 5.6

A female immigrant, age 24, 17 years in Sweden, a medical student; her father, age 54, is a businessman; her mother, age 52, is a nurse; her brother, age 21, is a university student. She is engaged to a fellow medical student, age 25. Reason for treatment: She had been unhappy for several weeks, and has now stopped attending the last term of university leading up to taking her medical degree; she complains of constant feelings of

loneliness. Form of treatment: crisis therapy, twice weekly, followed by long-term psychotherapy, once a week. Duration: 2 years.

Case summary:

She is fluent in Swedish and her native language. She had a good family situation as a child with warm, loving, hard-working parents and a younger brother with all of whom she has good relationships. She has friends, is well liked, and active. There seemed to be nothing in her external situation to cause the unhappiness.

Case excerpts (from sessions 1 and 9):

Session 1:

She complains of feelings of loneliness. She cries often, she explains. She feels as if life has no meaning. We die anyway. We die alone. She came to Sweden when she was 7 years old, she explained. She started school without knowledge of the Swedish language, but learned it quickly and was a good student. She had not been bullied, but recalled those first months at school when she couldn't communicate, having no Swedish and the loneliness she felt during that period of time. Had the approaching end of her school years and the start of her working life become a reminder of the beginning of her new life in Sweden, as a 7 year old, and the loneliness she felt then, combined with the existential loneliness many people can go through facing a life change? I asked myself, after our first meeting. The young woman started crisis psychotherapy, afraid that she would not finish her medical degree.

Session 9:

When she could remember her feelings of loneliness as a child and understand that they were the feelings of a lonely 7 year old immigrant child without language, and that those feelings were still a part of her – could acknowledge them, accept them, feel them, but see that her present reality was very different – the feelings of a child's loneliness disappeared. The existential loneliness caused by the life change could then be worked through. She returned to her studies and decided to continue in long-term psychotherapy.

STATE OF BEING: MISSING

The refugee/immigrant, throughout his/her life, may miss – to different degrees – something, someone or some place from the homeland. Feelings of missing are reported to be experienced to a lesser or greater extent during different periods of life in the new country. The immigrant may go back to visit or return to the homeland. The refugee cannot. Life in exile may be more difficult and complicated for the refugee who does not have the choice to visit, or finally return to the homeland. The traumas that he/she may have experienced also may influence feelings of missing.

During times of confusion, changes and crises, missing something, someone or some place from the homeland appear to cause great inner suffering even though the person is aware of why. These feelings seem to become even more complicated when what is missing cannot be defined. They are usually founded on reality, but can also be based on exaggerated reality. Seldom are they based on fantasy. To experience such feelings is painful, and appears to cause, influence or complicate the individual's difficulties, and gradually lead up to the *state of being*.

Cases – state of being: missing

The following case is an example of the *state of being: missing* when based on reality.

Case 5.7

A female political refugee, age 37, 5 years in Sweden, a home-language teacher, divorced. She has one son, 10 years old. Reason for treatment: depression, which has lasted several months. Life was without meaning, she felt indifferent about her work, her child and life in general. Form of treatment: psychological support work, once a week. Duration: 7 months.

Case summary:

In the conversations, she could finally admit to herself how much she missed her homeland, her family, her friends and her language, which she could not return to. She had not, previously, allowed herself to have these feelings.

P: "What good does it do to miss them. I can't go back…and I am not going to feel sorry for myself."

She shared her inner suffering through long descriptions of the world and the people she had been forced to leave, but finally could express the *missing* in emotions and tears.

In acknowledging, accepting and allowing herself to feel the inner pain of *missing*, she could reach a catharsis of feeling, without pitying herself. Feelings and tears do not bring back her homeland, her family, her world – but they released the psychological burden of the *state of being*: *missing*, that she was carrying within her, making her depressed and feeling indifferent to her present life.

The refugee/immigrant may be unaware that he/she is missing something from his/her former world. The *state of being: missing* can become even more complicated and difficult. The following case is an example of the consequences of the *state of being: missing,* when it is unconscious.

Case 5.8

A traumatized female refugee, age 36, 14 years in Sweden, an office worker, married to a Swede. They have 2 children, 8 and 10 years old.

Homeland traumas: bombings of her village and surroundings. Reason for treatment: diagnosed by a psychiatrist as being in deep depression and encouraged to be hospitalized, as there was a risk of suicide. Form of treatment: psychological support work, twice weekly. Duration: 13 months.

Case summary:

The treatment began during the springtime, when a psychologist was summoned to speak to her. There seemed to be no apparent outer difficulties, but the patient was so severely depressed that she could not work or look after her children. After several sessions, she remembered that the early springtime was the time of year that war had broken out in her country. She was a young teenager then. The forest she had loved to roam in as a child did not exist any longer. It had been bombed out, she explained. Her family was forced to flee to different countries, and it had been many years since she had seen the family members that had survived the war.

The psychologist believed that her deep depression was caused by the unconscious *state of being: missing*, missing her family and the landscape that she grew up in and loved. Her repressed memories were wakened by the springtime in Sweden. She had not allowed herself to remember consciously, as it was too painful to recall all she loved and missed. In the talks, she remembered her childhood and the things and people she longed for and missed. When she became aware of what she was missing, and why, and was able to express her feelings, the deep depression lifted. She could function again, and returned to her job and family. The sessions continued for several months. She acknowledged the *missing*, and could take herself and her feelings seriously enough finally to take the decision to make an expensive, but emotionally necessary visit to her brother and sister in another country, to share words unsaid to each other and years of life cut away or lost because of separation.

The case that follows is an example of the *state of being: missing,* based on an exaggerated experience of reality, and influenced by other inner conflicts that were more difficult for the person to admit to himself.

Case 5.9

A male immigrant, age 29, 5 years in Sweden, a data engineer; married to a Swedish woman, age 27, a nurse, (on infant leave). They have one child, 7 months old. Reason for treatment: concentration difficulties, aggressivity, misses the homeland and "the life he could have had there". Form of treatment: psychotherapy, once a week. Duration: 14 months.

Case excerpts (from sessions 1 and 4):

Session 1:

The patient explained that he was happily married, had a good job and a good life in Sweden and had "no reason to miss his homeland, but

he did". His parents had recently visited Sweden and he had visited the homeland a few months after the birth of his son.

Session 4 (after 1 month of treatment):

P: "Let me assure you I could never have the life style I have here in my own country. I have everything here that I had there, and more, and yet I miss home so much that I can't think of anything else. Sometimes I get so caught up inside myself with these feelings that I get angry at my wife and son." T: "You mean you miss home so much that it makes you angry at your wife and son." P: "I came to Sweden because of her, and now I stay here because of him." T: "Not because of your wife?" P: "Of course, I am here because of her too." T: "Why do you get so angry, then?" P: "I told you, because I miss home." T: "And you take that out on your wife?" P: "I guess so. I don't mean to, but I do it, anyway." T: "Or is it something else about her that is disturbing you?" P: "What? She is my wife. He is my son." T: "Even so, something could be bothering you about them." The patient is silent awhile. Then says, P: "She is with the baby all the time. She talks about the baby all the time. It is as if I don't exist anymore." T: "Can you tell me more about that…"

He explained more about his relationship with his wife, since their child was born, and his part in the new family. He felt left out. She was not interested in sitting down and talking to him or being around him, and showed no desire for any intimacy. When their son cried, he only wanted his mother.

P: "I don't have a place in her life anymore. I have no place in his life." T: "You must feel very lonely." P: "Yes, I do." T: "Could that be part of the reason you are missing your homeland?" P: "I don't know. Maybe." T: "Could we look into that…"

The conversations between the therapist and the patient about this subject continued for several weeks. Finally, he could confront his wife with the difficulties he felt in the new family life. She said she was not aware that she was being in any way different to him than before their son was born, and that she loved him and wanted the relationship to work. He began to communicate more with his wife and son. The therapy continued for several months afterwards. He no longer complained of missing the homeland.

STATE OF BEING: LONGING

"To long" usually means to feel that one cannot meet a particular person or place. The feeling is usually resolved by an encounter with what is longed for, or by acceptance that one cannot at the moment, but will some day. Longing for something known is in itself a painful process. If one cannot define what one is longing for, it can be even more complicated. The refugee/immigrant may long for someone or something from the homeland that has been lost or left behind. The immigrant knows he/she

can at sometime meet who or what is longed for. The refugee does not. The traumas that a refugee may have undergone can cause or complicate these feelings. Such feelings may be experienced on arrival in the new country, after a while, or on some occasions throughout life. Such feelings can lead to the *state of being: longing*.

Cases – state of being: longing

This case is an example of the *state of being: longing,* based on reality. Perhaps what is longed for represents something else.

Case 5.10

A male refugee, traumatized/tortured, age 35, 6 months in Sweden, a well-known journalist in his country; married, his wife, age 32, is a lawyer. They have 2 children 10 and 7 years old. Homeland traumas: 11 months imprisonment, severe and continuous torture, 6 months isolation. Reason for treatment: obsessive thoughts, insomnia, concentration difficulties. Form of treatment: psychological support work. Duration: 2 several-hour sessions.

Case excerpt (from session 1):

P: "I hate psychologists. There was one at the prison that tried to manipulate me with words, to convince me, as he called it, to change my beliefs. It was worse than the phalange (a torture). I've read a bit about psychological theories. Some of them make sense. They can be used in many ways". They talked awhile about everything. He was a highly intellectual, cultured, knowledgeable person. Finally she asked him why he had called her. He started laughing.

P: "It's so stupid. I can't even talk about it. If I told my friends they would laugh at me." T: "If you say so, but I won't." P: "In my country, he explained, the food is different. You can get almost everything here. When I came, I had a longing for a special sweet. You can't get it here, one of my friends told me. I forgot about it. But then I started dreaming about this sweet, smelling it, longing for it. I asked about it again. No, the ingredients for it don't exist in Europe, another friend explained. I started thinking about this sweet all the time, day and night. Not even in prison did I long for anything so much, not even my wife and children. I have more important things to think about than a sweet. The newspaper we are starting in exile, for example. I am working day and night on it. Yet, that sweet comes into my head, and I can't concentrate on anything else. I think about it all the time. Am I going crazy?" he asked. T: "You have shared so much pain with me." He looked surprised, P: "I long for a sweet. I'm not in prison, I'm not being tortured", he replied. T: "So, you are torturing yourself." P: "Why?" T: "Because you're longing. You long for something you can't have." P: "I have my freedom", he replied. T: "Maybe it's not enough," the therapist suggested. He looked at her. T: "What is the name of that sweet?" she asked. He said it. She repeated

the name of the sweet. T: “Did your mother make it?” P: “No,” he said.” My mother died when I was a boy. My sister did,” he explained. T: “You’re longing for the sweet and you laugh at yourself, because you think you should be concentrating on more important things,” the therapist suggested. P: “Yes, but I don’t have the time”. T: “To long? To feel? To cry?” He looked at her in torment. He had endured such terrible things in life. He had not given up. He was afraid of his own vulnerability. T: “You can cry. You can feel. You can long. I’m not laughing at you,” the therapist said. He looked into her eyes with such pain in his that she started crying. He stared at her. He started crying. He said nothing. T: “No-one, not even you, with all you are and all you did and are doing for your country, is free from longing. You long. You have the right to. Don’t laugh at yourself.” she said. He shook her hand warmly, and left.

They met one more time, the following week. He explained that the obsessive thoughts had lessened. He could cry now, he explained. P: “I can allow myself to cry. At least over the sweet I long for. The newspaper will come out for the first time this week.”

The following case describes the *state of being: longing* based on an exaggerated experience of reality.

Case 5.11

A female immigrant, age 31, 2 years in Sweden, a university teacher; her husband, age 35, is a professor. Reason for treatment: fatigue, indifference to work and life. Form of treatment: psychotherapy, once a week. Duration: 3 years.

Case excerpt (from session 9, after 3 months of treatment):

P: “Nothing has changed. I am just as tired as I was when I started here. It feels worthless. I know there is nothing wrong with me physically and yet I just want to sleep all the time. I don’t feel like teaching or doing anything. All I think about is the city I was brought up in.” T: “What do you think about?” P: “About the life I had there. I long for it.” T: “When were you last there?” P: “A few months ago. We spent a few weeks with some of my friends.” T: “Do you want to be there now?” P: “Yes, I long for the life I left. The life my friends lead.” T: “You told me that you came to Sweden to marry. Do you regret your decision?” P: “I love my husband. We have a good life. But I long for the past, the life I had.” T: “Did you realize that life in Sweden, as a married woman, would be so different for you?” P: “I thought about it, but being with my husband was most important for me.” T: “Perhaps you long for something that is no longer there for you – the past – if you want a life with your husband.” P: “What do you mean?” T: “The life you led before, as a single woman.” P: “But I love my husband.” T: “You can love your husband and still long for the past.” P: “I could always go back to it.” T: “But do you want to?” P: “No…” T: “Let’s talk about what you long for in your past life…and why.”

It was the woman's exaggerated longing for her life as a single woman in her native country that had caused the fatigue and indifference. When she could admit her longing but realize that she actually wanted the life she had with her husband, her fatigue and indifference subsided. A few month afterwards, she became pregnant and looked forward to bringing up a child in Swedish society.

Longing, but not always knowing what one longs for, is a feeling anyone might experience during different periods of life. It may lead to change and development, but also to self-pity and resignation (May, 1967; Tillich, 1972). The refugee/immigrant may experience existential longing, possibly complicated by the *refugee/immigrant situation.* Case 5.12 provides an example of such existential longing.

Case 5.12

A male refugee, age 50, 20 years in Sweden, a foreman in a large factory; married to a Swede, age 49, an office worker. They have 3 sons, 25, 23 and 21 years old. Reason for treatment: He didn't want to work anymore. The company doctor had given him short leave of absence and tranquilizers. His son suggested that he go to a psychologist. Form of treatment: short-term psychotherapy, once a week. Duration: 8 months.

Case excerpt (from session 1):

P: "My son is worried about me, thinks all I do is complain about life and Sweden. My wife gets on my nerves. She knows that and she's avoiding me," he explained. T: "Your sons were born in Sweden?" P: "Yes, my wife is Swedish." T: "But you came here because of the Junta in Greece?" P: "Yes, I was a student. I was very grateful to Sweden then. But now I hate the country. Sweden has been kind to me, but I long for something else. I don't know what." T: "Can't you return to Greece now that the Socialists have taken over?" P: "Yes, I can, and have thought about it every summer since the Socialists took over, but my life is here. The kids are all married and have their professions here." T: "So you are not longing for your country?" P: "No, it's not that, he said. I don't know what it is I am longing for, something that doesn't exist." T: "It must be painful to long for something that doesn't exist." P: "I can't do anything because of it," he said. T: "You have worked hard all your life. Your children are grown up and doing well. You did a good job." P: "What am I longing for then?" T: "I can't answer that for you. You'll have to ask yourself." P: "I didn't come to a psychologist for that kind of an answer!" he shouted. T: "…or take tranquilizers, or go to a doctor who gives you leave of absence" the therapist answered, a bit too provocatively. P: "So you think I am feeling sorry for myself?" T: "I didn't say that, but you did. But I am saying that you have to try to understand what it is you are longing for, instead of suffocating these feelings with self-pity or medication." P: "I am tired of life." T: "Could you try to tell me why?"

The sessions continued for several months. He was actually in a mid-life crisis, and had to look at what was left in life for him. When he became aware of the *state of being: longing* and could work it through, it led to awareness of what he wanted to do. Instead of giving up, he chose change and development, opening his own small import/export business in Sweden and Greece.

STATE OF BEING: GUILT

The refugee or the immigrant can experience guilt feelings for the same reasons as anyone else. In addition, he/she may go through these feelings due to past homeland experiences (Scarry, 1985; Zung, 1969). The refugee may feel guilt over being able to live in peace in exile. Some may try to help their homeland and the people in it. This might ease feelings of guilt. Others may feel they cannot help, or help enough. The *state of being: guilt* takes form. The refugee/immigrant who experiences guilt never seems satisfied or at peace with him/herself, and may place great demands on him/herself and others – so as to feel worthy of survival. Alternatively, he/she may become passive and resigned. Serious guilt feelings can lead the individual to question the right to survive (Bettelheim, 1943; Frankl, 1963; Freud, 1915; Klein, 1948). Feelings of guilt may come shortly after arrival in the new country, or some time later. These may be experienced throughout life in the new country.

Cases – state of being: guilt

This case describes the *state of being: guilt,* when it is conscious, based on reality (i.e. founded on a real event in the homeland or the new country, as described in Chapter 3), and experienced after some time in the new country.

Case 5.13

A female refugee, age 20, 5 years in Sweden, a student, her mother, age 44. She has 2 brothers and a sister, 22, 23, 28 years old. Reason for treatment: suicide attempt. Form of treatment: crisis therapy, twice weekly. Duration: 6 months. Previous form of treatment: family therapy, 13 months.

Case summary:

The young woman was attending a live-in junior college where she was doing well in her studies, and was fluent in Swedish. She was an open, joyful girl with many Swedish and homeland friends. She made a serious suicide attempt by cutting her wrists. She came to Sweden with her mother and 2 older brothers. Her father had been killed in the war her country was involved in. When the therapist met her, she had only 3 fingers left on her right hand. She was out buying bread in her home

country when she was 12 years old, and a bomb wounded her. The family fled when her oldest brother was called up for military service.

The therapist worked with the family for about a year after they came to Sweden. They had not yet been accepted as refugees, and the mother was deeply depressed and frightened that they would be forced to go back to their war-ridden country. The therapist met the family in supportive psychotherapy, once a week for over a year, until they finally received refugee status, and for several months afterwards, since the mother and the youngest brother were anxious for a long time after the family was granted permission to stay in Sweden.

One older married sister with 2 children and a husband were left in the town which they had fled from. The country was still at war. The sister came on a visit to Sweden but did not want to leave the homeland, mainly because her husband was suffering from a serious illness and could not be moved. The family began to adapt well to their life in Sweden, and in the years that followed, the therapist had almost no contact with them. Now and then, the young woman called to tell her how they were doing. Her oldest brother had married a Swedish girl. Her youngest brother was working in a factory. Her mother worked in an office and she was in junior college and was planning to go on to university.

Her brother called to tell the therapist what happened when the young woman attempted suicide a few months after their last telephone conversation. She was watching a news report on television at school with a few of her fellow students. Her country and the area where her sister lived came on the television screen. The area near her sister's house was shown. It had been bombed and many people had been maimed and killed. She started shaking, her Swedish schoolmates explained, and ran to the telephone and tried to get through to her sister. But it was impossible, as most of the telephone lines had been cut. She sat at the telephone for the next 10 hours trying to get through to her sister. She couldn't. She was convinced her sister and family had been wounded or killed. "And I sit here in the peaceful Swedish countryside and can't do anything," she screamed in despair to her friends. She went into her room and cut her wrists with a razor. A few hours later, her brother was able to get through to their sister. Nothing had happened to any of them or their house.

The young woman survived her suicide attempt, but it was several months before she could resume a normal life.

When the refugee/immigrant is unconscious of feelings of guilt or the *state of being*, it may seem puzzling to him/herself and others. The following case exemplifies.

Case 5.14

A female traumatized refugee, age 29, 8 years in Sweden, studying Swedish full-time. She has 2 children, 7 and 8 years old; divorced 1 year, her ex-husband was also a refugee. Reason for treatment: she was

reported to the authorities by her neighbor for abusing her children. Form of treatment: psychological support work, once a week. Duration: 1 year.

Case excerpt (from session 1):

She is very angry and on the defensive at the start of the session. P: "It's my business what I do with my children. I did hit them, but I don't usually. Just now, I am doing it," she explained. T: "Why now?" P: "I don't know. I have no patience with them."

The therapist asked her about her homeland. She knew it was at war and in the newspapers almost every day.

T: "Do you have family there?" P: "Yes, my whole family is there." T: "Do you hear from them?" P: "They try to write about once a month. I write every week, but now I haven't heard from anyone for over 3 months," she replied.

The therapist then asked her about her family. She explained that she had 2 sisters and a brother there, plus her parents. They lived in the area where violent atrocities and bombings were taking place.

T: "You must be worried." P: "There is nothing I can do," she said. T: "No…but you can be worried, anyway." P: "I have such a good life here in Sweden. I go to school, my children too. I send packages home, but I don't know if they get there." T: "You must be feeling very unhappy and guilty, otherwise I don't believe you would hit your kids." P: "What does that have to do with it? My children have everything. They don't know what war is!" she answered. T: "That's maybe why. They have everything. Your family has nothing and is suffering. You feel guilty. The guilt turns to anger and violence towards your children," the therapist suggested. She looked at her stunned.

The sessions continued. She became aware of her guilt over "living in peace while her family suffered". The abuse of her children stopped. Three weeks later, she got a letter from her sister. Her face was bright and shining, P: "They're okay."

The following case is an example of the *state of being: guilt,* when it is based on an exaggerated sense of reality.

Case 5.15

A male immigrant, age 30, 5 years in Sweden, a factory worker. Reason for treatment: aggressivity, alcohol abuse. Form of treatment: crisis therapy, once a week. Duration: 5 months.

Case summary:

The man was advised by his employer to meet the psychologist. He had been physically aggressive several times to male colleagues. During the last 3 months he had been arriving late for work. He had never met a psychologist and was very tense.

Case excerpt (from session 2, week 2 of treatment):

P: "There is nothing wrong with me. I am only here because they forced me to come. Otherwise I would lose my job." T: "Your foreman is

worried about you. He likes you very much, the personnel assistant of your company informed me." P: "I know, but he cannot help me. No one can." T: "Why not?" P: "Because I am worried about my sister in my homeland. I believe she is being badly treated by her husband." T: "In what way?" P: "I am not sure. That's all my mother said. In my country, it could mean anything from not giving her enough money for the household necessities, to beating her." T: "It must be hard for you to be here in Sweden when there are difficulties in your family, and you are not there." P: "Yes, it is." T: "Does your sister have other family members to turn to?" P: "My older brothers are there." T: "But you don't seem to think they can help her." P: "Yes, yes they can, as much as I could." T: "But you are worried and feel guilt that you are not there." P: "Yes. I am here. She is there. My life is good here. Her life is a nightmare." T: "And you feel guilty about that." P: "Yes. I can't do anything for her from here." T: "And yet you know your brothers are trying to help her." P: "They are trying to." T: "And still you feel guilty that you are not there." P: "Yes." T: "Could you do more than your brothers if you were there?" P: "Nothing more." T: "Even though you know that is so, it seems to be affecting your work. The foreman suspects you are drinking too much." P: "I am. But I can't think of anything else. I drink to try to forget about it." T: "Let's talk about that…"

The sessions continued. The therapist encouraged him to talk about his sister, his family and his guilt about his not being able to help out. They also discussed his use of alcohol. Halfway through the course of treatment, he decided to return to his homeland during vacation. Then, he would decide whether he would move back to the homeland. If he felt he could help his sister, he would, he explained. The alcohol consumption diminished, his aggressivity toward his colleagues stopped and he was once again at work, on time.

The final sessions took place after his trip back to the homeland. He explained to the therapist that he would remain in Sweden for a few more years. His sister had separated from her husband, and he and his brothers would help her economically. He had stopped drinking.

STATE OF BEING: SHAME

The refugee or the immigrant can experience feelings of shame for the same reasons as anyone else. In addition, the refugee and some immigrants may endure feelings of shame or endure the *state of being* because of something that happened in the homeland which he/she cannot forgive him/herself. It might be an event or situation, or a series of them, that he/she remembers and is aware of, or has forgotten and repressed. For example, he/she could feel shame over having left or been forced to leave behind others in war, prison or poverty, or over something that he/she was forced to do and would never do under normal conditions. The refugee may be ashamed over something he/she was forced to do in prison or under

torture, such as giving information about relatives, friends or colleagues, or running away (Bettelheim, 1943; Jacobson, 1943; Kristal-Andersson, 1978; Krystal, 1988; Roche, 1987; Scarry, l985). He/she reflects on the past with the superego codings of his/her early childhood periods and adult identity. These codings are the inner accuser and judge of past events, and envelop the individual to become the *state of being: shame.*

If a refugee/immigrant has done something that he/she regards as unforgivable, psychotherapy/support work may enable him/her to accept him/herself in the present – and go on without denying the past. The burden of the past may not be wholly lifted, but it can be accepted as part of past history. The following case offers an example.

Cases – state of being: shame

Case 5.16

A male refugee, age 28, 5 years in Sweden, an unemployed engineer. Reason for treatment: suicidal depression. Form of treatment: supportive psychotherapy, once a week. Duration: 15 months.

Case summary:

He had come to Sweden as a guest student but when a fascist regime took over in his country he sought and received refugee status. He had started psychotherapy after being heavily medicated for a year for a deep, suicidal depression. At the beginning of the supportive psychotherapy, he kept saying to the female therapist:

P: "There is so much I can't tell you." T: "I hope some day you will feel comfortable enough to be able to. I may be able to understand", she replied.

Case excerpt (from session, 24, after 6 months of treatment, about the mid point of the psychotherapy):

The patient reported a recurring dream:

P: "I hear the sound of footsteps. The room I am in darkens. I hear the screams of my childhood friends. I wake up sweating…I have been having this dream again and again since I left my country." T: "Does the dream have anything to do with reality?" P: "It's a dream." T: "Dreams can reflect reality." P: "It does…" (A long silence) T: "How does it reflect reality?" P: (A long silence.) "…I never told you that I was in prison before I came to Europe. I was 14 years old. I spent 6 months there. I believed then in human rights, but wasn't very political. I was arrested, tortured so much that I told everything I knew about my friends and my teachers…(A long pause)…You are the first person I am telling this to." T: "Thank you for trusting me." P: "How can I want to live knowing I told on my friends, my teachers…they were sent to prison…maybe killed because of me." T: "You were 14 years old…Your brother has a son of 14…could he stand that torture?" P: "No…he is just a child."

T: "And you were, too. Do you think you could have endured the torture without giving in to them…" P: "I haven't thought of it like that." T: "You are thinking about it as a man of 28 years old, but you were 14 years old then, a child…can you forgive a child?" P: "I don't know…"

The refugee/immigrant may look at past homeland situations with an exaggerated picture of reality due to strict superego codings. This may cause feelings of shame, or the *state of being*. It is the role of the carer to correct such harsh messages. Case 5.17 provides an example of the *state of being: shame* based on exaggerated reality.

Case 5.17

A male refugee, traumatized/tortured, age 26, 6 years in Sweden, a university student. Reason for treatment: concentration difficulties, relation problems. Form of treatment: psychotherapy, once a week. Duration: 2 years.

Case summary:

During his time in exile, although the young man was intelligent, he was unable to concentrate, learn the new language or relate to people, even his own countrymen. A social worker suggested he talk to a psychotherapist.

During the beginning and middle phases of psychotherapy, the patient shares the reason he feels shame. He has talked to the therapist about his family, with 2 older sisters, and a brother who was killed at the age of 13. The individual was then 17 years old. Soon after the death of his brother he was put in prison for 3 years, where he underwent torture innumerable times until he was 20 years old, when he was released. Shortly afterwards, he came to Sweden.

Case excerpt (from session 12, after 3 months of treatment):

T: "You did not force your little brother to give out pamphlets with you. He also believed that what you were working for was important." P: "My mother blames me. She said he always looked up to me and followed me." T: "Younger brothers of that age usually look up to their older brothers. If he had wanted to, he could have refused to come along with you. You said to me that he always had a will of his own, that he was stronger than you." P: "He was." T: "So he made that choice himself." P: "Yes, he did. I remember now. I did not want him to go along with me that day. I tried to stop him. I was angry with him. We all knew that the police would try to stop us. But we did not believe that they would shoot at us – not young boys…" T: "But they did…" P: "When my little brother fell down and the blood poured out of him, I fell on top of him, to try to protect him from the bullets, but he was already dead…"

The man did not want his younger brother to be politically active and tried to stop him from even coming that day. This event was shared during the beginning of psychotherapy. When he could finally retell himself, again and again, the same story and stop condemning himself for the death of his

brother, he could, for the first time during his exile, contact his family in the homeland, whom he thought hated and had disowned him. His mother cried with joy when she heard his voice and wanted to keep talking on the telephone. Now he telephones his family once a week. Towards the end of psychotherapy, he came in one day:

P: "I asked my mother if she still blamed me for my brother's death. I had to. I know I didn't cause it, but I know she thought so then. My mother was surprised by the question, and the telephone went dead a few seconds. I wasn't sure if she had hung up. I said Mother, Mother. She answered then, crying. *No! my son!* I do not blame you! He went with you because he wanted to. I could not stop him. I pleaded with him, she said. I told her then that I tried to stop him, too, but that I couldn't either, even when I got angry. I know, I know, she said. I knew it then. He was just a boy. He did not even get a chance to be a man. At least I have you, my son. At least I have you. She said it over and over again." (The young man cries as he talks of the telephone conversation to the therapist). T: "Your mother loves you very much." P: "I know that now."

Soon after, he started going to school, working part-time and making contacts with people, both from his homeland and with Swedes.

The refugee/immigrant may experience the *state of being: shame*, based on fantasy in relation to something in the past.

Case 5.18

A male immigrant, age 47, 30 years in Sweden, a restaurant owner, married; his wife, age 41, a housewife. They have 2 children, 20 and 18 years old. Reason for treatment: referred from a community mental health clinic because of deep depression, which has prevented him from working. A psychiatrist had convinced the man that it was better for him to talk himself out of the depression than to continue the medication he had been taking for a long period of time. Form of treatment: psychotherapy, twice a week. Duration: 1 year.

Case excerpt (from session 6, after 3 weeks of treatment):

At first, the man was not willing or motivated to work on his problems and disappointed in the doctor for refusing to continue anti-depressive medication.

P: "I want to rest and sleep. Those pills help me do that. You are asking me to try to understand myself. I don't want to. I came here over 30 years ago and I am still a foreigner. I came here for a better life – and sure, I got one, I have a nice house and car and a family I love – but what about my sisters and brothers back home. First it was poverty, and now it is war." T: "It can't have been easy for you to leave your family when you were such a young boy (17 years) and come to Sweden." P: "It was an adventure for me then. My mother wanted me to go to Sweden. Her cousin had come here, and he was already a 'rich man'," she said. I started sending money home to them soon after I came here and got a job

in a factory. And I never stopped sending them money." T: "Did your brothers and sisters want to follow you?" P: "No. They stayed in our village and built up our farm and our land, but they are still poor." T: "And you are not." P: "No. I have everything. My children have everything. And now they are at war with each other." T: "What feelings are aroused in you when you think of that." P: "I feel ashamed that I am here and they are there, that I have everything and they have nothing." T: "But you have always shared your income with them." P: "Yes. But I am still ashamed. It is not fair that I am here and they are there." T: "But they could have come here too. When you came, Sweden needed workers. It was almost open to those who needed jobs." P: "Not now." T: "No, not now. But would they come now?" P: "I already asked. I speak to them almost every day now, since the war broke out. No. They won't come." T: "And they did not come when you came. So why should you feel ashamed of the life you were able to build for yourself here? Your mother wanted you to come. Your family is proud of you, you say." P: "Yes." T: "Then why must you feel shame for the life you made, the life you live?" P: "I don't know."

STATE OF BEING: SEPARATION AND LOSS

Especially during difficult times in life, the sorrow and inner pain of separation or loss of a person and/or environment can be felt (Bibring, 1953; Bowlby, 1969, 1973). The refugee/immigrant will usually have gone through many separations and losses (McGoldrick, 1982; Vargás, 1977), and may or may not be aware that he/she might be in mourning. When such separations or losses are not realized or acknowledged, they may cause the *state of being: separation and loss*. Instead of allowing him/herself to grieve and, if only temporarily, find the inner acceptance that mourning may bring, the person seems to experience constant melancholy, sadness, lethargy and depression. These feelings affect his/her inner and outer world, and envelop life to become the *state of being*. For the immigrant, visits to the homeland can be a way of easing feelings of separation and loss. The *state of being* may well be more difficult for the refugee who cannot return to the homeland. The traumatized refugee has usually experienced sudden and violent separations and losses. The aware or repressed memories of these can cause inner agony, and may give rise to, or complicate the *state of being*.

Cases – state of being: separation and loss

The following illustrates the *state of being: separation and loss*, based on reality.

Case 5.19

A male refugee, age 28, 6 years in Sweden, a university student and taxi driver. Reason for treatment: insomnia, nightmares, isolation. Form of treatment: psychotherapy, once a week. Duration: 2 years.

Case summary:

The individual fled from his country because he had been active in a forbidden political party. One of his cousins had been imprisoned and died in prison. He fled alone. His parents, brothers, sisters and other family members remain in the homeland.

Case excerpt (from session 8, after 2 months of treatment):

P: "My family is so happy I am here in safety. I would have been killed, they keep telling me, when I call and I want to come home." T: "You want to go home." P: "Yes, I have nothing here. My whole family is in the homeland." T: "You have freedom. You are getting an education. Perhaps someday the situation will change in your country." P: "Yes, and then I could go back. But I am alone now." T: "I know, but you mentioned that you have many friends from your country and Sweden." P: "Yes. But they are not my family." T: "No, they are not." P: "I talk to my family often on the telephone, but when I do, I miss them more. It is so hard hearing about their lives, and not being able to be a part of it." T: "Can you talk more about that?" P: "My mother complains about her health. My father is getting old. I would like to be there, so I could help them." T: "Your life would be at risk, if you return." P: "I know that, so I think about them all the time. I dream about them all the time." T: "What do you think about them?"

The therapy continued 2 years. He finished his university education, started to work and met and married a woman living in exile from his homeland. His family was happy to hear that he married. He hopes the situation will change, and they can return together.

The following case is an example of how separation and losses, when not acknowledged and mourned, can finally cause the *state of being*: *separation and loss*.

Case 5.20

An immigrant female, age 42, a social worker, 19 years in Sweden; divorced. She has one daughter, 17 years old. Reason for treatment: constant melancholy, frightening dreams and nightmares, unsatisfied with herself, fear of relationships with men. Form of treatment: psychotherapy, once a week. Duration: 2 years.

Case summary:

The individual sought therapy with a psychotherapist in private practice. She explained during the assessment interviews that she functioned outwardly well. She was satisfied with her employment, had female and male friends, and her daughter was a "typical teenager", at times, difficult, but she felt she could deal with it. She, and her daughter,

had good contact with her ex-husband, a Swedish businessman, who is remarried, but has always shared in the care and responsibility for his daughter. She had met him when she was on vacation in a foreign country with her parents, both now dead. They wrote to each other and she came to Sweden, where they were married. They were divorced 9 years ago. We were too different, she explained.

Case excerpt (from session 30, after 8 months of treatment):

P: "I feel much better now. I feel more satisfied with myself in many ways, but I still feel sad all the time, and I don't know why. I have nothing to feel sad about. Last night I had another frightening dream." T: "Can you tell me about it?" P: "I was in the house I grew up in. My father and mother were there. My brothers and sisters, even my aunts and uncles and cousins, and the 2 dogs I had during my childhood before I left my country. It was not a party, but some kind of family gathering. I was a little girl in the dream, but I was also me, now, watching, an outsider, a stranger that nobody recognized. I was in the room, trying to get the adult's attention. Some faces smiled at me, the way you smile at a child you acknowledge, but do not want to talk to or play with. I was there, accepted, but not taken seriously. I started pulling at their clothes, running from one person to another. The more I tried, the less they acknowledged me. I was so alone. I cried and screamed. Then I woke up." T: "What were your feelings when you awoke." P: "I woke up frightened. I cried. I knew I was coming to see you, and I could get out of bed, knowing that." P: "Perhaps the dream is trying to tell you, even us something. Let us try to find out what it could be. You have been talking about your family in the last sessions." P: "It is the same season of the year I left my homeland to come to Sweden to be with my ex-husband. I wanted so much to come, but I didn't realize then all I would lose." T: "Lose…" P: "My family, my friends there…" T: "You make a trip there once a year." P: Yes, but the more years that pass, the stranger I feel to my family. And now that my parents are dead, even more so." T: "Could you tell more about those feelings?" P: "We are a close family. We met all of us together a few times a year. They still do. I lost all that. The continuous, the everyday contact. After the divorce, my parents wanted me to return with my daughter. But she would have lost her father. I am sure I am right about that. So I stayed. Each year that passed, I was more of a stranger to my own family. Now that my parents are dead, I feel I have lost everyone." T: "Your dream reflects your feelings, your fear of losing contact with your family." P: "Yes. The little girl inside me wants their recognition." T: "But you fear you have lost it." P: "Yes." T: "Could you try to go more into those fears…" P: "I can try."

The woman talks about her family, and during the following sessions cries and mourns the separations and losses she endured. After some months, the melancholy state lifted. She could understand why these separations and losses caused her melancholy state of being. She then worked for a long time on comparing her life in Sweden to the life

she could have had and could have in the future if she returned to her homeland. When she finished psychotherapy, she was in a relationship and her daughter had started university. P: "I take life from day to day. We will see where it will lead me."

Case 5.21 is an example of the *state of being: separation and loss* in the traumatized refugee when a life change in the new country is complicated by a traumatic loss in the homeland.

Case 5.21

A traumatized female refugee, age 39, 11 years in Sweden, a saleswoman; married, her husband, age 45, is a businessman. They have 4 children, 20, 18, 16 and 9 years old. Reason for treatment: depression after her 18 year old son left home to go to university in another city. Form of treatment: psychotherapy, once a week. Duration: 1 year.

Case excerpts (from session 8, after 2 months of treatment, and from session 28, after 9 months of treatment):

P: "I worry about my son, so far away from us now." T: "He is in another city, here in Sweden studying at the university." P: "Yes, and I am proud, but I felt so sad when he left our home. I got so frightened when he left." T: "We can try to understand why you got so frightened." P: "I don't know. I started thinking about my sister, when he told us he would be moving to another town to study. I was 6 years old when I saw my only sister killed before my eyes. She was 16 years old. She was about to finish high school. They didn't care, they just shot right into the camp. I remember it, as if it happened yesterday. My mother screamed for days and threw herself into my sister's grave. They had to pull her out. I was terrified. I don't remember if I cried or not. I was just afraid my mother would go into that grave, too. I loved my sister so. I was always with her…but I don't remember how I was after her death. I was always a good girl, they told me. I was an achiever in school. I tried to be everything that she was." The therapist listened silently. T: "You were reminded of your sister's death when your son left home to study." P: "Yes, I am so afraid that something could happen to him, to all my children." T: "Let's talk more about that…"

Session 28 (towards the end phase of the psychotherapy):

P: "The tears I have for my sister will never run dry. The grief I feel for her life unlived will never end. I have a life here in Sweden. I have my children, my friends, my husband. My children are living secure and good lives in Sweden. But when I think about my sister, her unlived life and the way she was killed, I feel only grief and hatred. Hatred for warfare, not people. Just war."

STATE OF BEING: SORROW

At certain times in life in the new country, the refugee/immigrant may grieve over what has been left behind or lost. Sorrow over the homeland

seems to come over the person – for fleeting seconds or moments, or for days, months or years on end. Sorrow may be experienced by the individual in different ways – according to his/her background and reasons for coming to the new country (Adler, 1927; Bowlby, l980; Freud, 1917; Jacobson, 1943; Klein, 1932). An immigrant may be confused over someone or something in the homeland – even when there is "nothing to feel sorrow over. I can go back if I want to". The feeling seems inappropriate. Yet it can be part of the immigrant's inner world. Because the refugee cannot return to the homeland, he/she can have conscious or unconscious feelings of sorrow over what he/she has been forced to leave behind. These feelings may become part of his/her inner world and experience of life in the new land (Fairbairn, 1943; Kristal-Andersson, 1975). Feelings of sorrow appear to be based on reality, or an exaggerated experience of reality, and may lead to the *state of being*.

It seems to be important to allow the refugee or immigrant to mourn. The *state of being*: *sorrow* may be alleviated by mourning. The mourning process may take many years. Finally, the individual may be able to accept and perhaps make compromises for losses and separations. The *state of being*: *sorrow* awakens or can be awoken again when an individual goes through an emotional or existential difficulty.

The refugee/immigrant may be unaware that he/she is sorrowful over all that was left behind or lost. Instead he/she may exhibit symptoms such as fatigue, concentration difficulties, aggressivity, sadness and depression. Usually, the individual, his/her family and persons around him/her may not understand why. This can have negative inner and outer consequences. Even with qualified therapeutic support, it can be difficult for the person to become aware of and understand that this is the reason for his/her current symptoms and difficulties.

Cases – state of being: sorrow

The following case exemplifies the *state of being: sorrow,* when it is conscious, based on reality and complicated by the *refugee/immigrant situation.*

Case 5.22

A male political refugee, age 33, 7 years in Sweden, a foreman in a factory in his country and also in Sweden; married, his wife, age 28, is a housewife. They have 2 daughters, 9 and 7 years old. Reason for treatment: depression, fatigue "had no energy to even get out of bed".

Form of treatment: short-term psychotherapy, once a week. Duration: 3 months.

Case summary:

He was active as a trade-union organizer in his country and had to flee, when trade unions were forbidden there. He now works within the Swedish trade-union movement informing people about his country. His friends encouraged him to go to a psychologist.

Case excerpt (from session 1):

The individual is not used to talking about himself. He and the psychologist talk about his country, the political situation there, his life in exile and the difficulty in working politically for his country in Sweden. He is very open and clearheaded about his political work. After a while, the psychologist tries to change the subject.

T: "I've been told by your good friend that you are feeling sad all the time and have had no energy for several weeks now." P: "Yes, just about now, several of our trade union colleagues will be executed. I couldn't convince the Swedish authorities to make an official protest." T: "You've tried?" P: "Yes, for months." T: "And you've given up?" P: "I don't know. I can't do anything more. I know they will die. I feel like crying all the time." T: "Why don't you then?" P: (angry) "I can't cry! Tears won't help. I must continue to struggle for my countrymen." T: "You are continuing." P: "I'm not doing enough." T: "You're doing what you can." P: "I'm not! I can't convince the Swedish government to protest officially against these executions." T: "So you're giving up, you mean, lying in bed and giving up?" P: "No! I haven't!" He got angry, then silent. Then the tears "that he felt like crying all the time" came. He cried so much, so deeply, in such despair, anything the psychologist could have said would have been meaningless. P: "They are dead, I know. I feel it. The news will come soon", he stated.

A few days later, the headlines in all the newspapers confirmed his fears. His colleagues had been executed. He was quoted describing the political atrocities taking place in his country. In the photograph in the newspaper, a retired hero of the Swedish trade unions sat beside him. "We had to fight for our trade unions in Sweden. I will help ensure that the trade unionists, who are refugees living in exile in Sweden, can too."

The following case is an example of the *state of being*: *sorrow,* when the individual and others around him/her are unaware that it may be the cause of destructive behavior.

Case 5.23

A traumatized male political refugee, age 58, 9 years in Sweden, an ex-lawyer and ex-member of parliament in his own country before the fascists took over, employed in Sweden as an office cleaner; his wife, age 54. They have 2 children, 33 and 31 years old, living in exile in different countries. Trauma: after the fascist take-over of his country, 6 months in

prison and torture, before being released and fleeing to Sweden. Reason for treatment: serious physical abuse of his wife. Form of treatment: supportive psychotherapy, once a week. Duration: 16 months.

Case summary:

He had agreed to meet the psychologist on the suggestion of the social authorities. He had seriously physically abused his wife, who refused to press charges against him.

Case excerpts (from sessions 2, 8 and 10, after the 2nd, 8th and l0th weeks of treatment):

Session 1:

P: "I love my wife. I never hit her before. Believe me." T: "I believe you." P: "Do you?" he asked hesitantly. T: "Your wife said so, too, to the police and the social authorities. She says you are just unhappy, that's why it happened." P: "It is said that men from my country abuse their women. It's not true" he explained. P: "I know it is a generalization about your culture." P: "But I almost killed her…I want to kill myself now" he said. T: "I understand you might feel that way, but wouldn't it be senseless. Your wife and your children express great love and admiration of you." P: "I hate myself." T: "Your wife forgives you. You must try to forgive yourself. We must try to understand why it happened."

Session 8:

After several sessions he started talking about the important government work he did in his country and the cleaning job he has now. Many of his friends and colleagues may still be in prison and suffering torture. His brother had been killed.

T: "You must feel great sorrow." P: "No, only anger." T: "I understand that, but don't you feel sorrow too?" P: "Only anger." T: "Are you working politically here?" P: "Not much", he explained. "There's so little I can do here!" T: "And you are cleaning offices in Sweden?" P: "Yes." T: "It must be very unsatisfying for you." (Finally, he was able to admit that it was, and that he felt useless.)

Session 10:

The psychologist asked him about his brother. He had been a lawyer too, he explained. T: "You both worked hard for human rights. Your brother gave his life, and you gave up your country." P: "And does it all matter? He is dead, I clean offices in Sweden. And beat my wife." He looked angry. T: "Are you taking out your pain and sorrow on her, in anger instead of tears?" the psychologist carefully questioned. P: "Who do you think you are talking to?" he screamed. T: "You're angry, but I think you are in deep, deep sorrow and mourning." P: "I'm not…" but then he cried.

Case summary:

For several sessions the psychologist encouraged him to go into his sorrow, grief and mourning for his homeland, his family and his

colleagues. He could show deep feelings now, in tears, in words and in anger. Finally they talked about his life in Sweden and the changes that had to be made for him to find a more satisfying place in his new country.

The conversations continued for over a year. He is now working in a voluntary organization for refugees from his homeland, learning Swedish and contributing his international judicial knowledge while assisting at a Swedish law office. He gives lectures in English about his country and feels he is finally doing something of value.

When the refugee/immigrant is unaware of, or does not acknowledge, the reasons for feelings of sorrow or the *state of being* – even if it is an exaggerated experience of his/her reality – it may place confusion and suffering on top of already existing psychological difficulties. The following case offers an example.

Case 5.24

A female immigrant, age 26, 5 years in Sweden, a physicist; married to a Swede, 29 years old, also a physicist. They have 2 children, 2 years and 2 months old. Reason for treatment: severe depression, risk of suicide after the birth of her second child. Form of treatment: supportive psychotherapy, twice monthly. Duration: 2 years.

Case summary:

She met her husband in her homeland and came to Sweden after their marriage. A few weeks after her second child was born, she became depressed. Anti-depressive medication was prescribed, as the doctor believed it was a severe postpartum depression. She was asked to stop breastfeeding the infant. Her husband called the psychologist, explaining the situation. The psychologist suggested that his wife call her. When she did, she asked for support. "I want to continue breastfeeding, I don't want to take pills." The female psychologist agreed to try to help her.

Case excerpts (from sessions 3, 4 and 10, after the 6th, 8th and 20th week of treatment):

Session 3:

P: "I feel so lonely in Sweden, like a stranger. I love my husband and children but I can't find a meaning in life." She explained that she had not been back to her own country since she came to Sweden 5 years ago. P: "It's too expensive to travel there. We are just getting on our feet economically."

Session 4:

She was asked about her homeland. Her face brightened up when she talked of the city she was born in, her family and friends. T: "You must miss them." P: "Yes." T: "You can't go back for a visit?" The psychologist suggested. P: "No" she said and started crying. T: "Is that why you want to die?" the psychologist asked her. P: "I miss home, but our life is here." T: "I understand that, but you want to die. Why?" P: (Screaming angrily)

> "I don't know!" She started crying desperately. T: "Could it be that you are mourning family, friends, your country?" P: "We don't have the money for a visit!" T: "Now, I see." In the sessions that followed, she spoke of her homeland, the people that she missed, longed for and now grieved.
>
> Session 20:
>
> She came in happily. P: "I can't see you all of June. We are going to my country for a month. Whatever the money, going home is better than committing suicide!" she said half jokingly. T: "And the love that I am sure you will find there will heal."

STATE OF BEING: LANGUAGE DEGRADATION

"Identity and self-concept" – a term used by Markus and Nurius (1986, p. 954) to refer to particular aspects of identity – to a large extent, is built around the language given by parents, the socioeconomic environment and education. Nuances, correct rhythm and intonation, gestures, and implied meanings of a language are built up from infancy (Mahler et al., 1975). Research has shown that language has a definite effect on our identity, self-conception, self-esteem and self-confidence (Baker, 1983; Casement, 1982; Condon and Fathi, 1975; Edgerton and Karno, 1971; Greenson, 1950). Indeed, it has been argued that "without language there is no distinctively human interior world; without the stimulus of interaction with others there would be nothing to talk about or think" (Jenkins, 1996, p. 38).

The refugee/immigrant must learn to speak and express him/herself in a new language. The ability to learn a new language has much to do with age, previous education, motivation and level of language ability in the native tongue (Henle, 1972). Learning a new language is a slow process that can take years, and may be difficult for the refugee/immigrant for different reasons. Even after the new language is learned and the person has been years in the new country, it may still be difficult or impossible for him/her to understand implied meanings or express him/herself with correct nuances, rhythms, tones or gestures. The person may be unable properly (or at all) to express his/her feelings, opinions or state of mind. He/she may not be able to express him/herself intellectually or with the abstractions he/she can utilize in the native language. He/she may speak the new language fluently but lack rhythm and tone, making him/herself difficult to listen to and understand. It can take many years for the individual finally to master these in the new language, if he/she ever does. Adults and older children may never lose their accent, and may be constantly reminded of it when they are not understood by others. During

times of emotional difficulties and crises, the individual may lose his/her ability to properly express him/herself in the new language and even, in some cases, in his native tongue.

The traumatized refugee may suffer from the symptoms and difficulties of enduring traumas, which may also cause language-learning impediments. And the child/youth with a refugee/immigrant parent with an accent or other speech difficulty may suffer from feelings of shame.

All the above may lead to severe feelings of inferiority, lowered self–esteem and degradation in the new country. To summarize, feelings of language degradation, and finally the *state of being,* seem to have several causes:

- the outer reality and inner experience that one's native language is not as useful, valuable or important in the new country;
- a comparative lack of skill in the new language;
- a lack of nuances, correct rhythm and intonation, gestures, and implied meanings;
- accent – even after the refugee or immigrant has mastered the new language, accent may be a constant reminder, to oneself and others, of being an outsider (Kristal-Andersson, 1975);
- the realization of an inability ever to express oneself as well in the new language.

Reports indicate that a lack of ability to speak or express oneself in a new language cannot be alleviated by speaking solely one's native language in the new country, as this may lead to isolation and poor adaptation (Giordiano, 1973; Hartog, 1971). Children may be affected by the parent's *state of being: language degradation.*

Certain special language circumstances

In addition, to the above there are certain special language circumstances that can cause feelings of language degradation, and the *state of being:*

Refusal to use the native language

At times, for one of several reasons, the refugee/immigrant reports refusal to use the mother tongue:

- in order to be part of the new country;
- because of difficult and painful memories in the homeland (Deutsch and Won, 1956; Fairbairn, 1943);

- to deny his/her background.

Some persons report a belief that they would master the language of the new country more quickly and efficiently if they did not continue to speak their native language. They assumed it might be easier for them to be part of the new country if they spoke the new language exclusively (Hoffman and Zak, 1969; Kristal-Andersson, 1975). Some refugees/immigrants may refuse to speak their mother tongue in the new country because of difficult past memories. The native language is a conscious or unconscious reminder of these. He/she seems to attempt to repress something about him/herself. Denial of the mother tongue may complicate and prolong a person's inner difficulties (Fairbairn, 1943; Greenson, 1950; Henle, 1972; Ochberg, 1988).

Loss of ability to speak the native language

An individual may lose his/her ability to use the native language because:

- he/she has no-one with whom to speak it;
- it is not kept up-to-date;
- he/she speaks a mixture of the native language and the new one;
- defective language ability in both the native language and the new one.

Cases – state of being: language degradation

The following case illustrates the *state of being: language degradation*.

Case 5.25

A female immigrant, age 29, 4 years in Sweden, studying at the university; married, to a Swedish man. They have 2 children, 3 years and 5 months old. Reason for treatment: a serious suicide attempt. Form of treatment: insightive psychotherapy, once a week. Duration: 18 months.

Case excerpt (from session 1):

The woman explains why she attempted to take her life.

P: "I was working as a journalist in my homeland, and wanted to do the same here in Sweden. I am studying the language at the university. I came to Sweden because of my husband. We had met in a foreign country, where we were both working. I would never have moved to Sweden – even for love – if I had known it would have been so hard to get started doing the work I did. Shortly after the birth of my second child I wrote an article about childbirth. I wrote it in English, a language in which I am fluent. A large magazine accepted it for publication. I received a letter from the chief editor. He wanted me to telephone him and discuss my fee and other possible articles I might be interested in writing for them. I was overjoyed, as was my husband who was worried about my dissatisfaction

with opportunities in Sweden. We both agreed we could not leave the country now, after the birth of our children. This job could be an important beginning for me, we hoped."

She decided to call the editor and "try to speak proper business Swedish on the telephone". She had always talked in English on the telephone, so as not to feel inadequate, she explained. Now she wanted to try out her Swedish.

P: "I asked my husband to listen to the conversation, just to check that I was speaking Swedish correctly. He agreed. I dialed the telephone number. The editor's secretary answered, and said very politely, 'He is busy on the other telephone right now. Can you wait?' in the best Swedish I could possibly express myself in and trying to be as businesslike as possible, I thought I said, 'Yes, I can wait until his conversation is finished.' But the secretary burst out laughing. I heard her repeat what I had said to someone and they were both laughing. My husband behind me was roaring with laughter. I hung up. When my husband, with whom I was now very angry, was able to stop laughing he explained what I had said, 'You said: Yes, I can wait until he finishes having sex!' 'How could I have said that?' I screamed in despair. 'You said, 'samlag' instead of 'samtal', that is you said 'sex' instead of 'conversation' '."

The rhythm and intonation of both these words in Swedish is very much the same.

P: "I was so tense about the telephone conversation that I could not hear myself," she explained. She made her suicide attempt a few days afterwards.

The following case describes how the *state of being: language degradation*, caused by a lack of nuances in the new language, may complicate the carer's understanding of the person's difficulties.

Case 5.26

A male refugee, age 43, 12 years in Sweden, a businessman; recently divorced from his Swedish wife who has custody of their 2 children, 5 and 8 years old. Reason for treatment: suicide attempt. Form of treatment: Crisis therapy, twice weekly. Duration: 6 months.

Case summary:

The patient was hospitalized. He spoke a seemingly fluent Swedish, almost without an accent. He could not, however, explain why he attempted suicide. A psychiatrist diagnosed him as schizoid, or incapable of expressing feelings. He was given medication, but no supportive conversations, as the psychiatrist who diagnosed him felt they would be useless. Two weeks later, a week after leaving hospital, he makes another serious suicide attempt. He wakes up at the hospital speaking his native language. An interpreter is called in. In an intensive interview, with a second psychiatrist, via interpreter, the man expresses

his inner pain, fear of being alone after the divorce and fear of losing the close contact he had with his children. The conversations, in his native language via an interpreter, and in Swedish continued. He meets the psychiatrist as an out-patient speaking both Swedish and using his own language, via an interpreter. The man, going through a life crisis, was at first diagnosed wrongly, as he could express his feelings and despair in his own language.

The following case illustrates when realization of the impossibility of mastering the new language can lead to the *state of being: language degradation.*

Case 5.27

A male refugee, age 50, 20 years in Sweden, an office worker; married to a Swede, age 45, a nurse. They have 2 sons, 18 and 21 years old. Reason for treatment: depression. Form of treatment: psychotherapy, once a week. Duration: 14 months.

Case summary (of the early sessions):

He is fluent in Swedish and a writer in his own language, and has even published several things in Swedish. He asks to speak to the therapist as he is feeling depressed, like an outsider, he explained, feeling lonely without being alone, frustrated and feeling no inner peace to write the book he is planning. He is at present at work on a book in Swedish, he explained, "but I miss my own language". His son had just got accepted at university to train to be a journalist, he added proudly. After a few meetings, it emerged that he was feeling a deep inferiority trying to write in Swedish compared to the way he could express himself in his own language. "Even after 20 years in Sweden, I express my thoughts better in my mother tongue," he finally admitted after several sessions. Once he could say this to himself and the therapist, he was able to look for ways to confront these difficulties. He decided to first write his thoughts out in his own language and then translate them into Swedish. A lengthy and tiring process, but a way to lessen his inner turmoil.

After several more sessions he could admit feelings of jealousy toward his son, who had achieved what he couldn't in Sweden; that is, a skilled knowledge of Swedish. The jealousy he felt towards his son had intensified his deep depression. He was guilty and angry at himself for feeling jealousy towards his own son.

The depression gradually lifted once he started working on his new book in his own language and accepted that he might never have the same ability in Swedish as he had in his mother tongue. He worked through the jealousy toward his son. Once this was aired, he was truly proud of his son and could even ask him for help in the translation of his new book into Swedish. His son was delighted, and told his father that he had so much to

learn from him as a colleague. Their relationship improved, and the man is now completely recovered.

STATE OF BEING: VALUE DEGRADATION

The refugee/immigrant usually comes to the new country with a value system formed from childhood. Faced with a new value system that may be different from his/her own, the individual is forced to compare and question values on a conscious or unconscious level. At times, this can lead to confusion and difficulties. Feelings of value degradation can become the *state of being* when the person cannot handle this process (Erikson, 1950, 1976; Kristal-Andersson, 1980; Marsella et al., 1985; Mezey, 1960). He/she faces countless conscious value conflicts when observing that the values and traditions of the homeland have little or no meaning for inhabitants in the new, and may sometimes even be considered ridiculous or wrong. When conflicts between the homeland's value system and the new country are conscious, they can be worked through. However, if the person is unaware that he/she is going through a value conflict, it may sometimes cause severe difficulties.

Cases – state of being: value degradation

The following case is an example of how a conscious value conflict can be worked through in psychotherapy.

Case 5.28

A female refugee of Moslem background, age 26, 3 years in Sweden, a housewife; her husband, age 35, is an officer cleaner. They have 2 children, a boy and a girl, 5 and 7 years old. Reason for treatment: severe depression, near-psychotic feelings. Form of treatment: psychotherapy, once a week. Duration: 3 years.

Case summary:

The symptoms developed after 2 years of waiting for asylum with the constant threat of it being refused. The patient's husband had been a construction worker in his homeland, had been active in a newly formed trade union which was then forbidden, and they had to flee. They came from a medium-sized town where they had both been raised in a strictly traditional and religious atmosphere. The woman still dressed in the attire of her country (a sari) in Sweden, but had been stopped from wearing a veil when she came here.

Case summary, and excerpt (from session 44, after 1 year in therapy):

The family had been granted political asylum several months before. The daughter was about to begin school.

P: "I bought a bathing suit!" This very lovely-looking young woman, wearing a scarf, said when she came into the office, very happy and satisfied. T: "Wonderful!" the therapist agreed. "You could buy a bathing suit for yourself!" P: "*No! Not for me!"* she said angrily. I can never wear a bathing suit. I'm not allowed to, because of my culture. You should know that!" she said surprised. T: "I know now. I just thought…young women like you in Sweden wear bathing suits." P: "*Not me!*" she said again angrily and then giggled. P: "My daughter…I bought it for her. She is starting school. Boys and girls will bathe together in a pool, learn to swim, and my daughter too!" she said proudly.

At first, the therapist didn't understand the importance of what had happened. Even in the new country, where most people bathe and swim, the young woman could not allow herself to go against the value system she had been brought up in, where women are not allowed to wear bathing suits publicly or even to bathe in public. However, she could allow her 7 year old daughter to wear a bathing suit and "swim with boys and girls together".

She was willing to make a conscious change in her homeland's value system for her daughter, but not for herself. She would allow her daughter to start Swedish school and be like any other child. She could allow her daughter to begin life in Swedish society, without guilt or a conflict of loyalty between two different cultures, and without from the start forcing the child to feel and act differently to other children in the Swedish class. This was an important conscious value change from her past.

In previous sessions, she expressed her indignation at never being allowed out of the house alone as a child. At the same time, she shared her fear for her children growing up in Sweden where "the children are so free". For many sessions, the therapist listened to her fears of Swedish society and could finally help her to realize that children can choose what is right and wrong for them, if given the freedom to do so. They usually choose what is right for themselves and others. It was better not to be restricted, as she had been. Her ability finally to go and buy a bathing suit for her daughter and to allow her to learn to swim with the other children was a result of those conversations. The therapist asked her when she would buy a bathing suit for herself. She giggled and changed the obviously very frightening subject.

The following case describes a conflict of values of which the individual was unaware, and how it was finally solved.

Case 5.29

A male refugee, age 29, 4 years in Sweden, a civil engineer in his own country, studying at university to take a Swedish degree in his field. Reason for treatment: hospitalized with severe depression and suicidal thoughts, unable to continue his studies. Form of treatment: medication and psychotherapy, once a week. Duration: 6 months.

Case excerpt (from session 1):

At the start of the session: P: "I just don't want to live. I don't know why." The therapist listens, but does not comment.

During the interview: T: "Why did you come to Sweden?" P: "I had to. I was in politics in my country. I was working actively in a socialist party. Then the right-wing military took over my country." T: "I understand. Have you family there?" P: "A mother, father and 2 sisters."

He explained that his family is very "old–fashioned". He was raised according to strict Moslem tradition. But he had left it, he said. T: "Why?" P: "I believe in sexual as well as political freedom." T: "You're not married?" P: "No. I came to Sweden alone." T: "It must be lonely for you here." P: "Yes."

Then he explained that he had many male friends from his country, "refugees like me", and sometimes they went out to dances.

T: "So you are meeting women, too?" P: "But I won't do that anymore." T: "Why?" P: "I don't like the girls I meet at dances." T: "Why not?" P: "Because all I have to do is dance a few times with them and then ask them if they want to sleep with me. They usually agree." T: "Most men would think that is great." P: "I did in the beginning. But I'm tired of it." T: "Tired of women and sex?" P: "No, it's those kinds of women I'm tired of." T: "But you said you believe in sexual freedom." P: "I know. Now I know what it is, I'm not so sure any more that the way I was brought up is so wrong. You do not have sex until you marry." T: "Could part of your 'not wanting to live' be to do with that?" the therapist suggested. "You went against a cultural value you actually seem to believe in." P: "I never thought of it that way. The women I met and slept with disgusted me afterwards. I was disgusted with myself, too." T: "Sometimes you feel lonelier and more unhappy going against a value deep inside yourself that was built up in childhood." P: "Sometimes I thought of my mother afterwards. How sad she would be to see me like that. I felt so guilty." T: "Guilt can make you even more depressed."

The conversations continued for several months. He became less depressed and no longer talked of wanting to die. He was introduced to a friend's sister, a young, educated woman from his culture who had recently come to Sweden. After a few months, they decided to marry. He said soon afterwards that he didn't need therapy anymore. He had taken his Swedish civil engineering degree, and had got a job in the north of Sweden, where they would move immediately after their marriage.

The next case illustrates how unconscious value conflicts can further complicate the individual's symptoms and difficulties.

Case 5.30

A female refugee, from a Catholic country, age 25, 10 years in Sweden, a waitress. Reason for treatment: manic depressive personality disorder. Form of treatment: medication and supportive conversations, twice monthly. Duration: 4 years.

Case summary:

The young woman came to Sweden when she was 15 after several years of separation from her parents, who were political refugees. She is manic depressive and is often hospitalized. She is attractive, and during her manic periods she is sexually promiscuous. During her depressive phases, she suffers extreme guilt, which has resulted in several suicide attempts. As a young child she was left with her grandparents, as her parents were working politically underground until her father was arrested and disappeared in prison, presumably tortured and killed. Her mother fled to Sweden. Her grandparents, because they were old and frail, sent the girl to a strict Catholic boarding school in her homeland, until her mother could send for her several years after her own exile. The girl was then 15 years old and entered a Swedish school. She was emotionally younger than her Swedish classmates because of her strict religious upbringing, and felt isolated and different. At 19 years, she had her first sexual contact, where she was almost raped. At 21 years, after several sexual contacts where drugs had been involved, she went into a mania and was hospitalized and released only after she had gone through, while hospitalized, a deep suicidal depression. Since then, she has gone through several manic-depressive states with attempted suicide. She has had medication, but refuses to go into the past. Sex before marriage is forbidden by the Catholic Church. Besides other background difficulties, the values of Catholicism and the sensitive age she came to Sweden to face a completely different value system led her into a deep, but unaware value confusion and inner conflict about her own moral code and the religious values she was inculcated with in her homeland.

STATE OF BEING: INFERIORITY

Feelings of inferiority may often start to develop in the refugee/immigrant as he/she tries to enter the new society (Kristal-Andersson, 1980; Moynihan, 1975; Murphy, 1964; Offer, 1971). These feelings can at first be based on the reality of the situation of being in a new country, may gradually become part of the individual, and influence his/her identity in and adaptation to the new country for many years. For example, one's own language, way of living, work and play habits, may not count as much or be as useful. Important tasks, such as accessing health care, are difficult. Simple tasks may become a problem, even shopping for food, paying bills, and knowing how to dress appropriately. After a while the individual adapts to the new country in his/her own unique way. It may take weeks, months or years until he/she does not feel inferior, and such feelings may crop up even after a long period of residence in the new country. These feelings may have a chain effect on other family members. Constant feelings of inferiority may lead to the *state of being*.

Feelings of inferiority and the *state of being* not based on the *refugee/immigrant situation* may relate to something within the individual's *childhood experiences* and/or *relevant background conditions* (Erikson, 1974; Hunter, 1964; Jacobson, 1964; Klein, 1957). It may be difficult for the person who feels inferiority related to background reasons to make a start in the new country. He/she already has low self-esteem, and may find it difficult to handle inner/outer changes.

The traumatized and/or tortured refugee may experience feelings of inferiority or the *state of being* for exactly the same reasons. These can be caused, further influenced or complicated by trauma during childhood or later in life, and by experiences of prison, torture, oppression or war (Bowlby, 1969; Eitinger, l960; Kristal-Andersson, 1976; Mezey, 1960; Terr, 1988).

Cases – state of being: inferiority

The case that follows is a summary of a year-long psychotherapy illustrating how feelings of inferiority can be caused by the reality of life in exile.

Case 5.31

A male political refugee, age 37, 5 years in Sweden, a factory worker (a university professor in his own country); married, his wife, age 30, is a housewife (a teacher in the homeland). They have 2 children, a boy and girl, 8 and 6 years old. Reason for treatment: depression. Form of treatment: psychotherapy, once a week. Duration: 16 months.

Case summary:

He was a professor of architecture, a respected intellectual and socialist in his own country. He and his family were forced to flee from their country after the take-over by the right-wing military regime. He was working as a manual laborer in Sweden. Due to many different but mostly bureaucratic factors in the Swedish societal system he could not work in his own profession. He did not protest against this decision, because he was thankful to receive political asylum. He had always felt that manual labor is as important as intellectual work, but had never done it before. He was encouraged to meet the psychotherapist by one of his friends, who was worried about him. He was in a deep state of depression and talked of suicide.

In the first sessions, after a long and intensive intellectual dialogue he got to know and trust the psychotherapist, at least on an intellectual level – through "discussion" – feelings were not mentioned. His depression and suicidal thoughts were not named, even though he knew why the psychotherapist had been contacted. He had an intellectual language, but not an emotional one.

After several more meetings, he was able to admit that he hated the work he was doing here. He hated himself because he could not "accept" manual labor. The therapist asked him why he had to accept it, as he was trained and had for many years been working in his own profession in his homeland. A long intellectual and political analysis began, defending manual labor. The therapist could, because she knew he trusted her after their previous "discussions", finally cut in and say, "But you're depressed and suicidal? Why?" Then his deep self-hatred as an inferior manual laborer came out, and his disappointment and anger at the Swedish system for offering him such work in exile. He could now admit that he, in fact, felt that he had been treated unfairly by the employment office.

This man, a well-respected peaceful revolutionary in his own country, felt that in Sweden he could not protest against a bureaucratic decision. It then came out that when he was being interviewed for employment, he felt tongue-tied and stupid. He was not sure, because they were speaking through an interpreter, if he was being made to feel stupid by the Swedish official, who he thought might have had a condescending attitude towards him. Anyway, he became stressed and could not explain himself or describe the skilled work he was doing in his homeland, even with the help of the interpreter.

After several months of psychotherapy, the intellectualizing disappeared. Feelings were expressed, first with anger, then with tears of deep despair. It was clear that the inferior situation he was placed in here had helped to cause the depression and suicidal thoughts. He had lost his inner strength, his confidence to be himself. The *state of being: inferiority* had become part of him and he experienced only what he could not do, based on the reality of his situation here, and how he was in fact forced to feel inferior by an insensitive representative of the new society. He had suicidal thoughts because he felt like a hypocrite, because of his political ideals, when he was incapable of doing manual labor without complaining about it. By finally being able to voice his despair, guilt and anger in words, and by my encouraging him to be totally himself again in the new country – a person who could fight for his own and others' rights – he could go back to the employment office, request further advice (consisting of more advanced language courses and the opportunity for discussion with Swedish colleagues of the same profession) about what use his knowledge could possibly have in Sweden. The deep depression lifted gradually.

At present, he is working as a paid apprentice with Swedes of his own profession. He is well liked and hopes someday to be able to do the same job, when his language abilities improve and he learns all the necessary terms in Swedish for his profession. He is met by his Swedish colleagues as an equal and experiences his inferior position as temporary, rather than it leading to a permanent *state of being*.

The next case describes how the refugee's *childhood experiences* and *relevant background factors* influence the *state of being: inferiority*.

Case 5.32

A male political refugee, age 33, 3 years in Sweden, unemployed (a doctoral student in his own country). Reason for treatment: continuous aggressive behavior. Form of treatment: supportive psychotherapy, once a week. Duration: l year.

Case summary and excerpts (from sessions 1 and 9):

The individual is encouraged by a social assistant to meet a qualified psychotherapist. He is angry at everyone and everything. He thinks everyone is prejudiced against him. He is dark-skinned, and short, and an angry expression is almost carved into his face.

Session 1:

He meets the psychologist with suspicion. P: "I wanted to see a psychologist, but now that I am here, I have nothing to say."

She asks him, softly and calmly, about his homeland and life there. P: "You read my file." T: "No, I didn't." P: "Read it, then. It's all there in it, who I am." T: "Couldn't you tell me yourself?" P: "Everyone knows who I am, but I don't." T: "We can talk about that." P: "About what? I am in Sweden. Everyone looks at me with disgust. I am dark and little. They don't like people like me," he replied T: "Everyone? That's quite a generalization." P: "Everyone! I can't even get a job."

The therapist asked him about his family. He explained that he had 2 brothers. P: "They are both tall and handsome. I am not." T: "Are they living in exile?" P: "No. I was the radical one. They're both married. I'm not. I won't meet a girl here. I'm too short and dark. Swedes hate dark persons. You know, you are one of them." T: "I don't hate anyone because they have a different skin color. I try to see the person beyond his appearance."

The sessions continued in that way. The therapist felt more and more under attack, as he got angrier and felt that she, too, was just as prejudiced as everyone else in Sweden.

Session 9:

T: "Perhaps there is some truth in everything you say. But I believe your way of looking at people in Sweden has more to do with your past in your country, than how it actually is here for you. It seems to me you grew up with the feeling that your brothers were better than you. You seem to feel inferior to them even now, in spite of your education and political values."

The comment made him so angry that he did not come back for 2 sessions. Then he returned, and they continued to talk about his childhood and his low self-esteem because of it, even here in Sweden. After a few months he got a job in a firm that took his education seriously. A Swedish colleague there was friendly and invited him to his home. As time went by during the therapy, there was less criticism of Swedish people.

The following case describes how the *state of being: inferiority* can affect a second-generation immigrant youth who has identified with the reality of her parent's *refugee/immigrant situation*.

Case 5.33

A female, age 17, born in Sweden of immigrant parents, a student; her mother, age 39, is an office cleaner, her father, age 45, is disabled, receiving a sick pension. She has one brother, 13 years old. Reason for treatment: apathy. Form of treatment: supportive psychotherapy, once a week. Duration: 2 years.

Case summary:

The young girl wanted to leave school and find full-time employment, in spite of high grades and a great interest in science. Since her childhood, she wanted to be a scientist and was supported by her science teachers, but at 17 years old she decided to leave school. The young girl was encouraged by her science teacher to meet the school psychologist. The psychologist saw her several times and suggested she meet a psychotherapist. Her parents, who want her to continue school, encourage her to do so.

Case excerpts (from sessions 1 and 9):

Session 1:

P: "I don't want to be here talking to you. I am only doing it for them." T: "Who?" P: "My parents. I know my decision to leave school worries them. But I just can't go on." T: "Why not?" P: "There is no reason to. I won't be able to do what I want to do anyway…to work as a scientist." T: "Why not?" P: "I have always been interested in science. My teachers have encouraged me. I have been best in the class throughout school. And I know that I can get through university…but then what? What kind of job will I get, with my looks, my last name. There are no jobs, no money for scientific research now, and how will it be in a few years. And who will be the first to be offered work? Well you know. Not the kids with foreign names." T: "You seem sure of that." P: "Just read the newspapers."

In the sessions that followed the young woman continues to express her fears, but decides to put off her decision to quit school. She talks more about her parents.

Session 9:

P: "My mother is devoted to my brother and me. When she was my age, she wanted to be a nurse. She had good grades, too, but she had to work. Now, she works at 2 cleaning jobs. My father was crippled in an accident at work. They came to Sweden for a better life, and they still have nothing. No money, no family, no friends, nothing. My brother is turning into a criminal. He was caught taking a pair of jeans from a shop. I can't let that happen. My mother does not have enough money to buy him the clothes he needs. I want to start work to help her."

During the sessions that followed the young girl continues to talk more about her mother and father. They had come to Sweden when they were young. Her mother was studying to be a nurse in the homeland and they planned to stay a year or so, hoping to save money and return to their country. However, political unrest in their country forced them to remain in Sweden. Her mother never felt she was good enough in Swedish to return to school and study nursing here.

T: "Do you think she could have?" P: "Yes. She speaks Swedish with an accent, but she understands everything she reads. She could have. She was just afraid, felt that she was not good enough, felt inferior to Swedes." T: "Why? It seems to me your parents were fighters, they left their own country to work here. That takes courage." P: "It left them when they came here. My mother had to accept any kind of work to earn money. Then I was born. Then the troubles in our country started. Then my father had the accident." T: "Isn't this your country? You were born here." P: "But I feel like a foreigner. I feel like my mother." T: "But you are not your mother, you are you." P: "I must help her. She can't go on doing 2 jobs." T: "Are you afraid, do you feel you are not good enough, inferior to Swedes with Swedish names?" P: "I don't know. Maybe." T: "Let's go more into the 'maybe' of what makes you feel inferior."

The following sessions focused on the young girl's feelings of inferiority, which seemed to be based more on the reality of her parents' situation, especially her mother's, rather than on her own. When she was able to realize that, she began to look at her own reality and resources. She continued her studies and went on to university as a science major.

State of being: non-identity

Identity and the related idea of self-concept can be considered in different ways. Social identity theory, generally ascribed to Tajfel (1978, 1982), posits that a person's self-concept is heavily dependent on, even integral with, his/her group affiliation. And E.H. Erikson's concept of "ego identity" (1968, p. 211) considers the individual's *childhood experiences*, societal circumstances and "sameness of self through time" (op cit., p. 19) – having varying feelings and thoughts in different situations, but still remaining the same continuous person, with a past, present and anticipated future. This definition also includes the culture, attitudes, moral code and religion in which the individual is raised. The refugee/immigrant has an ego identity formed in the homeland, combined by early childhood experiences, social circumstances and the individual's "sameness of self through time". He/she meets a new society and the people in it – sometimes very different from the ones in which his/her ego identity was formed. He/she seems to be compelled to compare and question the homeland identity. A state of incongruence seems to be

created. The homeland identity is questioned, which has probably never happened before. A conscious and/or unconscious process appears to begin, and seems to take many years with various phases and turns. Each time another comparison must be faced, he/she can experience confusions and anxiety – a loss of the "sameness of self". There is a conflict between two worlds – the old, which the refugee and the immigrant is no longer a part of, and the new, which he/she is not yet part of. He/she can then lose the sense of "sameness of self through time" so vital to personal identity. Over the years a fusion of both identities and ways of life can take place. However, if the person cannot handle this process, it can lead to loss of a sense of "sameness of self through time", and become the *state of being: non-identity.*

The fusion of the homeland identity and the new one may be further complicated as the children of the refugee/immigrant grow up in, become part of, and identify with the new society. Each child, adolescent and adult in a family may go through separate and different identity conflicts. These may become not only one person's conflicts, but also the family's, and can cause confusion, anxiety and strife in the family.

The traumatized refugee may experience identity conflicts and feelings of non-identity, and the *state of being*, for the same reasons. However, these may also be caused by trauma and could complicate the feelings, or the *state of being*. Any form of severe trauma may be expected to cause a feeling or condition of "not knowing who one is" and temporary recurring or permanent feelings of loss of "sameness of self through time". This could last shorter or longer periods of time, or become permanent. During and after a trauma, a state of "non-identity" appears to be a mode or defense to endure and survive it and its memories:

> *'If I am not me, I do not feel the abuse. If I am not me, I do not feel the pain. I am not me.' (From a case excerpt, a traumatized refugee speaks of torture experiences).*
>
> *'The purpose of torture is the deliberate destruction of physical and mental integrity. Where the body is the primary site of attack, it is the torturers point of access to the victim's identity and mind – and every physical scar has an emotional scar' (Schlapobersky and Bamber, 1987, p. 207).*

Cases – state of being: non-identity

The next case shows how the *state of being: non-identity* can complicate the life situation of a young adult going through a life-change and torn between two cultures.

Case 5.34

A male, age 23, born in Sweden of refugee parents, he recently completed a university degree; single, he has a brother and sister, 25 and 20 years old. Reason for treatment: "I don't know who I am." Form of treatment: psychotherapy, once a week. Duration: 18 months.

Case summary:

He was born in Sweden shortly after his parents fled from their country because it had been taken over by a fascist military regime. The young man recently finished his degree in engineering and is looking for employment. He explained in the first session that he has always had feelings of "not knowing who I am" since he was a child.

Case excerpts (from sessions 1 and 12):

P: "I don't know if I am a…or a Swede. I was born in Sweden. It is the only place I know. But I am dark and can speak another language, so everyone thinks that I am lying when I say I was born here. It has been going on since I was a child. Sometimes I take out my birth certificate to convince myself that I am Swedish. The Swedish language is my native tongue, I can speak…okay, but not as fluently as I speak Swedish. I am proud of my parents and my background, mostly. My father was a miner and a trade-union activist working for better workers' conditions when they fled to Sweden. He had been imprisoned and they feared for his life. But I haven't learned very much about their culture. I feel more Swedish." T: "You were born here." P: "And I want to work here, but it is harder for me to get a job than my friends with Swedish names." T: "I know that can be the reality here." P: "It's hard. I am a Swede too, but because of my name and the way I look, I am not considered one." T: "Does that make you feel that you don't know who you are?" P: "If only it was just that, but it is not." T: "Please explain."

In the first sessions, the young man explained the different reasons why he felt that he did not know who he was, what his identity is. P: "I am…, my parents say. But I was born in Sweden. Swedes ask me all the time, where I was born, because I am dark. I say I was born in Sweden and usually they think that I am lying. I look like a… but I feel mostly like a Swede, or that I just don't know if I am a… or a Swede, or what? Most of the time I feel I am nothing – not Swedish, not… A nothing." T: "Explain what feeling like a nothing is like."

The sessions continued to focus on the young man's feeling "like a nothing". His feelings of not belonging to his parent's homeland or to Sweden. His feelings of non-belonging to life, in consequence. He explained why he felt inferior to his friends with blonde hair and Swedish

names. He expressed his jealousy at the ease with which they could find jobs and a place in society. The therapist was mostly silent, allowing the young man to express his inner difficulties. Afterwards, the male therapist encouraged him to look at his own resources and the opportunities open to him.

After 3 months (from session 12):

P: "I got the job! There were 20 applicants, but I got it!" T: "Congratulations!" P: "I got it because of my grades and because of my language and 'cultural' abilities, they said. I will be traveling. I won't be able to come each week." T: "That's all right. We can arrange our sessions around your travels." P: "They are expecting very much of me…and I am not as good in the… language as they think I am." T: "I am sure you can increase your language abilities as you progress in the work." P: "I am a bit scared." T: "Lets go into your fears…"

The therapy continued for 18 months. It was focused on the young man's feelings of non-identity, then on the integration of both identities. His business trips took him several times to his parent's native country. Finally he could say, P: "Now I know who I am. Firstly, I am me, just me, myself. Secondly, I am Swedish, but not just a Swede, a Swedish-…, and I am proud to be both. But mostly proud that I can be who I am…just me."

This case that follows describes the way in which a part of the life style of the new country can be a conflict for the person of another culture and background and lead to the questioning of his/her own identity, and even the *state of being: non-identity.*

Case 5.35

A female refugee, age 25, 7 months in Sweden; married, a housewife, her husband, age 31, is studying Swedish (a college teacher in the homeland). They have 3 children, 5, 3, and 1 years old. Reason for treatment: severe insomnia, concentration difficulties. Form of treatment: support work, twice monthly. Duration: 9 months.

Case summary:

The woman arrived in Sweden with her family in the autumn. During the following springtime, she sought the help of a general practitioner for symptoms which had been going on for a month. She came to the medical clinic with her husband who explained that she was so tired and apathetic, after not being able to sleep for a month, that she could no longer care for the children. The doctor prescribed medication, and suggested she talk, through an interpreter, to a female psychologist.

Case excerpts (from sessions 1 and 3, after 1 and 3 weeks of treatment):

Session 1:

The woman explained that the family was forced to flee their country because her husband had been openly critical of the government.

Someone in the college had reported him. He was interrogated and tortured by the police. His father and brothers feared for his life and they fled to Sweden. They had recently received political asylum. She herself was not educated or involved in any way in politics. They left their homeland within a few days. She missed the family and the life they had there.

P: "Sweden is so different from our country." T: "Do you think so?" P: "Yes, the weather, the food, the way of life. Yes, almost everything."

The woman explained that until they arrived in Sweden she had always worn a headscarf and her face was veiled. P: "When we arrived at the airport, my husband said that I didn't have to wear the face veil anymore. I protested. I told him I would feel so naked without it. He said, that it would be easier for me in Europe if I did not wear it. I obeyed him. Now I understand why he said that. The women here are so different. You are allowed to show every part of your body without fear." T: "It must be a very great change for you to see how women dress, and are, here." P: "Yes. I think mostly it is good. I don't know if it would be good for me, or my daughters, but mostly it is okay." T: "Are there some things you object to?" P: "I don't know…"

Session 3:

T: "Let's try to go back to the week when you started to have sleeping difficulties. It was the beginning of April. Did anything happen?" P: "No, we have a nice apartment, my husband is studying Swedish. I will be, too, soon. Our family at home is in good health. Yes, now I remember, the sun shone and it was hot for the first time since I have been here. It was wonderful. No, nothing happened…I went for a walk through the town with the children." T: "Yes, everything changes quickly in Stockholm when spring comes…" (There is a long silence. The therapist notices that the woman is deep in thought). P: "Now, I remember…there was something I saw, something that worried me. I didn't want my children to see…" T: "What was that?" P: "We passed a park. Two young women were laying on the grass in the sun. They had taken off their shirts and bras…and lay there in the sun with their breasts bare." (There was a long silence.) T: "That must have been quite a shock for you." P: "Yes. I turned my kids around and ran. I don't think they saw them. But I scared the children, because everything happened so quickly." T: "You didn't want them to see the bare-breasted women" P: "No! Not my son, and not my daughters. That is forbidden. In my country a woman would be whipped, even stoned to death for such behavior. We cannot exhibit any part of our body in public. Not even our face. In Sweden, a woman can appear naked in public, and nothing happens to her." T: "Here, everything is very different from your country." P: "As I ran away, I kept thinking, I don't want my kids to grow up seeing those kinds of things." T: "I understand because your culture is different from this one." P: "Yes. But what is right and what is wrong? It all seems so

opposite here. All my life I have been taught to hide my body, my face." T: "Just a few months ago you took off the face veil." P: "Then my husband said I do not have to wear a head scarf anymore, either. I don't agree with him. I will always wear it. It is our culture." T: "As if even he wants you to change the way you are." P: "Yes, I don't know who I am anymore. I never had to think like that before." T: "What do you mean, can we discuss that?"

Case summary:

The conversations lasted for several months. After 6 sessions, the woman could sleep without medication. During the treatment, the therapist focused on the woman's threatened identity, and helped her to learn to cope with the differences in the new society and finally, to find the strength to feel free to choose the life-style values and identity with which she felt most comfortable.

The following case illustrates the social and psychological consequences to which the *state of being: non-identity* may lead.

Case 5.36

A male immigrant, age 16, 12 years in Sweden, unemployed; his father, age 40, a factory worker, his mother, age 36, a housewife. He has 3 siblings, 14, 12, and 9 years old. Reason for treatment: aggressive and criminal behavior. Form of treatment: supportive psychotherapy, twice weekly. Duration: 2 1/2 years.

Case summary:

The youth had been in trouble with the police since he was 10 years old. He often disappears from the family home and sleeps outside or in hallways. He is a poor student and has difficulty in reading and writing Swedish. He speaks the native language poorly, and cannot write it. The father has always been strict with the boy and his 3 younger siblings and sometimes beats them. He demands that the children follow the religion and traditions of the country of origin. The youth refuses to do so. His mother is illiterate and isolated. She suffers from numerous somatic ailments. Both parents have poor knowledge of Swedish.

When the meetings with the therapist began, a younger brother had recently been caught sniffing and stealing. The youth expressed himself in fluent, but simple Swedish. In the sessions, he was quick, intuitive and sensitive – nearly "ahead of the therapist" most of the time. In the beginning, he acted tough and was on the defensive, but gradually a trust and liking grew between the therapist and the boy. His facade of "tough guy" was soon broken down, and the therapist and boy "spoke the same language", that is, there was a mutual exchange. After several sessions, the adolescent went into his childhood experiences. He was 4 years old when he came to Sweden with his mother. His father had come the year before. The sessions continued revealing to the therapist a sensitive, but hurt and bitter young man – however, not the tough, hardened criminal personality that had been described by the social authorities.

He spoke of his first memories in Sweden. His mother was often in tears when his father left for work. He remembers not going out much and having few toys. The family was sending money home, he explained. He remembered feeling dumb and helpless when he started school, as he spoke almost no Swedish. He was laughed at and made fun of by the other children, and already in the first grade started defending himself and was considered a troublemaker. By 10 years old, he was stealing. Each time, it was reported to his family, his mother wept and his father beat him. He couldn't remember when he last cried tears. They had been back to the native land for 2 summer vacations. He was with his family and grandparents, whom the father economically supported. He loved the native land, but felt like a foreign tourist. He could not communicate with his family there as his knowledge of the home language was insufficient. He did not agree with many of the customs and traditions. I like the modern, Swedish way of life better, he explained. His parents dream of returning to the homeland when they save enough money. He wants to stay in Sweden.

P: "Perhaps I look like a…on the outside. But I am a Swede inside. At least I think so. He went into his feelings of not knowing if he was a Swede or a… 'I do not know anything about my own culture. I don't want to follow the religion. I know only the food my mother cooks from the old country and the religious holidays. I can understand what my parents say in their language, but I can hardly reply. We don't celebrate the Swedish holidays. When I was a kid, I lied and made up stories about the Christmases and Easters we had at our home. Mostly I walked the streets and looked inside at other families celebrating the Swedish holidays. I felt so alone, I was not a Swede and I didn't feel like a…' "

The sessions continued over many months. The youth was deeply confused, had loyalty conflicts and was guilt-ridden that he did not follow his parent's culture and religion. He did not feel he belonged anywhere.

The therapist believed that he had been acting out aggressively through the years the conflicts he was going through because of his *refugee/immigrant situation*, and that of his parents' and because of his suffering from the *state of being: non-identity,* which he could not cope with or work through on his own.

After 2 years of individual therapy and several sessions with the parents, and meetings with his teachers, the boy has committed no criminal offenses for over 22 months. His interest in school has improved. He is learning to read and write his own language, and Swedish. His parents have become more understanding of his situation and the younger children seem more harmonic. The father has stopped beating the children. The younger brother has stopped sniffing and stealing.

STATE OF BEING: ROOTLESSNESS

The experience of rootlessness and the *state of being* is reported as a diffuse feeling of not belonging, of not feeling secure in the feeling that one exists and is needed, loved and wanted by people, by life itself. Rootlessness is reported to be experienced as having "no ground or base". It appears to be an unconscious, wordless feeling that seems to cause serious mental anguish. Rootlessness appears to be experienced especially during a depression or other crises. To feel deep and continuous rootlessness can be a near-psychotic state of mind. Rootlessness appears to be further complicated by *childhood experiences* and other background conditions, and also by what the individual has endured in life and his/her current difficulties (Erikson, 1950; Frankl, 1976; Sartre, 1962).

A person going through any kind of difficulty can usually find support in contact with family, friends and perhaps his/her childhood landscape or environment, i.e. his/her roots. Often, a person goes back to his/her "natural roots" when "feeling bad". This in itself can be healing or therapeutic, and is often enough to overcome less serious emotional and existential confusions or crises. But, what happens when the person does not have this important natural therapeutic support? A difficulty may then become harder to deal with and resolve. During these times, when a person needs the belonging and comfort that roots can give, a refugee or immigrant may not have them, and may experience feelings of rootlessness – based, at first, on the reality of the *refugee/immigrant situation* at some time in the new country (Eitinger and Grünfeld, 1966; Feldstein and Costello, 1974; Mostwin, 1976). On arrival in the new country, the person may feel that he/she is without roots and a secure base. The feeling of rootlessness can come over an individual suddenly, or gradually, and last shorter or longer periods. The experience becomes a *state of being* when *rootlessness* envelops the person, and his/her existence seems to fluctuate between painful reality and psychotic feelings or psychosis.

The refugee may have been traumatically uprooted or had to flee in such a way that he/she was pulled suddenly away from his/her roots. He/she may have experienced situations and events that have led to feelings of rootlessness. The refugee knows he/she cannot return to his/her roots for an indefinite period of time. The *state of being: rootlessness* may be complicated and more severely experienced by the refugee who has had traumatic experiences in the homeland. In addition,

feelings of rootlessness, or the *state of being*, may be experienced because of the effects of trauma.

Cases – state of being: rootlessness

The following case exemplifies the moment when the refugee/immigrant's current problems and the reality of being without roots, or an exaggerated experience of that reality, intermingles with the *state of being*: *rootlessness.* This can cause even more severe problems. What might only have been a life change in the individual's own surroundings, with people of his/her own culture and background, has developed into a serious psychological disorder in the new country.

Case 5.37

A female refugee, age 29, 6 years in Sweden, an office worker; recently divorced. She has 1 child, 5 years old. Reason for treatment: psychotic behavior, followed by a suicide attempt. Form of treatment: supportive psychotherapy, twice weekly for 2 years, twice monthly for 4 years. Duration: 6 years.

Case summary:

The woman is hospitalized after a serious suicide attempt. She is from a country with very few other refugees in Sweden. She speaks a native language known by few, but has good knowledge of the Swedish and English languages.

Nine months before the suicide attempt, she and her husband, also a refugee from the same country, divorced. He decided to emigrate to another country, and she stayed with their child in Sweden. But she felt alone, insecure and unable to cope. She longed for her family, her country that she could not return to, and her language which she had no one to speak with.

About 3 months after the divorce, she goes into a manic-psychotic state. She returns to her childhood religious beliefs, but believes she herself is the daughter of God. She finds the security and roots she lost in this childlike belief that God will take care of everything. She gives away her money and does not take care of her child. Behind this euphoric irresponsible state lies a deep *rootlessness*. She belongs, if not to her homeland and not to the new country, to her childhood God, a God who gave her the only security she had as a small child against the constant bombings of her country. Her mother was very often out working. Her father was a soldier, and her other relatives had already perished.

In an intensive dialogue over months with a therapist she became aware of herself in the present in Sweden and of her *rootlessness*. She began to understand how her childhood and past life in a war-ridden country affected her deep feelings of insecurity and fear in the new country, especially after her separation and divorce. Over a long period of

time, she realizes and works through all this, and tries to start taking responsibility for herself and her child's welfare. She is able to acknowledge her insecurities, and tries to re-root herself and see the roots she already has in her new country: her child, some friends and the opportunity to live in a free and peaceful environment. This she was able to see once she became aware of her *rootlessness.*

Her path is a long and difficult one. Her first 6 years of life left deep emotional scars within her. During those years, she experienced nearly constant air raids, bombings, and foot soldiers invading her village. Her relatives had been killed before her eyes. Her own culture is very different from that of Sweden, her language spoken by very few. The knowledge that some of her relatives are still suffering in the homeland adds to her guilt. Her loneliness, inner pain and guilt are so real that the psychotic state she returns to sometimes is her defense against the real and existential torment of her *rootlessness*. At times, her child has had to be fostered, which has caused even deeper guilt and feelings of rootlessness.

The next case shows the *state of being: rootlessness,* due to the *refugee/immigrant situation*, repressed memories of traumatic outer events, and a life change.

Case 5.38

A male refugee, age 41, 20 years in Sweden, a business executive; married, his Swedish wife, age 39, is a teacher. They have 3 children, 18, 12 and 10 years old. Reason for treatment: feelings of panic, morbid brooding, concentration difficulties, insomnia, depression. Form of treatment: short-term psychotherapy, twice weekly. Duration:1 year.

Case summary:

He has a good job, and is accepted in Swedish society. When he asked for sick leave and medication for his symptoms from the company's doctor, she suggested that he meet with a psychologist. He agreed.

In the first session, he explained that his symptoms began when his son was called up for military service in Sweden. He had come to Sweden alone to avoid military service in his native country which is still governed by a military regime. After a year in Sweden, he met his Swedish wife. They have built a constructive life together, with 3 children, a comfortable house in the suburbs and successful careers.

His son, now l8 years old, had always wanted to be a pilot and decided to join the Swedish military. The man tried to convince his son to pursue his pilot career outside the military service. The son refused. It was then that the memories of his past homeland returned, of growing up under the strict military regime, and the faces of his childhood friends who had been massacred in the war or in prisons plagued his thoughts day and night. He had escaped their plight because his parents had sold everything they owned to send him to the safety of Sweden. It would probably have been impossible for him to stay in the new country, if he

had not married a Swede. At the same time, and even though he had a good life here, he started longing for his homeland, his parents, friends and the life he would have had there. He started feeling alienated from his wife, children, and colleagues. He isolated himself. He explained that when he looks at recent photographs of his family in the homeland, he realizes he does not know the children of his brother and sister. He feels as if he does not know his own family, his own roots. When the therapist asked why he cannot visit his native country, he explained that it is still too dangerous for him to return to his homeland, but his wife has gone there for several visits with the children. He does not feel a part of his native country, nor of Sweden. He had never felt or thought that way before. Now all he feels is rootless, afraid, fearful for his son and alone, even though he has a wife and his children love him. He developed a severe depression after a business associate asked him about his homeland.

In the psychotherapy, the therapist decides to focus on his feelings of rootlessness. After a month of treatment, he returned to work.

Case excerpt (from session 44, the middle period of the treatment):

P: "You tell me that I must put words to my feelings. But I find it so difficult. The feelings of panic hit me suddenly, even when I am at work. The pictures in my head of my homeland distract me day and night. I see the 2 landscapes, the Swedish one and the landscape of my native country, and I get a feeling of panic. I don't belong anywhere. My son's handsome, happy face turns into the face of my slaughtered best friend. I cannot breathe. I feel like I am suffocating. I feel I have lost both of them. That I have no one, no roots, no family there or here. I miss them so." T: "But they are there. They love you, you have constantly said that." P: "Yes. They do. My mother and my father are proud of me and come for visits to Sweden. But I haven't seen my brothers or sisters in almost 20 years. I have never met their children, or seen their homes." T: "But they are there." P: "I know, but I feel alone and rootless without them." T: "Can you explain?" P: "Like I am not a part of life, or of reality. Even though I know I am, sometimes I don't feel that way. As if, my family here or there are not mine. I don't belong to them or myself. Then I feel panic, or cannot sleep." T: "But you have roots." P: "I know that, when I feel okay, but not when I feel fearful, like I did when my son decided to go into Swedish military service." T: "I understand better now. Tell me about are your fears for your son."

The conversation focuses on his fears for his son's safety. That he can no longer protect him, as he is now an adult.

The sessions continue. The man comes to terms with his feeling of rootlessness, and the symptoms it caused. The symptoms subside, and finally disappear as he begins to be able to see once again what he has built up in life, the roots he has created, and the roots that are in his native country.

This next case describes an individual suffering from the *state of being: rootlessness,* due to an exaggerated experience of reality.

Case 5.39

A female immigrant, age 40, 11 years in Sweden, a translator; married to a Swede, 1 child, 7 years old. Reason for treatment: suicidal depression. Form of treatment: psychotherapy, once a week. Duration: 2 years.

Case summary:

She complains of a feeling of not belonging anywhere and thinking almost constantly about wanting to die. Her marriage is good. She likes her job. She has friends and her husband's family. She can return to her country for visits, and does so every few years. The feeling of not belonging and not having anyone came over her suddenly when her 7 year old child said a word in Swedish that she did not understand. When the child saw her mother did not understand, she went over to a Swedish person in the room. The suicidal thoughts began then, she explained. She questioned not only her existence and life itself but also her life in Sweden and the feeling that life could have been easier for her emotionally had she never moved here.

In the conversations that followed, she could share her ambivalence to Sweden and even to her husband and her "Swedish" child. Gradually, she realized everything she did have here. The suicidal thoughts subsided and finally disappeared when she gained insight into the exaggerated reality of her *rootlessness.* The depression lifted as several other aspects within the framework were worked through, and the psychological difficulty she experienced could finally be concentrated on, which was a midlife crisis, which included a decision on whether she wanted another child or not.

STATE OF BEING: BITTERNESS

Feelings of bitterness may be caused by childhood or other life experiences (Becker, 1962; Bibring, 1953; Erikson, 1950; Fromm, 1941; May, 1967, 1972). The bitter person is reported to feel deeply betrayed or cheated by people or life in general. He/she knows or feels that his/her life-situation cannot be changed. He/she is dissatisfied and angry. Bitterness often seems to be underpinned by deep disappointment and sorrow, which the individual is unconscious of, or cannot express, since it would be too painful to do so. A person can become enveloped by *bitterness*. Over time, these feelings of bitterness may grow into the *state of being*. Having to be around a bitter person can cause someone to feel unhappy and inadequate, feelings that the bitter person projects onto others. Usually, he/she cannot be reached by others, and refuses or does

not remain in treatment. However, if he/she enters psychotherapy or support work, the individual must learn to express the deep disappointment and despair that the feelings of bitterness represent. This can take a long time and be difficult for even the most patient and skilled mental-health worker.

The refugee and the immigrant may experience feelings of bitterness and the *state of being* for the same reasons as anyone else. Besides, he/she may go through the feelings and the *state of being* due to:

- the *refugee/immigrant situation*;
- ambivalence towards life in the new country;
- previous homeland experiences.

The immigrant has the choice to return to the homeland for a visit or even permanently. The refugee does not have that choice. He/she may continue to experience feelings of bitterness about life in exile, especially when going through periods of difficulty. The refugee may feel that it is not possible to be politically or religiously active in exile. He/she may feel disappointed, even betrayed by his/her children, who are not interested in his/her political or religious beliefs.

Cases – state of being: bitterness

This case illustrates difficulties in the treatment of an individual who suffers from the *state of being: bitterness*.

Case 5.40

A female refugee, age 55, 20 years in Sweden, an office worker (a university teacher in the homeland); her husband, age 62. They have 2 children, 29 and 25 years old. Reason for treatment: aggressivity, depression. Form of treatment: supportive psychotherapy, once a week. Duration: 7 months.

Case summary:

She is encouraged by the personnel advisor to see a psychologist. Several times recently, she has threatened her colleagues with aggressive outbursts. She has always been considered a good worker and is liked by her colleagues. Now, they are fearful of her aggressivity which seems to occur for no apparent reason.

Case excerpt (from session 3, after 3 weeks of treatment):

P: "If I knew why I was angry, I wouldn't be here. I am only seeing you, so I can keep my job." T: "Your job is not threatened. The personnel adviser is concerned about you, but you are not here because your job is threatened." P: "Then why am I here?" T: "To try to understand yourself and why you get so angry at work." P: "In the home, too…" she adds.

T: “Then we can look into that, too.” P: “You mean meddle in my private life, too?” T: “No, I don’t want to meddle, but I do try to make people understand themselves and their behavior.” P: “I get angry, when people don’t understand me. I get angry when they are stupid. I get angry because I am doing a job below my qualifications. I should be teaching sociology at a university.” T: “Why aren’t you doing that then?” P: “You can’t understand. You are a Swede. I came here as a refugee. I couldn’t speak the language. I had to start from scratch, learn the language, learn the way the life, everything. I never could learn Swedish well enough to even apply for a job at the university.” T: “Did you try?” P: “No, I knew it was no use. Competing with Swedes. I could read the newspapers. I knew I had no chance. Don’t you read the papers, refugees who come with professional qualifications work mostly as cleaners or office workers, like me. If they can master the language enough.” T: “I am sure you feel like that, and it is so in most cases, but there have been exceptions.” P: “I am not one of them. And now that I am an older woman, I have no chance to do anything. I watch my colleagues going up the career ladder, and I have stayed where I am.” T: “You seem bitter.” P: “Yes, yes I am. And can you cure me of being bitter? I don’t think so.”

The sessions continued, focused on her *refugee/immigrant situation*, her ambivalence to life in the new country. Even if had gone well for her children, she felt left behind. She talked about past homeland experiences and why she had fled the homeland with her husband who had been politically active, imprisoned and tortured. She was not political, she said. He worked in a library in Sweden and was thankful to be here. The woman was mostly provoked and silent or changed the subject, when the therapist tried to focus on her aggressive behavior. The woman believed that her aggressivity was always caused by the stupidity of other people. After 7 months, she stopped coming to the sessions. She gave no reason why she terminated.

If the *state of being: bitterness* remains unconscious, it can cause many problems and family tragedies. The following case provides an example.

Case 5.41

A male political refugee, age 54, 10 years in Sweden, a hospital cleaner (a lawyer and a member of parliament in the socialist government of his country); his wife, age 49, a home-language teacher. They have 2 children, 17 and 19 years old. Reason for treatment: physical abuse. Form of treatment: family therapy, three times a week, followed by individual supportive treatment, twice weekly. Duration: 1 month, 6 months respectively.

Case summary:

The man’s native country was taken over by a right-wing regime. He was imprisoned and endured 7 months of hard torture before he was released and fled to Sweden. His family followed shortly afterwards. Both his children were small when they came to Sweden and are now

teenagers. He is employed as a hospital cleaner and works actively in politics, in exile, for the socialist party of his homeland.

The psychologist was called one evening very late by his friend who explained that he had been arrested and needed psychological help. He had beaten up his son, very seriously. The boy is in hospital, and the police have arrested him. The next day the psychologist was allowed to see him in prison. He had seriously assaulted his son. The boy had several broken ribs and his eye had to have stitches. The man's wife was in shock. The 17 year old daughter explained what had happened. She was open, intelligent and very unhappy.

P's daughter: "My father loves my brother. He was just so angry with him. He has been very angry with him for a couple of years! It seems that he takes everything out on my brother. Sometimes you can't blame him. My brother has a big mouth. You don't answer back your parents in my culture the way Swedish kids can. But my brother thinks he is a Swedish kid and acts just like my father is stupid. My father was a leader of the socialist party in our country. He formed many of the ideas of that government," she explained.

T: "What happened?"

P's daughter: "It was about midnight. We were just going to sleep, my mother, my father and I. We all had work the next day. My brother came in reeking of beer. He was carrying a Coca-Cola can. My father hates Coca-Cola, it represents everything that is capitalism. He is angry that Sweden has become more and more Americanized since we came here. My father is convinced that the CIA helped the junta overthrow the socialist government in our country."

Many of the man's best friends were killed or tortured to death. The girl was very upset, defending her father, their country.

P's daughter: "My father is working here to restore the socialist regime in our country. My brother thinks 'all that is a lot of shit'. He says it over and over again to my father. My brother likes everything American, even capitalism. He often jeers at my father. Mostly my father does not listen to him. But he was so tired last night. He had worked all day and had just come home from a political meeting. My father has believed through the years the fascist government would not last so long. He thinks that we are both becoming 'too Americanized' in Sweden. He is disappointed about the double standards of the system here. He says it is more capitalist than socialist, and he is tired of Sweden. My father told him to throw the Coca-Cola can away. My brother refused. It still has something left in it, he said. My father said, I don't want Coca-Cola in my house. My brother started laughing, then sang the words of the Coca-Cola advertisement in English. My father told him to go to his room. My brother refused. I am 19, he said. I do what I want. My father called him, a good-for-nothing. He is disappointed that my brother finished school and goes around with a gang of kids my father doesn't like, mostly immigrant

and refugee boys who play tough. They're not bad, they have just seen a lot of American tough guys on television, she explained. Then my father shoved my brother. My brother hit him back. That's how it happened. My father could not stop beating my brother. My mother and I tried to get them away from each other, but we couldn't. It was like my father was a crazy, mean animal. I have never seen him like that." She cried.

T: "Your father must be very unhappy. I am sure he is not a crazy, mean animal, just a man in great pain."

P's daughter: "Yes, he wants to go back to our country. But he can't. His life would be at risk," the young woman explained.

That afternoon in a prison cell, the psychologist met a deeply unhappy and guilt-ridden man. He said little, but held his head in his hands most of the time. She asked him if she could bring his son the next time she came. He said yes. After 5 days in hospital the boy was sent home, but still looked very bad. One eye was bandaged. His father was shocked at the sight of his son, but showed nothing. They started talking. After 5 minutes, it was an argument about politics. The psychologist said nothing. Now and then, she placed herself between them when she saw a fist raised or a threatening gesture. That day she functioned more like a silent referee than a therapist. The arguments got louder and more heated. After over 2 hours of shouting, screaming and silence, the father in deep frustration started crying. The boy looked surprised. He had never seen his father cry. Then, the boy started crying. They embraced, crying on each other's shoulders. While he was still under arrest, several other sessions followed. The boy and the father started to communicate constructively with one another.

The police released the father after a few days. The lawyer was hopeful that the investigation would not lead to a trial. The psychologist discussed adolescent behavior with the father, and explained that during that period they often question the ideals and beliefs of their parents.

P: "I did, too, he said. My father was wealthy and right wing. Will my son be too?" he wondered. T: "Let him decide. You love him and you have given him your values. You have given up so much in life for those values. He knows that. He may just be testing you, your way of life."

The father had been taking out his bitterness toward his life in exile (and perhaps his right-wing parents) on his son. The boy was provoked by his father as a typical teenager, trying to find his own identity.

The psychologist had sessions with the father for several months. The boy spoke a few times to another psychologist, but didn't want to continue. That was several years ago. The boy went back to school, on to university and is now a social worker with teenagers from his homeland and works with his father in the same political party.

The following case illustrates the way in which the *state of being: bitterness* can lead to destructive symptoms and behaviors.

Case 5.42

A male immigrant, age 37, 9 years in Sweden, a technician; he is divorced, and has 2 children, 8, and 6 years old. Reason for treatment: insomnia, concentration difficulties. Form of treatment: psychotherapy, once a week. Duration: 2 years.

Case summary:

The man sought help for insomnia. He was mainly interested in medication, but the psychiatrist suggested he work through his problems in psychotherapy. He agreed. P: "The only reason I am in Sweden, he explained, is for my children. I have no friends, nothing here, except my children and the job."

He had been divorced from his Swedish wife 2 years ago.

P: "She got tired of me," he explained. T: "What do you mean, tired of you?" P: "She said she was tired of my complaining about life here and found another man. At first she said, she would go back to my country with me. But then she refused when she met someone else. I hate Sweden. But if I go back to my country, I'll never see the children again." T: "Are you sure?" P: "Yes, she would never let them come to my country, even for a visit. She doesn't trust me. I threatened I would keep them there. I was angry. Now, I don't sleep. I can't concentrate. I only think of everything I lost by coming here to be with her." T: "Can we talk about that?" P: "What's the sense? Talking won't make it easier for me to like Sweden, or to stay here, but I must." T: "We could try." P: "Why?"

After many sessions during which he expressed his bitterness and anger, he could finally begin to express deep disappointment and sorrow that his marriage had failed. Finally, he could cry and mourn. He then began to be able to talk about his loneliness and fear of future life in Sweden. From about the middle of the therapy, he became more hopeful about Sweden. He took a more active part in the care of his children and his wife agreed to share their custody. He began to socialize and date. At the same time, he applied for and received a better position in the company in which he worked. At the conclusion of the treatment, he had met a woman with whom he felt he could share life.

STATE OF BEING: SUSPICION

Anyone may feel suspicious of the new, unknown and different. Suspicion may be an adequate and necessary defense to protect oneself and others. A person may feel especially suspicious in meeting the unknown, as it can seem threatening and fearful. The refugee and the immigrant face innumerable unknown situations and people in the new country. These may create conflicts and confusion. At the beginning, he/she may feel suspicious, even without wanting to be. How a person encounters the new country also appears to depend on past homeland experiences, the *refugee/immigrant situation,* the different aspects of the framework, and also on how he/she is

met by the inhabitants of the new country. Suspicious feelings in the new country may take many years to overcome completely, and can crop up when faced with anything new – from the banal to the serious. Gradually, the new becomes familiar and suspicion subsides. If the individual continues to see the inhabitants of the new country as stereotypes in rigid "black and white" terms, he/she may remain suspicious of them. He/she isolates him/herself and family from the new society. The new country may continue to be threatening and unacceptable. These feelings may become the *state of being*. The attitude of the new country's inhabitants and society in general to the refugee and the immigrant can ease or complicate feelings of suspicion and the *state of being*. If he/she is met with a welcoming, open attitude by the inhabitants and the society, he/she may more easily be able to deal with his/her feelings of suspicion on meeting the new and unknown. However, if the inhabitants are suspicious, the refugee and immigrant's suspicion of them may remain. Suspicion seems to breed further suspicion. Instead of getting to know one another, people avoid and distrust one another. The refugee/immigrant may isolate him/herself or may be forced into isolation, and feelings of suspicion can become a *state of being*.

Feelings of suspicion, or the *state of being,* may also stem from childhood or past homeland experiences, or collective history. In children it can also be based on the *refugee/immigrant situations* of the parents.

The traumatized and/or tortured refugee may go through feelings of suspicion and the *state of being* for the same reasons. In addition, these can be influenced or complicated by the traumas of the past, or caused singularly by their effects. Because of homeland experiences, the traumatized/tortured refugee may remain suspicious even in the new country.

Severe paranoiac suspicion, at times referred to as "refugee paranoia", is difficult to treat. It may be seen in persons who have experienced lengthy and continuous atrocities during a war, concentration camp experiences or severe physical and mental torture, and/or long-term imprisonment.

Cases – state of being: suspicion

The two cases which follow are chosen to illustrate how previous homeland experiences can affect feelings of *suspicion*, or the *state of being,* in the refugee or the immigrant – either shortly after arrival, or sometimes throughout life in the new country.

Case 5.43

A woman refugee, age 29, 5 months in Sweden, a lawyer and political activist (in the homeland). Reason for treatment: depression, insomnia. Form of treatment: support work, once a week. Duration: 9 months.

Case summary:

The highly educated, politically active woman in her homeland had been several months in Sweden when she sought help at a mental-health clinic for her symptoms. She was doing an intensive Swedish course and planned to study international law at university. Recently, she had felt depressed and could not sleep. The woman wanted to speak English and Swedish to the mental-health social worker, but an interpreter was suggested. She agreed.

In session 1, she explained:

P: "I know I am depressed because of all I have gone through, but I need someone to talk it all through with."

However, during the first sessions, the woman said nothing about herself, her past homeland experiences or her difficulties. The psychotherapy supervisor suggested that the social worker meet the woman without an interpreter, as the woman had first asked. During the session without the interpreter, the woman expressed her suspicion about the language interpreter, another woman from her homeland, here over 10 years. The interpreter was an experienced and qualified translator, who was trusted and liked by other political refugees from her homeland, but the recently-arrived woman refugee confided in English to the social worker that she suspected the interpreter was an agent from her native country reporting everything she said to the military government from which she fled. In the next supervision, the social worker discussed the previous session and the woman's past in the homeland was considered. The social worker was willing to change the interpreter, even though she fully believed that the interpreter was trustworthy. The supervisor suggested that this should be discussed openly with the translator and the woman. In this session, the interpreter explained her own past experience of political oppression and prison in the homeland, and her escape to Sweden. The woman refugee believed her story. The interpreter stayed.

The following case illustrates how the *state of being: suspicion* can be caused and/or complicated by traumas which have occurred in the homeland.

Case 5.44

A male traumatized refugee, age 38, 10 years in Sweden, factory worker. Reason for treatment: constant pain in back and shoulders for several years, but refuses to seek medical care. Form of treatment: support work, once a week. Duration: 5 months.

Case summary:

He had survived war and escaped prison after 2 years of constant physical and mental torture. He isolates himself, except for one Swedish friend. The man is encouraged by his Swedish friend and fellow worker, to talk to the local pastor. He finally agrees to meet and talk with the pastor. After the first meeting, the refugee agrees to meet with him again.

Case excerpts (from the first meetings, and session 10):

The refugee revealed that he had been in prison and tortured, for the first time to anyone.

P: "You are a pastor, you can understand."

When the pastor asked him why he could not seek help for his bodily pain, the individual replied: "Doctors were involved in maiming and almost killing, then stopping the torture just moments before death. With the doctors present, my friends and I were tortured with electricity, with water, and with beatings and hangings. I do not trust any doctor, not there, not here. They use their knowledge to destroy, to kill, to humiliate." T: "But most doctors are not like that. I know that in Sweden they are not like that." P: "I believe all of them are like that. You can't trust them!"

During the first meetings, the refugee shared his experiences of torture. At first, he described what "his friends" had gone through. Then he revealed that he had been tortured several times with two different doctors present in the room. Finally, toward the end of the initial phase, he could share descriptions of his own experiences.

During the middle phase of the support work, he understood how these experiences had affected his feelings and suspicion of medical care in the new country. He could finally seek help for his constant back pain.

Session 10:

P: "Swedish doctors did not help the torturers…but maybe they would." T: "We could say that in Sweden a doctor is not faced with the decision of having to work with torturers or not…perhaps those doctors had no choice." P: "Oh, there was a choice for them – to be tortured and die themselves in prison…like a doctor I knew. He was tortured to death because he refused to take any part in the torture of others." T: "Could we say that doctors are like all other people. Some are bad, some are good, some are weak and some, courageous…" P: "You can say it that way, too. I went to the back doctor you recommended. I told him about the pain in my back and shoulders, and what I thought caused it…Because I told you about it, I could talk to him to, about the torture, to a stranger that wanted to help me. I could tell him about the beatings and repeated hanging by the shoulders for hours, the kind of torture that I know must have affected my back. I am having x-rays taken next week. You know, this quiet Swedish elderly doctor could not hold back his anger after I told him about the torture and the doctors that were present. He said he is in an international group of doctors protesting against torture worldwide. He assured me that

the radiographer he was sending me to was like him…in that same group working for human rights."

The next case illustrates how the person's *state of being: suspicion,* caused by the unknown of the new country, can affect his/her attitude to family, friends and others.

Case 5.45

A female immigrant, age 32, 7 years in Sweden, an office cleaner; she is divorced with one child, 9 years old. Reason for treatment: child's concentration difficulties, aggressivity in school, family conflicts. Form of treatment: family counseling, twice monthly. Duration: 8 months.

Case summary:

The mother and son were encouraged by his teacher to seek family counseling. The boy is intelligent, but had difficulty in concentrating and was aggressive toward other children. Even after 7 years in Sweden, the woman was isolated. After a few sessions, the counselor understood that many of the conflicts between mother and son were based on a lack of knowledge of Swedish society; the mother had developed a suspicious attitude towards her son. For example, in a school meeting with the boy's teacher, the mother was encouraged to see that he did his homework and did not watch too much television. She would try, she said and she did. One day soon afterwards her son became very angry because he was not allowed to watch television until he had finished all his homework. The mother explained that she suspected her son was lying to her when he told her that there was no school the next day. It is a Swedish holiday, he told her. She had to work the next day, and the boy was not doing well in school. She checked with her Swedish neighbor. The neighbor confirmed that the next day was indeed a school holiday. Most offices and factories would be working though, she explained. The last 2 years the holiday had fallen on a Saturday and a Sunday so it had not been a school holiday. She had suspected her son. He was not lying. This would never have happened in her own country, she said. She knew all the holidays there, as Swedish people know theirs.

The counselor focused the sessions to build up a more trustful attitude between mother and son. The mother was advised to learn more about Swedish society and her son's world, especially the school system. She was given several alternatives as to how to do this. While the counseling sessions continued, the boy's concentration at school improved and his aggressivity towards other children ceased.

STATE OF BEING: PREJUDICE

– *To be prejudiced*
– *To feel prejudice*

Prejudice can be felt or expressed in some form toward a person or group of a different sex or country, religion or creed, color or race. It can be

expressed verbally or by actions – as a superficial generalization or deep-seated conviction – from joke to open discrimination, hatred and abuse. Prejudice should not be condoned, but it must be understood (Allport, 1954). In the refugee/immigrant, feelings of prejudice, or the *state of being* appear to be built on two conceptions:

- The individual may come to the new country with prejudice against others, or become prejudiced while in the new country, which is referred to here as the *state of being: prejudice – to be prejudiced*.
- The individual may be forced to deal with other people's prejudiced attitudes against him/her, which is referred to as the *state of being: prejudice – to feel prejudice*.

Trankell (1971) studied prejudice with regard to immigrants in Sweden. He claimed that prejudice is a specific instance of a fundamentally human mode of behavior that persons can sometimes utilize in dealing with others. The pathological idiosyncrasies of prejudice (their irrational content, their unreasonable and antipathetic character) can be attributed to social and economic insecurities as well as lack of experience and knowledge of other cultures. Trankell believed that the role of prejudice is to defend the person's or group's primary interests, such as housing, family or societal values, economy, employment, etc. The implacability of prejudice (whereby an individual will adhere to it beyond all common sense and reality) is a defense against the anxiety that the menace inculcates in persons whose own living conditions and employment are insecure. The insecurity out of which prejudice arises is the evil that must be identified and rectified. Prejudice can also be rooted in an insecurity due to ignorance. Lack of insight into ourselves and others makes us defenseless prey to superstition and all kinds of delusions.

Allport (1954) defined prejudice as:

- thinking ill of others without sufficient warrant;
- feeling, favorable or unfavorable, toward a person or thing, prior to or not based on actual experience.

Ethnic prejudice is regarded by Allport as "antipathy based upon faulty and inflexible generalizations. It may be felt or expressed. It may be directed toward a group as a whole or toward an individual because he is a member of that group" (p. 9). Allport defined the prejudiced person from several different perspectives:

- *A historical perspective,* according to exploitation theory. The individual is seen in a societal context. Racial prejudice is a societal attitude propagated among the public by an exploiting class for the purpose of stigmatizing some group as inferior, so that exploitation of either the group itself or its resources may be justified. In this perspective, historical stereotypes exist, such as Gypsies, Jews, and Kurds.
- *A sociocultural perspective.* Attitudes of prejudice develop within the total societal context, e.g. traditions and beliefs that can lead to hostility and conflict (and may move with migrants), upward mobility of groups, density of populations, and various types of inter-group contacts.
- *A situational view,* i.e. past patterns give way to current attitudes. On this view, it is the atmosphere of an environment which breeds prejudice – economic competition between groups, social mobility; types of contacts, and relative density of different ethnic and racial groups.
- *A psychological perspective and the psychodynamic viewpoint.* The prejudiced person is frustrated because of basic physical, biological or psychological needs that are not being satisfied, and this can lead to hostile impulses discharged against minorities (Bettelheim and Janowitz, 1950; Freud, 1915; Fromm, 1941, 1959, 1973; Reich, 1946).

The frustration or scapegoat theory describes prejudice as hatred, anger and destructive aggressivity displaced upon a logically irrelevant victim. Destructive aggression and hatred can be projected onto another person instead of oneself (Freud, 1915, 1930). Prejudice has also been attributed to ego-defensiveness (Dollard et al., 1939), and related to the concepts of the "authoritarian personality" (Adorno et al., 1950, p. 1) and, more recently the "right-wing authoritarian" (Altemeyer, 1993, p. 131). According to character structure theory a certain type of person tends to become prejudiced. It is claimed that he/she has an insecure and anxious personality, and clings to an authoritarian and exclusionist way of life (Reich, 1946).

Allport (1954) described different degrees of passive and active prejudice and how they may be expressed:

- *antilocution* – most individuals who have prejudices talk about them, but many persons never go beyond this mild degree of antipathetic action;
- *avoidance* – if the prejudice is more intense, it leads the person to avoid the disliked groups, but this too is more passive than active;
- *discrimination* – the prejudiced person makes detrimental distinctions of an active sort. He undertakes to exclude all members of a certain group from some types of employment, residential housing, political rights, etc;
- *physical attack* – under certain conditions of heightened emotionalism, prejudice may lead to acts of semi-violence and violence;
- *extermination* – the prejudiced person can finally kill and exterminate people of different races or religious and political beliefs.

"Contemporary theories of prejudice in social psychology emphasize factors close to the interaction situation and residing in the individual … several components come together to provide explanations for prejudice" (Jones, 1997, p.145). In this respect Jones refers to research in Canada by Zanna (1994) who has suggested four influences on the development of prejudice: "*stereotypical beliefs* (i.e., the notion that typical members of the group possess certain characteristics or traits), *symbolic beliefs* (i.e., the notion that typical target group members violate cherished majority- or dominant-group traditions customs, and values, *emotions* that are aroused by a member or members of the group, and *past experiences* with members of the group" (Jones, 1997, p. 146). Jones also discusses the terror management theory of Solomon et al. (1991). On this view, people develop what is called a "cultural anxiety buffer" (p. 93) in response to the fear of death. "According to the theory, when one is confronted with death anxiety, the social-comparison, cognitive, and emotional processes enable one to bolster the commitment to a cultural worldview by embracing those who share it, and by rejecting those who threaten it" (Jones, 1997, p. 147).

Jones explains that in more recent years:

> *"…social psychological ideas about prejudice have expanded from the earliest, a firm belief in the intentional, self-serving nature of prejudice, to the view that prejudice may well be unintentional and even unconscious … . This*

> *shift away from individual motivation toward unconscious cognitive processing of biasing social information tacitly acknowledges that prejudice may have origins outside the individual prejudiced person even if its expression is directly reflected in individual behavior" (op. cit., pp. 149-150).*

Refugees and immigrants, like anyone else, can be prejudiced or feel prejudice either because of personality factors or due to past or present societal influences. This is discussed below.

Prejudice – to be prejudiced

Refugees and immigrants may come to the new country with their previous prejudices. Many refugees have fled from the blind prejudice of religion and political oppression, torture, and war and its atrocities. In exile, the refugee can be prejudiced against the individuals, groups or nations that have in any way been, or are assumed to have been, involved in causing the past homeland experiences. If a refugee or immigrant expresses prejudice against another minority group in society, it may be significant to understand the historical background of the prejudice. An individual may arrive in the new country with positive or negative generalizations and prejudices against its inhabitants. The first impressions or actions of an inhabitant of the new country can influence the person's attitude toward other people in the new country and lead to prejudice against them.

The conditions that cause feelings of prejudice may envelop the person's existence, and become the *state of being: prejudice – to be prejudiced*.

Prejudice – to feel prejudice

What happens to the world of the refugee and the immigrant who must live with the prejudice of the inhabitants of the new country? May (1972) discussed several steps that can lead to violence as a result of feeling the prejudice of others. When an individual or a group feel that they are denied the right to realize their potential due to prejudiced attitudes, they may turn passive, self-destructive or aggressive. If their aggressivity does not lead to constructive change, it can cause destructive behavior. Without affirmation, the individual or group may turn aggressive. If that aggressivity is not listened to and acted upon to try to change conditions, it can be followed by violence in the society. Anger and aggressivity are

used destructively against society instead of being used constructively for change.

The consequences of feeling prejudice are reported by the refugees/immigrants in this study some times to overwhelm the person's life so as to become the *state of being: prejudice – to feel prejudice*.

Cases – state of being: prejudice

– *to be prejudiced*
– *to feel prejudice*

The following case illustrates how the individual's collective and historical background can influence his/her conscious/unconscious feelings of prejudice – to be prejudiced or the *state of being.*

Case 5.46

A female immigrant, age 31, 2 years in Sweden, a housewife; her husband, age 38. They have 4 children, 14, 12, 10, and 6 years old. Reason for treatment: hysteria, refusal of medical treatment. Form of treatment: supportive conversations, once a week. Duration: 3 sessions.

Case summary:

The woman was food shopping when she collapsed with severe abdominal pain. She was taken to the local hospital by ambulance. When the female doctor on duty wanted to examine her, the woman became hysterical and refused. She spoke no Swedish or any other language in which she could communicate with the hospital staff. No interpreter was available. When her husband arrived, and spoke to her, he explained to the nurse that his wife was afraid that the dark-skinned female doctor was from…, a country that their own country had been at war with for many years. The hospital was small, and the doctor was the only specialist available. She tried to assure the woman, that even though her parents had come from that country, she was not her enemy, but only wanted to help her. The resident psychologist visited the woman 3 times. The woman talked of her country's history and the atrocities they endured from the enemy country. T: "But the doctor you met was born in Sweden, and she just wants to help you." The female doctor visited the woman several times and talked with her. Finally, the woman agreed to be examined by her.

The following case describes a person's prejudice towards inhabitants of the new country based on the actions of one of them.

Case 5.47

A male refugee, age 35, 6 years in Sweden, a home-language teacher (university teacher in the homeland). Reason for treatment: depression, nightmares. Form of treatment: psychotherapy, once a week. Duration: 2 years.

Case summary:

During the assessment sessions, the patient explained that he had fled from almost constant police harassment in his homeland, a country in Africa. He was met at the airport on arrival in Sweden by an unfriendly Swedish policeman. He was detained for several days in a small locked room. Afterwards, he was suspicious of all representatives of the Swedish authorities, including the lawyer assigned to his asylum case. He received asylum in Sweden, but trusts no one. He believes that all Swedes are negative or prejudiced against black-skinned persons.

After the assessment sessions, the psychotherapist concluded that the depression had developed because of several *states of being: missing, longing, sorrow* and *bitterness*. But the *state of being: prejudice* prevented him from working through the depression caused by the other *states of being*. Instead he was constantly angry and complained about Swedes.

It seems that his first, realistic impression of the unfriendly policeman had formed a stereotype of "unfriendly Swedish authorities" and led to a generalization of this attitude towards most Swedes and finally prejudice against them. He had agreed to undergo psychotherapy only with someone who "was not a Swede".

The focus of the treatment was on the *states of being,* the traumas, experienced in the homeland and on arrival in Sweden.

This case below describes the *state of being: prejudice – to feel prejudice* which is caused in the refugee or the immigrant by the consequences of extremely prejudiced behavior on the part of a small, but dangerous, set of people.

Case 5.48

A male refugee, age 45, 17 years in Sweden, an office worker (a lawyer in the native country); his wife, age 39, a nurse's assistant. They have 2 children, 19, and 15 years old. Reason for treatment: physical abuse. Form of treatment: crisis therapy, once a week. Duration: 6 months.

Case summary:

The man, his wife, and first child came to Sweden after he had been released from 5 years imprisonment and repeated torture. They had built up a good life in exile, while he continued to be politically active to help to achieve democratic change in his homeland. He and his family had been quickly accepted by many Swedish people, but he was aware of the growing animosity to refugees. In their l7 years in Sweden, he or his family had never experienced discrimination or prejudice against them. Then one evening, on his way home, he was attacked and physically abused by a gang of Swedish youths. "Get out of Sweden. Go back to your own country," they screamed as they kicked and beat him. They left him unconscious on the freezing winter street. When he woke up, he was in a hospital. Someone had informed the police of the attack.

Several weeks afterwards, the man began to experience insomnia or nightmares, became aggressive to his family and took sick leave. A friend suggested that he meet a psychologist that he knew. The imprisonment and torture he had endured in the homeland were mentioned. After several sessions, the man expressed his despair and anger and finally, fear to the therapist. The man was too upset to return to work, but continued treatment. After several months, he returned to work.

The repressed traumas of 17 years before had been awakened by the incident.

STATE OF BEING: THE SCAPEGOAT – A SYNDROME

– *To be the scapegoat*

– *To feel like a scapegoat*

The scapegoat is defined as an individual, group or culture that is forced into weakness and powerlessness by others, and is compelled to bear blame and suffering for the mistakes, fears and inadequacies of others. In the end, the scapegoats may themselves believe that they are weak and powerless. The persons who are the scapegoaters are afraid to admit to their own weakness and powerlessness. Instead, they project or force these feelings onto the scapegoat. Because the latter mirror their own insufficiencies, the scapegoaters hate, beat up or massacre them. By doing so, the scapegoaters attempt to annihilate the sides of themselves they most fear, and are reflected in the scapegoat. Scapegoating, i.e. to turn a person, group or culture into a scapegoat, and being or feeling like a scapegoat, occurs for various economic, societal and/or psychological reasons (Adler, 1927; Bettelheim and Janowitz, 1950; Deaux et al., 1993; Erikson, 1950; Freud, 1921, 1930; Fromm, 1959; Jones, 1997).

A syndrome is something influenced by something else. It is a progressive ongoing process or course of events. The *state of being: the scapegoat – a syndrome* is the result of two-sided fears – on the one hand, the fears of the scapegoaters; on the other, those of the scapegoats (or those who feel like them).

The scapegoat – to be the scapegoat

Refugees and immigrants easily become scapegoats in their new communities (Fromm, 1959; Gans, 1962; Hunter, 1964; Kristal-Andersson, 1981; May, 1967, 1972; Wong, 1962; Wurmser, 1994). As the cases in this study demonstrate, they report feelings of vulnerability due to the *refugee/immigrant situation*, the *states of being* they go through, and the other aspects of the framework. They may already feel the lack of

self-confidence, lowered self-esteem, passivity, helplessness and self-hatred to which scapegoating gives rise. Because of this, they appear to be more sensitive to the negative attitudes and actions of others.

Already on arrival in the new country, refugees, and some immigrants, may suffer from the feelings of, or the *state of being: scapegoat*. They may previously have been forced into being a scapegoat or feeling like one – in their childhood and/or because of other personal or collective experiences in the homeland. Such experiences can remain within the individual and may cause him/her to feel like a victim or scapegoat in the new country, even if he/she is not one. However, if the person also has to endure mental and physical scapegoating from the inhabitants of the new country, he/she may suffer severely (as he/she may also be reminded of the past). This appears to be especially the case for the person who has survived traumatic experiences. How the refugee, traumatized and/or tortured refugee, immigrant and their children deal with scapegoating may also depend on other aspects of the framework.

The scapegoat – to feel like a scapegoat

The feeling of being a scapegoat can be experienced by almost anyone at one time or another in their lifetime – e.g. when unjustly blamed, criticized or judged; or when wrongly treated and unable to offer any defense. The person may feel weak and powerless against the attack of others, or experience fear. One may feel sorry for oneself and unable to cope (Bion, 1961; Eisenberg and Cialdini, 1984; Fromm, 1959, 1973). If someone constantly feels like a scapegoat, it can lead to the *state of being: the scapegoat – to feel like a scapegoat.* It envelops the person. Now, he/she judges, blames, criticizes and attacks him/herself, with or without these attacks occurring outside him/herself. In some individuals, to feel like a scapegoat or endure the *state of being*, may be due to specific *childhood experiences*. A refugee/immigrant may, at the same time, experience both components of the syndrome of the *state of being: the scapegoat*.

Cases – state of being: the scapegoat – a syndrome

– *To be the scapegoat*
– *To feel like a scapegoat*

The case that follows provides an example of the *state of being: the scapegoat – to be the scapegoat* when it is based on reality.

Case 5.49

A refugee family; a man, age 35, a factory worker, his wife, age 34, works at a day-care center. 13 years in Sweden. They have 2 sons, 16, and 17 years old. Reason for the visit of a social worker: victims of prejudiced actions. Form of treatment: family counseling. 2 sessions. Duration: 2 weeks.

Case summary:

The man spent a year in prison and was severely tortured before being released and given asylum in Sweden due to pressure from Amnesty International. He was then 22 years old. His wife was then 21 years old and worked in a day-care center in the homeland when military police killed several parents in front of their children. The family was well taken care of by the Swedish authorities on their arrival. They were immediately given an apartment and places for the children at a day-care center so that the parents could study Swedish and then start working. Early one evening, 5 months after their arrival, the woman was walking home with her sons, then 3 and 4 years old. Two men approached her and called her a "dirty black bitch". One man tried to grab her breasts, the other kicked her between the legs. She shoved them off. The children started screaming. The men got scared and ran away. She was shocked that this "could happen in Sweden" but did not report it to the police. The neighbors and the day-care center personnel were horrified and sympathetic.

The event occurred 13 years ago. Recently, the family, after years of saving, bought a small house in a residential area of the same city. Two days after arriving in their new home they received human excreta in an envelope, accompanied by a note saying "Get out" through their mailbox. A week after that, they received a second letter with excreta, threatening them that if they did not listen, their house would be set on fire. The man filed a police complaint. The police were sympathetic but could not do anything except contact the social authorities. A social worker visited the family. The wife explains that her husband cannot sleep, isolates himself and is deeply depressed, avoiding his wife and children. Family counseling is offered. He will not accept any kind of treatment.

P: "It's not my problem. It's theirs," he says to the social worker.

The following case exemplifies the psychological consequences that the *state of being: scapegoat – to feel like a scapegoat* may cause, when it is based on the reality of the *refugee/immigrant situation.*

Case 5.50

A female refugee, age 27, from a Middle East country, 2 years in Sweden, unemployed (an executive secretary for an international company in the homeland). Reason for treatment: depression, suicidal thoughts. Form of treatment: psychotherapy, twice weekly. Duration: 2 years.

Case summary:

She was forced to flee her homeland when the man she was living with, a lawyer, was seized by government soldiers and executed shortly afterwards. She left behind her modern-thinking, loving parents and sister, brothers and their families and came to Sweden alone. In her own country, she was independent, confident, open and satisfied, and she loved life. After about 9 months of exile, she started feeling like a scapegoat – with lowered self-esteem and lowered self-confidence, feeling sorry for herself, depressed and unable to cope. Several real incidents led up to this.

When she came to Sweden, she immediately tried to find a job in an international company. She was confident of her secretarial skills in several languages. She was fluent in English and French, and she was already learning Swedish. When she was interviewed for a position at the first large company, she was refused because she was "Moslem". The personnel director explained to her, that they served pork in the lunchroom at least once a week. She left the interview, laughing to herself. He had not even asked her if she ate pork. Later she told me in our conversations that her family had never been religious Moslems, and she had eaten pork. After 9 months in Sweden, the shock of exile, the death of her beloved and all that had happened so quickly to her, and also her loneliness in the new country, caused her to go into a deep depression. She couldn't get out of bed, couldn't cope with anything and didn't want to live, she explained.

P: "I had lost all desire to continue the struggle…and to laugh!"

She went to the local psychiatric clinic and met a psychologist, who was as fluent in English as she was. But the psychologist refused to talk to her about her depression and loneliness and suicidal thoughts because she felt she "could not understand her", as she was from a "different culture".

At that point, she felt even more desperate, lonely and sorry for herself. She felt that there was "something so different and bad" about herself because she happened "to come from the Middle East". Even though she could express her problem in perfect English to the Swedish psychologist and her feelings were based on a reality that any sensitive person could understand and listen to, she was refused treatment and left alone to mourn the sudden and traumatic death of her beloved, and her sudden exile from the family, friends and country she loved and missed.

Gradually she started socializing and making friends, from Sweden, other countries and her homeland. She was basically friendly and open, but instead of being allowed to express her sorrow, longing, missing and mourning to a qualified, sensitive professional, she started writing out her inner pain in a diary and sharing some of it with her newly-found friends. She also had telephone contact with her family each week. All this was keeping her going outwardly. But inwardly, she was still desperate with an inner pain that gave her suicidal thoughts.

Early one evening, when she was waiting for a bus in the center of town to go home, a blonde blue-eyed man in his 30s came over to her and

asked her angrily why she was in Sweden, “you damn black bitch you,” he said. She didn’t answer. He then took her by the arm, pushed his face close to hers and said in a loud voice, “Get out of this country, black bitch!” then knocked her to the ground and walked away. No-one on the busy street tried to help her. She got up. She was shocked but not hurt physically. She made her way home to her apartment, and cried, screaming to herself over and over again: *Black bitch, black bitch, black bitch*. Her suicidal thoughts were transformed into action. She took pills, but then called a friend who came over at once.

A second psychologist met her shortly after this event. When the woman met the current psychologist, she spoke Swedish very well, with almost no accent. She said defensively,

P: “I don’t like psychologists.”

The woman explained why. The psychologist tried to create a secure atmosphere so that the woman could express her anger, disappointment and frustration about her previous treatment.

P: “She was wrong, wasn’t she?” T: “She was admitting her own limits to you. But that did not help you. Could you tell me how you feel with me now. I am a psychologist, too.” P: “I don’t know.” T: “You may feel somewhere inside yourself that I might also tell you that I can’t understand you and refuse to help you.” P: “Perhaps…” T: “But I won’t. Sometimes we may misunderstand each other because of the differences between us. But I will always try to work it out with you.” P: “They hate dark people here. I can’t stand it.” T: “Let’s talk more about that.”

The *state of being*: *the scapegoat* was based on the reality she encountered. She was so vulnerable because of everything she was going through; that is, the *states of being*: *the stranger, sorrow, loneliness, longing, missing*. and then, *value degradation, inferiority, rootlessness, bitterness, suspicion, prejudice – to feel prejudice, to be prejudiced*.

At first, the woman sought professional help, but was refused treatment. Perhaps being a Swedish drunk’s scapegoat would have given rise to less difficulty and not led to a suicide attempt if she had been under psychological care. She started feeling like *a scapegoat* because of her *refugee/situation*, the *states of being* she was going through, all based on reality, and also a traumatic life crisis she had not worked through. She tried to meet all of this constructively, but was, at first, stopped at every turn.

During the first term of therapeutic work, the woman started to socialize again and thought about looking for a job or enrolling in university.

P: “I am not thinking about suicide anymore. I never wanted to die anyway. I know my family loves me. I must find a way to live here. I must.”

By the ending of therapy, the woman had worked through the *state of being: the scapegoat* and understood how it had complicated her

life-situation. She also worked through her traumas and the other *states of being,* such as, the *state of being: prejudice*.

P: "I can't be in fear of every blonde man I stand next to in the street or on the bus. Since it happened, I've met so many Swedes who are nice. I can still feel a twinge of judgment inside me – when is the fist going to be shaken at me! It's ridiculous. On the bus, sometimes I stiffen and feel afraid. I have to remind myself that most people wouldn't do what he did to me. In fact, on the bus the other day, I saw a man be impolite to a woman who was a foreigner. He pushed ahead of her. Another man said to him, 'She has just as much right to get on the bus, as you do!' You know, I went over and thanked that man. He looked surprised. I told him what happened to me once. He said, I am so sorry and ashamed of my countrymen who do that! So I know now, there are all kinds of people in this world, even in Sweden."

The work continued even into the last phase on the *state of being: the scapegoat.* She could now summarize and conclude how it had affected other *states of being*, the other *aspects* and the presenting symptoms, difficulties and problems.

P: "I'll never forget those experiences. They left a scar within me. A scar I didn't need, after the death of my fiancé, after being ripped away from my family and my life at home. But I know now it was just one psychologist who didn't know or understand enough to help me, and one man who shoved me. The others – the indifferent, who watched him hurt me, they are everywhere…and then there are others, who care, who understand, who try to change themselves and their surroundings." T: "You are doing that now."

The case that follows illustrates the *state of being: the scapegoat – to feel like a scapegoat* when it is based on past and present realities.

Case 5.51

A male immigrant, age 23, 11 years in Sweden, unemployed. Reason for treatment: obsessive death thoughts. Form of treatment: therapy, once a week. Duration: 2 years.

Case summary:

He came to Sweden with his parents from the Middle East, who changed their last name to a Swedish one shortly after arrival. He is dark-skinned. He is unemployed, but has been looking for a job for several months, since he finished university. In the first session, he explained that when he applies for a position, they always ask him to come for an interview, but when they see him and his dark skin, they say the position has already been taken. This has happened several times and now he won't apply for any more jobs in his subject area. His past life in Sweden had been difficult. He had not been bullied when he started a Swedish school at 12 years old, but was avoided by the other children. He was the only immigrant in the class. He was isolated and had no friends,

but loved to read and excelled in school. His parents never accepted their life in the new country, and were both unhappy and depressed throughout the years. They always dreamed of moving back to the homeland, but never did.

Three years before, when he was 20 years old, a drunk on the subway called him a “nigger”. He said in fluent Swedish that he was not one, and that he even had a Swedish name. The drunk man called him a liar, shoved him and started fighting. Two other Swedes joined in the fight. The young man, as a result spent 3 days in hospital. The incident was reported by the hospital to the police, but his family did not want him to press charges. They were afraid and wanted him to forget about it and not to make trouble. He pressed charges. The 3 men were reprimanded by the court, but received no sentence, as the court said that he had fought back.

At the beginning, therapy focused on his death thoughts and why he had them. The *state of being: the scapegoat*, the other *states of being* he was going through, especially, *non-identity* and *inferiority*, and his relationship to his parents were worked on throughout the psychotherapy. After 2 months of treatment, he gained enough self-esteem to once again seek employment. A short time afterwards, he found a job where his trilingual skills and academic background were seen as a great asset to the international company. At the termination of treatment, he had moved from his parent’s home to his own apartment and was socializing with both men and women.

6. ASPECT TWO – THE ADAPTATION CYCLE

The second aspect of the framework is "the adaptation cycle". It considers the length of time the individual has been in the new country and its effects. It is a way of determining how well he/she has become part of the new country, its influence on other aspects of the framework, and present difficulties. The process may finally lead the person to become part of the new country. Within a family, any one member may be at a different stage and go through the adaptation cycle in divergent ways.

The *adaptation cycle* deals with the time the individual has been in the new country and its effects. Adaptation is a word used to describe the process of the refugee's and the immigrant's acceptance of him/herself in the new country. Adaptation is a process in continuing interplay between the individual and his/her surroundings, characterized by a mutual shifting and modification of behaviors and situations, so that conflicts between inner and outer competitive forces can be eliminated in one way or another (Trankell, 1971). Adaptation for Westin (1971, 1975) is a dynamic, never static process which should be examined in terms of psychological and societal changes. A cycle is a recurring period of time in which certain events or phenomena repeat themselves (Webster's, 1974, 1984). Westin (1971) described an assimilation cycle based on the amount of time the individual has been in the new country and its effects. The cycle has three stages: *arrival, confrontation* and *flashback*. Within each stage the refugee/immigrant has certain feelings and a relationship toward the new country and the homeland. These are compared, and at times are in conflict with each other. These stages occur over the years in the new country, for longer or shorter periods of time, and lead to the individual becoming part of the new country or remaining an outsider.

At the very start of her clinical work, the author noticed that the amount of time in the new country, and how the individual adapted to it, seemed to have an influence of fundamental importance in psychotherapy and support work. They appeared to affect the refugee or immigrant's (and his/her family's) way of managing the aspects of the framework and the way in which difficulties are handled. The author started using the structure in diagnosis and treatment, calling it the "adaptation cycle". It helped to determine how well the individual/family has become part of the new country, its influence on the aspects of the framework, and present difficulties.

The adaptation cycle is represented in the table below:

Table 6.1. The adaptation cycle.

Stage	Relationship to the new country	Relationship to the native country
1. Arrival	The unknown	The absent
2. Confrontation	The new	The obvious
3. Flashback	The different	The missed

Stage 1. *Arrival* contains all the contrasts, comparisons and conflicts between *the absent* of the homeland and *the unknown* of the new country.
Stage 2. *Confrontation* contains the contrasts, comparisons and conflicts between *the obvious* in the past homeland and what is *the new* in the new country.
Stage 3. *Flashback* contains the contrast, comparisons and conflicts between *the missed* from the past homeland and that which remains *the different* in the new.

During each stage of the *adaptation cycle*, the person encounters the new country in contrast to the homeland. Each stage contains comparisons to be dealt with on a conscious and unconscious level. These comparisons can lead to conflict within him/herself and with others. If the person overcomes these, he/she ascends to the next stage of adaptation, or remains – if only inside him/herself – a part of the past homeland. This process finally leads the person to become part of the new country.

In the reports of the total population of the study, it appears that each person goes through these stages differently. Some ascend from one stage to another in a short time, while others remain at one stage for many years and may never be able to leave it. The stages appear to be further complicated when they turn into a cycle, i.e. recur again and again. The person may have successfully gone through a stage and ascended to the next, only to fall back again.

Stage 1 – arrival

During this period, the *unknown* of the new country is in contrast to the *absent* of the past homeland. The refugee/immigrant encounters the concrete *unknown* outer world and the emotionally *unknown* inner world of the new country. The familiarity of the past homeland is *absent.* To ascend the *arrival* stage, one appears to have to accept the emptiness of the *absent*, and be able to work through its personal meaning, so as to be able to open oneself to the *unknown*. This occurs in comparisons and conflicts between the *unknown* and the *absent*. Uncertainty lies in the *unknown*, while the *absent* contains the security of the known. If the refugee/immigrant avoids encounter with the *unknown* he/she may remain at the *arrival* stage, never to ascend to another. He/she remains an outsider in the new country, even

after living there for many years. Life appears to be centered on the *absent*. He/she dreams of returning to the native land and remains at the *arrival* stage. However, if he/she can meet the *unknown* of the new country and accept the *absent* of the past homeland, even as temporary, he/she seems enabled to move on to the second stage.

STAGE 2 – CONFRONTATION

At this second stage, the *unknown* can be encountered as the *new.* The person reports confronting the *new* that is in contrast to the *obvious* of the homeland. He/she appears to perceive and judge the *new* through the *obvious*. He/she must revise and accept his/her personal reference structure, which is still in the *obvious*. At times, this is reported to be a difficult and confusing process of revision in which both the *new* and the *obvious* are questioned. During the *confrontation* stage, he/she seems to be more vulnerable in relationships with people both from the former homeland and in the new country. Many situations occur which may cause incongruity and anxiety. The individual may regress back to the *arrival* stage. The process within the *confrontation* stage appears to take many years, sometimes a lifetime, and occurs and recurs over the years. Most refugees and immigrants seem never to be able fully to ascend to the next and final stage *flashback*. They cannot deal with all the conflicts of the *new.* Instead, they remain in the *confrontation* stage the rest of their lives. However, if the individual is able to confront the *obvious* with the *new*, he/she may attain integration and ascend to the *flashback* stage.

STAGE 3 – FLASHBACK

During this stage, the person thinks back over the past. The *missed* of the homeland is in contrast to all that remains the *different* within the new. How well the individual functions in and is a part of the country seems to makes little difference at the *flashback* stage. Retrospection continues in the form of silent reflection or melancholy over the *missed* of the homeland, which has changed its meaning. The individual reports experiencing flashbacks to the previous existence in the homeland. These appear to happen occasionally or constantly throughout the final stage. He/she does not experience the temporary emptiness of the *absent*, as during the *arrival* stage. At the *flashback* stage, the *missed* is always there. Flashbacks are said to overpower everything else within the person and finally can turn into the existential insecurity that seems to be so characteristic of this final stage. The *missed* then seems to become an inevitability. The person may experience this as not fully belonging to the

country, or as existential insecurity. If existential insecurity goes on for a longer period of time, it can turn into existential emptiness, which may lead to an extended interval of deep despair and questioning of life.

The *different* is reported to be continually noticed during the *flashback* stage and hinders the person from fully being part of the country in which he/she lives. Integration of the *new* has taken place, but he/she may feel that that it does not belong to him/her. He/she can never fully be a part of it – despite speaking the language, knowing the ways of the country, and having accepted many of its values and attitudes. He/she may be familiar, even at home, with the workings of the society. But still, within him/her, the *different* seems to be always present, experienced in all that he/she cannot deal with or accept. He/she can always be made to feel a lack of acceptance. This can be experienced in many ways – from a banal comment or being stared at on a subway or bus through to serious acts of discrimination and prejudice. The country the person has been part of for many years can suddenly become the *different* yet again.

During the *flashback* stage, there seem to be no satisfying solutions to the difficulties of the adaptation process. The conflicts that still remain between the *different* of the country he/she lives in now and the *missed* of the homeland cannot be worked through, until he/she can go back – if even this helps. The immigrant may be able to do this. The refugee cannot. The *different* at this stage may no longer even be unknown to him/her, but some individuals cannot accept it and their reservations can be expressed in isolation and sometimes depression. The *flashback* stage seems to be comparable with mourning the death of a loved one and all the inner pain of accepting the death. If the person can work him/herself through this period, the *missed* may become a source of inspiration and growth.

Cases – adaptation cycle

The following cases are chosen to illustrate the stages of the *adaptation cycle* and how these may influence the refugee/immigrant and his/her family. The first case exemplifies the *arrival* stage, and how each member of the family can go through this first stage in different ways.

Case 6.1

A refugee family; 2 adults, the man, age 35, is a factory worker; the woman, age 33, a housewife, studying Swedish. Two children, a girl and a boy, 10 and 12 years old, are in school. One year in Sweden. Reason for

therapy: to help with practical and social adjustments. Form of treatment: home visits, once a month. Duration: 2 years.

Case summary:

The man is a political refugee. He has completed an intensive Swedish course and is working in a factory. He misses relatives remaining in his native country, and is worried about friends who are still in prison. He is politically active on their behalf in Sweden. He accepts what is *absent* and is trying to be open to the *unknown*. He dreams of one day being able to return. This may or may not keep him in the *arrival* stage. But he seems willing to meet the *unknown* and accept the reality that the *absent* is, just now, *absent.*

The woman has been on several Swedish courses, but cannot concentrate on learning the new language and speaks it poorly. She still goes to language school and likes her student friends and the teacher there but misses home. She misses almost everything and everyone that is *absent*. She has not tried to look at the *unknown*.

The children have started school in Sweden. They have already learned the language and have made friends at school. The children like living in Sweden, they say, but miss friends and relatives in their homeland and some of the food. Otherwise, they like Sweden. The children meet the *unknown* openly. The *absent* is accepted.

Case excerpt (from visit 13, after 1 year):

The family is by now familiar with the social worker. On this occasion, when she visits the family, the children are upset and ask her to help them. The Swedish holiday is approaching and, like other children, they want to dress up in costumes and paint their faces, and go around to the neighboring houses, ring the door bell and be given candy and other treats. Their parents refuse to allow them to do so. The children had tried to explain that all the children do it, but their mother and father see it as begging. "In our country, only paupers beg for food" the mother says. The social worker tries to explain that it is not begging, but the traditional way children celebrate this holiday. The mother cannot be convinced, even though the father agrees to allow them to join in.

Conflicts are beginning to arise in this family. The children are open to the next stage of adaptation, *confrontation.* The man may gradually be able to go into the *confrontation* stage, but his wife remains in *arrival*, unable to open herself to or accept the *unknown.* The social worker suspects that conflicts may arise between them as each family member goes on, or remains in the first stage.

The next case describes an individual at the second stage, *confrontation.*

Case 6.2

A male refugee, age 39, 5 years in Sweden, in skilled employment (similar to the work he did in his homeland), living with a Swedish woman. Reason for treatment: uncontrolled aggressivity. Form of

treatment: crisis psychological conversations, followed by psychotherapy, twice weekly, for 6 weeks, then once a week. Duration: 2 years.

Case summary:

He went into a deep depression, after an argument with his girlfriend, when he hit her. He then called the psychotherapist and asked for treatment "or to talk about it. I feel so guilty, I want do die," he explained. The man has a good knowledge of Swedish. In the first meeting, he pointed out that he would like to be able to return to his own country one day, but realizes and accepts it may be many years before he can. After a few conversations, it became clear that much of his personal inner structure of reference was still in the *obvious*, structured in his past homeland. He was trying to *confront* the *new* on a conscious level but was not always able to on an unconscious level. This was revealed in the conversations. At first, this was hard for him to see or admit. He could express himself in both Swedish and English and was open with his inner thoughts, as he wanted to be helped. His Swedish girlfriend meant a great deal to him.

Case excerpt (from session 5, after 3 weeks of treatment):

P: "I don't want to lose her because I'm trapped in the traditional male role of my homeland. I am not!"

T: "You may not want to be, but sometimes it may just 'pop up'. You were brought up as a man in your culture," the psychologist explained when he told him what had led up to his hitting his girlfriend. It was a seemingly banal argument over some furniture they were planning to buy. He said no to a rather expensive sofa. She did not agree. He became furious. He did not understand why. "Something happened inside me and I hit her. She was so shocked, she has not said anything about it. Now maybe she will leave me." T: "Maybe she is trying to forget about it. She loves you. She knows you are trying to change." P: "In my country, a man's word is law. My father was like that. I am against that way of thinking." T: "You may be against it intellectually and consciously, but our unconscious mind can play tricks on us, and sometimes the values we are brought up with can just 'pop up', as during the argument with your girlfriend. It probably had more to do with Sweden and your relationship with her than just 'that argument'." P: "Can I ever change?" T: "Yes, because you want to. You consciously and intellectually reject some of the traditions and attitudes of your homeland. This is not easy. You were brought up with them." P: "They are not all wrong. I am proud of my culture." T: "And you should be! But you are revising and rejecting some parts of it and re-accepting parts of it, too, as you confront everything that is new and different." P: "It sounds very confusing." T: "And it is. That is probably why you hit someone you really love, but who is so culturally different from you." P: "When will it stop? When will these comparisons end?" T: "It takes time, like all change. Finally, you put together the parts

of the new culture you want and reject and re-accept parts of the old culture. You integrate the old and the new into a whole, usually a very interesting and creative whole!" P: "How long will it take?" T: "It seems to me that you want to confront the new and the different. It is a process. You must give it time and be patient with yourself."

The conversations continued for more than a year. Many aspects of his *confrontation* stage were dealt with as well as other factors in his life. He felt that he was "getting old" and had not achieved what he wanted to in his political and private life. He wanted children. Finally, he was able to confront his girlfriend with this. When the conversations ended, he had just become the proud father of a daughter, and had started a newsletter about the political situation in his country. It was being published in English, German, Swedish and his own language.

The final case in this chapter illustrates the type of difficulties reported to be commonly experienced by refugees/immigrants during the third *flashback* stage. This man came to his new country as a refugee, but he is now free to return to his homeland.

Case 6.3

A male refugee, age 58, 25 years in Sweden, employed in an academic profession; married to a Swedish woman, age 52, an economic consultant. They have 2 children, 19, and 21 years old. Reason for treatment: severe depression and suicidal thoughts. Form of treatment: psychotherapy, once a week. Duration: 1 year.

Case summary:

He came to Sweden as a political refugee. Since then, the oppressive regime he fled from has changed to a democracy. He describes himself as not having the will to live. He thinks constantly about the past, his childhood and student years in his homeland before he was forced to flee, "At the oddest times, when I should be concentrating on something else," he explains. He feels in a constant state of depression and melancholy.

He is open and direct about his life and his feelings. After a few sessions, he expresses his ambivalence toward much of the Swedish way of life. He is upset that his daughter, who is studying medicine, is living with her boyfriend. P: "I think they should marry, but I can't tell her that. My wife thinks she is too young and would be angry if I suggested it. She thinks I am still following the moral code of my culture…That's not the only thing. There is so much else I've been thinking about, about my culture and religion. I left it all so long ago, and now I can't stop thinking about it. My father and my mother are dead now. I miss them so. I miss my country, the landscape, the light, the people, even the way of life, as backward as it was. My father was only a simple fisherman. He couldn't read or write."

In session after session, he put into words all he missed and longed for. He laughed and cried, almost thinking aloud. The psychotherapist

was silent mostly, trying to be the mirror for his reflections. His deep depression began to lift. He no longer spoke of suicide, but he could not find “any meaning in it all”.

After much thought and discussion with his wife, he decided to return alone on a trip to his homeland, to the village he came from “to review the past and where it all started. Maybe I will understand myself better then”.

After a month he returned. He was like a happy child when he told the therapist that most of the people from the village remembered him, that there were welcome home parties, and many long talks, with laughter and tears about the past and stories of his mother and father and him as a child and teenager.

T: “Did you find what you were looking for?” P: “Meaning in life, you mean? Yes, it is here, with my wife and children. We have a good life.”

7. ASPECT THREE – CHILDHOOD EXPERIENCES

This chapter describes the third aspect of the framework, "childhood experiences". Combined with the refugee/immigrant situation and the other aspects of the framework, insight into the individual's childhood experiences should generate a deeper understanding of present emotional difficulties and the ways in which these might be handled.

On a psychodynamic viewpoint, people tend unconsciously to reestablish and repeat certain *childhood experiences* and relationships. These have been active or passive experiences, ones that have been peaceful, calm and full of love, or – by contrast – frustrating, conflicting, painful and traumatic. Experiences vary and are unique to each person. He/she is influenced by his/her *childhood experiences* throughout life. At times, a person may seem unconsciously to regress to these, especially during periods of difficulty, crisis and change (Bowlby, 1969; Erikson, 1950, 1968, 1976; Fairbairn, 1943; Fenichel, 1946; Freud, 1917; Jacobson, 1943; Klein, 1932). In psychotherapy and support work with the refugee and the immigrant, complete psychodynamic and environmental factors can be important to consider. The person comes to the new country with his/her unique constitutional and genetic makeup. He/she sees and deals with life in the new country through experiences gained in early childhood in the homeland (Mezey, 1960). Combined with the *refugee/immigrant situation* and other aspects of the framework, consideration of the person's *childhood experiences* can lead to a deeper understanding of present emotional difficulties and the ways in which these should be handled.

THE PSYCHODYNAMIC PROFILE

Clinical observations based on the psychodynamic viewpoint suggest that the nuclei of character formation are patterned in the infantile and early childhood phases. The psychodynamic view stresses that the care of parental figures, as well as the secure or insecure environment of infant and child, influences the adult personality – the total character structure and basic feelings of security (Freud, 1917; Klein, 1932; Mahler et al., 1975; Piaget, 1929).

Gender

The gender of a child may determine his/her way of seeing, understanding, surviving and struggling later in life. The attitude to the male or female infant at birth and how he/she is handled and treated by the mother or initial carer, and afterwards by others in the child's surroundings, shapes the way

he/she experiences him/herself, and also his/her gender role later on in life. The child may have been lovingly nurtured into a particular gender role, or it may have been demanded of or forced upon him/her (de Beauvoir, 1953; Coles, 1964, 1986a, 1986b; Deutsch, 1945).

Age at the time of specific experiences

Age, and the specific experiences that occur over time, have a significant impact on the developing child. Traumatic experiences, such as separations, sudden changes in environment, man-made and natural catastrophes and war and its atrocities, can affect the child's personality development. According to the child's age and mental development, he/she interprets, reacts to, and has conscious and unconscious feelings and memories about these experiences (Bibring, 1953; Bowlby, 1973; Mostwin, 1976).

Reinforcement

Another factor in the total character structure – and the way the child (as an adult) will react to and solve psychological and outer difficulties – is the reinforcement the child is offered within the environment. When parents and the people around the child have been rigid, harsh and punitive, or open, gentle, permissive and fair, the super-ego codings of that individual later in life will also turn that way (Miller, 1983).

Constitutional and genetic factors

Regardless of culture, each person inherits a unique constitutional and genetic heritage that affects his/her total character structure. Constitutional factors and how they are dealt with and satisfied in the early years influence later personality (Eriksson, 1950, 1968; Fenichel, 1946; Mahler et al., 1975).

Environment

From accounts of the total population of the study, the outer environment in which the individual spent his/her childhood comes across as important for the therapist and support worker. Was the person born in the city or in the country? Did he/she grow up under primitive or modern conditions? Was the area he/she was born in afflicted by natural catastrophes? Did the person grow up in a peaceful atmosphere without outer tension, or was the environment one of war or revolution? Were his/her surroundings afflicted by both natural and man-made catastrophes? If the country was in a state of revolution or war, were the people or family members directly involved in

it? Was the area in which the person was born and raised raided by soldiers and/or police? Were people ostracized, violated, tortured, maimed or killed? Were there air strikes, bombings? How much did the person hear or see of this as a child? To understand the refugee and some immigrants, it appears to be of utmost importance to know about the outer chaos and violence they were part of before coming to the new country.

Cases – childhood experiences

The following cases illustrate the influence of *childhood experiences* on the other aspects of the framework. The first provides an example of how a childhood trauma can influence a current life change – a difficult mourning process.

Case 7.1

A traumatized male refugee, age 38, 10 years in Sweden, a kiosk owner; his wife, age 32, a housewife. They have 2 sons, 12 and 8 years old. Reason for treatment: hospitalized in a near-psychotic condition. Form of treatment: conversations with psychologist, twice weekly. Duration: 5 months.

Case summary:

He is a deeply religious Moslem. He lives in exile in Sweden because he and his 2 brothers had worked actively for the rights of their people. Several months before his hospitalization, he received news that his mother had died in a camp in the occupied area in Israel where he was born and raised. He could not go back for the funeral, as it would have been too dangerous for him. He mourns her, spending day after day in constant prayer. He cannot work. Several months later, after an air trip within Sweden to visit friends, he goes into a state of near-psychosis, and is hospitalized.

His family calls the psychologist whom he had met for a few sessions when he first came to Sweden. Then he was restless, couldn't concentrate and was not sure he could stay in Europe away from his people and the direct political struggle. But his life was at risk if he returned. In those sessions, 10 years before, the psychologist recalled he spoke with deep love and admiration for his mother, who had raised her 3 sons alone after his father had been killed by soldiers in a camp raid. He was 7 years old at the time. He saw his father killed and afterwards his bloody, bullet-ridden corpse. He explained that his mother had given up everything so that her sons would have enough food, education and if possible freedom. Ten years before, the sessions were conducted in English. Now he spoke fluent Swedish, with almost no accent. He greeted the psychologist when she came into the hospital ward to see him. He then explained what had happened.

Case excerpt (from session 1):

P: "In the airplane I was nervous and afraid. I am used to flying, but I was scared. I spent the weekend with my friends and when I flew back,

there was a storm. The plane shook. I felt sick. The stewardess tried to help me, but I had to hold my mouth so I wouldn't scream out in fear, and put my hands over my ears so I wouldn't hear the noise," he explained. T: "What was the noise like?" P: "The plane was shaking," he said. "I thought of my mother. I would be close to her, if I died, I thought. Then I thought of my children and I wanted to cry. But I was in a plane. I missed my mother so. I do now too." T: "You were a scared little boy on that plane and maybe now, too." He laughed. P: "I am grown up. I have kids of my own. I've been fighting for my people's rights." T: "I know, and now you are scared. You long for your mother. You want to join her. You feel guilt for feeling that way. I think you do now. That's why you are here." P: "I can't work. It's been months. Not since she died. Why was I so scared? Why am I so scared now?" T: "I don't know. We must try to understand why. Were you scared when you were a little boy?" P: "No! I started working for my people when I was eleven." T: "I know, but you might have been scared anyway." P: (Angry) "No!"

He is not the first refugee who worked politically as a child and denies, at least consciously, the fear a child, 11 years old, must feel running through machine-gun fire and/or bombings to get messages or food through.

T: "The noise? What could it have reminded you of?" T: "I don't know." T: "You heard so much noise as a child…bombs, airplanes, machine-guns…" He put his hands over his ears and screamed. P: "My father. my father…," in Swedish and then Arabic. Then he sobbed and cried.

P: "I am an orphan now…he said. An orphan. I have no one."

He cried and sobbed like a frightened 7 year old, a 38 year old man who had worked in guerilla warfare under extremely hazardous circumstances most of his life.

The sessions continued for several meetings at the hospital, until he could be released. He mourned his mother deeply, and the past and his life in exile. Shortly after release from the hospital, he was able to start working. The sessions continued for several more weeks until he came in one day, and said:

P: "God is enough for me now. He gives me strength. I am not alone. I have Him, my people, my family. Thank you."

The next case describes ways in which childhood gender roles in the homeland can affect the refugee/immigrant in the new country.

Case 7.2

A female traumatized refugee, age 33, 5 years in Sweden, a physician. Reason for treatment: suicidal thoughts, confusion, nightmares, fear of depression. Form of treatment: psychotherapy, once a week. Duration: 3 years.

Case summary:

The woman was forced to seek exile in Europe because of her work for equal rights for women in her native country. She was a human rights activist during her student years and afterwards. She had been imprisoned several times and tortured. During her last imprisonment she had been raped. She told no one. After she was released, her family insisted that she flee the country. Her brother was already in exile in Sweden.

The therapist met the woman a year after she had begun to work as a physician in Sweden. In the first sessions, she explained that she liked her work at the hospital and felt accepted by her patients and the staff. She had been dating a fellow colleague, a Swedish physician. He was very polite, she explained, and although they liked each other very much, there was no sexual relationship.

Case excerpt (from session 8, after 2 months of treatment):

The woman explains:

P: "In my country, a woman who has been raped is considered a useless being, dirtied, unacceptable for marriage, unfit even to live. Though it is illegal, families kill these women, to keep the family honor. I worked to change this tradition in my country. I tried to have these girls and women protected. Neither my family, nor anyone else, know that I was raped. You are the first person I have told. They were always against my political work. My brother, who also worked for human rights in our country, was a bad example to me, my father always said. He is a teacher and has always kept out of politics. If he knew I had been raped, I don't know what he would have done to me. He is very traditional." T: "You have kept this to yourself for many years." P: "Yes, and now I have met someone who loves me and I love him. He wants to marry me. But, I can't." T: "Why not? Because he is a Swede?" P: "No…I think my father would accept that, as I am so old now…in their eyes." T: "Then why?" P: "I have been raped." T: "So you feel useless, dirtied, unacceptable for marriage, unfit even to live. I am just repeating your words…"

The woman starts to cry. She nods her head, "yes". Many of the following sessions were focused on the sexual, mental and physical tortures she endured during imprisonment, and also on the role of a woman, and her sexuality in her culture. The therapist mostly listened.

After 13 months of treatment, the woman married. By the end of the psychotherapy, she had given birth to a child. She plans to continue to work after her child leave.

The following case has been chosen to illustrate the way in which the refugee/immigrant's childhood environment can affect presented difficulties and/or other aspects of the framework.

Case 7.3

A female immigrant, age 37, 12 years in Sweden, employed as a janitor; she is divorced and has one daughter, 11 years old. Reason for

treatment: feelings of panic, unable to work. Form of treatment: psychodynamic crisis support work, twice weekly. Duration: 5 months.

Case summary:

The woman had been married to a Swede, who had met her when he was on vacation in her country. They had divorced several years before. She was experiencing severe feelings of panic, so much so that she could not continue to work. She had no reason to feel panic, she explained to the doctor who encouraged her to contact a psychologist. After several sessions with the woman, the psychologist was perplexed as to the reasons or underlying causes of the woman's panic. She discussed the case with the supervisor, who asked about the woman's psychodynamic profile.

The woman was the fourth child of 7 siblings. Her father was a fisherman. As a child, she had lived in primitive conditions in an area that was plagued with lightening, hurricanes and floods. The supervisor mentioned that the weather had been very harsh lately, and wondered if that could have been one of the reasons for the woman's feelings of panic. It's probably not the only reason for her feelings of panic, but it could have helped to bring them on, she explained.

In the session that followed, the psychotherapist encouraged the woman to talk about her childhood environmental conditions, and whether the recent weather conditions in their area could have reminded her of them. The woman thought a long time.

P: "I remember as a child how afraid I was of the lightening, of the floods, of the hurricanes. I was always afraid my father would not come home. One day, a few weeks ago, I waited for my daughter, when the lightening started. I was nervous until she came home. She was on her bicycle and I was afraid she would get caught by the lightening. Maybe that was the start of the feelings of panic." T: "You are afraid of losing her, like you were of losing your father." P: "Yes." T: "Let's talk more about that."

8. ASPECT FOUR – RELEVANT BACKGROUND CONDITIONS

This chapter describes the fourth aspect of the framework, "relevant background conditions". The casework appears to demonstrate how important it is to consider relevant background conditions, and how each one may affect the individual and family member in the new country. This appears to further facilitate comprehension of the individual's and/or the family's refugee/immigrant situation, other aspects of the framework, and symptoms and presented difficulties.

From reports in the casework, it became apparent that – besides *childhood experiences* – the refugee/immigrant may also be influenced by what can be called other *relevant background conditions.* Within this fourth aspect of the framework the following *conditions* are considered: *age on arrival in the new country and at present, sex and gender roles, homeland, environment, landscape, climate, culture, religious and political background, racial origins and ethnic background, society, language, education, employment and socioeconomic level in the homeland and in the new country.* In understanding the individual's and/or the family's symptoms and presented difficulties, the *refugee/immigrant situation* and the other aspects of the framework, it is important to consider *relevant background conditions* and how each one may affect the individual and each family member in the new country.

THE CONDITIONS

Age at present and on arrival in the new country

Age is a factor shared by all. However, how the person regards his/her age may depend on constitutional, genetic and *childhood experiences*, and other *relevant background conditions*. People of different backgrounds can judge age differently. In some countries and cultures, a person may be considered older or younger than he/she would be in other ones. Consequently, one may experience oneself as older or younger. For example, a 24-year-old woman from one culture may experience herself as old and hesitate to contemplate further development or change, while another woman of the same age from a different culture would not; a 13-year-old child in one culture is politically active and taking part in political conflicts, while in another culture a child of the same age is still in school and at play.

The individual's age on arrival in the new country may influence each aspect of the framework and the individual's subsequent life there. For instance:

- the way in which the individual feels and experiences him/herself;
- the present inner and outer life-situation;
- the individual's opportunities and limits in the new environment.

The physical and mental age of the person and how it is regarded by the inhabitants and society of the new country also appear to influence the way the refugee/immigrant will feel about him/herself (Adler, 1927; Brody, 1967; Condon and Fathi, 1975; Deaux et al., 1993; Ellemers et al., 1999; Tyler et al., 1999).

Sex and gender roles

The individual's sex, and the attitudes and roles of gender in the environment in which he/she was born and raised seem always to be important factors to consider. These factors may influence the person's pattern of thoughts, feelings and actions. During difficulties in the new country, even the refugee/immigrant who has revised his/her attitude to gender roles may regress back to a gender role inherited from where he/she was born and raised. To fully comprehend the refugee/immigrant, such gender roles should be considered (Gaw, 1976; Hartog, 1971; Kaplan, 1961).

Homeland

The homeland is defined as where the individual was born. Inhabitants of a country may have varied background origins and ways of life, and different groups may have limited or no contact with one another. A person arriving in the new country could be from a different background to the majority population of his/her homeland. He/she might be as foreign to someone from the homeland as he/she is to the people of the new country. He/she may accept and tolerate others from the native land, or have passive or active prejudice toward them. If a person's attitude to his/her homeland, or the new society's view of it, has affected him/her in the new country, he/she may be enabled to recognize its effects during a psychotherapy or support work process founded in the described framework.

Environment

The homeland environment and social circumstances of the person's childhood and adult life continue to influence him/her later on. Ability to handle the outer environment of the new country may well depend on experiences in previous environments (Peterson, 1967; Vargás, 1977).

Landscape

Within a country there can be different landscapes (countryside, mountain, island, desert, jungle, sea, city, town, metropolis). A person born and raised in a certain landscape appears to be formed and affected by it in some ways. Even the person who has spent several years in a certain landscape is influenced by it as far as being accustomed to a specific way of life and attitudes. In changing these, a person may not usually be aware of how it can affect their inner world (Durkheim, 1968; Handlin, 1951).

Climate

As with landscape, the climate we are accustomed to might affect our inner world, with regard to what our bodies and minds seem able to cope with. It may intensify feelings and moods already existing within the person, or cause and create them. An individual who is depressed in a climate he/she is not used to may experience depression more deeply because of the cold or heat, the lightness or darkness. This is an important factor to consider (Durkheim, 1968; Handlin, 1951).

Culture

The individual takes to the new country the particular culture of his/her homeland. Depending on the person's unique character structure, he/she may or may not be open to the differences of the new country. Such differences are many, and he/she might have to confront them in a some times lifelong process which can lead to confusion and guilt, and also to conflict. Each family member seems to have to confront and make compromises between the homeland culture and the new one, rejecting some of the differences of his/her culture which are difficult or impossible to integrate into the new one, or vice versa. Each person appears to solve these cultural confrontations in his/her unique way. During times of personal confusion, an individual might want to, or does, return to the cultural background in which he/she was born and raised to find security and a sense of belonging. In working with the refugee/immigrant, it is important to realize and respect this, so as also to be able to recognize the samenesses between us all. A deeper understanding can be gained by the carer who has insight into the individual's homeland culture and how he/she and each family member deals with it in the new country (Deane, 1957).

Edward Stewart (1971) developed a framework (on a number of dimensions) to comprehend the components of the cultural reality an

individual brings with him/her into a different culture. He explains that culture provides us with a set of assumptions and values about ourselves and the world around us. Each person carries these assumptions and values in his/her mind, and they serve as the context within which we relate to ourselves, to others and to the physical environment. Since these are often unconscious, the person tends to assume that his/her own cultural assumptions are right and natural. The individual fails to understand that these are by no means common to all human beings: "Research on culture and the self-concept has suggested that the members of Eastern and Western cultures evaluate the self in radically different ways" (p. 106). Researchers such as Triandis (1989) and Markus and Kitayama (1991) have argued that whereas Western cultures encourage people to adopt an individualist orientation to the self, many other cultures (especially Eastern ones) encourage people to adopt a collectivistic orientation to the self (Tyler et al., 1999).

Cultural differences

If the cultural differences of the refugee/immigrant are met with tolerance in the new country, his/her confrontation with the new culture can be facilitated. If not, he/she may not feel accepted, and will find it difficult to accept or to make compromises with the new culture (Berry and Kim, 1988; Callao, 1973). Outwardly, people of different cultures may seem different. Inwardly, however, they appear to have similar basic needs and feelings that cut across cultural boundaries. However, the way we express and deal with these can be different from culture to culture. How we express and deal with pain, sorrow and anger can be culturally different. These begin to evolve when different cultures meet and influence each other.

Inner conflicts, life changes and life crises

People of different backgrounds may have different culturally conditioned ways of perceiving mental disturbances. A person who is considered psychotic in one culture can in another one be considered close to God or viewed as holy. In yet another culture this person could be considered to be possessed by the devil or evil powers and be treated accordingly – as a witch if a woman, or feared if a man (Campbell, 1970). How we react to life changes can vary culturally.

Religious/political background

Some immigrants may have left their native countries because of passive prejudice and the oppressive attitudes of others. Refugees have been

forced to flee because of open oppression, prejudice and violence. These refugees/immigrants are a mixed group, encompassing highly educated people with skilled professions and/or economic resources to invest in the new country, people from the middle or working classes, and the uneducated poor. Most of them have suffered in one way or another for their political or religious beliefs. Many have experienced the atrocities of violence and war, mental and physical torture, prison, loss of possessions and disappearance or killing of family and friends. Many have endured traumas because of these experiences.

Religious background

The religion that a person is born to and raised may affect the person throughout life. Some persons are raised in a strict, at times fundamental religious atmosphere, following religious tradition and values through prayers, rites, ceremonies, observances and holidays. Others are not, and instead may be surrounded by the religion in the environment or society, and have both aware and unaware knowledge of it. Interpretation of the same religion can be very different from person to society to country (Johnson, 1959). Each person may comprehend, follow and be affected by religion in different and unique ways.

Different religious/political beliefs – their consequences

According to reports in the casework, religious and political beliefs can lead to a strengthened identity or a confused one. These beliefs seem to complicate the *refugee/immigrant situation* as well as other aspects of the framework. Sometimes, they may give the person strength throughout his/her lifetime outside the native country (Bettelheim, 1960; Epstein, 1979; Erikson, 1968; Lichenstein, 1977).

From the reports of individuals in the study, on arrival and for a short time afterwards, regardless of other background conditions or experiences, people can become overwhelmed on encountering another religion or political system. They can feel confused by the new religious environment and/or political system. It may not affect the person or his/her family more than to recognize the outward characteristics of places of worship, traditions, ceremonies, observances, holidays, etc. in the new country. This also pertains to political refugees and immigrants who recognize the different political system and way of life that it entails.

After a time, the refugee/immigrant and each family member may be affected by religious and political differences. It is here that the

individual's education and past experiences can help him/her intellectually to analyze, tolerate and accept the differences. The person may do this, either on an outward and superficial level or on a deeper one. However, religious and political differences can take a long time to tolerate. After a time in the new country, a refugee/immigrant may become even more religious or political than he/she ever was in the homeland. This may be caused by the desire to hold on to the homeland or to find an identity in the new country. It may also occur because the person now genuinely comprehends the beliefs, and finds wisdom and strength in them from a distance. A child who was born in the new country or grew up there, may turn to the religion and political beliefs of parents and forefathers as a part of searching for his/her identity or because of his/her own religious and political convictions. For other reasons, another child may do the opposite in the new country; i.e. turn against the religious/political beliefs of the parents.

Skin color

It emerges clearly from the casework that skin color can affect life in the new country. It can produce a momentary first impression of little or no importance. However, it can also lead to fear, generalizations, passive and active prejudice, oppression, persecution and violence.

When a person of one hue comes to an environment where he/she is distinctly different in appearance from the inhabitants, he/she can be affected by it – on arrival, for a short-time afterwards or during his/her whole lifetime in the new country. This is based especially on the *refugee/immigrant situation*, caused by the reality of the person's different appearance, or an exaggerated experience of that reality. In the search for identity, the child of a different appearance from the majority population who comes to a new country or has been there many years (even one born in it) may over-identify with the appearance of the majority. This can occur in both destructive and constructive ways (Sluzki, 1979; Sylvander, 1982).

Ethnicity and ethnic background

There is "a basic social constructionist model of ethnicity that commands a considerable amount of support within anthropology. … the model's four elements are as follows:

- ethnicity emphasizes cultural differentiation (although identity is always a dialectic between similarity and difference);

- ethnicity is cultural – based in shared meanings – but it is produced and reproduced in social interaction;
- ethnicity is to some extent variable and manipulable, not definitely fixed or unchanging; and
- ethnicity as a social identity is both collective and individual, externalized and internalized" (Jenkins, 1997, p. 40).

The ethnic background of an individual may effect his/her total identity. The word "ethnic" has many meanings. In this dissertation, it is used to designate a member of a minority or nationality group that is part of a larger community. Ethnic group is defined sociologically as an assembly of people racially or historically related, having a common and distinctive culture. Glazer and Moynihan (1975) state that social scientists tend to broaden the use of the term "ethnic group" to refer not only to subgroups or minorities, but to all the groups in a society characterized by a distinct sense of difference owing to culture and descent. This itself reflects the somewhat broader significance that ethnicity has taken on in recent years. People of the same ethnic background can be part of different cultures, societies and countries. Refugee/immigrants from different parts of the world may stem from the same ethnic background, such as the Kurds.

The ethnic background of the refugee/immigrant may be different from that of the inhabitants of the new country. Perhaps the refugee/immigrant has never been in an environment where there are people from ethnic backgrounds different from his/her own and has never had to see him/herself as different from others. How he/she solves these confrontations is based on the experiences gone through in the new country, his/her *childhood experiences*, other *relevant background conditions*, past experiences in the homeland, and his/her life-situation in the new country.

Society

An individual is a part of the society in which he/she was born and raised. From working with these groups, it emerges as essential to comprehend the meanings that their past and present societies have for them. Society is defined in several closely inter-related ways. In the Oxford Dictionary (1961), it is defined as an "association of persons united by a common aim or interest or principle" (p. 1023). A society can have one or many cultures and ethnic groups within it. Each society can have a different structure, and ways, means and mechanisms of functioning as far as right and

wrong, laws, bureaucratic and institutional systems, etc. are concerned. For example, societies can have different ways of dealing with the individual in mental incongruence. In many cases, care for the mentally ill is so cruel that individuals fear seeking help.

The refugee/immigrant knows the society in which he/she was born and raised. He/she is then faced with learning the new one. Each person handles this learning process differently. It can take a shorter or longer period of time, sometimes a lifetime, to fully understand another society. When both the carer and the person are aware of this, the individual's way of dealing with the new society might more easily be confronted – if this is necessary.

Language

In understanding the refugee/immigrant, the native language may be a significant background condition to consider. It is important to note that there may be language differences within one and the same language, which can create misunderstandings and conflicts even between people with the same language (Casement, 1984; Edgarton and Karno, 1971; Henle, 1972; Kristal-Andersson, 1978). On arrival and for a short time afterwards in the new country, the native language and the way the individual uses it may influence how he/she encounters the new language. It may also affect how he/she will come to express him/herself in the new language.

Education

Education can be defined as formal schooling or training, but the concept may also encompass informal instruction, apprenticeship and tutorage. Education in the homeland can affect the individual's world in the new country, especially with regard to how he/she meets and perceives people in it and the way he/she is met by them.

Employment

The casework reveals how important it is to know how the refugee or immigrant was employed in the homeland as well as what he/she is doing at present in the new country. Most immigrants arrive in the country with an opportunity for employment – of the kind they had in the homeland or something else. The refugee has usually been forced to leave his/her employment. It is uncertain whether he/she will be able to do the same kind of job in the new country. This may have a severe effect on the individual.

Socioeconomic background

It emerges from the case material that people from different economic and social backgrounds within the same country may sometimes express and handle inner difficulties differently. For example, someone coming from a lower socioeconomic background may not be able to express in words the anguish he/she is experiencing in the same way as someone who was raised under better conditions. There seems to be little scope for expression of feelings when reality is the outer struggle for daily survival for such basic needs as food, water, or shelter. At least some emotions appear to be shared by all, but within the varying economic and social strata of a country, the expression of these seems to differ. A person coming from oppressed or poor economic conditions tends to endure mental anguish without words or expression. He/she seems not to take his/her emotions seriously until they became so unbearable that they lead to crisis. He/she denies his/her emotions, and they may find expression in psychosomatic symptoms or destructiveness (d'Ardenne and Mahtani, 1989; Baker, 1983; Brody, 1967; Feldstein and Costello, 1974; Freire, 1972; Hunter, 1964; Martinez, 1973; Minuchin et al., 1967; Reissman et al., 1964).

Refugees and immigrants from the same country have differing socioeconomic backgrounds. The economic and social status of a person is usually closely related, but not always. For social or religious reasons, in some areas, a person might live under poor economic conditions but have high standing in the community or culture. This is so, for example, in Hindu and Moslem countries.

Regardless of their past socioeconomic background, in the new country, refugees, and also many immigrants, are most often forced to take low paid, unskilled jobs. The often drastic changes, both social and economic, that they are confronted with appear to influence the other aspects of the framework, especially the *states of being* and the *adaptation cycle*. This can lead to lowered self-esteem, which can last until the employment situation improves.

Downward socioeconomic change in the new country

Refugees may come from a relatively high social and economic level in the homeland. Political refugees, in particular, may have lived in affluent circumstances as children, but worked politically in their homeland for the rights of the poor and working class. Accordingly, the adult refugee may identify with these groups in the new country. However, during times of

difficulty, a person may regress back to childhood as a means of solving life's dilemmas. He/she can then experience added self-hatred and guilt because he/she desires the accustomed economic and social comfort of childhood.

Upward socioeconomic change in the new country

After a while in the new country, the refugee/immigrant may work his/her way up to a higher economic level and better social conditions than he/she had in the homeland. The casework suggests that this can lead to guilt and feelings of self-condemnation – "Everything is going well for me, but what about the others who are left at home?" These sometimes unconscious conflicts are due to the improved economic situation in the new country and can deepen an emotional crisis. Past economic and social conditions should be considered in understanding the refugee/immigrant. It seems also important to assess the change in the refugee's/immigrant's economic and social position in the new country and how it has affected him/her and the family. He/she may retain the same reaction patterns in the new country, produced by past socioeconomic circumstances in the homeland.

Cases – relevant background conditions

The effects of *relevant background conditions* on the individual/family in the new country are considered in cases throughout the dissertation. Here are three examples.

The following case illustrates how a person's *religious background* can cause or complicate presented symptoms and problems.

> Case 8.1
>
> A female refugee, age 29, 7 years in Sweden, a psychology student; her husband, age 31, is a social worker. They have 2 children, 5 and 3 years old. Reason for treatment: her initial reason for seeking psychotherapy was for her professional training. "But there is so much about myself I have to understand." She also had feelings of depression, indifference to school and at times her family, and also suicidal thoughts. Form of treatment: psychotherapy, once a week. Duration: 3 years.
>
> Case summary:
>
> The woman and her husband had fled to Sweden while at university in a Latin American country. Several of their friends had already been imprisoned or disappeared because of the political activities they were involved in. Their children were born in Sweden. The marriage seemed to be a harmonic and functioning one. Her husband was now a social worker in Sweden, and she would soon be a psychologist.

The woman had a secure childhood in a middle-class family. Her mother was a housewife. She was the youngest of 3 children. The homeland had not been in political turmoil at that time.

P: "I remember mostly love, care and laughter. My mother was religious, a Catholic, and my father followed her example. They loved each other and us very much. They never fully understood why I became politically active at university, but they supported us when we had to flee. They loved and accepted my husband from the start. We were both very young. They have spent two summer vacations here. They love their grandchildren."

It was difficult for the therapist to understand the woman's depression and suicidal thoughts. She felt the woman had had a secure start and a good marriage. Her studies were going well. The children were in a Swedish/Latin American day-care center and were happy there.

About a year before she started psychotherapy, she had had an abortion. She explained:

P: "I had to. I was in the middle of my studies. We were both on a study loan. Two children are enough. We both agreed on it. We discussed it at first alone and then with a social worker at the hospital. It was a reasonable and realistic decision for us." T: "It sounds reasonable."

(The therapist reflected on the material gathered during the psychotherapy sessions and formed the hypothesis: Could the abortion be connected in some way to the woman's depression and suicidal thoughts? Abortion is forbidden by the Catholic Church. The therapist knew that the woman's religious parents had visited her the summer before the start of psychotherapy, shortly after the abortion.)

T: "Did you tell your parents about the abortion?" P: "Oh no! I wouldn't tell them, or my husband's parents either…My mother is a Catholic. His parents are too. They wouldn't understand." T: "Why not? P: "Abortion is against their religion. I don't know how my mother would react. She has never questioned religious teaching. The only time she got angry with me that I can remember was when I did not want to do all the 'Hail Marys' I was supposed to, after confession. I was 6 years old. When I told her that, her face went red with anger. I remember that even now. I was afraid. She hit my brother once, when he did not want to go to Church. When she is in Sweden, we all go to the Catholic Church on Sundays. It is beautiful there." T: "You return to your traditions when your parents come?" P: "Yes, as a way of showing respect, even though I don't believe in it."

The therapist realized that the depression and suicidal thoughts could be based on the religious values of her upbringing. Having an abortion had resulted in feelings of guilt. Even though she was no longer religious, she had acted in opposition to the attitudes and values of her religious background. Her suicidal thoughts were perhaps her way of punishing herself. The therapist tried out the hypothesis.

T: "Was it shortly after they left Sweden that you started feeling depressed?" P: "Yes. I thought it was because I missed them so." T: "I am sure it is part of it, but…" P: "Only a part?" T: "Your suicidal thoughts. You seem to be punishing yourself for something." P: "I would never kill myself. They are just thoughts." T: "I know, but it must be painful to have them, anyway." P: "Yes. I don't know why. My parents love me so. I miss them." T: "Could it possibly be…you are going through penance for a deed that you cannot forgive yourself for?" P: "What?" T: "The abortion…you disregarded the views of the Church, your mother and father." P: "I don't believe in all that. I told you." T: "But your parents do, and the Catholic Church still forbids abortion." P: "An attitude out of the Middle Ages." T: "And yet you go to church with your parents when they come to Sweden." P: (Angry) "Out of respect!" T: "I know, but you could still be that little girl who believes that if she does not do her penance, she will not be forgiven. And the Church does not forgive abortion…so you cannot forgive yourself; instead you torture yourself with the 'ultimate punishment', suicidal thoughts." The woman remains silent a long time, then starts crying.

The patient, in the middle of psychotherapy, became aware of how her culture and religion had unconsciously influenced her depression and suicidal thoughts. She then continued to look at her culture's values and attitudes, and how they could have affected and affect her life in exile. By the end phase, she could make some significant choices and conclusions for herself and her children.

P: "I'll never take anything for granted again, not after our work. I used to have matter-of-fact answers, opinions and judgments about the culture and religion I was raised in – and other ones…I felt I knew what was right and wrong, bad and good, etc. I don't anymore…not after I have seen how my culture and religion affect me. At first when my children asked me about things like God, I said there isn't one. Now I am not so sure if I should answer that way, not after I've looked into myself. I may not agree with Catholicism, but I am not sure that I have left it behind. I can accept myself more now. I am no longer afraid to express my feelings and show my moods in the way I was when I first came to Sweden and saw how controlled most people are. I can be myself! Laugh out loud, cry, get angry, and not care if I stand out among the quiet Swedes…In fact, I think they like it!"

The next case depicts the confusion and conflicts that *societal contrasts* may cause in the individual and the people around him/her.

Case 8.2

A male immigrant, age 31, 2 years in Sweden, unemployed. Reason for treatment: aggressivity. Form of treatment: supportive psychotherapy, once a week. Duration: 9 months.

Case summary:

He was encouraged to start therapy after becoming aggressive several times at social and employment offices. His motivation for starting was "If I don't they'll put me in prison soon!" He came from a society where bargaining and manipulating officials were some of the means employed to get by.

Case excerpt (from session 12, after 4 months of treatment):

P: "I get angry when they don't listen. At first I try being nice. I like Swedish people. They are so calm. Then I offer them something…a present, or money – I even offered my first month's salary to the man at the employment office, if he helped me to get a job." T: "What happened then?" P: "He said that we don't do things that way here. Then I got angry." T: "And you threatened to hit him." P: "Yes. I am so tired of their attitudes here. In my country, I knew what to do…a present, money – finally helped. Here nothing…only waiting…and waiting…" T: "It must seem frustrating to you when you can't get people to do the same things for you here in the same way as in your homeland." P: "Yes! That's when I get mad." T: "I can understand that, but you scare people when you do." P: "I am beginning to understand that now. Like a child who doesn't get his own way." T: "Yes."

The final case in this chapter describes how the past *socioeconomic background* can affect life in the new country

Case 8.3

A female refugee, age 37, 5 years in Sweden, a cook at a day-care center; she is a widow with 2 children, 13 and 11 years old. Reason for treatment: anxiety. Form of treatment: psychotherapy, once a week. Duration: l year.

Case summary:

She was born and raised in a Latin American city slum area, and had been a union activist. Her husband, who had also been a union activist, disappeared after being taken away by the police. She now works in a day-care center in Sweden. She worries constantly that she will not have enough money to buy food and pay the bills. Her worry finally creates so much anxiety within her that she can't work or think about anything else. In her homeland, she seldom had enough money for food and to care for the children or to pay the bills. It was part of her daily reality there from her own childhood onwards as the oldest of 5 children. In Sweden her economic anxiety is not based on reality. She is in employment and receives child benefits. If she could not buy food or pay her bills, she would receive assistance from the social office. She knows this as these are her rights in Sweden and those of every other person. But her anxiety is phobic, deeply embedded within her, and based on her background as a child and adult in her home country.

After several months of weekly therapy sessions, she began to feel less anxious about her economic situation. She was finally made aware during the therapeutic work that her present anxiety was not based on the economic reality of her situation in Sweden but on the anxiety, fear and hunger she had endured as a child and adult in her homeland.

9. ASPECT FIVE – THE REASON
– For fleeing or leaving the homeland
– For selection of the new country

This chapter presents the fifth aspect of the framework, "the reason" for which the refugee or the immigrant fled or left the homeland, and also the reason the new country was selected. The inner consequences of the reason are considered (first for the refugee, then for the immigrant). An account is given of the similarities and differences between refugees and immigrants in this respect. The ways in which the reason can cause and complicate the difficulties which the individual or the family member is undergoing, and influence the refugee/immigrant situation and the other aspects of the framework are also discussed.

From the accounts provided, to comprehend the world of the refugee and the immigrant, it comes across as essential to know the *reason(s)* he/she left the homeland, and also the *reason* the new country was chosen (Allodi and Rojas, 1985; Baker, 1983; Berry and Kim, 1988; Callao, 1973; Eitinger and Grünfeld, 1966; Hathaway, 1991; Jönsson, 1995; Malzberg and Lee, 1956; Mostwin, 1976; Murphy, 1964; Sluzki, 1979; Weinberg, 1961).

Two highly significant differences between the refugee and the immigrant should be borne in mind in understanding the fifth aspect of the framework, the *reason.* These are that the refugee is forced to leave the homeland, and may not have selected the asylum country, and cannot return to the homeland. By contrast, the immigrant selects and emigrates to the new country, and can visit and permanently return to the homeland.

The consequences of these two factors within the *reason* may affect, and/or complicate – on arrival and throughout life in the new country – how the individual and family deal with the *refugee/immigrant situation* and the aspects conceptualized in the framework. Each family member is affected differently by the *reason*, and it can cause tension and conflict.

To understand the *reason*, several questions should be posed: Why did the refugee/immigrant leave the homeland? Was he/she part of a group or did he/she escape or emigrate alone? Why? What were the circumstances leading up to it?

The refugee

When the *reason* an individual had to leave his/her homeland is known, the circumstances around which he/she came to the new country should be carefully considered – first, the general situation of the political, religious,

ethnic/racial group the refugee belongs to; and, second, the individual and each family member's particular *reason* to flee. The person may not refer to it, but it is necessary for the carer working with him/her to have this knowledge, and even more specific details of the political situation in the country when the patient was there, the current situation, and different religious and political factions.

The refugee individual and family

After establishing what section of the homeland population the refugee/family belongs to, it is then necessary to learn the individual's and each family member's particular *reason* for being forced to flee. Were they fleeing from religious or political oppression? Were they forced to flee because of violence, torture, imprisonment, loss of possessions, or the disappearance or killing of relatives, friends, or colleagues? Was the country at war? If so, when did the war start? How were they involved?

The casework indicates that it may be important for the following questions to be posed: Did the individual flee alone or with the family or in a group? How did he/she flee? Under what circumstances and conditions? Was it planned? Did it happen quickly or was there enough time to plan? If so, how much time? Could possessions be taken or sent to the country of exile? Did he/she know that he/she was about to flee? Did the other people around know about it? Did the other persons fleeing with him/her know that they would have to flee the homeland?

Some refugees have had time to plan and prepare to flee, others have not. A few may have known for years that sooner or later they must flee the homeland, while others did not realize this. Was the refugee or were any other family members in prison, under torture or in hiding within the country before fleeing? If so, for how long and under what circumstances and conditions? Had the refugee been separated from his/her close family? For how long? In hiding? What were living conditions like during separation and concealment?

In some situations, not all family members are told that they will have to flee until a short time or immediately before departure. This may be to protect them from having information which could be unintentionally disclosed or forced out of them by questioning, physical and mental abuse, or torture. Unfortunately, such lack of knowledge can lead to later inner difficulties.

In refugee families, usually not everyone has been politically active. The person who is active must flee, and the others must follow whether they want to or not, because of the risk for them if they stayed. Usually there are no alternatives, except to split up the family (if this has not already happened). To lose everything for another person's sake puts great pressure on relationships between family members in the new country (Eitinger and Grünfeld, 1966; Malzberg and Lee, 1956; Murphy, 1964). If the family members had already been separated from each other in the homeland due to imprisonment or hiding, and were reunited just before fleeing or afterwards in the new country, they must also go through the joyful, but sometimes difficult and painful process of "getting to know each other again".

Did the refugee and family come directly to the country of exile? If so, how? Under what circumstances and conditions? Was it a fearful and/or traumatic experience? If so, in what ways? If he/she and the family did not come directly to the country of exile, where did they go first? Were they in hiding? Were they staying in the homes of strangers, friends or at a hotel or rooming house? For how long before coming to the country of exile? Were they in a refugee camp? Under what circumstances and conditions? For how long before coming to the country of exile?

Selection of the new country

Why was the new country selected as the country of exile? Was it selected by the refugee? If so, why? If not, who made the choice? Why was the country chosen? If the family came as a unit, were all in agreement over the selection of the country of exile? If not, why not?

THE IMMIGRANT

Some immigrants left their native country for similar *reasons* to refugees. If so, the consequences of life in the new country are similar to those described for the refugee. Others are in search of a better life than was possible in the homeland. In past years, the openness of immigration policy has varied from country to country. Usually, it has been restrictive. However, there has been open immigration between the Scandinavian countries for many years. At the time of writing, the European Union allows open immigration for people coming from member countries, but restricts access to people from outside.

Personal reasons for immigration

A person may come to the new country for personal reasons, i.e. because of a loved one, marriage or search for adventure, something new or the utopia they dream of finding.

Marriage

Some people emigrate because they want to share life with a person native to the new country or an immigrant living there. Marriage between people of different cultures can be difficult and complicated. Most often, people are unaware of how background and homeland environment can affect intimate relationships. Difficulties and conflicts can arise, as in all marriages, but when these are due to background differences, they can lead to deep and often seemingly inexplicable complications. These can be based on differing attitudes to gender roles, to economic and religious values, or to bringing up children and other responsibilities. The spouses' language differences can create misunderstandings. The spouse who goes through difficulties in the new country may be misunderstood by his/her partner who, being part of the country, has never had to compare his/her own culture with another one. These conflicts lead to tensions and sometimes separation or divorce.

If separation or divorce becomes necessary, the *choice of returning to the homeland* is available to the immigrant, but can be complicated – especially if he/she has spent many years in the new country. If there are children involved, the *choice of return to the homeland* for a parent – who goes without the children or with them – must be carefully considered. If the immigrant who has been married to someone from the new country divorces and decides to stay, he/she must refind his/her identity without the partner who – most probably – had been a bridge into the new land. This can be a difficult process. Identity crises can result. They are even more serious and complicated within the immigrant, who must now find his/her place alone in the new country. This severe "double" identity crisis can be misunderstood by the carer working with the immigrant who is not aware of these conditions.

Marriage between immigrants

After a time in the new country, an immigrant may return to the homeland and meet a person with whom he/she wants to share his/her life. This person then comes to the new country to live with the immigrant who has lived there for some time. They may avoid the difficulty of coming from

different backgrounds. However, the immigrant who has lived in the new country is usually unaware of how he/she may have changed inwardly. In the terms of the framework, the new partners are at different levels of the *adaptation cycle*. This can be confusing and lead to conflict. The person who has lived in the new country for a while may have difficulty in understanding his/her spouse's situation. It may be too challenging or painful to see, and relive in, another individual what he/she has already gone through. He/she may try to make light of the spouse's difficulties in the new country by not taking them seriously. Or he/she may identify with them and live through them once again. Then, they share a mutual unhappiness which becomes destructive of their present life and relationship. The immigrant may feel such compassion for the spouse going through the *states of being* and the *adaptation cycle* that he/she helps the spouse too much, thereby making the newly arrived individual overly dependent and unable to get by in the new country without help. These different situations can lead to misunderstandings and conflicts, even hatred, and finally separation and return to the homeland, with or without the children.

Students

Regulations vary from country to country for foreigners studying in different countries. Despite the fact that students are in another country only for a limited time, they can also experience all the difficulties of the immigrant described above.

Inner consequences of voluntary immigration

What are the psychic consequences for the immigrant and/or the family who have left poverty, hunger, unemployment in search of a better life and finally found it? It might be assumed that this brings a sense of satisfaction. For many immigrants, this can be the case. They have worked hard for what they have built up in the new country and enjoy and accept their lives there. This leads to feeling part of the new country.

However, some immigrants, who have found outer material security in the new country, can never fully convince themselves that they have left their poverty stricken past behind. They may live in economic and material abundance, yet they constantly worry and fear that this standard may change or that they could lose it. Members of this group place great demands on themselves, physically and mentally, often achieve high material standards, but are never truly content. Families of these

immigrants may live materially well but often have inner difficulties. The children may identify with their parents, but place unrealistic demands on themselves and never feel satisfied with themselves or successful enough. This can finally lead to crisis. Immigrants from this group can feel guilt that they have succeeded in leaving their past impoverishment and have left their family and friends behind in it. Success can lead to self-condemnation and feelings of guilt. The person may try as much as possible to help the people left behind economically, but can feel it is not enough. It can lead to the *state of being: guilt.* It also affects the immigrant's family and others. Finally, he/she can hate and condemn him/herself and others in the new country because he/she and they have what others in the homeland do not. The individual can then become bitter, aggressive, or depressed and withdrawn, and isolate him/herself from the very life he/she has built up.

Some immigrants who left poverty in the homeland and now have a higher material standard of living may simply deny the past. Denial of past environment can express itself through repression, refusal to attach significance to the past or complete denial of a poverty-stricken past. Sometimes, the immigrant can show indifference, lack of tolerance and even dislike and hatred for poor people and countries.

Other immigrants from this group may over-compensate for a poverty-stricken background in the homeland by meeting their needs and desires with an abundance of material possessions. Most often these people never seem satisfied, and either hoard or are overly generous (Cannon, 1977; Deutsch and Won, 1956; Gelfand, 1976).

Cases – reason

The following is an in-depth case concerning a refugee; however, the *reason* she came to the new country and her difficulties in it are comparable to those of other refugees and immigrants. The case shows how the *reason* influences current difficulties, and also complicates the *refugee/immigrant situation* and the aspects. It is treated in some detail because it provides a good illustration of how the components of the framework are utilized in psychotherapy.

Case 9.1

A female refugee, age 34, 6 years in Sweden, student on a university teacher-training course (grade-school teacher in the homeland); divorced, 3 children, 12, 10 and 5 years old. Reason for treatment: mental

exhaustion. Form of treatment: psychotherapy, twice weekly. Duration: 3 years.

Case summary:

The woman came to Sweden 2 years after her now former husband. He was politically active in his homeland and was being sought by the police when he fled to Sweden 2 years before her. She left her job, family and friends to join him here. After a few months, when she was pregnant with their third child, she discovered her husband was having an affair with a Swedish woman. When she threatened to return to her homeland, he physically abused her. She almost lost their unborn child. The baby was saved, and she had, as she explains, "a breakdown". She "went silent" and "was in mental hospital for the first time – for 3 weeks." Her husband promised to end the affair with the Swedish woman. When the child was about 1 year old and she had started a Swedish language course, she realized that he was still seeing the Swedish woman. Supported by several refugees and Swedish women friends, she decided to separate from him. When she tried to, he abused her again. She went to the police. Finally, he accepted the separation. Time passed; the children thrived in the peaceful atmosphere of Swedish life and liked school, so she decided to stay.

The therapist met her 4 years after her divorce. She was soon to finish the teacher training program where she had acquired specialized skills to teach children of her background their culture, language and history. She sought psychotherapy after one of the Swedish professors whom she trusted and liked, had suggested it. She had had a "nervous breakdown" a week before the examinations that would have given her teacher's qualifications in Sweden. She had been hospitalized for a few days, prescribed tranquilizers and "rest". The psychiatrist told her "You're just doing too much," which was true, in part. However, her sensitive professor understood that her symptoms and difficulties were more than just the product of "overwork".

Two psychotherapy sessions twice a week were subsidized by the government.

Case excerpt (from the evaluation sessions):

P: "I don't really know why I'm here. I just know I have to understand what happened to me when I broke down and why. It was in front of the kids. I scared them and I scared myself. I went crazy, screaming, hitting walls, crying. I couldn't stop." T: "Have you reacted that way before?" P: "Not in front of anyone. As a teenager, I banged my head against the wall until I started bleeding. I was trying to study and couldn't concentrate. My mother put me to bed like I was a baby." T: "Maybe you needed that." P: "Maybe, but now I am a mother alone with 3 children. I can't do that kind of thing anymore. When I was pregnant here in Sweden and found out that my husband was unfaithful, I felt crazy, but I didn't show anything. I just went quiet, and was hospitalized for 3 weeks."

In the evaluation sessions, the therapist understood that the woman was anxious about a life change (obtaining her teacher's qualifications).

P: "I worry about getting a job. It must be close to the area we live in. The children like the town and school they go to. If I can't find a job here, I don't know what will happen. I can't uproot them again and again, first leaving my homeland, then the divorce from their father…Now I don't know anything anymore. I didn't even take the exams. I don't have the teacher's qualifications. I can't get a job anyway."

Utilization of the framework for case assessment (based on the evaluation sessions):

The therapist understood the woman had to work through a life crisis, including a divorce and a childhood trauma. (She had seen her father killed in front of her.) Several components of the framework appeared relevant, and may have been caused or complicated by the *reason* (i.e. that she had left her homeland to rejoin her husband in Sweden):

Presented difficulties: "a nervous breakdown" (the patient's terminology) a week before university examinations that could have given her teacher's qualifications in the new country (a life change).

Previous life crisis: separation and divorce.

Refugee/immigrant situation: In 4 years in the country of exile, despite being responsible for 3 young children, she had learned the new language well enough to be admitted to teacher training college. She supported herself and her family with a student loan and odd jobs (mostly office cleaning – evenings, weekends, vacation times) and summer jobs. Outwardly, she seemed to accept life in Sweden and had adapted to it, and she had some Swedish and refugee women friends. She was shy of men, even her teachers at school who were friendly and respectful. She suffered from *loneliness* which could be based on the *refugee/immigrant situation,* complicated by the *reason.*

States of being: The woman was going through several *states of being: the stranger*, *loneliness*, *missing*, *longing*, *sorrow*, *guilt*, *inferiority*, *suspicion*; and these were complicated by the *reason*.

Missing – based on reality.

Longing – based on reality.

Missing and *longing* had complicated the presenting symptoms and difficulties and had affected the woman's life crisis.

Severity: at times, near-psychotic feelings, based on the reality of the *refugee/immigrant situation*, the *reason* and its interaction with other aspects.

Sorrow – based on the reality of life in exile, her divorce and complicated by her *childhood experiences* and the early trauma.

Missing, longing, sorrow must be worked through more deeply in the middle phase of psychotherapy. She had to set words to the *states of being*, accept her feelings about *missing, longing,* and *sorrow* and learn

ways in which she might finally try to compensate for the separations and losses and realize how these have been complicated by the *reason*, and be able to differentiate present feelings of missing, longing and sorrow from her early traumatic experiences.

Loneliness was caused at first by the real situation, exile, and the *reason* for coming to the new country – leaving her profession, family and friends to join her husband. She subsequently discovered he was having an affair with a Swedish woman while she was isolated in an apartment with the children in a new and strange country. The *states of being*: *missing, longing and sorrow*, based on reality and the *reason*, made the *state of being: loneliness* more painful and complicated. The individual's *childhood experiences*, especially the traumatic experience of the sudden loss of her father, were awakened during the crisis, separation and divorce. Later, her exaggerated experience of *loneliness* in the new country was based on the previous reality of it, her *childhood experiences* and the *reason.*

The *state of being: sorrow* complicated by the *reason* and mourning the *separation and loss* of her homeland were also mixed with the early trauma of the loss of her father, combined with a life crisis, separation and divorce from her husband, which complicated the present life change – finishing university.

Adaptation cycle: She was in the second stage: *confrontation.* At times it was complicated by the *reason.* It seemed she was willing, on both an aware and unaware level, to confront the *new* and deal with the contrasts, comparisons and conflicts of the *obvious* from the homeland. However, at times the *reason* caused difficulties in her *confrontation* with the *new.* She was positive towards the way in which her children were meeting and accepting the new country and the people in it, and she appreciated the generally favorable attitudes of the Swedish people she and the children had met. She was proud of her home culture and the Swedish acceptance of it. Her difficulties in progression in this stage were mainly based on her *ambivalence* to the new country due to the *reason*, i.e. she had moved to Sweden with reluctance.

Childhood experiences: In the evaluation sessions, the therapist had learned that she was raised with her brother, who was 3 years older, by her widowed mother in a refugee camp. Her father had been killed when she was 3 years old. At the beginning of the psychotherapy, the woman related her traumatic experience as a 3 year old child watching her father being shot in the head and dying in front of her. "They said I didn't talk for a year after that. I don't remember anything. He loved me a lot, my mother always told me." She also spoke of the violence and atrocities she witnessed as a child and youth growing up in a refugee camp. The therapist understood that these experiences had to be worked through and perceived as connected with the anxiety surrounding other separations in the woman's life (exile, divorce, university).

Reason: She explained why she came to Sweden. P: "I came here for my ex-husband's sake, leaving a job I loved, my family and colleagues… Why?…He ruined my life."

Transition-related conditions: In the evaluation sessions and in the initial phase of psychotherapy, the therapist understood that the woman's *previous homeland experiences,* and the *traumatic experiences in relation t*o these: the atrocities she had seen, her upbringing as a child, young girl and woman in a refugee camp, and the trauma of her father's murder, and *lowered self-esteem* in the new country due to the *reason* must be worked through, and also other feelings on a conscious and unconscious level: her feeling of *loss of society,* her *ambivalence* in the new country; and her *dream of return to the homeland.*

Further case assessment, during initial phase of treatment:

In this phase, the therapist could now assess how severely integrated within her the *states of being* complicated by the *reason* had become, and what must be worked through.

The stranger – Based perhaps on the immediate reality on her arrival, but now based on "fantasy", or on the existential experience of feeling like "a stranger" to life, brought about by living in exile and the *reason*. This *state of being* might also have been based on the early loss of her father and her deep depression afterwards.

Severity: an existential conflict that she seemed to be unconscious of, leading to her confusion, which she needed to become aware of, as it complicated her difficulties.

Loneliness – The therapist in the evaluation sessions believed that the *loneliness* the woman complained of could be based on feelings of reality because of the *reason* she came to Sweden, life in exile and her divorce. However, during the initial phase of therapy, the therapist became aware that *loneliness* was also based on exaggerated experiences of reality, considering that the individual, after 4 years in exile, had some good friends, and a social network around her and the children. During this initial phase, the carer also understood that the *state of being: loneliness* could be to do with her *childhood experiences* and the early trauma of her father's death.

Severity: neurotic and sometimes near-psychotic feelings – the deep and repressed pain of *loneliness,* complicated by the *reason* had affected her inner and outer world, and the symptoms. The therapist understood that the woman must become aware and be able to differentiate between when her experience of *loneliness* in the new country was based on reality and when it was based on the exaggerated experience of reality, and why and how this can interact and complicate her way of perceiving the actual situation.

Guilt – based on reality and exaggerated feelings about reality. It could be that the demands the woman places on herself (and her children)

have to do with her ethnic identity and her guilt that she left her people, the political struggle and her work there.

Inferiority – based on the reality of her *refugee/immigrant situation*, exaggerated feelings about the reality of it, and fantasy, complicated by the *reason.*

Reality: She lost her teaching profession and had a temporary loss of identity in the first year here. Then she believed she could never learn the language and become a teacher, and felt inferior (on a wordless level) to Swedish women because of the relationship her husband was having with a Swedish woman.

Exaggerated feelings of reality: Her present feelings of inferiority, which are based in part on the presented symptoms and problems, and the great demands she placed on herself to succeed in the exams. These are greatly exaggerated as she is a good student and has been studying Swedish and other subjects at university level.

Severity: Neurotic feelings which must be worked through to prevent more serious consequences and gain insight into how *inferiority* interacts with and complicates her symptoms, difficulties and life situation. She must become aware of and understand why she feels inferior. *Inferiority* helped to cause and complicate the symptoms and difficulties, her past life (even in the homeland), her life crisis and life change in the new country. *Inferiority* seems also to be complicated by the *reason.* She must work through *inferiority* and be able to differentiate between the reality of it, based on the *refugee/immigrant situation* and her exaggerated feelings of reality, based on the great demands she places on herself, which may have to do with her ethnic identity. It may also have to do with her *childhood experiences* and her image of herself as a woman – almost based on fantasy, as she is an attractive woman. The early loss of her father may add to her lack of self-image as a woman and her loss of self-esteem because of separation and divorce.

Suspicion – based on reality, now based on exaggerated feelings of reality and fantasy, complicated by the *reason. Suspicion* was caused by reality at the beginning of her stay in the new country, the *arrival* stage. Her husband was lying to her. She felt it but could not confirm it and so she felt suspicious, jealous and aggressive. Her husband said she "was crazy" and she started feeling that way. When she found out the truth, her suspicion subsided but then generalized toward all Swedish women (exaggerated feeling of reality). Although she was usually a person who did not see things in black and white, she was afraid of Swedish women and felt she could not trust them, except for the friends she had made, and they were the exceptions.

Severity: Confusion which could lead to neurotic feelings and conflicts in her life in Sweden. The therapist, who was a Swedish woman, felt that this could be worked out in the relationship between them. She was prepared for feelings of transference.

Case excerpt (from the initial phase of treatment, session 20, after 10 weeks of treatment, working through the *state of being*: *the stranger* and the *reason)*:

P: "I feel like an outsider. Sometimes I can't enter the classroom, even though I know I have friends there. I can't go in. Sometimes, it hurts so much inside me that I have to sit down in the corridor." T: "You can't go in to the classroom with your classmates or you don't allow yourself to go in?" P: "You mean you think I am not allowing myself to go in?" T: "What do you feel about that – not allowing yourself to go in?" P: "To belong, to be part of everything, to live. I thought I would be killed after my father died. I was afraid. If they killed him, they could kill me." T: "Your fear of being killed – could that alienate you from everyone even now?" P: "Am I afraid of being killed even now?" T: "Maybe, not with a machine-gun, but killed inside…"

P: "Life and death have always been so close to me." T: "I guess they are, living in the midst of a war." P: "I always felt outside life, like I didn't have a right to live, even though my mother loved me and I knew my father did." T: "But he wasn't there to show it. That makes it hard to feel loved." P: "And now I can't go into a room filled with people who I know like me because of it?" T: "Because sometimes inside you are still the little girl whose father was once murdered in front of her eyes." P: "Because I was afraid then does not mean I have to be now…" T: "Yes, it does. That's what I mean."

P: "I didn't feel like an outsider in the refugee camp. I never had those problems. I never should have come here." T: "What do you mean?" P: "I came to Sweden only because of my ex-husband. I would not have left my homeland otherwise." T: "Can you explain?" P "You know I came here to be with him, and what did I come to…a nightmare." T: "Please tell me…"

Case excerpts and comments, from the middle phase of psychotherapy:

Case excerpt (from session 118, after 59 weeks of treatment, working through the *states of being: loneliness, missing, longing, sorrow,* and the *reason*):

The therapist could help the woman differentiate the reality from the exaggerated experience of reality of *loneliness*, and how it affected the other *states of being*. The woman was able to delve more deeply in working through the *reason.* Through this therapeutic work, the therapist hoped that more severe difficulties could be prevented in the future.

P: "I felt so alone the year I came here. I sat at home most of the time. I had always been an independent and active woman. Teaching meant very much to me. My mother always helped me with the children. My husband had done everything to get us here and used to write saying how much he missed us. When I came here, I didn't understand the language or anything. But he was never home. I felt something was wrong. I felt it without knowing

it. He kept telling me I was crazy. When I got pregnant, I was totally dependent on him. I had no language and no friends, and I didn't know my way around." T: "You must have felt so alone when you came here." P: "I had never been alone before. The way we live, we have people around us all the time, family, friends, children. When I came to Sweden, I sat in an apartment alone for a year. I was so lonely." T: "And you missed and longed for your family, your home." P: "Yes." T: "It was a difficult beginning. You left everything, your family, your work, your homeland for your husband, then you knew inside something was wrong. And he lied, said you were crazy. Now did you know you were not." P: "I needed him so then. I had missed him so much. Then I came here and he hardly talked to me, touched me, and I had no one to turn to…" T: "You must have missed and longed for your family and friends very much." P: "I do now too…(crying)…I feel so lonely sometimes without them. I don't know what to do." (A long pause) T: "You have friends here, too…" P: "Yes, friends at school called when I didn't come for the exams. My teacher did, too. He said I can take them when I feel better…that I shouldn't worry." T: "You are not alone now." P: "I understand that. But it feels lonely sometimes anyway." T: "You are so far away from so many of your loved ones." P: "Yes…" (She cries a long time.)

Case comment, the *state of being: guilt* and the *reason*:

The *state of being: guilt* combined with the *reason* has complicated the presenting symptoms and her past life crisis, and the present life change. At the beginning of the middle phase, the therapist understood that the individual must become aware of her *guilt* complicated by the *reason* and how it has affected her situation. The therapist would try to encourage her to use it constructively in her work.

After getting to know the woman's history by the end of the initial phase of treatment, the therapist believed that the demands the woman placed on herself and her anxiety at not being able to fulfill them, helped to cause the presenting difficulties, "her breakdown". The therapist had a good knowledge of the woman's culture and knew now how deeply she identified with it. Therefore, the therapist believed that the woman could be suffering from *guilt*, based on the reality and complicated by the *reason,* that she was no longer directly in the midst of her people's struggle. This *state of being* became an exaggerated experience of reality. The woman must succeed and achieve as she is representing on an aware and unconscious level, her group, and feels she must compensate (the *reason*) for her peaceful life in exile which she did not actually choose.

Case excerpt (from session 125, after 63 weeks of treatment, working through the *state of being, guilt* and the *reason*):

P: "My people have suffered so much." T: "But you have, too." P: "Sweden is a paradise of peace, no soldiers, no guns, no bombs all over the place. I grew up with that. At least my children can grow up in peace. But the others…my brother, my cousins, my friends, their children. They are all in the middle of it. Two months ago, there was another killing,

another raid." T: "You are still very much a part of it." P: "Of course, television, newspapers, the telephone." T: "I mean inside you." P: "I can't bear to see the continuous suffering of my people." T: "Could that be why you are making yourself suffer so? You can't bear their suffering…because of feelings of guilt, you make yourself suffer too." P: "By not taking the exams?" T: "What are your thoughts about that?" P: "I was afraid I didn't know enough." T: "That you wouldn't be perfect." P: "I don't like making mistakes." T: "Everyone makes them." P: "I could fail." T: "Would you? You are doing very well at university." P: "I have to. I want to teach. At least I can teach the children of my homeland, living here in Sweden, to be proud of their heritage and not to forget who they are…our people, our struggle." T: "Are you afraid you will forget it?" P: "I don't know. It seems so far away…in the peace and silence of Sweden." T: "And you feel so guilty that you must be perfect, and that you can't be." P: "I never thought of it that way. I studied so hard, and was still too afraid to go to take the exams…and now I don't have the teaching qualifications to be able to work with children here in Sweden."

T: "Could it be that the guilt that you feel away from your people's struggle actually prevented you from getting the teaching qualifications?" P: "Yes…Perhaps…I was torturing myself over the possibility that I wouldn't pass…Yes…Maybe." T: "So we could then say that if you place fewer demands on yourself, you might succeed anyway and could then teach the children their own culture." The woman was silent a long time.

A few weeks later she came in.

P: "I passed the exams. My teacher gave me an oral examination. It was easy. I can teach in September."

Case excerpt (from session 142, after 72 weeks of treatment):

Through the woman's free associations, the therapist realized that she has deep feelings of *inferiority* as a woman, which she had even before she came, and which became especially prominent in the new country and were complicated by the *reason.*

P: "I didn't think I could pass them. Everyone was so much better than me." T: "You often seem to regard other people as better than you." P: "It hasn't been easy to learn the language, the ways of the people here in Sweden. I have to push and fight with myself, constantly. Everything was easier back home. Here, I can't do anything easily. I didn't have to come here. I didn't choose to leave my homeland. I left my home, my life there, because of him."

T: "And yet you've only been here 4 years and you are soon finishing university and getting your Swedish teaching credentials." P: "I doubt myself all the time." T: "But why?" P: "I learned to since I was a child. I never believed I was good enough. That I was pretty enough. In school, I used to hide as I didn't want to be seen." T: "You must have been a pretty child." P: "I look at pictures. Yes, I was. But I felt I was ugly. I thought my mother was lying to me, when she said I was pretty…she said that to make

up for me not having a father, I thought." T: "It must have been difficult to grow up without him." P: "We all missed him. I hardly remember him. My brother did. I used to feel jealous when the other girls' fathers hugged them, caressed them. Even though I had my brother and my uncles, I wanted my father." T: "A little girl can feel that way. No-one is good enough to take the place of a father and to make you feel loved and accepted…and pretty." P: "Then…and now? Why do I feel that way now, too?" T: "What do you think about that?" P: "I remember my husband used to laugh and say: you'll never believe that you are beautiful, but you are. But not next to a Swedish woman…" T: "Why do you say that?" P: "He is living with one now…blonde, blue-eyed. I can't change my eyes, my skin." T: "Why should you?" P: "I feel ugly here in Sweden…Not as good as them." T: "You said you felt ugly before too…" P: "Then and now. Then, because of my father…now, because of my husband. I mean my ex–husband." T: "Yes…But your father left you because he was killed, and you had difficulty believing even then you were intelligent and pretty – not having a father to tell you so. Your ex-husband was unfaithful. You left him, isn't that so?" P: "Yes." T: "Yet you feel he left you because of a woman you now feel inferior to because she looks different to you." P: "Even as children, we all liked blonde and blue-eyed dolls. Everyone likes blonde and blue-eyed women better. Some foreign nurses looked like that." T: "And you felt inferior there?" P: "Yes." T: "To blonde and blue-eyed women, as you now feel to some women in Sweden…but you are you…and beautiful as you are…but it seems to me that you do not accept yourself as you are, even now." P: "No!" T: "Then it must be hard for you to believe that anyone else accepts you." P: "Yes." T: "Let's try to understand why you cannot accept yourself as you are."

Case excerpt (from session 149, after 75 weeks of treatment, working through transference, and the *reason)*:

P: "You are just like Swedish women, after all." T: "Why do you think so?" P: "You think like them. You never say anything. When you say it, you weigh every word. You are not honest. You are never just yourself." T: "I don't know what you mean." P: "I know where I come from. It was bombed and beaten into our heads. My father was murdered because of it. I know who I am, but Swedes don't know who they are." T: "Life has been different for us, but I am trying to understand what you went through." P: "I am proud of who I am. You don't care. You don't know who you are. Otherwise, you couldn't steal each other's men." T: "Do you think I would steal a man from a woman in the way you feel she did from you?" P: "You might." T: "Because I have blonde hair and blue eyes?" P: "I don't know. It seems ridiculous." T: "You said that I was just like all Swedish women. I think like them. I am not honest. I am never myself, because I don't know who I am. Swedes don't know who they are. If we had been bombed and beaten and murdered, we would. Then we wouldn't steal each other's men." P: (The woman starts laughing). T: (T is

silent). P: "Did I really say that?" T: "Yes." P: "It sounds ridiculous. It is ridiculous. Black and white. Different words, different descriptions, but the same…"

Case comment:

During the middle phase of psychotherapy, the therapist became aware of the most significant goals of the work with regard to: the *refugee/immigrant situation,* the *reason,* the *states of being*, her existential feelings of "being *the stranger*"*, suspicion, loneliness,* and how these had affected *missing, longing, sorrow* and her *guilt*; and how *inferiority* had caused and complicated the presenting symptoms and difficulties. It was possible now to see how the *reason* was interrelated with the *refugee/immigrant situation,* the specific *states of being,* the *adaptation cycle, childhood experiences* and certain components of the *transition-related conditions: previous homeland experiences; traumatic experiences in relation to these; ambivalence; lowered self-esteem; the loss of society; the dream of return to the homeland; the choice.*

The therapist did not share this theoretical knowledge with the individual, but having a clearer idea of what the *states of being* were based on and their severity facilitated the working-through of the other aspects. The individual must work especially through her *childhood experiences* and *previous homeland experiences* and *traumatic experiences in relation to these*; the early trauma of the loss of her father and other traumas resulting from her early environment as a child and young girl in a detention camp, and how they have affected and affect her life situation and relationships with people, especially men; the *refugee/immigrant situation*, where she should become aware of how the differences between the two worlds are affecting her; the *reason* and the ways in which it influenced the aspects. Even though she has accepted life in Sweden, there is *ambivalence* to it. With regard to *transition-related conditions*, she must continue to work through *previous homeland experiences,* and *traumatic events experienced in relation to these:* the atrocities of war that she grew up with and lived through, and her present *lowered self-esteem*. The therapist believed that now that she had obtained her qualifications and could apply for a teaching job, she would gain more confidence. Even though she is at the second stage of the *adaptation cycle – confrontation*, the therapist feels that she has the inner resources to move on toward stage 3 – *flashback*. In the individual's words:

P: "My children have the right to grow up in a peaceful environment. I know how growing up in a refugee camp has affected me. And now that I can see the difference it makes having the freedom to grow up in a peaceful surroundings, I want to give them that chance. Then they can choose where they want to be. And I will follow them. My political objective and purpose in life in the years ahead is to make my children and others proud of their heritage and identity in Sweden, a peaceful land that accepts us as individuals. They will have the opportunity to grow up in

peace and decide for themselves whether they will continue the struggle back home or here in Europe."

The following case describes an immigrant whose *reason* for coming to the new country affected her life situation, the *refugee/immigrant situation* and the aspects. Because she had sought psychotherapy "to try to understand herself", it was not until the middle phase of the treatment that the therapist understood this.

Case 9.2

A female immigrant, age 35, 8 years in Sweden, an English teacher; divorced, one son, 6 years old. Reason for treatment: "to try to understand herself". Form of treatment: psychotherapy, once a week. Duration: 2 years.

Case summary:

She came to Sweden after she fell in love with a Swedish man whom she separated from 3 years ago.

Case excerpt (from session 42, after a year of treatment):

P: "I wanted him to come to my country. He wanted me to come to his…and I came here. Now I am here and I hate it, but a boy needs his father. We share custody of him. But I hate it here." T: "You chose to stay here after the separation because of your son, but you hate it." P: "Yes." T: "Why?" P: "It's hard to make friends. I am alone with my son most of the time after work. I don't like the weather. I'll never get used to it." T: "Is there anything you like about it?" P: "The countryside, the way of life…yes." T: "You came to Sweden for his sake. Now you are separated, and you hate it here, but you stay for your son's sake, so he'll be near his father. Is that right?" P: "Yes." T: "Could that be why you are so unhappy here? It seems to me you will have to find your own reason to want to stay here, otherwise you will go on being unsatisfied with life here and hating it." P: "I know." T: "Why don't we try to find out if that reason for staying here could exist or not…"

This case illustrates how the *reason* can complicate a life-change.

Case 9.3

A male immigrant, age 65, 40 years in Sweden, a recently retired factory foreman; his wife, age 63, a seamstress. They have 2 children, 2 sons, 28 and 30 years old, and 4 grandchildren. Reason for treatment: confusion, unhappiness, restlessness. Form of treatment: supportive psychotherapy, once a week. Duration: 9 months.

Case summary:

He had always lived an active life. Until his recent retirement, he had worked in the same factory since he came to Sweden 40 years ago. He was foreman of the largest section in the factory. In the first session he explained he felt confused, unhappy and restless. "I never had time to think about myself before, I was always so busy. Now all I have is time to

think. And I think about everything – the past, the present, the future," and "I must straighten my thoughts out."

Case excerpt (from session 17, after 4 months of treatment, the middle phase of supportive psychotherapy):

In this session, the therapist realized the *reason* he had come to Sweden was affecting the symptoms.

P: "I came to Sweden for a better life. I got the house, the car, the furniture I dreamed of. I worked hard for it. But what I lost I can't get in material objects. I lost my family, my country. I am losing my language." T: "You came to Sweden for a better life. You got what you wanted, but you feel you lost out, too…your family, your country, your language." P: "Yes, and I can't go home. My kids are married here. I have grandchildren." T: "Would you leave your country if you could do it over again?" P: "No, but I ran away from the poverty, the corruption of it all" T: "That's a good reason to look for another place to live." P: "But look what I lost." T: "Let's look together at it…"

During the next sessions the individual talked of and worked through the *reason* he immigrated to Sweden and what he had lost and was mourning from his homeland. Then in the sessions that followed, he could start seeing what he had gained – a good life for himself, his wife and children – by leaving the old country.

Case excerpt (from session 30, after 7 months of treatment):

T: "It seems like yesterday that I left my homeland and my family. But, it was 40 years ago! I am surprised how much I remember. Speaking with you has helped me to recall it all…all I lost, everything I missed, the weddings, the funerals, the family gatherings…I don't know if I would have left my homeland, if I knew then how much I would lose. But I won in escaping from the poverty, the corruption, the misery. We live well here, and I was able to help my parents have a more comfortable life. I gave my wife, my children…and myself, better opportunities. I have my family here, too. My children, my grandchildren. Finally, I can say that… is my homeland, but Sweden is my home. Now I can enjoy my retirement!" T: "What are your plans?"

10. ASPECT SIX – TRANSITION-RELATED CONDITIONS

This chapter describes the sixth aspect of the framework, "transition-related conditions". These are previous homeland experiences; traumatic experiences in relation to previous homeland experiences; the wait for the decision of asylum; after-effects of the wait for the decision on asylum; lowered self-esteem in the new country; loss of society; ambivalence, or was it all worth it?; dream of return to the homeland and how it affects life in the new country; refugee "turns" immigrant, because of a change in circumstances in the homeland; choice of return (when the option becomes available). The ways in which each condition can affect the individual and the family are discussed.

Transition-related conditions contain several components. These are specific to the world of the refugee and the immigrant. Each of them can affect the individual and the family in different ways. The components of *transition-related conditions*, for refugees and immigrants separately, are shown in table 10.1.

Table 10.1. Transition-related conditions in the refugee and in the immigrant.

In the refugee	In the immigrant
Previous homeland experiences	Previous homeland experiences
Traumatic experiences in relation to previous homeland experiences	Traumatic experiences in relation to previous homeland experiences
The wait for the decision of asylum	The wait for permission to stay
After-effects of the wait for the decision on asylum	After-effects of the wait for permission to stay
Lowered self-esteem in the new country	Lowered self-esteem
Loss of society	Loss of society
Ambivalence, or was it all worth it?	Ambivalence
Dream of return to the homeland and how it affects life in the new country	Dream of return
Refugee "turns" immigrant, depending upon change in circumstances in the homeland	
Choice, when the option is available, of return to the homeland	Choice of return to the homeland

THE REFUGEE

The refugee can suffer greatly from the effects of the different components of *transition-related conditions*. The traumatized and/or tortured refugee may experience the effects of these even more severely.

Previous homeland experiences

The refugee may have had one, several, or all of the following experiences in the homeland, for political, religious, ethnic, racial reasons: oppression and violence; physical and mental abuse and torture; imprisonment; the atrocities of war; the loss and death or disappearance of relatives and friends; loss of possessions. These may or may not have been traumatic or have been experienced as traumas by the refugee. For example, a refugee may have fled because of oppression of his/her group and in fear of pending violence and imprisonment. He/she may be from a war-ridden country but may have been protected from the atrocities of it, or come from an area of the country which had not yet been touched by the horrors of shootings, bombings, soldiers, etc. (Allodi and Rojas, 1985; Amnesty International, 1975, 1984, 1987).

Traumatic experiences in relation to the above previous homeland experiences

Oppression and violence

Oppression can be passive or active. Methods of oppression and violence can vary, as also can experiences of it – from individual to group to country (Amnesty International, 1975, 1984, 1987). However, the consequences of oppression and violence are ultimately common to all. Unfortunately, it is a human condition, and felt and experienced regardless of background (Bettelheim, 1943, 1960; Fanon, 1967; Fromm, 1973; May, 1972; Miserez, 1987).

Atrocities of war

Feelings about and experiences of the atrocities of war, the disappearance or loss or killing of relatives, friends, colleagues, and the loss of possessions are also shared by all.

Imprisonment

Imprisonment and torture of a refugee can be a threat or a reality. Prison conditions can be different – being imprisoned in one's home, living years in a tiny cell completely isolated, being in a camp with thousands of others. It is impossible to make any general statements about imprisonment or prisons and the conditions or life within them (Amnesty International, 1987).

Imprisonment because of religious or political background

The psychoanalyst Bruno Bettelheim (1943) – a concentration camp survivor – observed that individuals with deep religious or political

beliefs were better able to live through and survive the horrendous conditions of World War II concentration camps. In the author's psychotherapeutic work with refugees, she has also observed that the persons who were able to survive prison and torture were mostly those who had faith and did not question their conviction. This seems to apply irrespective of sex and age and other *relevant background conditions*.

Prisoners of war

These include soldiers who are children and adolescents. They may also be people of an occupied territory. They can be forced to stay within a certain area under difficult conditions and be detained for different lengths of time – from weeks to months to years. In detention camps, disappearances, torture and executions occur.

Abuse and torture

Abuse and torture exist in almost a hundred countries of the world. Such abuses include being beaten, tear-gassed and arrested without explanation, interrogated and forced to sign statements, and imprisoned, sometimes for several years, where one can be subjected to various torture methods. For the most part, torture is carried out to obtain information and/or to shatter the person's integrity using any means available – from the most primitive methods to complicated ones. Torture can be carried out on persons of all ages. How an individual endures torture can never be generalized. Many do not survive severe torture. The victims of torture have close relations who are also affected – during and after the person's imprisonment and torture. These experiences may have been forgotten or repressed. The individual or family members may not realize how it affects life in exile (Kristal-Andersson, 1981; Scarry, 1985; Somnier and Genefke, 1986).

A sore can heal. A soul can heal. Perhaps, scarred but healed. But this sometimes does not happen when the person has experienced the total loss of self or identity that these experiences can cause. The person may suffer a total loss of integrity or a total loss of the will to survive (Barudy and Vieytes, 1985; Eitinger and Grünfeld, 1966; Fairbairn, 1943; Figley, 1985; Krystal, 1988; Miserez, 1987; Scarry, 1985; Terr, 1988, 1989).

Psychotherapy and support work

The traumatized/tortured refugee reports the need to have courage to recall, describe and work through his/her experiences. It takes patience and time for the carer to listen to and share the hardships of the person who

has endured and survived them. The individual must recognize these sores and enable healing to take place by being able to finally allow him/herself to describe and express the traumas in different ways, in as much detail as possible. The carer can lead the way to what can be a lifelong process of healing. The scars will always be there, but the person can learn to be aware when these affect him/her and how to "take care of them". Memories of traumatic experiences may surface, especially during times he/she goes through an emotional conflict, life change or life crisis. Such experiences are reported sometimes to cause a temporary, recurring or even permanent loss of sense of self or identity (Freud, 1930). To work with a traumatized and/or tortured refugee, a carer should be able to create an atmosphere that allows the person to share these experiences and leads him/her to learn to "take care of the trauma", i.e. to recognize that it is a part of him/her, a shadow in the past, but not one that has to shadow life itself.

By having as much knowledge as possible about past traumatic experiences, the carer is better equipped to comprehend the individual and what he/she may have endured, even if he/she cannot talk about it. Knowledge of the following is necessary:

- The psychology of trauma and the psychological consequences of different traumatic experiences, especially those caused by organized violence, and also of how to approach and work with these.
- The situation of the country when the individual lived there, with regard to the basic amenities of life, such as housing, food, water and schooling.
- The means of oppression, conflict and warfare endured in the native country.
- Information about the specific prison where the individual was kept and the conditions in it. This information may sometimes be obtained from Amnesty International or the International Red Cross.

In treating the tortured refugee, it is essential to have knowledge of the factors above, and also:

- The exact methods of torture used in the individual's country in and out of prison.
- If possible, the exact methods of torture used at the prison where he/she was held.

This information may sometimes be obtained from Amnesty International or the International Red Cross.

The wait for the decision on asylum

Was the individual a quota refugee or an asylum seeker? Countries taking refugees have different procedures in investigating cases, and different regulations can apply concerning where the individual/family can stay in the country during the asylum procedure and what they have the right to do during that time. They differ also with regard to the medical treatment and social and economic support on offer while waiting for asylum. In certain countries, the living conditions for asylum seekers in the detention camps can be close to inhumane. This seems to affect the individual and each family member later on in different ways.

The circumstances

Over the years, the procedures for handling both quota refugees and asylum seekers have changed. Therefore, it is important to know the following: What was the year of arrival? What were the bureaucratic procedures and ways of handling these groups at the time? Did they arrive in the country with refugee status? If so, how were they treated by the authorities and other institutions and agencies on entry and in starting out in the country? If asylum seekers, how did they arrive in the country and what were the official procedures immediately on entry? How long did they have to wait for permission to stay? Where did the wait take place? What were the living conditions of the individual/family during that time? How were asylum seekers treated by the authorities and other people around? How was the waiting period experienced by the individual and each family member? What are the possible *after-effects?*

Quota refugees

The official refugee quota, or the number of refugees that a country takes in, is based on a United Nations recommendation fixed according to the size of the country's population (Hathaway, 1991; Jönsson, 1995). The quota refugee has fled directly from the homeland or has been in a camp in another country. Usually, close family relations of the quota refugee are accepted into the country at the same time or shortly afterwards. On arrival in the country of exile, these refugees are usually given social support.

Asylum seekers

The largest group of people seeking asylum are known as "spontaneous" asylum seekers outside the official refugee quota. They come directly from their native countries without applying for or receiving the right to asylum beforehand and may arrive without passports or other official travel documents. In most countries, an immediate investigation is carried out by police or government authorities. If an individual/family is not accepted into the country, he/she is sent back to the homeland or country of departure. If allowed to seek asylum, the individual/family is allotted, if necessary, a minimal amount of economic support and medical care.

The official asylum procedure of a particular country can take days, weeks or years. During that time, in some countries, the individual/family can choose where to stay and may be allowed to work or study as a member of society. In other countries, they are placed in a detention camp with other asylum seekers of different countries and with different reasons for seeking asylum. Each camp is run separately with varied living accommodation and arrangements for children and adults. Usually, asylum seekers are not permitted to take on employment or go to school during the wait for a decision.

Inner and outer consequences

The individual has sacrificed a great deal to get to the new country, and usually left much behind. Now he/she is between two worlds – not there, not here – with the constant threat of being refused asylum. The individual and each family member are also influenced by others waiting for asylum; either getting their refugee status or being refused it and deported. These circumstances cause continuous tension, stress and pressure, which affect the individual/family. Ways of reacting can be with patience, in silence, in trust, in prayer; or with stress, inability to concentrate or think about anything else, with constant discussion, appeal and plea; or in passivity, with depression, insomnia, fear, anxiety, suicidal thoughts and even suicide attempts; or with anger, aggressivity and abuse; or with mental and physical sickness. The waiting period can cause personal and family crises, and also strained relations and serious conflicts between personnel and asylum seekers, as well as among asylum seekers themselves. However, there can also be loyalty, sympathy and sharing between them. The individual/family that has experienced traumas in the homeland may suffer deeply from everything described above. During the wait, the

individual and each family member may build up certain positive and negative attitudes toward the new country, based on the people he/she meets in the camp or out in society. The negative attitudes and prejudice he/she meets can cause the individual/family to have similar feelings toward all inhabitants of the new country.

After-effects of the wait for asylum

Because of the complications caused by this period, it may take longer for the individual/family to adapt to life in the new country. The person who has lived in a detention camp finds that life is very different out in society. For varying periods of time, he/she has lived in an isolated, segregated world, which can cause *lowered self-esteem.* Because of the passive environment, he/she may have lost self-confidence and may be more hesitant about being able to start out in the new country than he/she would have otherwise been. If the individual feels that he/she was treated with mistrust and disdain during that time, he/she may then meet the inhabitants in the same way. The feelings are generalized to include persons working in any public institution, even those wanting to support the individual and the family, such as the social and health services, schools, etc. This makes starting in the new country difficult.

After-effects include mistrust, suspicion, prejudice, passivity, aggressivity, lack of motivation, loss of self-confidence and lowered self-esteem. These *after-effects* can go on for many years, sometimes a lifetime, affecting negatively the *refugee/immigrant situation* and aspects of the framework, especially the *states of being,* the *adaptation cycle* and the other components of *transition-related conditions.* If parents have these feelings, the children may also experience them.

For most people this is a difficult period. Even if it has not been mentioned, it may be important that the carer should consider questioning the individual/family about it, and then work through the effects it has had.

Lowered self-esteem

The refugee can experience *lowered self–esteem* on arrival in the new country and for some time afterwards. There are some refugees who never regain the self-esteem they had before life in exile. Children are influenced in different ways by the *lowered self-esteem* of their parents (Callao, 1973; Deutsch and Won, 1956; DeVos, 1983; Feldstein and

Costello, 1974; Garza and Guerro, 1974; Hallowell, 1936; Lidz, 1968; Mostwin, 1976; Sluzki, 1979).

On arrival

When the individual reaches the country of exile as either a quota refugee or an asylum seeker, he/she is confronted with the new. When fleeing the homeland and before, he/she has already encountered many new and uncertain circumstances. Depending on how the individual or family is met on arrival and what happened before, this can give rise to *lowered self-esteem.*

For sometime afterwards

There are several reasons why the refugee experiences *lowered self-esteem* even some time after coming to the new country. This is because of:

- the *after-effects* of waiting for asylum;
- the *refugee/immigrant situation*;
- disappointment in finding out that, if he/she is educated and/or has a profession or trade, he/she may not be able to work in it;
- studying for a profession in the homeland and not being able to continue;
- difficulty in finding living accommodation of equal standard to what the individual/family had in the homeland;
- what the individual/family may go through in everyday life in the new country;
- emotional and existential conflicts;
- being without roots, the obvious, home;
- traumatic experiences of the past continually recurring in memories, in painful feelings, mood swings and behavior which are not recognized as part of oneself.

As a permanent, lifelong condition

Some refugees experience *lowered self-esteem* as a permanent, lifelong condition both because of the reasons given above and due to the effects of all they went through in the homeland. Many educated refugees who worked for years in the homeland in their own fields can never again work in them. Older refugees can suffer from a permanent *lowered self-esteem*, because the older they are when re-rooted, the more difficult the process.

The traumatized refugee and/or tortured refugee may be more prone to *lowered self-esteem* as a permanent, lifelong condition.

Loss of society

The refugee who experiences this condition reports the feeling of not belonging to or taking part anywhere – either in the home country or in the new one. A part of the purpose of life has been lost and cannot be found again in the new society. *Loss of society* comes after living in the new country a short time or later on.

At least at the beginning of life in the new country, most individuals/families are usually determined to try in some ways to be a part of it. But both the homeland and the new society seem to be out of reach. The refugee may isolate him/herself, and give up actively trying to be part of the new society. In many people, this can lead to difficult problems, especially for those who have been active members of their homeland societies. The experience of *loss of society* can complicate the relationships between family members if only some of them are affected by it (Adler, 1954; Garza-Guerro, 1974; Josephson and Josephson, 1962; Mostwin 1976).

Ambivalence

The individual/family can suffer from *ambivalence* – or "Did I/we do the right thing in fleeing or leaving the homeland?" Even under the most positive life-conditions in a new country, the individual/family after a while may question whether what he/she did was right (Feldstein and Costello, 1974; Novak, 1971; Vargás, 1977; Westermeyer, 1989; Westin, 1975). *Ambivalence* and questioning of what was done can make the other aspects of the framework more difficult to endure.

Dream of return to the homeland

The *dream of return to the homeland* can be a hope for the individual/family who wants to return or a threat for the refugee or family member who does not want to go back. The refugee hopes to return to the homeland in daydreams, fantasies, dreams and plans. However, the *dream of return to the homeland* can remain an illusion. The refugee may never be able to fulfill the *dream of return to the homeland* and it can add to the refugee's and the family's difficulties. Or the *dream of return to the homeland* can finally be realized, and becomes a matter of choice. The refugee becomes an "immigrant", at least emotionally. This is explained further on in this chapter. The traumatized and/or tortured refugee and family may also *dream of return to the homeland*, despite what he/she

endured there. The difficulties of life in exile cause the traumatized and/or tortured refugee to *dream of return to the homeland*, especially if past traumas are repressed. He/she and their family can then go through the same difficulties as the refugee.

On arrival

The *dream of return to the homeland* is born on arrival in the new country. Depending on the individual's background and the *reason* he fled, the *dream of return to the homeland* can already be present (Feldstein and Costello, 1974; Novak, 1971). On arrival, refugees may not at all have, or dare to have, the *dream of return to the homeland* at a conscious level (Eitinger, 1964; Frankl, 1959).

After a time

After a time, the *dream of return to the homeland* can take on different forms. The *dream of return to the homeland*, already born on arrival, grows as time passes and life in exile goes on, and the desires of yesterday have been realized, compromised with, or crushed. The refugee begins to dream of how it would be if he/she could return. He/she cannot, but dreams in any case.

If the *dream of return to the homeland* of the refugee is a conscious one, it can lead to even the family of the refugee not being allowed to be part of the new country. He/she may isolate him/herself, and lives in the dream of returning someday. Within a family, each member is influenced by the *dream of return to the homeland* differently and may not have the same feelings about it. This can create guilt and loyalty conflicts in children and other family members who want to live in the new country.

If the *dream of return to the homeland* is more unconscious, the refugee may constantly complain about life in the new country and criticize everyone and everything in it. This can include his/her own children, who have perhaps become a part of the new society. The refugee may feel ashamed or guilty about these feelings and become passive and isolated, or turn into a bitter and perpetual fault-finder or openly aggressive person. He/she does not realize that the *dream of return to the homeland* is making him/her unhappy in the new country.

Dream of return as a possible reality

For the refugee living in exile, the situation in the native country and the possibility of his/her returning to it can change from day to day. Such

changing situations cause refugees to have something to hope for. However, working for a possible return to the homeland (which could take months, years or a lifetime) means that the refugee/family may never try to become part of the new society. The *dream of return to the homeland as a possible reality* can awaken the same difficulties within the traumatized/tortured refugee and family, especially if traumatic experiences have been repressed. For the individual and family members who have not repressed past traumas, the *dream of return to the homeland as a possible reality* can cause questioning and conflicts. Painful memories of the past may recur, causing once again the symptoms of trauma. Each time the *dream of return to the homeland as a possible reality* comes up because of outer political changes, or just in discussion, the traumatized/tortured refugee and their family members may return to the traumatic events in memories, feelings or dreams.

After many years – realization he/she may never return

After many years in exile, the individual/family comes to the realization that a return may never be possible. The years have passed, and the individual/family has made a life in the new country. Perhaps the refugee has lived as long there as he/she had in the homeland. The children have grown up or have been born in the country of exile. The refugee accepts that the country of exile is home, that home is what one makes of it, or he/she becomes resigned, disappointed, pained and depressed. This realization can bring either a state of perpetual melancholy or peace of mind.

When the dream of return becomes a reality

Even after a short time in the new country, when the individual/family learns that a return is possible, there can be different reactions – from disbelief, joy, excitement through to mixed feelings, fear, and perhaps even the realization that the family does not want to go back. If family members have different feelings about returning, this can lead to family conflicts, separation and divorce.

After some time in the country of exile it is even more complicated. Choices must be made that create anxiety. Even for the individual/family that finally has the chance to do something long wished for, deep inner conflict may arise. Each family member must look at the life he/she has built up in the new country and the life that he/she would have to rebuild in the homeland. The years have passed and he/she is older. The children

have been raised in the new country. What would the consequences of returning to the homeland be for the refugee and the children? The *dream of return to the homeland* can be realized. However, it can turn into a nightmare depending on how it is conceived and handled.

In considering returning to the homeland, the traumatized/tortured refugee who has not forgotten or repressed the traumas may painfully re-live these. The traumatic experiences of the past may be awakened even in the person who has repressed them. In making the decision or choice to return to the homeland, he/she must consider how these experiences could affect him/her and the family again.

Refugee "turns" immigrant

The individual and family become or *"turn" immigrant*, at least emotionally, when political and social changes in the homeland occur that allow them to return, but they remain in the country of exile. According to the framework, the refugee's world turns into that of the immigrant, with all its psychic and outer consequences, especially as far as *ambivalence* and *choice of return to the homeland* are concerned.

THE IMMIGRANT

The *transition-related conditions* that the immigrant and his/her family may face are similar to those already considered for the refugee. Many immigrants have experienced similar hardships to refugees, although they are not classified as refugees. They may have entered the new country as immigrants, or received immigrant rather than refugee status. Therefore, it is essential for the carer to learn the *reason* for immigration and the circumstances behind it in order to be able to treat and work through the difficulties of the individual/family.

In the case of immigrants, the components of *transition-related conditions* to consider areas follows.

Previous homeland experiences

The individual/family may have gone through or been at risk of experiencing oppression. In addition, the individual and the family may leave the homeland because of severe poverty or the hardships of nature. It is difficult for these groups to be accepted into most countries of the world for these reasons alone.

The individual/family may have experienced traumas in relation to *homeland experiences*.

The wait for permission to stay

If the individual does not have a work permit on arrival, the *wait for permission to stay* can create similar difficulties within him/her as described for the refugee. If the individual/family left the homeland for similar reasons to the refugee, but cannot prove these in the same way as the refugee, this individual/family may suffer deeply through the period of the *wait for permission to stay*. If he/she has not declared or been able to prove "a well grounded fear of persecution" (UNHCR, 1970, pp. 12-13), the individual/family is sent back to the homeland after the *wait for permission to stay*.

After-effects of the wait for permission to stay

The immigrant and family members are affected by the *after-effects of the wait for permission to stay* in similar ways to the refugee.

Lowered self-esteem

Even though the immigrant/family chose to leave the homeland to come to the new country, *lowered self-esteem* can be experienced on arrival and afterwards.

Loss of society

This condition appears to be experienced by the immigrant in the same way as the refugee, especially if he/she was active in society in the homeland.

Ambivalence

In similar ways to the refugee, the immigrant/family may experience *ambivalence* about life in the new country. The immigrant/family left the homeland in search of a better economic and material standard of living. Even if this has been achieved, the immigrant/family may realize that much else has been lost, such as contact with friends and family, the homeland environment, etc.

The *refugee/immigrant situation*, the *states of being*, the *adaptation cycle* and *transition-related conditions* of the immigrant and each family member have affected their inner world. Therefore, even under the most positive and improved outer circumstances in the new country, after a while the immigrant and/or family members question if it was all worth it. In contrast to the refugee, if this *ambivalence* continues he/she can return to the homeland, for a visit or to stay permanently. The alternative or the *choice of returning to the homeland* is always there.

During the early years, *ambivalence* can be appeased by visits to the homeland. The immigrant/family compares cultures and life styles, and what has been gained and lost. Usually, such homeland visits are emotionally important to family members. As the years go by, the immigrant/family goes through emotional difficulties. *Ambivalence* to the new country may make these difficulties more painful, complicated and harder to get over. Children grow up. The immigrant gets older and the questioning or *ambivalence* continues. He/she may now have family, friends and a successful life in the new country, but still be disturbed by *ambivalence*. Often, the children of immigrants identify with their parents' *ambivalence* about life in the new country and, therefore, it may continue into the next generation.

Dream of return to the homeland

The immigrant and each family member can experience the *dream of return to the homeland* in similar ways to the refugee. However, the immigrant's *dream of return to the homeland*, in contrast to the refugee's, can always be realized. That is, the *choice of return* is always there. In the beginning, the immigrant/family accepts life outside the homeland and returns to it for visits or permanently. However, after a time, the *dream of return to the homeland* can give rise to different feelings. Contemplating, sometimes even planning for return, may ease the difficult, sometimes painful feelings aroused by the *dream of return to the homeland*. If, after many years in the new country, the *dream of return to the homeland* is still not fulfilled, it can continue to complicate the difficulties of the immigrant and family. Alternatively, the *dream of return to the homeland* can finally be realized, and turns into the *choice of return*.

Choice of return

Should I/we go back to the homeland or not? This opportunity to choose can lead to continuous and painful inner conflicts within the immigrant and each family member. The *choice of return* to the homeland is always present. The immigrant and family may work and live in the new country to enable them to return. However, as the years pass, the native country changes, as too does the immigrant and the family members who have become part of the new society. The *choice of return* may still be reality or has become the *dream of return to the homeland*. The *choice of return* gets more difficult to deal with and can lead to anxiety in the immigrant and each family member, and also generation conflicts.

This can have positive and negative effects:

Positive effects:

- One knows that one can visit or return permanently to the native country, and one always has something to look forward to and work for.
- It is possible to return to one's native environment and see and meet relatives and friends. Difficulties in the new country can be compensated for by these visits.
- Visits to and contacts with the native environment strengthen the capacity to deal with life in the new country.
- If one cannot become a part of the new country, or does not want to be, a permanent return to the homeland is always a possibility.

Negative effects:

- Knowing that the alternative is always there to visit or return permanently to the native land, one may never attempt to be part of or make an effort to relate to the inhabitants of the new country, learn the language or way of life.
- Even though one has lived in the new country for many years, one lives in one's own world, dreaming of visits or permanent return to the homeland.
- All economic resources go towards saving for the next trip or permanent return to the homeland.
- One isolates oneself from life in the new country, on the excuse that one is saving all resources to return to the homeland.
- One compensates for what has been lost in leaving the old environment by exaggerating to relatives and friends in the homeland how well one is doing materially in the new society.
- One may plan an eventual permanent return, but as the years pass there are changes to both oneself and the native country. One can feel like an outsider in the environment and home country in which one once lived.
- One realizes that the final decision to return permanently to the homeland cannot be made.

The combination of no longer being a part of the old, not having become part of the new and being unable to make the *choice of return* can lead to emotional conflicts which can complicate the *refugee/immigrant situation*

and current difficulties. The *choice of return* is always there, but it can in itself lead to anxiety and inner pain.

Making the choice

The time may come when the *choice of return* to the homeland must be made. If the final decision is made to return permanently to the homeland, it can lead to constructive planning, which takes each family member's present and future life into consideration. On the other hand, it may lead to disappointments or difficult compromises, and separations between husband and wife, parents and children.

Cases – transition-related conditions

The following case exemplifies the *transition-related condition: previous homeland experiences.* A repressed trauma in the homeland is awakened in the new country.

Case 10.1

A male traumatized refugee, age 39, 18 years in Sweden, a civil engineer; divorced with one son, 15 years old. Reason for treatment: severe back pain, thought to be psychosomatic. Form of treatment: supportive psychotherapy, once a week. Treatment duration: 1 year.

Case summary:

He was sent to the therapist by a medical nurse. He had had physical back pain for over a year, treated with medication, tranquilizers and sedatives and physical therapy. He was highly medicated when the therapist began treating him, and the therapist felt that it would be impossible to work with him because of it. When he mentioned this to the patient he agreed that he would try to limit his medicine intake. He had difficulties in sleeping without it he said. He explained that the pain in his back started a year ago but that he had had sleeping problems for a year before that. He had already told the therapist that he had been divorced for 2 years. He asked the patient if it had something to do with this. He did not think so, he said. But it was difficult for him to live alone in a rented room after the marriage. It reminded him of his homeland, he said. In what way? the therapist asked. He was silent a long time.

T: "I must have asked a difficult question." P: "No, he said. I am just thinking." T: "Could you share your thoughts with me?" P: (He was silent a long time) "…It reminds me of a prison cell. I feel as lonely as I did when I was in prison." T: "Why were you in prison?"

He was silent. P: "I was just a kid. I was 14 years old. I was active in a human-rights movement in my country."

He left the office that day. The therapist knew that he had probably experienced some kind of torture. For several months, the therapist said nothing.

He stopped taking sedatives and tranquilizers and found it hard to sleep. He started talking about his nightmare, a recurring nightmare of being abandoned. He went back to it again and again. The therapist took up the dream, referring to his divorce.

One day the man came in. P: “I am going to tell you something I have never told anyone, he said. I was raped by men. I was forced to watch a girl of 15 years old whom I worked with being raped. I heard a friend of mine scream until he was finally silent. I knew he was dead. They raped me again and again. They hung me up. They wanted information. I finally gave in.”

The therapist listened to him. The patient saw the tears of rage that the therapist could not hide. He cried, finally, too. I have to leave now, he said. The therapist said nothing.

In the next session he began to tell the therapist the details of his 6 months in prison. He had, for over 25 years, held his trauma and the guilt of giving in to the torturers silently within him. He was not sure if it led to the torture and death of others. Over the next months, he described the tortures that he had to endure. He described the other boys and girls he worked with in the organization. He laughed and cried at the memories. The therapist asked him for more and more details of the methods of torture, descriptions of his friends, and the ones he feared were arrested because of what he called his “cowardice”.

Case excerpt (from the middle of therapy, session 23, after 6 months of treatment):

T: “Would you call your son a coward if he went through what you did?” P: “He would not survive. He is just a child”. T: “You were younger than he is now,” the therapist reminded him. He was silent. When the therapist asked him to share his thoughts with him, he said he had never thought about himself as a child when he thought back to that time. P: “I think of myself only as a squealer and a coward.” T: “You were 14 years old.” P: “I was 14 years old. I didn’t want to live afterwards, but I survived. I didn’t want to go back to school. My parents knew nothing of what I went through in there. Finally, they sent me away to a school in another country. I thought I could forget. I did for many years.” T: “But your body didn’t.” P: “The pain in my back, you mean. Yes. I never told the doctors that it was caused by the suspension of my body for hours and hours, day after day.” T: “They cannot help you if they do not know what your body has gone through.”

Case summary:

He continued in treatment a long time. During that time, he returned to the doctor who had treated his back and told him of the physical torture that he believed was causing the pain. He was sent to specialists, and is now without physical pain.

One day towards the end of the treatment, he came in:

P: "You want me to forgive myself. I know that. I listen to you. I watch your eyes. No…No…I can never forgive myself for giving them the names of my friends. But I forgive the child. He couldn't do anything else."

The following case illustrates the ways in which the *transition-related condition: after-effects of the wait for asylum* can affect the individual.

Case 10.2

A male traumatized refugee, age 28, 5 years in Sweden, unemployed. Reason for treatment: violent behavior. Form of treatment: supportive psychotherapy, once a week. Duration: 18 months.

Case summary:

He was from a Middle East country and had spent 2 years in prison, 1 year in isolation. He had waited in a camp for asylum for a year and another 8 months in order to be placed in an area of Sweden where he could find work. He had been living in exile for 5 years and had been working in a factory but was now unemployed after physically attacking a Swedish foreman. He suffered from alcohol (and possibly hash) abuse and had gone to a drug treatment center but left it after a short time "as they don't understand foreigners". He is now in supportive therapy, which he was motivated to start "because if I don't, the social office won't help me economically, and I can't get another job after what I did."

In the evaluation sessions, he spoke bitterly about his time in the detention camp waiting for asylum. The therapist concluded that his aggression toward Swedish people, especially those he was dependent on (the foreman of his previous job) could have something to do with his wait for asylum. But during the beginning of therapy he did not take it up. At about the middle phase, the therapist decided to ask him about this period.

Prominent *state of being: bitterness*.

Other *states of being*: *the stranger*, *loneliness*, *missing*, *longing*, *inferiority*, *suspicion*, *scapegoat*.

Case excerpt (from session 32, after 8 months of treatment):

P: "I am always waiting, waiting, waiting. Sometimes it feels like I am back in prison." T: "Two years there. A long time for a young boy." P: "A year alone in an isolation cell. It was the worst torture. I was so happy to have the ants in the cell. I watched them, helped them build. I had nothing to do." T: "Did you feel that way in the refugee camp in Sweden too?" P: "Yes, sometimes. I sat and sat and sat. It was just wasting time, just like prison." T: "You sat a year in isolation because you hit a guard." P: "Yes. We were both young. But he was a guard. He liked bossing me around. I hit him." T: "Did you feel that way at the factory?" P: "Yes. I couldn't stand it, when he bossed me around, told me what I could and couldn't do. In the refugee camp, it was always like that too. I

knew I couldn't say anything to them or get angry. Maybe I'd get kicked out of Sweden." T: "So you held it inside you." P: "I learned to in prison." T: "Then it gets bottled up and comes out all at once." P: "While I was waiting for asylum at the refugee camp, I used to hit the wall with my fist, so I wouldn't hit the people working there. I hated them. You have to be patient. Everything takes time here in Sweden," they kept saying. When you are finally allowed to stay, it takes time to find a place to live, a job…it took 8 months!" T: "I know. Eight more months sitting in the refugee camp…like a prisoner." P: "I hated them all when I left." T: "It wasn't a very good beginning." P: "No. I hated them. They hated me. They were glad to get rid of me. One of the Swedish men working there even said so." T: "It must have made you feel all Swedes are like that." P: "Aren't they?" T: "Are they?" P: "You are different. And a few others." T: "Could it be the anger you felt in prison with the guards in your country, then in the refugee camp in Sweden with the persons working there has made you feel angry with everyone around you, especially people in authority?" P: "I never put it together that way." T: "Let's try to look at it that way…for a while." P: "Okay."

The next case describes the *transition-related condition: choice of return* to the homeland and how it can affect an adolescent.

Case 10.3

An immigrant girl, age 16, 10 years in Sweden; father, age 42, is a kiosk owner, mother, age 40. She has 2 brothers, 9 and 7 years old, born in Sweden. Reason for treatment: depression. Form of treatment: counseling with the school psychologist, once a week. Duration: 7 months.

Case summary:

She is excellent in school, but constantly depressed. One of her teachers suggested she talk to the school psychologist.

Case excerpt (from session 5, after 5 weeks of counseling):

P: "I hardly remember my homeland. I've been back twice, and even though my relatives and the friends I made there are wonderful people, I could never live like them. I know that. But my parents want to go back there. They are planning it." T: "When do they plan to go back?" P: "When they have enough money to build a house and retire." T: "How do you feel about that?" P: "I don't want to go back there forever. But I don't want to lose my parents and brothers. I feel so lonely and sad just thinking about it all the time." T: "All the time?" P: "My parents have always talked about it." T: "Always? It must make you feel that it's no use liking Sweden." P: "Yes. But I do. I have my friends here. I like the life for girls here. I want to stay. I get sad when I think about it and I do all the time, since I was little. (She cries)…I want to feel I am at home somewhere, but I don't." T: "Your parents are still too young to retire. It could be many years until then." P: "They don't think so. It is a matter of time, they always say." T: "A matter of time. What do you think they

mean?" P: "They don't know. They are both working very hard, but we (the children) cost a lot and they send money home to my grandparents. They don't have the money to retire." T: "So you know that." P: "I don't know…I feel it, but I don't know." T: "But you feel it inside, and you see the reality of it all." P: "Yes, I do." T: "And you feel what's right for you. You like Sweden. You like school. And you know that they can't go back just yet. By the time they can, you will be an adult or very close to being one and will be able to choose for yourself what you want." P: "I am 16 years old." T: "Right now, you seem to want to let yourself be a part of Sweden. You have been here most of your life, so why don't you?" P: (Smiling) "I never really thought of it that way."

11. SUMMARY OF PART I

These further comments consider the general objectives of part I, its research methods, the purposes of the formulation of the key dimensions, the similarities and differences between refugees and immigrants, and also the practical application of the framework. Whether the framework might also be related to the majority population is also discussed, e.g. in relation to people who have moved from one area to another in their own country, or have lived or worked in another country for a lengthy period of time and then returned.

The general objective of this dissertation is to approach the question "In what ways does moving from one country by will or by force, affect the inner and outer world of the refugee, the immigrant and their children?" A further objective is to formulate a framework whose practical application might allow psychotherapists and other support workers more efficiently to be able to apply their experience and theoretical knowledge in helping these groups.

Part I consists in the theoretical description of a conceptual framework that evolved since 1975 from the author's clinical work, supervision and theoretical studies. At that time, the need for research to approach an understanding of the psychology of the refugee and immigrant in the field of clinical research seemed fundamental. There were few systematic research studies concerned with the inner difficulties of the refugee, the traumatized and/or tortured refugee, the immigrant and their children in the fields of psychology and psychiatry.

In recent years, for the most part, the extensive literature and studies now reported in this area are based on short-term research. The structure of the framework was formulated over a 28-year period in a long-term clinical research study. It was based on a large population of 903 refugees and immigrants – adults, adolescents and children – coming from 104 countries from all parts of the world. The individuals and families had sought asylum or emigrated to Scandinavia at different stages of their lives, and for different reasons.

A descriptive qualitative-clinical approach was utilized in an endeavor to obtain profounder understanding of the psychology of these groups. In treatments, in the supervision of others, and in the study of related research, their varied symptoms and difficulties were studied and elucidated in psychotherapic and related supportive work – individually, in families and in groups.

The key dimensions of the conceptual framework were formulated in stages (as stated in interaction between clinical practice and literature study). In particular, it became apparent that the inner difficulties of the refugee and the immigrant appear to be specific and distinct, and not always considered or understood. Further, the inner problems of children born in the new country are often not taken into account. The carer is often faced with multiple symptoms, problems and difficulties that are confusing to sort out and handle. It seemed essential to the author that the carer learned to consider these key dimensions in order better to understand how they cause, influence and complicate the symptoms and problems of the refugee, the immigrant and their families.

The key dimensions were formulated in order to develop a conceptual framework that would allow the carer to be able to consider and respect the unique personality of the individual, regardless of his or her background; and to be able to recognize and determine the common difficulties, behaviors and actions of the refugee and immigrant. The principal purpose of the formulation of each key dimension was to attempt to identify the components that seemed to be specific to the inner and outer world of the refugee/immigrant, and to recognize the ways in which they interact (on a conscious or unconscious level) in relation to presented symptoms and difficulties. The conceptual framework – as it developed – enabled systematic patterns to be found in the worlds of the refugee and immigrant. The understanding obtained appears to generate certain tentative guidelines for specific forms of care and treatment. These are considered in part II below.

Other purposes were to try to recognize similarities and differences among these groups (and also between them and the majority population), and to provide the carer with a practical instrument to help to classify and organize the complex set of problems of these individuals and families. The carer might then be able to focus on those particular elements within the framework that may have caused or influenced the problems by which they are confronted. The aim of the framework is to point to the most prominent experiences and processes that the refugee and immigrant may face. No claim is made that all the individuals in these groups have all these experiences or go through the processes in the same way.

The key dimensions of the conceptual framework and their practical applications have been illustrated by 69 cases compiled from reports of the total population (903). Each component was illustrated by three cases

– two refugees and one immigrant (except where there was very strong reason to depart from this rule for illustrative purposes). Most of the cases depict adults and adolescents in individual and family psychotherapies and support work. These were chosen to provide the reader with a concise description of the components of the framework in practical applications. However, the total population also consisted of children. The framework can be applied to their treatment and care in an equivalent manner. Due to limits on the length of the dissertation, it was necessary to extensively edit the case-study material in this respect.

The first key dimension, the *refugee/immigrant situation,* is used to describe how the outer processes of change the person goes through in the new country may affect the inner world. It seems to affect both the refugee and the immigrant in similar ways. Perhaps, it may also affect the person from the majority population who has made similar outer changes within his own country. Case 4.1, for example, describes a typical family conflict between generations in refugee and immigrant families caused by this component.

A second key dimension, the first aspect of the framework – the *states of being* – evolved from common conditions reported to be experienced in the new country in similar ways by the total population of the study. The cases compiled are employed in an attempt to illustrate the specific ways in which one or several of these shared feelings, thoughts or conditions seem to be experienced over different periods of time – separately or simultaneously – and with varying degrees of severity.

A further dimension, the *adaptation cycle,* considers the length of time in the new country and its effects. Refugees, immigrants and their families all report having been affected by this second aspect. Each individual seemed to be influenced by it in different ways, and it was not possible to generalize similarities or differences of affect on these groups. Perhaps the *adaptation cycle* might also be applied to persons from the majority population, who have made outer changes within their own country. The purpose of the *adaptation cycle* is to provide an instrument to determine the inner effects of length of time in the new country. It should be applied as an abstract structure that depicts different phases of life. In the literature relating to these groups, there have been numerous attempts to define stages/phases of adaptation based primarily on the period of time the individual/family has been in the new country. The author is of the opinion that it is impossible to recognize adaptation in this way.

Throughout her clinical experience, each person's process of adapting to the new country was found to be highly personal. Accordingly, the stages of the *adaptation cycle* should be considered as an abstraction, and not a reality. The cases were chosen to illustrate the *arrival, confrontation* and *flashback* stages in the new country and the various comparisons, conflicts and difficulties that were reported to affect the refugee and immigrant individual/family.

From the outset, a psychodynamic viewpoint was adopted, and the third aspect – *childhood experiences* – was a key element in this. The effects of *childhood experiences* over the life-course are unique to each one of us. The cases were selected to exemplify how *childhood experiences* affect refugees' and immigrants' lives in the new country.

From the reports of the population, it became apparent that – in addition to *childhood experiences* – the individual and family can also be influenced by a fourth aspect, *relevant background conditions*. According to the individual's personality, the refugee/immigrant – adult, adolescent or child – reported having been affected in one or several ways by components of this aspect. It turned into a key dimension in the framework when it became apparent that there were many other variables essential to study in order to comprehend individuals from these groups. Several components of this aspect could also apply in treatment and care of individuals from the majority population who have made outer changes within their own country (such as age on arrival to a new place, environment, climate, landscape, and educational and socioeconomic changes). Numerous cases illustrate the various effects recounted of *relevant background conditions,* and the difficulties and conflicts to which these can give rise.

A further significant key dimension lies in the fifth aspect of the framework – the *reason* for which the individual/family fled or left the homeland, and the *reason* the new country was selected. At an early stage in the research, this aspect was formulated when it became apparent that the inner consequences the *reason* had on the individual/family in the new country were, for the most part, not being considered by mental-health carers. The inner consequences of the *reason* have been extensively discussed. Perhaps this aspect might also be utilized so as better to comprehend persons from the majority population who have made outer changes. An in-depth case illustrates how the *reason* a person came to the new country influenced actual difficulties, and also complicated the

refugee/immigrant situation and aspects of the framework. It also describes in greater detail the practical application of the framework in psychotherapy.

The final key dimension, the sixth aspect, *transition-related conditions*, contains several components. The differences and similarities in the ways in which each one might affect the refugee or immigrant are discussed. There are some components of this aspect that might also be utilized with persons from the majority population who have made outer changes, e.g. previous experiences in the place of origin, traumatic experiences in relation to these, lowered self-esteem, loss of society of origin, ambivalence, dream of return, and choice of return. Case 10.1, for example, illustrates the *transition-related condition: previous homeland experiences,* and *traumatic experiences in relation to these.* If these *conditions* had not been examined by the psychologist, the difficulties could not have been understood or treated.

From the late 1980s, the literature and research on the refugee, the traumatized and/or tortured refugee, the immigrant and their children have increased considerably. However, the studies seem not to have been based on long-term clinical research, and are not fully comparable with the framework or its purpose in qualified treatment and care.

In recent years, clinical projects and research studies targeted at the support of refugees have been started all over Scandinavia. In some of these, the conceptual framework has been utilized as an instrument in their planning and realization. Over the years, it became apparent that a specific, specialist training program based on the framework for psychotherapic and related supportive work was necessary, which would intertwine actual case supervision and theoretical studies in a process. Part II follows with a description and evaluation of a training program based on the framework.

PART II –THE FRAMEWORK IN A TRAINING SETTING

Part II of the dissertation consists in a description of a year-long training program based on the framework for psychotherapists, psychoanalysts and support workers. The seminar took place 1992-93 in Finland, under the auspices of the Center for Extension Studies at Åbo Akademi University. The nature of the program, and methods of data collection, documentation and evaluation are described. Research evaluations are depicted. In conclusion, there is a discussion of general methodological background, and the lessons of the training program are applied to the conceptual framework.

12. A TRAINING PROGRAM

This chapter acts as an introduction to the training program, its background, planning, structure and realization. The methods of documentation and evaluation are described.

The author came to realize that a specialized training program based on the framework for psychotherapists, support workers and other carers seemed essential. Its goal was to contribute to the expansion of psychological understanding of these groups, and to build up the knowledge, insight and confidence of professionals and others in their work with them. Goals were as follows:

- The main purpose of the specialized training program was to teach the framework and its application in different modes of psychotherapeutic and related support work.
- A further significant goal was to educate the psychotherapist/support worker in how suitably to utilize his/her profession, previous knowledge and experience in the treatment and care of the refugee/immigrant and their children.
- A final goal was for the psychotherapist/support worker to gain insight into how his/her own cultural identity and attitude to persons of different backgrounds can influence the psychotherapeutic and supportive process.

The training program had fifteen participants and took place 1992-93 in Finland, under the auspices of the Center for Extension Studies at Åbo Akademi University. Through lectures, seminars, literature and case supervision, the participants gained insight into the framework and how to use it in treatment and support work. Other relevant themes were taken up in reading material and lectures.

BACKGROUND

In 1991, the author received a letter from Christina Saraneva, a psychoanalyst from Finland who had translated the author's published papers on the framework into Finnish. She proposed starting a training program especially for psychotherapists and psychoanalysts working with refugees/immigrants in Finland. The Center for Extension Studies at Åbo Akademi University was prepared to sponsor and administer the program.

Kerstin Sundman, education planner at the Center, sent out a letter of inquiry to psychotherapists, psychoanalysts and different institutions in Finland to find out whether there was interest in such a program. By the autumn of l992 a sufficient number of applications had been received. Most had worked with refugees/immigrants in Finland and/or internationally, while some had little or no experience with these groups. Several worked exclusively with them, others with both Finns and refugee/immigrant groups. They came from all over Finland, and were of different ages, with varied professions and work experience, employed at different types of institutions. Some had no formal training in psychotherapy or psychoanalysis (see chapter 13).[1]

PLANNING THE PROGRAM

A tentative outline of the program was developed. Before a plan was formulated, the following issues were to be solved after the first meeting with participants: individual and group needs and expectations; type of casework; mode of supervision; the location.

Finland

Finland has a long and painful history of war and oppression – both during and prior to this century. The project leader (the author) was of the opinion that Finnish health-care workers, through their own work experience and their own personal and family history, must have insight into the consequences of warfare, oppression, poverty and emigration, and the traumas and hardships that they cause. Each participant must, in some way, have been affected in his/her personal background by these experiences. This could be their most essential learning instrument in understanding the world of the refugee/immigrant. Therefore, when building up the program, the author suggested that the knowledge and resources and expertise that were already available in Finland be uncovered and utilized. This became a significant goal.

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1 In previous years, the author had had positive results of group supervision with persons of varied work categories and experience. With this in mind, it was decided to go ahead with the training program. The training program and casework supervision were led and carried out by psychoanalyst Christina Saraneva and the author. The research project was conducted by the author, under the supervision of Professor Alf Nilsson, Department of Applied Psychology, Lund University. Kerstin Sundman, education planner at the Center of Extension Studies of Åbo Akademi University, administered and coordinated the program.

Lectures, seminars, workshops, course material, casework and supervision

The training program was to include lectures, seminars, workshops, literature studies and casework. An important part was to be the casework, which would be continually supervised. Due to the varied professions and work experience of the applicants, and the different areas in Finland from which they came, alternative modes of supervision were to be considered, i.e. individual supervision, supervision in smaller groups, or in one large group.

Research goal and participants' contributions

The primary goal of the research project was to depict and process-evaluate the psychotherapies based on the framework carried out during the training program. Because the program applicants were of varied professions, this goal was widened to include process documentation and evaluation of the framework's application to psychotherapeutic and support work.

At the first introductory meeting, the research project and what participation in it would entail was explained and discussed. This was done to determine whether the applicants were willing to take part. Twelve of the fifteen applicants agreed to participate. At the second meeting, the remaining three assented. This meant voluntary participation in:

- continuous oral evaluations of the lectures, seminars, literature, tape recordings after each group meeting, and more extended tape recordings at the end of each term;
- the submission of ongoing oral tape recorded and written summations and reports of casework sessions;
- tape-recorded documentation of the supervision, and continuous evaluation of it;
- the suggestion, throughout the training program, of possible additions and changes to the program;
- responding to three written questionnaires at different points in time – at the final seminar, one month after the conclusion of the program, and six months afterwards – for the purpose of assessing the casework. On the questionnaires, relevant items would be repeated at varying intervals. The questionnaires would enable evaluations on various types of scales and also contain more extensive questions.

It was explained that the material would be destroyed five years after completion of the dissertation.

STRUCTURE OF THE TRAINING PROGRAM

Formulation

The training program was formulated in the light of the purpose of the research project; topics of lectures and seminars were to be chosen to coincide with the participants' needs as they defined them, and also with the evolution of the group's learning and supervisory processes. It was planned that the training program should be developed in stages, according to the needs of the participants. Each participant was to have an active role in its development. Accordingly, only a few of the lectures and seminars and part of the course literature, other material and seminars, and also a tentative time schedule, were planned in advance.

Duration

The training program was to be held over a period of thirteen months during weekends, three to four weeks apart. It would consist of l00 hours of theoretical study, and 70 hours of supervision with a lecture on the framework and its use at each supervisory meeting. Lectures would also be given at five literature seminars and at the four three-day seminars/workshops (See Appendix 2).

Accreditation

The training program was regarded by Åbo Akademi University as the equivalent of twelve study weeks, which could be included in various higher professional specialist academic degrees. A participant had to attend 80% of the program to attain accreditation.

Course literature and material

There were l,600 pages of required course literature (including part I of this dissertation in preliminary manuscript form) and some audio-visual material. Additional books and articles and other material were recommended. The invited lecturers and the participants were requested to suggest literature and other material. The participants were also encouraged to read novels, poetry, and see theater and film about refugees/immigrants. The literature and material were discussed during literature seminars (see Appendix 3).

Literature seminars

The topics of the literature seminars were tentatively planned, but finally decided upon in the course of the program. There were several guest lecturers at these seminars.

Planned topics

The planned themes of the lectures, seminars and workshops were:

The framework

Lectures on the framework were to be given throughout the program – with regard to its use in various modes of psychotherapy and psychoanalysis, and in psychotherapy forms such as art, play and drama, in support work, and also in projects in society. The framework's use was to be illustrated in different phases of crisis, short- and long-term supportive and insightive psychotherapy, psychoanalysis and support work with the individual, family and group. The similarities and differences between utilization of the framework in the treatment and care of the refugee, traumatized/tortured refugee, immigrant, adult, adolescent and child were also to be illustrated. Throughout the supervision, the participants would learn to apply the *refugee/immigrant situation* and aspects of the framework in their own and others' casework.

Psychotherapeutic and support-work processes

As well as lectures on the framework, there were to be lectures and seminars on the processes of psychotherapy/support work and the utilization of different treatment "tools" such as transference, counter-transference, and so on. These were also to be worked with throughout the supervision. Various psychodynamic theories and other psychological viewpoints were to be discussed, as too were other methods appropriate to the treatment and care of the refugee/immigrant adult, adolescent and child.

Two lectures were to be given on dreamwork, followed by a workshop on the participants' own dreams. Subsequently, the dreams of the refugee, the traumatized/tortured refugee and the immigrant, and also working through traumatic experiences in dreamwork, were to be dealt with. Dreamwork was to be taken up all through the supervision in relation to the casework.

Inner and outer qualities necessary

At the start of the program, a lecture was to be given on the qualities necessary for working with the refugee, traumatized/tortured refugee and immigrant. Throughout the supervision, these qualities were to be discussed in conjunction with the casework.

Personal and collective history

At the start and during the whole training program, participants would be encouraged to consider their own personal history and their country's collective history with regard to warfare, oppression, etc. In the classwork and supervision, the participants would further discuss these experiences and their influence on their lives, and also how to use these better to understand the refugee/immigrant. This theme would be returned to in a final lecture on the Finnish personal and collective identity and its inner consequences, to be given by psychoanalyst Martti Siirala.

Prejudice, discrimination and racism

Prejudice, to some degree, exists in all of us and can affect our feelings, attitudes and actions, even those of the most qualified carer (Becker, 1975; Bettelheim, 1943, 1960 and Janowitz, 1950; Kristal-Andersson, 1986). Therefore, during the beginning of the training program and before the start of the casework and supervision, prejudice was to be carefully defined, discussed and worked on.

In the first three-day seminar, one day was to be dedicated to different theories of prejudice, discrimination and racism, how these develop within the individual and group, and the various ways in which the individual and/or group experiences and reacts to prejudice. In group work, the participants would be asked to submit and discuss concrete examples of individual and group discrimination, etc. in their communities and the country. To conclude the seminar, the participants' own prejudices would be taken up – how they evolved, developed, and might influence treatment and care of the refugee/immigrant. This day was scheduled at the beginning of the training so as to permit a forum for the ambivalent or negative attitudes that the worker might have toward certain persons of different backgrounds and to allow these to emerge without guilt or condemnation. Hopefully, this would then create an openness that would continue throughout the training program.

In the supervision, the participants' prejudiced attitudes, as they were revealed in the context of the casework supervision, were to be dealt with – as too was the prejudice in society that affected the psychotherapist/support worker and/or the individual/family or group members that were in treatment/care. How to deal with and work through in treatment and support work, the individual's prejudiced and racistic

attitudes and/or actions would be discussed in the context of the individual's framework.

Cultural identity

The carer may not be aware of, or have reflected over, his/her own cultural identity until faced with dealing with persons from other cultures. In work with refugees/immigrants, the carer must understand the influence that his/her own cultural identity may have. He/she must be able to deal with questions, misunderstandings and conflicts concerning his/her country, culture and inhabitants. Therefore, the psychotherapist/support worker must have insight into his/her own cultural identity as well as that of others. A lecture and group work were planned on this subject at the beginning of the program. It was then to be dealt with continually during the entire process. In the supervision, the participants were to be continuously made aware of the ways in which their own culture may be affecting them or the persons in treatment/care.

Knowledge of cultures

The carer treating a refugee/immigrant should have some knowledge of the individual's and/or family's native country, background and culture. After the start of the program, when the countries and cultures with which the participants worked were known, lectures and/or reading material were to be organized with reference to these particular groups.

Because cultural differences can complicate the treatment process, the carer should acquire knowledge of the specific culture of the individual/family in his/her care, the differences that might arise between them, and how these could affect the psychotherapy and support-work processes. In the training and supervision, it was planned that the participants would learn to recognize these cultural differences and be guided to comprehend, respect, and if possible, accept them. It was regarded as most important to be able to distinguish the samenesses in all individuals and families, despite cultural differences.

Awareness of cultural barriers

Throughout the training program, and especially during the supervision in the context of the casework, the participant would learn to become aware of misunderstandings and cultural barriers, the complications that can came up because of these, and how they can influence the process. The participant was to learn to recognize and be able to work through these

within him/herself and with the refugee/immigrant in treatment. The following cultural barriers are what Barna (1973) has described as the "stumbling blocks" (p. 35) to intercultural communication:

1. Language – with or without an interpreter – ways of expressing things can be misunderstood.
2. Non-verbal communication – lack of comprehension of obvious verbal signs and symbols, such as gestures, postures and vocalization, is a definite communications barrier.
3. Preconceptions and stereotypes – the carer's over-generalized beliefs about an ethnic group, culture, a person of a different color, etc.
4. Tendency to evaluate – to approve or disapprove of the statements and actions of others rather than to try to comprehend the thoughts and feelings and actions expressed.
5. High tension or anxiety – usually present in cross-cultural experiences due to the uncertainties present.

Participants' seminar on a particular culture

Each participant would be asked to choose and study a specific culture represented in the casework and lead a seminar on it. This culture project could be performed individually, in pairs or in a group. The participants were to organize and carry out the seminar in any way in they wanted. There was a compulsory in-depth interview with someone from the culture, reflection on and explanation of how to work in psychotherapy and support work with an individual/family from this culture, and consideration of it in relation to the *refugee/immigrant situation* and the aspects of the framework. It was intended that the various components of the treatment "tool" within the process could develop, and lead to alternative therapeutic prognoses.

Trauma – its consequences and treatment

Different kinds of traumatic experiences and their consequences would be defined and discussed throughout the program, especially in the casework supervision. Various methods of trauma treatment in psychotherapy, psychoanalysis and support work would be described, analyzed and applied within the context of the framework

In the first three-day seminar, definitions of trauma were to be introduced in a lecture, and in the participants' presentation of themselves

through the personal and collective traumas they had experienced. In the supervision, various modes of working through traumatic experiences were to be taken up and illustrated in relation to the casework and in the context of the framework.

Torture methods – physical and mental rehabilitation

Throughout the training program, in the context of the casework supervision and in the theoretical part of the training, the psychology of torture and its consequences were to be studied. Torture methods, different types of imprisonment, oppression and warfare and their physical and mental consequences – especially in the homelands of the refugees and families in treatment – were to be examined. Various modes of specialized physical and mental health care for these groups were to be discussed. A lecture and a seminar on this theme (with a guest lecturer) were scheduled for the second three-day group meeting.

Traumas and torture experiences, their detection and/or symptoms, and possible complications for both the carer and the individual/family that might arise were to be constantly considered throughout the supervision. Utilization of the framework in psychotherapy/support work with these individuals and/or family members was continually highlighted.

Utilizing an interpreter in psychotherapy and support work

A seminar on using an interpreter was to be scheduled as early as possible in the training. In the supervision, utilization of an interpreter in psychotherapy/support work would be discussed in relation to the casework.

Burnout syndrome

It was regarded as essential that carers should have knowledge of the burnout syndrome and its process. Burnout was discussed throughout the training. During the supervision, the participants would learn how to avoid burnout and how to detect signs of it within themselves and their colleagues (Farber, 1980).

Building networks

In contrast to ordinary psychotherapy and some methods of support work, the person working with the refugee/immigrant must at times deal with the individual's/family's outer world in different ways. In this context, contact networks between professionals and others involved with the

refugee/immigrant are most important. One day of the final three-day meeting was to be dedicated to the concept of networking in client work and out in society – utilizing the framework to improve communication between a variety of carers. There would be two lectures on the subject. In group work, the participants would formulate concrete ways of continuing to collaborate in casework and in questions concerning the refugee/immigrant in their communities and society at large. The participants would be encouraged to build a network of their own.

Other lectures, seminars and workshops that evolved during the program

As the training program progressed, and the participants' individual and group needs were further defined, several other lectures and seminars were organized.

Support work, crisis and limited therapies

At the beginning of the program, an experienced social worker was of the opinion that the training program focused too much on long-term psychotherapy. Several participants were working in social work, and limited and crisis psychotherapy. After a group discussion, it was decided that some lectures and a certain part of each supervision would be dedicated to the utilization of the framework in support work and limited and crisis therapies. Several lectures, seminars and group work sessions were then devoted to these themes.

Refugee/immigration laws and policies

In the supervision, in relation to the case material, the worker learned to comprehend and work through the negative effects that refugee/immigration laws and policies may have had on the well-being of the individual/family. However, towards the middle of the program, one participant expressed the need to learn more extensively about refugee/immigration law and policies in Finland. Several others participants simultaneously expressed that need. A lecture and a seminar were organized, given by a lawyer who specialized in national and international refugee/immigrant law.

Group therapy and support-group work

A mental-health nurse working with refugees in groups suggested that more time be spent on the utilization of the framework in group psychotherapy/support work. A lecture and a seminar were organized.

Children and adolescents in therapy and support work

A child psychiatrist expressed her desire that, as well as supervision of her casework with children, more extensive time be allotted to lectures and seminars on work with the refugee/immigrant child and adolescent, and on the application of the framework to these groups. Additional lectures and seminars were organized accordingly.

Support work in a refugee camp

A Finnish psychologist who had recently returned from work in a refugee camp in Malawi was invited to describe her experiences.

REALIZATION OF THE TRAINING PROGRAM

The three-day introductory and second meetings were especially significant. The goals of the training program and research project were explained, and potential participants asked if they were willing to take part on the basis of these. At the second meeting, the structure, location and mode of supervision were chosen. It was hoped that these meetings would create a democratic climate and mode of communication that would continue throughout the classwork and supervision.

Introductory three-day meeting

This consisted of an introductory lecture on the framework, and lectures on the qualities necessary for work with the refugee/immigrant, personal and collective history, and trauma. This was followed by group work on the participants' own culture, and a lecture and group work on prejudice. Time was allotted to map out the needs and expectations of each participant with regard to the theoretical part of the program and type of supervision.

Presentation of the participants and the group leaders

A half day was devoted to detailed personal presentation of the participants and the group leaders. Each participant was requested to present him/herself to the group and asked, to the extent that he/she felt comfortable, to share his/her personal traumas – especially with regard to Finland's collective history of war, oppression, poverty and emigration.

Presentation of the research project

The research project, its goals, the documentation and evaluation, and the applicants' voluntary contributions to it were discussed.

Second meeting – decisions on mode of supervision, structure, schedule and locations

The second meeting consisted of large-group supervision (with all the participants and the two supervisors) and a lecture on the use of the framework in psychotherapy/support work. Alternative modes of supervision were discussed and decided upon, and also dates and location of the program. The program would rotate between three cities, Åbo, Helsinki and Vasa. The supervision would be held in one large group. Each meeting would include five hours of supervision and two hours of lectures. In addition, four three-day seminars and five four-hour literature seminars were scheduled.

Protocol

A protocol of the training program and scheduling of the lectures, seminars and supervision is to be found in Appendix 2.

METHODS OF DOCUMENTATION AND EVALUATION

Data collection and documentation

As stated above, the program consisted of required reading of a preliminary version of part I of this dissertation, and l,600 pages from other books and articles. Certain audio-visual material was also made available. During the program, the literature seminars, lectures and workshops were tape recorded.

Evaluation

Evaluation of the theoretical part of the training program by the participants was carried out via oral tape-recorded reports at the end of each group meeting. Written evaluations were made during the training program, at the end of each term, a month after its conclusion, and in a longer follow-up questionnaire six months after course completion.

THE SUPERVISION

Goals

With regard to psychotherapy and support work with the refugee and immigrant, the goals of the supervision were that participants should learn to:

- utilize their previous training and work experience;
- identify common difficulties;
- deal with specific refugee/immigrant difficulties;

- recognize and respect not only differences, but also samenesses;
- handle complications in therapeutic and support work processes that can come up because of differences;
- recognize and deal with cultural barriers;
- utilize an interpreter and other ways of communicating;
- gain self-confidence;
- avoid burnout.

A further goal was *to develop the supervision according to the needs and expectations* of *the group* and even *the particular ones of a single participant*. Throughout the supervisory process, the participants would be encouraged to define these. As far as possible, the theoretical parts of the training program were to be developed in relation to the supervision process.

In the supervision, the participants would learn how to:

- acquire and assess information about the *refugee/immigrant situation* and the aspects of the framework;
- map out and work with the most prominent symptoms and difficulties;
- recognize the effects of the symptoms and difficulties on the *refugee/immigrant situation* and the aspects of the framework;
- focus the therapeutic process on these, and work through them with the individual/family;
- choose the most appropriate psychotherapy or other method of treatment/care.

Specific factors to consider

There are several specific factors to consider in supervision of the psychotherapist/support worker in the treatment and care of the refugee/immigrant individual and/or family. One of the principal purposes is for the participants to gain insight into the feelings and situations that can arise – ones which that they generally never have had to confront or deal with before. In order to be able to do this satisfactorily, the carer needs certain inner and outer qualities. Crafoord (1988) points out essential qualities for the psychotherapist. These include:

- having undergone psychotherapy or psychoanalysis oneself;

- theoretical and practical knowledge;
- the ability to use the insights gained from the above;
- personal integrity;
- the ability to share, understand, contain and empathize with another person's feelings and experiences;
- the ability to understand and interpret a situation;
- the ability to confront and be confronted;
- the ability to meet aggressivity and criticism;
- flexibility;
- imagination;
- courage;
- endurance.

In addition to the above, the framework implies that certain *inner qualities* are necessary in work with the refugee, traumatized/tortured refugee and immigrant:

- awareness of the effect of one's body language, eye-contact, appearance and attire on the person of a different background;

and the ability to show:

- respect for differences, humility, openness, and carefulness – so that the individual's anxiety in recalling past homeland experiences will not be aroused, until he/she is ready and able to deal with it;

and the ability to recognize and feel:

- universality – based on the belief that, at the very core of their being, people are alike with similar needs and most often suffer for the same reasons.

And the ability to utilize in deeper comprehension of the refugee/immigrant:

- one's personal and collective history;
- knowledge of one's cultural identity;
- awareness of cultural barriers.

The outer qualities necessary are knowledge of**:**

- the refugee /immigrant's country, culture, society and background;
- cultural differences;

- varied methods of psychotherapy/support work;
- the psychology of trauma, and the psychological consequences and treatment of these experiences;
- the psychology of torture, and the psychological consequences and treatment;
- methods of torture, imprisonment, oppression, conflict, warfare in the individual's/family's homeland;
- utilization of an interpreter;
- national and international refugee/immigrant laws and policies.

Mode of supervision

Co-supervision in a large group

Due to financial restraints, it was decided that supervision in a large group was the most realistic alternative. At the start, a few of the participants wanted individual supervision, while others wanted small-group supervision in their local areas, so they would not have to travel. Only a few had experience of large-group supervision. When the costings and the learning process for the alternative modes of supervision were discussed, it was decided to pursue casework supervision in one large group throughout the training program. Another factor considered in choice of this mode was the fact that Finland is officially a bilingual country (with inhabitants largely speaking Finnish but also Swedish). The program was to be held in Swedish and English.

Documentation of the supervision

Among the works especially considered for researching the supervision were Berg Brodén (1992); Dewald (1987); Ekstein and Wallerstein (1958); Fleming and Benedek (1966); Kirk and Miller (1986); Lambert (1980); Langs (1979); Patton (1980); Szecsödy (1990); and Wallerstein (1981).

Data on group supervision consisted of fifty-six ninety-minute tapes, tape-recorded and written evaluations, and questionnaires (see Appendix 5). The participants were also asked to submit ongoing tape-recorded oral and written reports and summations of their casework sessions (see Appendix 4). The fifty-six recorded tapes of the supervision have been transcribed. Written evaluations and questionnaires have been coded.

Evaluation of the supervision

The supervision was evaluated at the end of each group meeting by the participants, at the end of each term throughout the program, at the final meeting, and one month and six months after course completion. The oral evaluations were tape recorded. In addition, written questionnaires designed by the author were employed (see Appendix 5).

13. CASEWORK IN THE TRAINING PROGRAM

This chapter describes the casework of a training program based on the conceptual framework. It provides a background to the selection of casework, and methods of documentation and evaluation. Six cases and two examples are documented in detail to illustrate aspects of the framework and its application. The chapter concludes with a discussion of the casework.

The casework of the participants began during the second meeting and continued throughout the duration of the training program. Twenty-two cases were supervised.

Participants

The fifteen participants of the training program included:

- one psychoanalyst – in private practice, doing psychoanalysis, psychotherapy and supervision;
- two child psychiatrists – working at children's hospitals, one also involved in supervision;
- five psychologists – one working privately; another, at a mental-health center affiliated to a large general hospital with adolescents and adults; the third, an assistant psychology professor; the fourth, director of a refugee reception center; the fifth working at an employment center;
- four psychiatric nurses – three working at mental-health centers; the fourth at a refugee reception center; one also employed by the Red Cross;
- three social workers – one working at a refugee crisis center; another at a social office for refugees; the third, a research assistant.

Cases

Finland has strict regulations in allowing refugees and immigrants entrance and asylum. Persons seeking refugee status or those who have received it often have difficult, complicated and traumatic past homeland experiences. These persons usually need mental and physical treatment/care on arrival and afterwards. The immigrants residing in Finland are few, and usually highly educated and/or living with or married to a citizen of Finland. Five of the participants worked with refugees who were waiting for asylum, the others worked with refugees and immigrants who had already been granted residency. It was

suggested that each participant should start or continue to work with one or two cases, and describe them continuously throughout the supervision to illustrate ongoing developments. However, those who wanted to discuss a particular case on any one occasion of supervision could do so. The cases could be of adults, child and adolescents, and/or families in crisis, in short or long term psychotherapy, psychoanalysis and/or support work.

Some of the participants were employed at institutions and easily could procure cases for supervision. When it became known that they were on the training program, they received referrals from mental-health centers, hospitals and other institutions in nearby areas. One participant received an individual of immigrant background for psychotherapy from the government health-insurance authorities. Three participants were without cases at the beginning of the program. Two of them, because of personal circumstances, could not take on casework during the program. The participants' casework was carried out in the areas where they worked and resided. Several community projects were discussed, organized and started.

The twenty-two cases and the different types of casework are listed in table 13.1 overleaf. Six cases and two examples are presented. Factual descriptions have been slightly amended to protect anonymity.

Implementation of casework supervision

Supervision was conducted in five-hour blocks – every third, fourth week over thirteen months. Usually, four or five cases could be supervised during each meeting. A case was allotted 45-60 minutes. Each participant could take up their case(s) and receive supervision as well as comments and opinions from the supervisors and the other participants. At the start of each supervision, brief reports were given by the participants about the development of the cases that were brought up in the previous supervision (if these were not going to be brought up that day). Psychotherapies were taken up first, followed by support work. Some of the cases were supervised continually throughout the training program, while others were taken up either one or several times. At the end of each supervisory session, time was allotted to mirror feelings, thoughts and suggestions for improvement.

Table 13.1. Casework by type, worker, and symptom/difficulty. Summations of and excerpts from the casework.

Type	Worker	Case	Symptom/difficulty
PSYCHOTHERAPY			
CRISIS			
Adult	Psychiatric nurse, mental health center	Female refugee, 29, Bosnia	Hallucinations, panic
Child	Child psychiatrist, hospital	Refugee girl, 4, Somalia	Passive, regression
Family	Psychiatric nurse	Female refugee, 26, 2 minors 3, 5, and mother, 53, Somalia	Psychotic feelings, abusive behavior
TIME-LIMITED			
Adult	Psychiatric nurse, reception center	Female refugee, 39, and 3 minors 12, 10, 5, Bosnia	Depression
Child	Child psychiatrist, hospital	Refugee brother/sister, 11, 8, Vietnam	Psychotic behavior
SUPPORTIVE PSYCHOTHERAPY			
LONG-TERM			
Adult	Psychiatric nurse, mental health center	Male refugee, 38, Bosnia	Depression, insomnia
Adult	Psychiatric nurse, hospital	Female refugee, 27, Somalia	Psychotic behavior, physically abusive
INSIGHTIVE PSYCHOTHERAPY			
SHORT-TERM			
Adult	Psychologist, mental health center	Male refugee, 20, Kurd/Iraq	Panic, fear
Adult	Psychologist, mental health center	Female refugee, 33, Iran	Depression
Adult	Psychoanalyst, private practice	Male immigrant, 28, Egypt	Physically abusive, followed by depression
SUPPORT WORK			
CRISIS			
Adult	Psychiatric nurse, refugee reception center	Male refugee, 29, Bosnia	Psychotic feelings, panic
Adult	Social worker, refugee crisis center	Male refugee, 28, Kurd/Iraq	Psychotic behavior, suicide attempt, depression
Youth	Psychologist, employment center	Male refugee, 18, Somalia	Depression, passivity
Family	Psychologist, reception center	Refugee family, male 35, female, 29, 3 minors 7, 9, 11 Bosnia	Father refuses to allow children to attend school
Family	Psychologist, reception center	Refugee family, male, 30, female, 25, Somalia	Depression
TIME-LIMITED			
Youth	Psychologist, employment center	Male refugee, 19, Vietnam	Passivity, lack of interest
Group	Psychologist, employment center	Male refugees (17-21)	Difficulties getting started in Finnish society
Group	Social worker and psychiatric nurse, community project	Female refugees (20-23)	Difficulties with life in exile
LONG-TERM			
Adult	Psychologist, reception center	Male refugee, 30, Somalia	Aggressive, then depressed
Adult	Social worker, social office	Male refugee, 29, Rwanda	Physically aggressive
Adult	Social worker, crisis center	Male refugee, 30, Kurd/Iran	Depression
Family	Psychiatric nurse, reception center	Refugee family, female 31, 2 minors 13, 8, Lebanon	Depression, oldest boy aggressive

Methods of documentation and evaluation of the casework

Casework data consisted of tape-recorded oral reports from the psychotherapists and support workers during the supervision. Written reports of the sessions were compiled by the psychotherapists and support workers. A form constructed by Malan (1959, 1976, 1979), and translated and modified by Maini and Nilsson (1983, cf. also Stenlund, 1996) was employed. Further questions on the session-report form with regard to the components of the framework and treatment process were formulated by the project leader (author). In addition, several questions about the casework and its results were asked orally, and then inserted into the three questionnaires. Copies of the session reports and questionnaires are shown in appendices 4 and 5.

As well as carrying out the oral and written casework evaluations throughout the training program, the casework was assessed in the three questionnaires utilized at the final seminar, one month after the program's conclusion, and in a follow-up six months afterwards (see Appendix 5).

Summations of and excerpts from the casework

Summations and excerpts from eight examples of the casework in the training program follow, including three abbreviated examples of the participants' written session reports (cases 13.1, 13.2. and 13.3 below). See Appendix 4 for the report forms used. All excerpts are from material tape-recorded during the supervision. They were selected by the author to exemplify aspects of the framework, and vary in length according to the kind of explanations required.

Case 13.1 – insightive psychotherapy, short-term

Duration: 12 months, once a week

Therapist: Female psychologist/psychotherapist for adults and adolescents, age 30

Patient: Male refugee, age 20

Summary of the therapist's three written session reports

First written report (after session 1):

Case summary: A male refugee, from Iraq/Kurdistan, age 20, single, studying Swedish, a teacher in the homeland, high-school education, politically active. He came to Finland a year ago, quota refugee status; family in homeland: father, (he was 5 years old when his mother died), 3 sisters, one imprisoned because he fled.

Symptoms: (Individual's description) "Breathing difficulties, palpitations, anxiety attacks, panic in situations of stress, alone, with people, when angry or sad; nightmares that I can't remember, I wake up sweating; forgetfulness. Symptoms started 4 years ago when I was 16 after a terrorist attack in my village. Now, the attacks come less frequently, but they are still a severe problem for me."

Referral: From a district medical center.

Previous help for problem: First visited a local medical center, and was sent to a district mental health center, where he received medication from a psychiatrist, but he feels it did not help.

Decision to undergo psychotherapy and motivation: He is not really clear about what therapy involves, or what to say during the sessions. He hopes that by understanding the symptoms psychologically, they can be alleviated. The therapist explained that psychotherapy is about what is going on within oneself and learning to understand and express one's own feelings. Then he said, "but I don't know what you want".

Significant comments and observations during the introductory session: "I want to live in peace and quiet and avoid conflicts." "I'd like to study and then be able to go back to my homeland and help my people."; "I worry about my family – but I try not to think about them as it makes me anxious."

Indications for time-limited psychotherapy: He has good intellectual abilities as well as the ability to express himself; and will be able to undergo treatment for about a year (Treatment could be supportive, clarifying, not too deep).

Individual's goal for treatment: Symptom alleviation; to be more at peace with himself; to be able to study and become better equipped to help his people in the homeland.

Therapist's goal for treatment: Symptom alleviation; he wants to educate himself and finally be able to return to his homeland and help his people. I try to acknowledge that he could work to achieve his ambition and be a part of Finland, too. I would like to guide him to be better able to function in his new country.

Second written report (sessions 2 and 3):

Focus of the sessions: Difficult memories of past experiences awaken anxiety and panic within him. He wants to try to forget them so that he can function in his daily life; he has feelings of confusion, hate, anger and sorrow. He experiences these in his dreams and nightmares, which he cannot remember. The importance of daring to meet these feelings within himself. He has the will to continue to struggle. His identity as an adult in Finland.

How does the individual relate to or how is he influenced by the components of the framework: *Refugee/immigrant situation*: He feels like a second-class citizen, unconsciously willing to give up part of his identity

by saying to the therapist "It will be easier for you to call me Esko," which is a Finnish name, instead of his Kurdish name. 1. *States of being*: *the stranger, loneliness, missing, longing, inferiority, guilt, sorrow, loss of identity.* 2. *Adaptation cycle*: Seems to be at all the stages – *arrival, confrontation* (mostly), *flashback.* 3. *Childhood experiences*: Mother's sudden death when he was 5 years old. Since then feelings of loneliness and of being an outsider, even in his own family. At an early age he was forced to take care of himself and "be like an adult". The second youngest of 4 children. His father is still alive. One sister is in prison because he escaped to Finland. Otherwise, he knows nothing about his family. 4. Relevant background conditions: *culture* – belongs to an oppressed group, has struggled for the Kurdish people's rights to their culture and language. At 9, he was chosen by the village teacher to go on to further education. Six months before he was forced to flee he was in a special teacher's education program for Kurds. 5. *Reason*: Active in society, teaching the Kurdish language and culture, forced to flee; cannot return. 6. *Transition-related conditions*: Conditions under which he fled: as a teenager, forced to flee his village; fled to Turkey, and then to Finland; *traumatic experiences*: early loss of mother; *experiences of torture, imprisonment, loss of relatives, friends*: family members and friends imprisoned; conflicts with other Kurdish groups; *lowered self-esteem*: *"*second-class citizen"; *ambivalence*: "There was nothing else I could do;" *loss of society*: guilt feelings, sorrow; *dream of returning*: "…to help my people".

Therapist's thoughts directly after the session: This will be difficult; because of differences in cultures; will I be able to understand, contain and deal with the difficult experiences he has had in the homeland and as a refugee in Finland? Confused feelings.

Hypotheses about the "core-problem": Early loss of mother as a 5 year old, loneliness, an outsider since then; feelings of anxiety and panic return in stressful situations; unclear identity, especially in relating to women; intellectual, had early in life to assume the responsibility of and act like an adult; alienation as a refugee in Finland; has left his homeland, family and relatives "but does not want to reflect on it, as it is too painful."

Third written report (after last session):

I. Core-problem:

A. Basic desire/fear: Dependence/fear of it; no close relationship with anyone after his mother's death when he was 5 years old. Difficulty in showing feelings and accepting weaknesses, vulnerability and painful feelings: anger, disappointment, hate and sorrow, which in turn create panic, anxiety and breathing difficulties.

B. Organization of self-integrating defenses maintaining self-esteem: Strong cultural identity and feeling of belonging to "his own people"; ability to struggle, believe and hope; to intellectualize; to repress difficult feelings and conflicts (can express them in poetic form).

C. Feelings/states of mind experienced by the individual and verified by the therapist: Alienation, being an outsider, a second-class citizen, inferiority, oppressed in his own country as a Kurd, in Finland as a foreigner. Being in danger; guilt feelings about having left the homeland, about his people, and his sister's imprisonment. He has difficulty in verbalizing feelings – especially when we speak Finnish, perhaps because of lack of language ability, but writes poetry and can express his feelings in Kurdish.

D. How does the *refugee/immigrant situation* influence the neurotic complex: Feelings of alienation, loneliness, desertion, anxiety, panic and breathing difficulties, in both Finland and the homeland; he struggles to adapt to and survive in a foreign culture and unknown society, and is open to the new; but feels sorrow over the loss of the old and familiar, repression of difficult feelings and conflict.

E. Which of the six components of the framework add to or still influence the core-problem? 1. *States of being*: *the stranger, loneliness, missing, longing, inferiority, suspicion, guilt, shame*. 2. *Adaptation cycle*: second stage: *confrontation*, *flashback* to what is missed. 3. *Childhood experiences*: mother's sudden death at an early age. 4. *Relevant background conditions*: *culture* – Kurdish. 5. *Reason*: forced to flee, did not want to. 6. *Transition-related conditions*: *traumatic experiences*: loss of mother; loss of homeland, family and friends; relatives and friends imprisoned; conflicts with other Kurdish groups; *dream of returning*.

II. Symptom improvement combined with a certain improvement of the core problem: Relief from panic and breathing difficulties; improved ability to recognize, meet, express and verbalize feelings about the past and present, and see the relationship between past feelings in present situations, as regards his *childhood experiences* and history – and draw parallels between then and now; improved ability to understand his identity as a refugee and Kurd in Finnish society, and to examine his relationships with women.

Reason for ending psychotherapy: Was accepted into university in another city.

III. Therapist's evaluation of the psychotherapy (scale 1-4)**:** 3 *Now*, shorter time-limited psychotherapy; 4 *if a longer time* in psychotherapy had been possible.

Excerpts from the taped documentation of the supervision

From sessions at the beginning of psychotherapy:

The following excerpt describes the individual's feelings of non-identity, which could lead to the *state of being*:

T: "In the first session, I asked him what I should call him. He gave the Finnish name Esko. That felt strange as his name was not Esko, but a Kurdish one. He said it was simpler in Finland as everyone can say Esko, and for him it didn't mean anything as he knows who he is anyway. At

first, I had a difficult time pronouncing his Kurdish name, but I insisted on using it. It felt impossible for me to call him Esko. I couldn't do it." Supervisor 1 (S1): "His identity and how he feels in Finland may be something you could go more deeply into. He does exactly what many refugee/immigrant children/adults tend to do when they start school or a job. They ask to be called something typically native to the new country. The teacher or employer complies to make the person feel more at ease or because they, too, think it is easier. The child/adult is unconsciously trying to belong to the new society. He says he knows who he is, but it seems to me that somewhere within himself he is not sure who he is in the new country. It is unconsciously or consciously a way of denying one's identity." T: "Intuitively it felt so wrong to call him Esko. I acknowledged that he wanted to be called Esko, but said that I preferred to call him by his Kurdish name. He was okay about it. Since then we have not discussed it, but it is something that is always actively there." S1: "It will certainly come up again. Someone who has been so active for most of his life teaching the Kurdish culture, language and identity, is beginning on an unconscious level to deny it."

The therapist gathered information about the individual's *childhood experiences* especially in the context of the presented symptoms:

T: "He went on to talk about how he felt in his family. After his mother died he was brought up by his sisters. He had always felt an outsider and different, because he was the only one that was politically active."

Core childhood experiences problematic present in life in exile: S1: "Perhaps the panic of feeling alone when his mother died when he was 5 years old has come back once again, as it did when he was a teenager in his homeland. Perhaps this should be dealt with in your work with him."

Components of the *refugee/immigrant situation*:

Social situation in exile: T: "He acts like a person who wants to become part of Finnish society, and is open to Finnish people." S1: "Does he have friends?" T: "He has a Kurdish friend, but he explained how full of conflict contact can be between Kurds here. He has one real friend, he said." S1: "He lives alone?" T: "Yes." Supervisor 2 (S2): "Does he have a girlfriend?" T: "No, he doesn't, and I think that is a large and difficult area – girls and sexuality have not been touched upon. He explained that women in his country are looked down on and he has always resented that. He was surprised at the first question other Kurds asked him – what he thought of Finnish women. He was provoked. What could he know about them?" S1: "We must remember that compared with Scandinavia, sexuality is almost a forbidden subject in other countries. I am careful when raising a subject with a person from a different culture, trying to reflect on what sort of reaction it could provoke in him/her if I am unsure."

Finnish youth gang attacks: T: "He had received a telephone call from home and read a letter from his sister over and over again alone in his apartment, and then went out to have a beer. On his way home he was stopped by a gang of youths in the center of town. They asked why he was here in Finland, walking on their streets. He said, he was on his way home. He always walked that way, he explained to them. He thought it was a joke. This is my country, one of them said. I am on my way home. I'll go now, he said. I'm the one who tells you when and where you should go, said a member of the gang. Then the youth knocked him down. There were people around. A Finnish man came up and defended him, telling the youth to leave him alone. Then this man was knocked down. Other people stopped the fight. The thing that most upset him, he explained, was that the Finnish man who defended him was also knocked down, and that was what he thought about all the time. He had encountered prejudice before he said, but not violent prejudice and what he could not understand was that the Finnish man was beaten up, too. After this incident, he has isolated himself more and more. However, he explained, it would not stop him from continuing with his studies or plans for the future." S1: "What were your feelings when he told you this?" T: "I became angry, full of sorrow and I felt ashamed. Because this prejudice is a reality in Finland and something that happens all the time. It is one thing to know that, but it is another to hear someone you know tell you how it feels to be affected by it. I felt ashamed that my countrymen had acted like this. I don't fully understand my own feelings." S1: "He mentions that he was most upset about the Finnish man who defended him being attacked. Could he in someway be referring to you?" T: "Now I see. It has something to do with our relationship. I am helping him too." S2: "Something tragic is repeated. He is putting you in danger as he put his family in danger." S1: "You should perhaps delve deeper into this and make him aware of it, when he trusts and accepts the therapeutic alliance. How many people really are in danger because of me, my identity and my political convictions; and how much of it could be in my imagination."

The individual's feelings of being the stranger or an outsider as a child and at present which could turn into a *state of being* are discussed:

S 1: "He gets a telephone call and letter from home, then is beaten up by a gang of Finnish youths. This chain of events makes him feel like *a stranger* or an outsider. Then, he reveals that since childhood he has felt like an outsider. This chain of events reinforces the psychological feelings of alienation and could lead to his experiencing the *state of being: the stranger.* He expresses his psychological alienation; at the same time he seems to need to be an outsider. Why?" Participant (Gm): "Perhaps his feeling of being an outsider at home led to his becoming the only one in the family who is politically active."

When the refugee feels suspicion: T: *"*He fears that someone here from his homeland wants to hurt him." S1: "It is sometimes difficult to

decide whether a refugee's feelings of persecution are based on reality. Are they feelings based on the unknown of life in exile, the *refugee/immigrant situation* or the *state of being; suspicion* or are these feelings based on the individual's reality now or in the past? We must accept his suspicions and wait until he can or will give more details about what his work involved and why he is so afraid, in order to decide whether his fear is based on reality, an exaggerated experience of it or fantasy. However, it is of the utmost importance to respect the refugee's experience of his/her reality at least until we know more about it."

Working through primarily the presented difficulties: S1: "It is important that you as a therapist are there for him and that he tells you as much as he wants to tell you to help him express himself and ease his symptoms. Working with his current problems in Finland, for example his Kurdish identity here, will lead to his gaining trust in you and deciding whether he wants to tell you more about his political background and life. A listening, accepting attitude on the part of the therapist at the beginning of psychotherapy is the best way of handling the situation. What you do not know does not matter as yet. It may be explained later on when he trusts you. It can be more difficult to work in psychotherapy with refugees because what sounds like paranoid fear may in fact be justified."

Middle phase of psychotherapy:

T: *"*As to the *refugee/immigrant situation,* he has difficulty with life in the new country due to the situation in the homeland. He spoke of the sorrow and pain he felt about what is going on in his homeland right now while he is trying to make a start in Finland trying to educate himself and find a place here. He also started comparing city life herewith that in his country. In one session, he was silent a long time, and when I asked him to share his thoughts with me, he said that he was thinking about the difference between spring here and in his country. There it is already hot in the spring. He described the mountains, the countryside and the clean air. I asked him what most impresses him about Finland. He said the 6 months of darkness and cold, and that it had something to do with the contact between people. In Finland people turn away from each other and are suspicious of one another."

Final phase of psychotherapy:

The individual shares with the therapist *transition-related conditions: previous traumatic homeland experiences*:

T: "He spoke for the first time of his imprisonment at 16 years along with 2 friends, a boy and a girl. He was forced to watch the girl being raped by several men. He couldn't stop it and felt it was his fault. He escaped and found out that his friends finally did, too. He then talked about what he did as a teenage revolutionary. The symptoms started then, but he thought it was something somatic. He had no awareness then that he was afraid. Several times during these sessions he said that it awakens

so much inside him to remember this period of his life, and he doesn't want to remember. At the same time, he does now and is able to reflect and talk about it. I say very little, as I know the psychotherapy is close to its end." S1: "He is so young, and I understand that he had to repress *past traumatic experiences,* memories, losses and feelings to survive. At the same time, he has been using his energy in constructive ways even in Finland, and now he has been accepted into university. He can express himself intellectually and in poetry, and I think you handled it well not pushing him to go more deeply into his feelings, especially as it is not a long-term therapy. It could have woken deep despair and anxiety within him. I am still not sure he could deal with it. If there had been more time you could have gone more deeply into his shyness and sexuality in relation to women, now even more complicated knowing he saw his female friend repeatedly raped. He blames himself, and it may give him a negative feeling about his own masculinity. However, during the therapy he has made several female (and male) Finnish and Kurdish friends, and that is a constructive development."

S1: "Does he discuss his symptoms any more?" T: No, but he describes how he felt before he began therapy, when he first came to Finland and was listening to a radio broadcast and heard that a party leader had been shot and killed while at a meeting in Europe discussing the Kurdish situation. This was someone he respected and admired, who always gave hope and belief to his people. When he heard the news, he fainted and was unconscious for over 6 hours. Then he woke up feeling panic, with breathing difficulties and the other symptoms he eventually had to get help for. Now he understands that learning of the death of this leader recalled what he must have felt when he lost his mother."

The final session:

T: "He came early. We sat quietly together during the first minutes. Then he said that this was the last time and that it was difficult for him to express how sad he felt about it. At the same time, he knows he is on the way to something new and challenging. He talked about moving and said it was easier than other times when he was leaving his home and family, then his homeland. Now he feels free and knows he can and will be coming back to visit friends. It does not feel the same as leaving somewhere for good. Then he recalled that he never said farewell to his family and it was an involuntary move which he could not even prepare for, so different from the change he is making now. I tried to convey how stimulating it was for me to work with him and that he will always have his inner resources, talents and abilities to take with him wherever he must go. It feels empty for me now in one way, but also hopeful that life is developing constructively for him. I feel he is going to make it, and that this contact has been good for him."

Comments of the project leader (author)

This was the first time the therapist had worked with a traumatized refugee. She had limited knowledge of Kurdish culture. The young man's symptoms were typical of the traumatized/tortured refugee. The therapist applied the framework to the psychotherapy and focused it on the *refugee/immigrant situation,* the *states of being,* the *adaptation cycle,* and *transition-related conditions.* In mapping out the individual's *refugee/immigrant situation* and the aspects of the framework, the therapist could use the information to connect *childhood experiences, transition-related condition*: *past homeland experiences* and the traumas because of these, and the *dream of return*, to his reactions to present events in the new society. During the supervisory process, the therapist was able to work through her feelings of counter-transference. The treatment goals of both the therapist and the individual were achieved; that is, to alleviate the symptoms and to enable the individual to function better in the new society.

Case 13.2 – Insightive psychotherapy, short-term

Duration: 10 months, once a week

Therapist: Female psychologist/psychotherapist for adults, age 43

Patient: Female refugee, age 33, married, one child

Summary of the therapist's written session reports

First written report (after session 1):

Case summary: A female refugee, from Iran, age 33, married, a son, 12 years old, quota refugee status, 2 years in Finland, grade-school education, a shopkeeper living with her husband in a medium-sized town, forced to flee because of Kurdish background.

Referral: From a doctor at a district medical office to a mental health center.

Symptoms: (Individual's description) "Sad, cries often; heart pain; breathing difficulties; difficulty with movement in one shoulder, and pain after an operation; easily irritated, especially by my child"; worries about the family's economic situation in Finland; the difficulties became more severe when a sister in Finland moved to another city. They have telephone contact (but telephone bills cause further stress). Continuous longing for her family in the homeland, "cannot think about anything else".

Previous treatment: In Iran and in Finland, temporary help through medication.

Decision to go into psychotherapy and motivation: She has had a difficult time since she came to Finland. Now she does not know what to do – "needs all the help she can get," she says, "medicine may be a

temporary help, but doctors or the social office can't help me. What is wrong with me?"

Significant comments and observations during the introductory session: "It would be better to be back in Iran or perhaps to move somewhere else in Finland, or to another country." Her mother died when she was 6 years old. Father remarried. She has a close relationship with her second family. Relations between her husband and her seem good. He was the interpreter. Whether she is willing to have an outside interpreter or not is still not clear. She wants to wait before making that decision.

Indications for time-limited psychotherapy: Seems to have resources for psychotherapy, honest and able to express feelings and thoughts. Needs to regain her self-esteem and her belief in the future.

Individual's goal for treatment: Symptom alleviation; to be healthy, not have continuous mental and physical pain, not be sad and cry all the time, and be able to work.

Therapist's goal for the therapy: Give time and space for her to work through her sorrow and pain over fleeing the homeland, and to adapt to life in Finland; see her able to function in everyday life again.

Second written report (sessions 2 and 3):

Individual's status at the beginning of the sessions: Comes with her husband; she looks sad, expectant; tries to speak for herself as best she can in Finnish and English; her husband helps with interpreting.

Focus of the sessions: Differences between Finland and Iran; feelings of loneliness – her sister has moved to another city; her shoulder makes it impossible for her to work; irritation with her son – she wants everything in order; her fatigue; she wants to be left in peace to think in silence. She thinks mostly about her family in Iran and her shoulder pain.

How does the individual relate to or is influenced by the components of the framework?: *Refugee/immigrant situation***:** Differences between Iran and Finland. 1. *States of being*: She is going through nearly all of them, *longing, missing* are severe. Most of the *states of being* are based on reality, some on an exaggerated perception of it. 2. *Adaptation cycle*: *arrival, confrontation*. 3. *Childhood experiences*: Mother's death at 6 years old. Family closeness had been a significant support. 4. *Relevant background conditions*: *culture* – Kurdish. 5. *Reason*: Kurdish background, husband politically active. Conditions under which the individual fled**:** suddenly and quickly; within 24 hours her family and her sister's family fled. 6. *Transition-related conditions: past traumatic experiences*: her brother was shot and killed 5 years ago because he was against the regime's treatment of Kurds; *ambivalence*: wants to return to the homeland; *lowered self-esteem*: does not have any; does not understand anything in the new country; unable to manage daily life here; *loss of society*: everything is new and different; *dream of returning*: it prevents her from having any desire to try to get to know the new society. "What would you do if you went back to Iran?" I asked. She has difficulty

thinking of or seeing any alternative other than returning to her family in Iran that has always supported and helped her. Now, even here, one sister in Finland has moved out of town.

Therapist's thoughts directly after the session: This is difficult; many inner and outer problems, one on top of the other. But this woman should be able to get therapeutic help; to find herself in the new country and to cope with daily life again.

Hypotheses about the "core-problem": Past and present *loss* – of mother, brother, family and homeland (causing sorrow – pain, depression, anxiety); *loss* of her sister in Finland; *loss* of work capacity; identity, *loss* of whole self (family so important to her identity); feeling of loneliness, and that no-one understands.

Third written report (after last session):

I. Core-problem: *States of being: separation and loss, loneliness*.

A. Basic desire/fear: To return to the homeland, to the secure family network; not being able to manage; completely losing herself and not being able to function, being no one and having nothing, falling back to the way she was a few months ago.

B. Organization of self-integrating defenses holding up self-esteem: Control: to be able to care for and structure everyone and everything around her. "Here, I am sick, therefore I can't do anything." Thinks about how she was in Iran. She could do everything. "Here in Finland I have the feeling that everything I do is wrong. I can't do anything here."

C. Feelings/states of mind experienced by the individual and verified by the therapist: Mourning; sorrow; anxiety; depression; confusion ("what am I suffering from?"); physical pain; worry about the future ("How will I manage?").

D. How does the *refugee/immigrant situation* influence the neurotic complex? The *state of being: separation and loss* is always present. She feels she has lost everything, and is now wholly dissatisfied with herself as a mother and wife in the only family she has left.

E. Which of the six components of the framework add to or still influence the core-problem? All of them! 1**.** *States of being*: All the *states of being* but especially *the stranger, rootlessness, loss of identity, separation and loss, sorrow, missing, longing.* 2**.** *Adaptation cycle*: *arrival* and *confrontation* stages. Great difficulties with adaptation. 3. *Childhood experiences*: mother's death when she was 6 years old. 4. *Relevant background conditions*: *culture* – Kurdish. 5. *Reason*: husband's political activities. 6. *Transition-related conditions: traumatic experiences*: Loss of mother, murder of brother (start of symptoms: depression, anxiety); *ambivalence*: Was it worth all the change and the loss of family? *lowered self-esteem*; *loss of society*; *dream of returning.*

II. Symptom improvement combined with a certain improvement in relation to the core-problem: The physical symptoms improved, and she

has a better understanding of the core-problem. *States of being: separation and loss* and *loneliness*; depression and sadness somewhat alleviated. She gets sad, but can think about other things not just her family in Iran and her past life there. She is no longer as impatient with or irritated by her son, and their conflicts have lessened. She is working again and functions in daily life. She and her husband have rented and run a dry-cleaners. She has made new contacts with people and seems less depressed.

Reason for ending psychotherapy: She and her family decided to move closer to her sister in Finland, and find similar work there.

III. Therapist's evaluation of the psychotherapy (Scale 0-4): 2 3 ("I would rate the psychotherapy between 2 and 3, closer to 3.").

Excerpts from the taped documentation of the supervision

From sessions at the beginning of psychotherapy:

The individual's framework in the context of the presented symptoms:

The *refugee/immigrant situation*: S1: "In what ways has the *refugee/immigrant situation* affected her?" T: "She has lost her work identity and self-esteem. She and her husband used to have a large store in the city they came from. When she speaks of it, she lights up. It was a successful one and she had good contact with her customers. She was never alone, as she is now. She says she lost everything when they fled. We have nothing. We had a good life there. I had my whole family there. I miss them so much. We had a big, modern house and a car. Now, we live in one room, without a kitchen and all I do is worry about money. I can't even work anymore. My shoulder hurts so much."

The *reason*: T: "I believe the *reason* and the way she fled influence her symptoms and problems, the *refugee/immigrant situation* and the *states of being* that she is going through. She explained that it all happened in one night. She had no time to prepare or even to say farewell, as the secret police came into the store and threatened to imprison her husband if he was not willing to give them information concerning 'Kurdish terrorists' in the area. Five years before they shot and killed her brother. That is when her depression and anxiety began, she explained." S1: "What were your thoughts when you heard that?" T: "I felt frightened. My difficulty was understanding if the fear and uncertainty I was feeling was my own or was a reflection of hers." S1: "She is depressed because of all she went through in the past. What is their situation in Finland?" T: "They are both unemployed. He has taken the required courses in Finnish and has been placed as an apprentice in several stores, but they do not want foreigners. She has been so depressed and in such physical pain that it has been impossible for her to continue language classes. She went for a few months. Their l2 year old son likes school, is doing well and has made friends. But he is always angry with her, she explained."

The therapist emphasizes that the individual's *refugee/immigrant situation* influences the symptoms:

The next supervision:

T: "I believe her depression has a great deal to do with her *refugee/immigrant situation.* The atmosphere during the past sessions has been heavy and hopeless. She is afraid she will never be able to manage life here and be healthy enough to work. Sometimes there are pauses and we sit in silence." Gm: "Does she have suicidal thoughts?" T: "Not directly, but she has said that it would be best for her and her family if she was dead. She would be rid of her physical and mental pain, and they could get on with life. She suffers so much." S2: "Is it possible to let her know that you believe she has the resources to cope with life even here just as she could in Iran? Or is she too depressed to hear that?" T: "I tried to do that, but I don't know if she accepted it." S1: "There does not seem to be an immediate risk of a suicide attempt, but it is important for her to express her feelings about wanting to give up and that you are there to listen." T: "Sometimes she comes in and just cries. I sit opposite her and feel her inner pain and deep sorrow. I feel a closeness between us. She just feels I am near. I don't have to say anything." S1: "How does it feel?" T: "It feels very difficult and at times hopeless. She is a resourceful woman who has lost so much leaving her homeland. Neither she nor her husband seem able to get started here. There is no work for them. They live in an outmoded one-room apartment, and had a large, modern house in Iran. That is one of the reasons she is always so irritated with her son, she explained, he has no place to move around."

T: "Her husband no longer takes her to the sessions. At first, she was afraid she could not come here herself by bus and train. But now she uses public transport and has decided to restart her Finnish language lessons." S1: "Your belief in her resources, your respect and willingness and determination to understand and offer her support has made her more independent and open to the new society. You have become a woman friend as well as a possible representative of your society, perhaps a role model as well as a therapist."

Role of the therapist in networking with other carers**:**

S1: "Do you feel she exaggerates the discomforts of her living conditions?" T: "Frankly, no." S1: "Can something be done about it?" T: "The family has a refugee coordinator involved in organizing their practical life. I could contact him, but in psychotherapy training we were taught not to get involved with the outer world of the patient as it can lead to complications in the process." S1: "I agree with that as a general rule. However, if you feel it is an outer problem that is influencing her inner difficulties, it might be a good idea to make written or verbal contact with this coordinator and suggest a change in their living conditions." (The therapist had telephone contact, then a meeting with the refugee

coordinator who then contacted the housing authorities. A few weeks afterwards, the family was offered, and moved into a modern 3-room apartment.)

Middle phase of psychotherapy:

Because of the outer changes in the individual's life and the improvement in the *refugee/immigrant situation*, her symptoms and problems show some alleviation:

Employment: T: "After a few months she returned to her Finnish lessons and got a temporary job for a few hours a day in a local store. She was well liked and stayed there 2 months until she and her husband decided to rent a dry-cleaners. Psychotherapy continued throughout this period, as well as frequent visits to a physiotherapist. Her shoulder pain lessened and she recovered full shoulder and arm movement."

T: "She talks about her son and his aggressivity toward her and their continued conflicts. 'He complains that I am always sad and crying. He is doing well in school and is liked by everyone. But at home, he is always angry with me and can't sit still.' 'He is not used to seeing you so depressed', I said. 'I have been this way for 2 years, all the time we have been here. He was 10 then.' 'He remembers how you were', I said. 'Perhaps you are right. It has been hard on him,' she said. 'But he is doing well', I reminded her. 'Yes,' she said. 'He will soon be a teenager. Do you have problems with the personalities of teenagers in Iran?' I asked. She smiled and said, 'They can be just as pushy there as here.' 'It could be that, too. Naturally, it is not easy for a child to see his mother as depressed as you have been', I suggested. 'I'm not that bad anymore, am I?' she asked. 'No', I said."

The *transition-related condition: lowered self-esteem* caused by the *refugee/immigrant situation* has also improved:

T: "At times, she comes in excited at the way her life is getting started in Finland. She is doing well at school and likes the job she goes to for two hours a day. She has started to take care of the house, but her husband and son still help her – and she is going to let them continue to help, 'just like a Finnish woman', she said, and laughed."

Final phase of psychotherapy:

T: *"*The family has decided to move to the same city in Finland where her sister and family live". S1: "How does that feel?" T: "She is moving to a large city. It is hard to find apartments there and work, but it was their decision. She said that she wanted to move from the beginning, even though she knows that life would be easier for her here in many ways. But being close to her sister is more important to her. I respect that."

Discussion of goals achieved during treatment:

T: "She thanked me for our time together. But I feel she is not sure, and nor am I, that the psychotherapy has been of real value. However, she

has started to work, copes with her daily life once again, and has had the strength to realize her desire to move. She seemed less sad and depressed when our talks ended." S2: "Do you feel that you accomplished the goals of the treatment?" T: "I believe that I did to some extent. The physical symptoms were alleviated. Her depression and sadness has been somewhat alleviated. She functions in the home, with her family, and is working. She can deal with her son more caringly and tolerantly, and has greater understanding of her *refugee/immigrant situation*, especially the *states of being: separation and loss* and *loneliness.* She still thinks very much about her family in the homeland, but she realizes that she must build a life here. She knows that they would want that."

Comments of the project leader

By mapping out the framework, it was possible to focus on working through especially the *refugee/immigrant situation* and how it affected the individual's symptoms and problems. In addition, the *states of being,* the *adaptation cycle*, the *reason*, and several components of *transition-related conditions* could also be dealt with. Although the therapist was aware of the complications in the individual's *childhood experiences*, she concentrated on dealing with her present life situation. In contrast to traditional psychotherapy, in work with the refugee/immigrant, it is sometimes necessary for a therapist to network and/or have contact with people related to, or working with, the individual/family. This was taken up in the supervision with regard to the possible consequences for the therapeutical process. Afterwards, the therapist contacted the refugee coordinator to discuss the family's living conditions and the ways in which it complicated the individual's symptoms.

Case 13.3 – psychotherapy, time-limited

Duration: 8 months, once a week.

Therapist: Female psychiatric nurse/psychotherapist, age 46

Patient: Female refugee, age 39

Summary of the therapist's written session reports

First written report (after session 1):

Case summary: A female refugee, from former Yugoslavia, a professor of biology, her husband is a scientist, they have 3 children, 12, 10 and 5 years old; the family has been in Finland for 6 months. They have a 1 year residence permit, depending on the situation in the homeland.

Symptoms: (Individual's description) "I constantly think about the weeks when I was taken by police, questioned and tortured." That was when the depression and anguish started. Since then, she has experienced

depression, insomnia, nightmares, fear and panic, concentration difficulties, irritability, tiredness, and lack of energy. Recently found out that her university colleague and best friend, taken at the same time as her, had died in prison. He was probably tortured to death. Since then she has had sleeping difficulties, and can no longer deal with the depression and sorrow on her own.

Referral: From the refugee reception center.

Decision to go into psychotherapy and motivation: No previous experience with mental health care but is motivated to try psychotherapy rather than medication alone. She feels that talking about her situation and experiences might help alleviate the mental anguish.

Significant comments and observations during the introductory session: Feels that her whole self was wounded and humiliated by the torture.

Indications for time-limited psychotherapy: The patient has a 1 year visa. Form of treatment: psychotherapy for 6 months, afterwards an evaluation of the results. Eventual continuation to long-term psychotherapy depending on the evaluation and an extended visa.

Individual's goal for treatment: Symptom alleviation; to come out of her "sickness" as she describes it; feels motivated to try the treatment and does not see any other alternative to continued and stronger medication.

Therapist's goal for treatment: Symptom alleviation; to be able to give her hope, the will to live, and a feeling that she is accepted in Finland and can build a constructive life here. Right now, she is in a vacuum.

Second written report (sessions 2 and 3):

Individual's status at the beginning of the sessions: Quiet, somewhat nervous, avoiding eye-contact; turning to the interpreter; talks softly, showing little sign of emotion; sorrowful, depressed.

Focus of the sessions: Allowed the individual to take up what she felt was most important, which was the torture experiences. Will concentrate on these, even though it is difficult and awakens anxiety in both of us and the interpreter. Another main theme was the death of her colleague which occurred a few weeks ago. He was in prison and probably died because of torture, she explained. She makes connections between what has happened and her mental state.

How does the individual relate to or is influenced by the components of the framework? *Refugee/immigrant situation*: Cannot function in the new country because of torture experiences. 1. *States of being*: *guilt, sorrow, loss of identity*. 2. *Adaptation cycle*: seems to be at all the stages, but mostly *confrontation*. 4. *Relevant background conditions*: *culture*. 5. *Reason*: her and her husband's lives were in danger. 6. *Transition-related conditions*: experiences of *torture*, *imprisonment*, *loss of relatives*, *friends*; *colleagues imprisoned* and *killed*; *lowered self-esteem*; *loss of society*.

Therapist's thoughts directly after the session: Mainly discomfort, affected by the descriptions of her torture; wondering how it is possible to help someone to overcome these experiences; feeling that an interpreter is a hindrance in communication, but I have no other choice; feels good that she is motivated to continue the psychotherapy. She needs her individual identity, especially her professional identity, to be accepted in the new country as well as being able to "mirror" the loss of her collective group identity. Has knowledge and intelligence that she is not yet able to use in the new country because of language difficulties and the sudden and new life situation, which complicate the *refugee/immigrant situation*. Several components of the framework are relevant, especially the *states of being* and the *transition-related conditions*, i.e. the *torture* and *prison experiences* and those of her colleagues, in particular her colleague who recently succumbed to torture.

Hypotheses about the "core problem": Reaction to torture and the *refugee/immigrant situation*; *confrontation* stage of the *adaptation cycle*; the *states of being*: *guilt* and *shame* have not yet been expressed, but are present, especially with regard to her colleague's death; lack of energy and inability to help herself or her family's situation in the new country; frustration and further anguish that she cannot overcome her mental and physical symptoms.

Third written report (after final session):

I. Core-problem:

A. Basic desire/fear: To be free from her depression and anguish; to get back her strength and ability to function.

B. Organization of self-integrating defenses holding up self-esteem: Repression; somatic symptoms; rationalization.

C. Feelings/states of mind experienced by the individual and verified by the therapist: Sorrow; guilt; shame; experienced personality change; humiliation; feelings of inferiority in the new country.

D. How does the *refugee/immigrant situation* influence the neurotic complex? She had to flee the country suddenly and against her will. Working this through will take a long time. At the same time, she is going through the *arrival* and *confrontation* stages.

E. Which of the six components of the framework add to or still influence the core problem? 1. *States of being*: *sorrow, guilt, shame, inferiority.* 2. *Adaptation cycle*: *arrival* and *confrontation*. 5. *Reason*: forced to flee, life in danger. 6. *Transition-related conditions: torture experiences*; and the humiliation experienced in connection with these.

F. How do the *traumatic/torture experiences* influence the *refugee/immigrant situation* and six aspects of the framework? She experiences herself as "wounded" and "powerless" because of them. She experiences life and her personality "then and now" very differently.

II. Symptom improvement without amelioration of the core-problem: She functions better in her daily life, but the pain and sorrow is there and can "be activated" at any time, especially in connection with events in the homeland.

Reason for ending psychotherapy: Full-time employment; impossible to meet the therapist who worked at the mental health center one day a week.

III. Therapist's evaluation of the psychotherapy (scale 1-4): 3.

Excerpts from the taped documentation of the supervision

From sessions at the beginning of psychotherapy:

The individual's *childhood experiences*:

T: "Concerning her *childhood experiences,* she was the youngest of 3 children, with an older sister and brother, father, (a civil engineer), mother; a housewife. Father insisted that his daughters have equal access to education. She became a professor of biology, married."

The aspects, the *reason* and the *transition-related conditions: prison* and *torture* and the ways in which these affect the individual's symptoms:

T: "At the start, I noticed how the *reason* and the *transition-related conditions* of *prison* and *torture* influenced her present symptoms. She came to Finland due to her political opinions. She worked in an organization opposed to the regime. She was taken by the police several times, then imprisoned and tortured. When she got out of prison the last time, (because of pressure put on the regime by many of her colleagues), she fled to Finland together with her family. I discussed the treatment by asking her what she felt were her most serious difficulties, 'depression and fear', she said. She feels afraid in Finland, especially when she sees policemen or anyone in uniform. Even though she knows that she is not in any danger here, she gets afraid. She has headaches, insomnia; if she can sleep, she has nightmares, and wakes up screaming and sweating. Her husband says she talks in her sleep. At times, her body starts to shiver for no reason, outwardly and inwardly."

T: "She was active in the resistance movement, more so than her husband, who was not involved in politics, she explained. She went to villages, talked to people about the movement, and distributed printed material. She was at the university the day the police came and then they took her for questioning for the first time. They told her they knew everything about her and her work in the movement. But she knew they did not. They questioned her and threatened that she and her colleagues would be tortured. She revealed nothing. She was tortured after this questioning, beaten over her whole body from the feet up by 4 men; one man was without a hood, the rest had hoods over their faces. She lost consciousness and does not know what they did to her after that, whether they injected her with a chemical, used electricity or what. This torments

her, not knowing what they did when she was unconscious. The day after, she woke up in a cell. There was a bowl of water, and she could wash her face. Then she was taken for questioning again. They threatened that something would happen to her family if she did not reveal what she knew. After questioning, she was put back in the cell but then interrogated again. Finally, one day a commander said that they would release her, but that they could take re-arrest her at any time. She continued in the resistance movement even after this. She and 2 university colleagues were on their way to a village. They had printed material with them. The car was stopped by the police. She had a suitcase with the material in it at her feet. Her colleague asked for it. She gave it to him. It all happened so fast. The police searched the car and opened the suitcase. Her colleague said that the suitcase was his. They took the printed material. 'We were beaten.' She fell down. She showed me a deep scar on her neck. The 2 others, the driver of the car and her friend, were taken away by the police. One of them was the colleague who recently died in prison. Before leaving her on the deserted road, a policeman forced horse or cow shit into her mouth and down her throat. Afterwards, she did not dare to return to her home, but stayed there 3 or 4 days in hiding. Even her husband did not know where she was. During that time the resistance organized their escape. They took the children and a few clothes. She has been depressed since then, connects it with the torture, and she and her family having to flee and leave everything behind. A few weeks ago she learned that her colleague died in prison. She believes he was tortured to death. When she talked about this, she showed emotion for the first time and started to cry."

The *state of being: guilt* is discussed:

T: "I have met her 3 times since the last supervision. I realize that the *state of being: guilt* overpowers her life here in Finland. She said that she thought about her dead friend all the time. I asked her about him, how long she had known him. She said that she had known him from when they studied together at university and started working politically in the resistance movement. The last few years, they had worked together intensively. She said this and began to cry. I asked her to tell me more about him. She described his appearance and said that he was always happy, positive, ambitious and an optimistic person. Then, she said she should not have given the suitcase with the material inside to her friend. She felt that if she hadn't given the suitcase to him, she would have been dead instead of him. She said that sometimes she feels that it would have been better if she too had died. But it would be terrible for her children and husband, she added. They need her, but she still felt that way sometimes."

Working through *transition-related conditions* such as *torture*. Other *traumatic experiences* are also discussed:

A few sessions later:

T: "She is sleeping better since the therapy began and she can concentrate on Finnish language studies. She says that I am helping her understand herself. But she is afraid that all she is sharing with me about her life and homeland is too depressing for a Finn to listen to." S1: "Is it?" T: "I don't think so. So many older people in Finland have gone through war with all its pain and loss. I hear about it even now in my work with Finnish patients. My father was wounded in the war. He still has nightmares and talks in his sleep, my mother says."

Training-group member (Gm): "I think the refugee questions whether the therapist, who hasn't had traumatic or torture experiences, can understand and listen to accounts of them. That is why the refugee doesn't tell the therapist everything, 'saving' the therapist from getting upset." S1: **"**Yes, that is quite usual in treatment with tortured or traumatized refugees. The person may 'check out' whether the therapist is able to handle the descriptions of and feelings associated with these horrendous experiences." Isn't it too much for you, who have always lived in a peaceful country?" The person may ask this, or indicate it wordlessly. Therefore, it may at times be important to convey that you can absorb, listen to, understand and empathize (not pity), despite being born in a country that at present lives in peace. As I listen to what my patient has seen or experienced and survived, tears of pain or anger may come into my eyes; I try to convey to him/her that I am there to share these experiences. He/she is not alone anymore. As therapists/support workers we can show feelings if we must and still be trusted by the person, perhaps even more so. He/she must be encouraged to describe torture and traumatic experiences in minute detail, so that he/she does not have to have bear and live with these experiences alone anymore. Many people, in all cultures, may hope that by not talking about their experiences they will forget them, or they feel they will not be able to cope in their everyday lives if they remember and speak of them, or that no one else is strong enough to listen to them. This has happened to many people who were in concentration camps during World War II. However, minds and bodies remember many years afterwards, and it affects the person consciously and unconsciously throughout life until the trauma can be shared and worked through. Just be your professional self and listen. Verbal or intellectual comments about these events are not necessary, and mostly not even appropriate. The role of the therapist is to have the capacity to listen and contain these horrendous events therapeutically. Nothing more or less."

From sessions towards the middle phase of psychotherapy, after several supervisions:

T: *"*She says again and again in the sessions that she has difficulty talking about the torture. She says that during and after the sessions she feels so angry; the only way she can express it is by crying." S1: "If she

does not want to talk about it, or if she stops you from asking questions, it is important to respect her integrity in the matter. However, there are different opinions about reviving memories of these experiences. Torture and/or traumatic experiences are excruciatingly painful, and anxiety-inducing to remember and work through. If the person cannot or will not do it, I believe the therapist should respect that, even when it would be best for the person if these experiences could be talked about and worked through. For some reason, she cannot go into deeper detail than she does. There could be many reasons, which have to do with her, the situation or something else. Eventually, you may know. Perhaps not. It is a time-limited psychotherapy, and it is up to the individual how far she wants to go during the 6 months."

On several occasions, the individual's *refugee/immigrant situation* is discussed and worked through:

T: "She said that it was difficult for her to see people going to and coming home from work. Before she had a profession that she loved. Now she feels she is useless in Finland and can do nothing except think about the past, and worry about the situation in her homeland now for all the people and her friends, her family and colleagues. I said that I understand that she wishes that these circumstances didn't exist, but she must work through them, start to feel better and find the strength to start to function once more. I said that I believe that her friend would also like to see her start feeling better." S1: "Did she respond to your encouragement?" T: "No." S1: "Perhaps it came too early in your work together."

At a later session:

T: "I asked her what she plans to do in Finland. She said she would like to find the same sort of work, as a university teacher. She feels the situation can only get worse in her country, so she would also like to learn the Finnish language well enough to follow the newspapers and be able to explain the situation in her country to Finnish people." S1: "Can her plan be realized?" T: "I don't know. It is difficult to get a job at the university. She is a professor. She speaks English. Perhaps. She explains the situation in her country so simply and clearly when she speaks of the conflicts there. I believe she could be an asset to Finland in that way, too, by giving lectures about her country to different groups. It is all so confusing for many people." S1: "Can it be arranged somehow?" T: "As far as her getting work at the university, I could make inquires. She could lecture about former Yugoslavia, too. She could do it in English until she learns Finnish." S1: "In that case, too, taking care of the outer situation may help to ease inner difficulties. You cannot take away her pain and sorrow over the loss of her colleague and her homeland, but you can help to ease her life in the new country, and the *refugee/immigrant situation*."

The *refugee/immigrant situation* is affected by the mass media:

> T: "She starts feeling better, then she sees, hears or reads news about former Yugoslavia on the TV, radio or in the newspaper, and then she gets depressed again."

Through dreamwork, the individual continues to work through the *refugee/immigrant situation*, the *transition-related conditions: traumatic experiences* of *prison* and *torture,* and the *state of being: guilt*:

> T: "She said that I have given her strength. It always feels better after the sessions. She can concentrate on her language studies and sleep better but dreams a lot. In the evening when she goes to bed she feels stronger, but then the nightmares come during the night. She wakes in the morning, weak and in fear. Then she feels afraid all day afterwards. If she sees a policeman, she knows he is Finnish, but she automatically walks to the other side of the street. I suggested she write down her dreams and take them up in the sessions. When she talks about her dreams, it is without any sign of emotion: Dream one: She is in a street in Finland and the police start chasing her. The police wear the uniform of her homeland. She is running, but cannot get away. She wakes up in panic and fear. Dream two: She is walking on a road in the homeland with her dead colleague. The police come and shoot at them. Her friend is shot and falls. She is taken by the police, but tries to fight her way free to help her dying colleague. She cannot break free. She wakes up screaming. Dream three: Takes place in Finland. Several policemen dressed in the uniform of her homeland bang on the door of her apartment. Her children scream and cry, but she cannot see or get to them. The police break down the door and take her and her husband. She hears the neighbors scream, 'Don't take them. Don't take them.' She wakes up screaming these words. I asked her thoughts and feelings about the dreams. They had to do with her experiences in the homeland, she said. I said nothing. There was nothing I could add. I realize she is working through her trauma through these dreams. I see that allowing her to describe them is therapeutic in itself."
>
> T: "She talks about a recurring dream about her torture experiences, and that in them she gives information about her colleagues that lead to their imprisonment and death. In reality, she knew that she did not. She wakes up in a panic. It stays with her the whole day." S1: "Did she give information under torture? It is quite possible. Many refugees suffer from deep-seated guilt that under torture they may have said and done things that hurt their family and/or colleagues. Could this be coming out in her dreams?" T: "I feel that she is working through her guilt over her colleague that died in prison. But I do not think she gave any information under torture, at least not when she was conscious. She suffers because she does not know what happened when she was unconscious." S1: "Perhaps you should try to go more into that – what her fears,

thoughts and fantasies are about, what she might have said or done when she was unconscious." T: "Another recurring dream is that she is being tortured. The police are in the room just as they were in reality. She feels like vomiting, but she holds herself back, until she can't stand it. She wakes up crying with the feeling that she has to vomit." S1: "What does she associate with this dream?" T: "She is holding back the information, but can hardly manage, and is in a panic because she is afraid she will 'throw it all up' and give her colleagues away." S1: "The person him/herself often has the wisest and most interesting interpretation of his/her dreams. Naturally, there can be other interpretations. It could be her anger or other emotions she is holding back. It could be re-experiencing her feelings under torture. However, I believe that the individual should have the final say about what his/her dream can mean. But, the therapist can reflect on the different possibilities, and may be able to take these up and use them during the work."

The individual speaks the new language in psychotherapy. It helps to improve the *refugee/immigrant situation,* and to prevent feelings of, or the *states of being: language degradation, inferiority*:

S1: "Even though she is still upside down in her feelings, she is showing signs of improvement and independence. She has enough Finnish to use the telephone. On two occasions when the interpreter could not come, she said that she could meet you anyway and try speaking Finnish. I believe that if you see her without an interpreter she may, even with limited Finnish, tell you more than she seems to be doing in front of the interpreter." T: "The interpreter couldn't come. She called me and said she was feeling bad and asked for the session anyway. She said she felt bad because of the recent events in her homeland. She was having nightmares again. She said that she was able to cope with her daily life now. The children are getting along well at school and day-care center, and she had a meeting with someone in the Department of Biology at the University. Perhaps she can begin there. We spoke Finnish. She said she would like to continue the psychotherapy, trying to speak Finnish without an interpreter." S1: "How did you feel speaking Finnish with her?" T: "It felt good. But she cannot express her feelings in Finnish as she can when the interpreter is there. I suggested to her that we continue with the interpreter because of that." S1: "I remember the goal of your work: to give her hope, and for her to find the strength and will to start a new life in Finland. Her attempt to speak Finnish signifies that she is trying to get started in Finland on her own. She seems less afraid and more positive toward life. Perhaps you should reflect on that and why she wants to speak in Finnish without the interpreter." T: "She feels that she is beginning to function better in her daily life. An example she gives is that she no longer feels afraid of policemen. But I don't really understand what you mean about speaking in Finnish." S1: "If you respect her desire, even though it will be more difficult, you are respecting her autonomy and attempt to be

self-sufficient in the new country. She cannot express her feelings in words now in Finnish, but that will come with patience and, if necessary, by using a dictionary."

Working through the *state of being: guilt*:

T: "During each session, she talks about her colleague, their apprehension and her escape, and her guilt that he was left in prison and she could flee." S1: "It is important that she returns to these events again and again, and describes them in detail. You could ask questions about the details, e.g. time of day, weather, landscape, how the suitcase and material looked, her thoughts at the time, etc., so that she describes these moments and her feelings, and what she saw and did in as much detail as she can. Her feelings will be aroused by the memories. In this way you can help her work through her deep, almost suicidal guilt feelings towards her colleague."

Final phase of psychotherapy:

Towards the final phase:

T: "She says that she still dreams, but doesn't have nightmares. She begins to have ordinary dreams about her daily life here and in the homeland. She is getting more active in her language studies and works at the university a few hours each day. They asked her to give a lecture about the present situation in former Yugoslavia. She will, in English or with an interpreter. She has not decided." S1: "Often people who are active in their own countries are active in exile, too. Some persons are be motivated by living in exile. Perhaps it is a way of running away from inner anguish. We know that, too. However, in this case it is constructive."

T: "The final 2 months of therapy were without an interpreter. She prefers trying to speak Finnish. I try to encourage that." T: "She told me she sang a folk song with her children about a flower that is the first one to bloom in her homeland. The flower is a symbol of freedom. The song says: You must not pick it, but leave it in the earth. Take only its smell with you. Then she started to cry. It was the first time she was able to show emotion and cry in front of her children, she said. She could not sing any more because of her tears, but her children kept singing while they hugged her. They continued to sing the song again and again. They understand so much, she said. They do not complain and seem to feel okay in Finland." T: "She finished therapy because she was offered full-time employment at the University. She would continue her Finnish language studies, but lecture about former Yugoslavia for several different departments here and at other universities. Until she could speak better Finnish, she would be working alongside a professor at the institution. She said it would be impossible for her to come to the mental-health center the one day I am there, as it would mean her taking a full day off, due to travel connections. She was very thankful for the therapy."

Comments of the project leader

The therapist was hesitant working in psychotherapy with a person who had suffered severe torture. Though experienced, the therapist felt inadequate, as she had never worked with torture experiences before. The psychotherapy was concentrated on working through these experiences, and how these affect the individual's symptoms, present life situation and the aspects of the framework, especially the *refugee/immigrant situation,* the *states of being*, the *adaptation cycle*, and the *reason.* The therapist's and patient's treatment goals were to ease the symptoms and be able to start a new life in Finland. The focus of the supervision was on encouraging the therapist to utilize her long clinical experience and inner resources, as well as to deal with the inner pain and difficulty in containing torture experiences. The therapist learned how to guide the person to allow herself to describe these experiences in detail, express feelings about them, and gain insight into how they have been affecting life in exile. Counter-transference was worked through during the whole supervision. At the time the treatment concluded, the individual's symptoms had been somewhat alleviated, as too had the complications within the aspects. She could function well enough to take on full-time employment.

Excerpts from the documentation of cases 4 – 6 follow without session reports.

Case 13.4 – insightive psychotherapy, short-term

Duration: 7 months, twice a week

Therapist: Male psychoanalyst, age 51

Patient: Male immigrant, age 28

Excerpts from the taped documentation from the supervision

From sessions at the beginning of psychotherapy:

Reason for therapy:

T: "The patient is from a large city in Egypt, a physician, he emigrated to Finland after marriage to a Finnish woman. He sought psychotherapy because of depression after their divorce. He had been aggressive and had hit his wife on several occasions. He was worried about himself, as he had never hit anyone before."

Case summary:

T: "He met his ex-wife in Egypt when she visited the country as a tourist. They became a couple almost immediately. He came to Finland to visit for a week, then they telephoned and wrote to each other. There were conflicts even then. They decided to marry 3 years ago. He came to Finland, leaving his medical practice, hoping to be able to start one here

or work at a hospital as he is fluent in English. But he could not practice medicine here immediately. He had to learn Finnish first. Most of the time, during that early period, they quarreled. He felt dependent on her because of the language. He speaks good Finnish now. We speak Finnish in the sessions. He is intelligent and ambitious, and is now working here as a hospital doctor."

The individual's *childhood experiences*:

T: "He is the youngest of 2 children, the only son of a wealthy Egyptian family. His father was a businessman, his mother a housewife with a chronic heart condition. The first 5 years of his life she was bedridden and could not hold him. He has always had close contact with his mother and is closer to her than anyone else, he explained."

From the first session:

T: "The first time I met him, he was depressed. He stared at the wall until he said, I hit my wife. What do you think of that? I said: I am not here to judge you, but to allow you to try to understand yourself and your behavior. He was more relaxed after I said that. He said his marriage was difficult. It lasted over 2 years. For more than 6 months, his wife did not talk to him. If he asked her something, she did not answer. He became provoked by the silence. He understands that Finnish women are very independent and make decisions themselves. For example, he wanted his wife to help him with some papers in Finnish. But she wouldn't. She said after the marriage that she had never wanted to get married and that she was sorry she did. Before and during, she was having affairs with other men. He said he is sorry that he hit his ex-wife. He knows it is not right, but he could not stop himself. When she got angry, she swore at his mother and parents and that hurt him so much that he hit her."

After 11 sessions:

T: "He started talking about what actually happened in the relationship. He explained that she was mostly mean to him and did not cook or clean. He had to do everything."

The significance of first studying the common components of the refugee/immigrant's personality and behavior is stressed, before looking at the framework:

S1: "Before we discuss the particular aspects of the individual's framework, I would like to ask the group to look at the common components of this case. Do you think that a Finnish man would act differently if he found out that a woman had been unfaithful to him before and during their marriage?" Gm: "It seems to me that someone from any culture could be provoked by such behavior." S1: "Do you notice other commonly shared characteristics and behavior?" T: "He has idealized her. A man from any culture can do that. 'I will never find a wife who is so attractive and presentable. She knows how to dress and act', he explained. Gm: "Both are in love with a fantasy of what they think a man or woman

should be like, and these fantasies may be culturally conditioned. Both of them see each other as objects; there is not very much real love. Narcissistic disorder is not especially cultural." S1: "His super-ego is very strong. He even goes back to his homeland during the Christmas holidays, to find out what his family and friends think of his actions. It seems to me that you have to work with his super ego as well as his aggressivity. Anyone has the right to be angry when humiliated, but he was not able to control his primitive feelings."

Relationship with parents: S1: "Did he go into his relationship with his parents?" T: "No. We haven't gone into that yet. He did mention though, that his mother wanted to separate from his father early in their marriage, too, but they didn't". S1: "Why? Was it because of unfaithfulness?" T: "Yes, in the early stages of the marriage, the father had other women." S1: "Then he may have identified with his mother on that level." T: "Yes" S1: "Was his father abusive to his mother?" T: "No." S1: "Perhaps, unconsciously, he is angry with his mother when a women disappoints him, when she does not cook or clean or cater for him, as his mother could not do for the first 5 years of his life, even though she seems to have compensated for it later on in his childhood."

Abuse: S1: "Was it continuous abuse?" T: "No, he hit her when she cursed his family. He got very angry and lost control." S1: "It seems to me that he could be discovering his aggressive side, rather than that he is a wife abuser. It seems to me that the abuse is not so significant in this case. He must be made aware that he had no words for his humiliation. He was hurt so deeply. That could happen to a Finnish man or woman, too. He must get to know the dark or destructive sides of himself, and how they can be used constructively." T: "Yes, he said he felt so helpless, without any words to express his feelings." T: "I believe anyone as violent as he was becomes that way when he/she lacks contact with his/her aggressivity. He is working on it now. S1: "It is important to see the difference between a man who is violent by nature and one who is so angry and humiliated and without words that he uses violence for the first time. Naturally, he could easily turn violent if the relationship continues as it has. Now he has decided to separate from her. I think that, at this moment in time, it is a good decision, until he understands where his aggressivity is coming from and why." S2: "Anyone in his place could feel humiliated. As is usual in a psychoanalytic psychotherapy we should consider the fact that he is an only son and much younger than his sister, born late in his mother's life. For the first 5 years of his life his mother could not take him in her arms. The depression could also be caused by this early deprivation of symbiotic closeness; and because it went on so early, perhaps he has no words for this. Otherwise, it sounds very typical of many couples I have had in therapy. The Finnish girl travels outside the country and starts a relationship with a man from a different culture, and then there are many problems when the man comes to Finland. Also, she swore at his mother. Even a Finnish man would feel humiliated. Mothers are significant everywhere." T: "If you

consider his narcissistic personality, there seems to be no cultural difference here either. The problem of narcissism appears similar everywhere." S1: "There is much in this case that has nothing directly to do with immigrants or refugees in particular."

The goals of treatment:

S1: "Have you and he reflected on the goals of the psychotherapy?" T: "He wants to work with his aggressive side to ease his depression and on his separation anxiety because of the divorce." T: "There is a narcissistic disturbance here but it must be treated in a long-term psychotherapy or analysis." S1: "Do you believe the separation anxiety can also be to do with separation from his homeland, family, friends, work, but especially his mother? His relationship with her may have something to do with the difficulty he has with women. I would concentrate more on this. If we look at it psychodynamically, I suspect there is an emancipation from his mother that he has not successfully accomplished. The psychological bind to his mother as we experience it can be somewhat cultural but may have more to do with his mother's poor health, which he has had to live with all his life. He has also become a doctor, perhaps unconsciously, due to a desire to take care of or cure his sick mother. Also universal. It is always important to consider the common components within the individual whom you are working with, rather than exclusively the cultural ones. It makes it easier to understand the individual."

The framework:

S1: "How would you assess what your patient is going through in the light of the framework?" T: "As far as the *refugee/immigrant situation* is concerned, there are many things in Finland which he has difficulty with. Mainly the fact that he could not be the respected doctor he was in his homeland but had to start again by retaking a medical examination in the Finnish language; but also, the way of life and attitude to foreigners, cultural and sex role differences, and so on. The *states of being* he seems to be going through are: *the stranger, loneliness, missing, language degradation, value degradation.* His *childhood experiences* especially his relationship with his mother, is influencing the symptoms. His *reason* for coming to Finland, as an immigrant because of a woman, also influences the symptoms. *Transition-related conditions: lowered self-esteem, ambivalence*. As an immigrant, the *choice of return* is open to him." S1: "Considering the *refugee/immigrant situation* and the different aspects, especially separation from his own country, perhaps it would also be important during the process to work through all that he has lost by moving to Finland. I believe you can help him to decide whether it would be best for him to live and work in Egypt or in Finland."

The *refugee/immigrant situation*: S1: "He could not work as a doctor, that is, in his profession when he came to Finland, until he learned

the language and could retake the medical exam here. This is an interesting aspect of what we do in Scandinavia to many refugees and immigrants. They are not allowed to or cannot find jobs in the professions they are trained for in their homelands. He cannot be the same person he was in the homeland. He feels, perhaps unconsciously, castrated by both his wife and society. Perhaps his abuse was not only aimed at her but also because she represented Finland.

Language difficulties and the *state of being: language degradation:* S1: "He comes from an upper-class, wealthy background. He attended international schools. He is fluent in English. They speak English. Are you sure that (she) can express herself as well as he can in English?" T: "No". S1: "I'll explain how the *state of being: language degradation* may have influenced the individual's *refugee/immigrant situation* as well as other aspects of the framework. Difficult misunderstandings and problems can arise when a couple cannot express themselves in their own languages, in this case Arabic and Finnish, even if they seem to be fluent in the mutual second language, English. Primitive feelings can be wakened by the inability to express nuances and lack of vocabulary. It is not unusual that one becomes more aggressive, and may turn to body language. He has discovered his primitive self, and it seems to be a shock to him." S1: "Perhaps he also went back to his homeland to find his roots again and to speak his own language."

Cultural comparisons and differences: T: "It is the first time I have worked with someone from the Middle East. But he is very good at explaining the way of life. He explains when he is confused, as with his ex-wife's family, which he describes as typically Finnish – they don't seem to talk to each other, he says. They are just silent and look at each other or watch television. In Egypt, it is never like that in a family. People are always talking, and discussing things with each other. Daily life is shared." S1: "In working with refugees/immigrants, if you ask in a humble, non-judgmental way about their culture when you are not sure about it, they usually respond positively. The person explains and notices that you are interested. A generous atmosphere is created, and this leads to trust and a deepening working alliance. What does it wake in you when you hear about how an immigrant sees the Finnish way of life, the culture, family life?" T: "It is true, many families don't discuss things. Instead, we do things together." S1: "Did you explain that?" T: "I said there are different kinds of families in Finland as in Egypt. I don't think it is very different here in Finland, either, with regard to wife abuse. We can even kill our wives here, or the whole family!" Group: (Laughter). "Sometimes it is important to explain the new society. You may hear severe criticism of your society, seen through the eyes of the refugee or immigrant. At times, it can be funny, at times difficult, humiliating and painful. You can recognize yourself and your own limits because of it, or you can be provoked by opinions and criticisms that may be highly exaggerated or untrue."

Middle phase of psychotherapy:

The individual's divorce and its consequences:

T: "The divorce process is going well. He no longer isolates himself. He has gained insight into his aggressive feelings towards his ex-wife. She called and wanted to meet him. He said he was busy. She wanted to meet him and give some of his things back to him, but he asked her to organize it another way. She came anyway and she started fighting with him. He got angry, took her glasses and threw them on the floor. They did not break. Afterwards, she went with her father to the police and pressed charges. The police questioned him but decided that it was not a police matter." T: "This woman told the police everything that had happened to them throughout the years. During the last few months his wife and her father had threatened that they would do everything to see that he would be thrown out of the country, but the police said that he did not have to worry about that." S1: "It was good that the police supported him. It can be very different. For example, the police could take her side of the story seriously, and not even listen to or consider his side of it."

Gm: "Does he want to continue psychotherapy now that the separation has worked out?" T: "Yes, he does. I brought it up as soon as I noticed that the anxiety of the separation and divorce was over. He wants to continue and go deeper into himself, his aggressivity and basic personality. It wasn't possible to do this earlier as he was in such a deep depression. 'He trusts me. I understand him', he said." S1: "You have gained his trust because of your professionalism in understanding human universalities, as well as respecting the cultural differences and showing humility in dealing with these differences."

The *refugee/immigrant situation*: T: "He understands now that his stay in Finland was his first one outside his own country, and he did not realize how different life would be, or how difficult it would be to live here as far as language, environment, weather, the way of life and culture were concerned. He realizes all this now. This spring, when his depression had partly lifted, he noticed it was because the weather and the light was more like it is in Egypt. He would not marry a woman from Finland again or for that matter from any culture other than his own, when he sees what it has done to him living in a foreign country. He is almost sure he does not want to continue to live here."

Childhood experiences and their effects on the individual's present life in the new country:

T: "We are now working on his relationships with his mother and with women. He has begun to socialize, mostly with Finnish women, but he said that he will return to his country when he wants to marry again and choose a woman from his culture." Gm: "Does he explain why?" T: "It is easier to understand them, he says. Although he is very intelligent, he is very immature and superficial in his emotional life. He seems to see life

and roles in it in a childish way." S1: "It seems to me that he may have trouble with a woman of his own culture, too, as he has not freed himself emotionally from his mother. At times he seems to despise women in his descriptions of them and not be able to see them as individuals. He has such a superficial picture of women. Perhaps he should get more insight into that. A way of going about it could be to encourage him to express what he thinks the differences are between women from his culture and Finnish women, and guide him to see a woman as an individual."

T: "It was after an international medical conference in Egypt when he saw his mother and father again that he realized what his mother does to him. She has a chronic heart condition, but he is not sure how serious it really is, or if she just uses it to get attention. She complained to him and asked him what to do about it. Yet, she has lived with it as long as he can remember and she has always had the best medical care. She has even been examined in the United States. Something clicked within him on that visit. He realized that she was trying to manipulate him with her sickness. She so needs and is so dependent on his love, he explained. He loves her, he said, but not the way she wants me to. She wants to own me. I must live my own life. I saw it all, my childhood in front of my eyes, when I was there. The guilt I always felt when I wanted to play with my friends or do something outside the house. I realize now why I had to leave Egypt and marry someone so different from my mother, to free myself of her need of me. Then suddenly in the middle of the city I was born in, I had the feeling that I felt very much at home even in Finland." S1: "Does he feel that way because of you and the therapy?" T: "The therapy has enabled him to see himself in other ways. He said this is the first time he did not have to feel dependent on anyone." S2: "But isn't he dependent on you and the therapy?" T: "Yes, right now. At the same time, he is freeing himself from his past and seems to be on his way towards freeing himself from me. He has decided to do his specialist training in England. He said he sees himself so differently now, because of the psychotherapy."

Final phase of psychotherapy:

T: "He met his ex-wife and there were no arguments. He will soon go to England and continue his studies. He will not return to Finland. He has decided to return to Egypt and re-open his private practice and teach at the university. He has already been offered a teaching position there. He met different women here and enjoys their company in a more relaxed way. He is very thankful for our work. Next week is our last session. I am glad that it has gone so well for him. He seems to be free to choose the life he wants and plans to continue in psychotherapy in England."

Comments of the project leader

The individual had immigrated voluntarily because of a relationship with a Finnish woman. The psychotherapy focused on alleviation of symptoms of depression and, for the individual, gaining insight into his aggressivity. In

the first weeks, the therapist, an experienced psychoanalyst, chose to gain the trust of the individual and then focus on; with regard to the framework, the refugee/immigrant situation, the states of being, childhood experiences, the reason, and the transition-related conditions: lowered self-esteem and ambivalence. The supervision was based on explicating the framework's application to psychoanalytic psychotherapy.

Case 13.5 – support work, long-term

Duration: 11 months, about once a week; plans to continue contact for 2-3 years

Support worker: Female social worker, age 31

Patient: Male refugee, age 29

Excerpts from the taped documentation of the supervision

Background to the support work:

The first meeting:

Social worker (Sw): "A male refugee, age 29, from a country in Africa, waiting for asylum for 2 years. He is black, tall, muscular, and wears a high yellow hat all the time, even indoors. He has an 8 month old son with a Finnish woman. Their relationship is difficult. I'd like to discuss him and my feelings about him and his threatening, aggressive attitude. Firstly, I'd like to explain that in Finland a social worker is assigned for a period of up to 3 years to the individual/family who has received refugee status. It is our job to help them integrate into society. When the receptionist at the desk of the social office gave this man a first appointment with me, he was unfriendly and threatening. She does not usually complain about people. I don't know what happened. He came late to our first meeting. I had heard that he was threatening, but I felt he looked unsure, even frightened. I met him in the waiting room, shook his hand and we went into my office. There is a basic questionnaire that everyone must fill in. He wrote the answers carefully and we agreed to meet again the next day, as he had many questions about financial matters, etc."

The second meeting:

Sw: "During this next meeting, he became angry. 'I demand everything!' he screamed and came close to me. He was threatening and angry. His appearance changed completely. He did not seem to be the same person that I had met the day before. I said he should calm down, that it would be all right. I must get to know him and learn his needs. He said that he had a hard time controlling himself. I thought it was good that he could say that. I tried to discuss financial matters with him and the conditions we have. I suggested that the next time he come with his girlfriend, with whom he lived. He got angry and left, but the

next time he did come with her and their child. However, he came without an appointment. The outer door of the office is locked, as a security practice. I opened the door and he screamed, 'Where's the boss? Where's the boss?' His girlfriend looked at me and wondered who I was. I introduced myself as the social assistant and we went into my room. The woman was about 25 years old, soft-spoken and humble, the opposite of him. I wanted to create a relaxed atmosphere, and looked into the pram at the then sleeping baby. The man had chosen a chair in the corner of the room, so he could see both of us. Then the baby started crying. He reacted harshly, took him up hastily, almost violently, from the carriage and put him on the floor so he could crawl around. A few weeks before, black and blue marks on the woman's arms and face were noticed by another social assistant. I was not on the case then. His threatening attitude heightened the tension in the room. He has different sides. He can be polite, well-mannered and unsure, like the first time, or angry, even in a rage."

The third meeting:

Sw: "They came without an appointment. Against his will, he agreed to the money we could offer. He felt it was too little. There are other people who get more, he said. This meeting went well, but I could see that they had difficulties in agreeing about their collective finances. She said she understood why we had our financial-support policies. All in all, it seems his relationships with those in authority and with women are complicated and difficult."

The *reason*:

S1: "Why did he come to Finland?" Sw: "He tells different stories. His childhood and youth were not secure or good, he has explained. He said nothing of his relatives. He was a university student when he fled his country because of the pending civil war. He left just before it broke out. He had political ideas, but he was not active, he explained. Something happened before he fled that he would not talk about. I am not sure if anything he says is true. Recently, he started at the university here, but the language is difficult for him, that's a stress factor, too." S1: "What language do you speak with him?" Sw: "Finnish, but we also use English." S1: "In this case, we not only consider that he is a refugee but also a man who you believe or know can be violent. You explained that you heard from a colleague that he abused his wife, and saw that he was harsh, almost violent with his son right in front of you. I wonder what that wakens within you?" Sw: "A threatened feeling. The woman he lives with needs support, but he does, too. At the same time as I feel anxiety about working with him, I feel sympathy and want to support him." S1: "The cause of the individual's problems and symptoms can be difficult to understand when the framework cannot be mapped out."

The individual is not willing to talk about his past, but the *transition-related condition: past traumatic experiences* are suspected:

S1: "Eventually, I hope you can learn more about what has happened to him in the past. A person is usually violent when he/she has him/herself experienced violence. His country was in conflict and there is something he does not want to talk about. You can almost assume that he has experienced violence. If there is an opportunity to do so, I would ask him more about his past."

The framework:

S1: "Let's try to consider his *refugee/immigrant situation* and the aspects of the framework: The *refugee/immigrant situation* and the *transition-related conditions: waiting for asylum*, and also possible *traumatic experiences* and how these may have affected his present behavior. He waited over 2 years for asylum. It was denied at first. That's a long time to wait and it can take many years for a person to get over this emotionally trying experience. It can leave deep scars afterwards, at times, suspicion for many years to come of the local inhabitants, especially state and community employees. Another important fact to consider is that he may have had traumatic experiences in his past. In cases of traumatic and/or tortured refugees, expressions of aggression and violence can stem from the past traumatic experiences that usually have not been worked through. I sense this with him; on that he is a black man in a white world. He is perhaps trying to hold on to his identity, which is difficult to do in a predominantly white society. He could even be exaggerating his outer appearance or clinging to his identity, with that large yellow hat he wears all the time."

Transference/counter-transference:

S1: "In Scandinavia, officials working with asylum seeks, refugees and immigrants can often be young, attractive women like yourself. What does all that waken in men who are not used to women in positions of authority? I believe it can sometimes be very provocative for some men to meet attractive women who have authority over them. For a black man, the fact that the woman is also white may affect him on a conscious or unconscious level, just as the fact that he is black can affect you. However, it may have nothing to do with being prejudiced. Dealing with persons who are different from us wakes aware/unaware feelings within the individual and the care."

The following supervision:

Sw: "I met him 3 times since the last supervision. He is less aggressive and listens to what I say. I am very thankful for all the feedback and suggestions. I feel completely different with him and he is more relaxed during our meetings because of it. The session after the supervision, I said I wanted to discuss how we should continue our work together. I did not take up financial matters or any of the practical

questions that are part of my job. It is difficult when I have two different roles to fulfill. As a social worker, I have to organize things and also discuss his life and feelings. Discussing the continuation of our work, offered an opening. I said that I believed it was important for both of us to try to make a go of our work together. I made it clear to him that I care about him and I want his life to go well in Finland. He was friendly, and there was a calm atmosphere in the room. I noticed that he gets intimidated when he feels pressurized. Then he cannot listen. I was satisfied with the session and I believe he was." S1: "It is very good that you have reached a working agreement, one that can lead to an alliance despite his aggressive attitude to you. And you are preparing the opportunity for him to perhaps share his past homeland experiences." Sw: "It is rather interesting when you dare to be yourself, it goes well."

The individual's difficulties in the context of the framework:

S1: "Now that you are acquainted with him how would you map out his problems in the context of the framework?" Sw: "With regard to the *refugee/immigrant situation*, he must come to terms with life in Finland, and his relationship with his girlfriend and son. He feels different and alone as an African in our small Finnish city, one of only a few here. Moving onto the *states of being*, I believe he is going through: *the stranger, language degradation, inferiority*, *rootlessness, suspicion, prejudice* and *feeling like a scapegoat*, both based on reality and an exaggerated feeling of it. In terms of the *adaptation cycle*, he is at the *confrontation* stage now but often regresses back to the *arrival* stage, especially when he feels threatened and anxious. I am not sure of anything about his childhood. The *reason* he actually came to Finland is still unclear to me. With regard to the sixth aspect, *transition-related conditions*, I am not sure what *previous homeland experiences* he had when it comes to oppression, violence or the atrocities of war, and whether any of these were traumatic or not. He waited for asylum over 2 years, a long time, and I learned that he only and finally got asylum because his girlfriend was pregnant." S1: "As you say, we know so little about his *background* and *previous homeland experiences*. If we look at the *state of being: being a scapegoat* returns all the time, and that leads to both passivity and aggressivity in him. Many refugees and immigrants can feel like, or become scapegoats, and isolate themselves or be destructive to themselves or out in society."

Goals of the work:

S2: "What is the goal of your work with him?" Sw: "It is my job to have contact with him for as long as 3 years and see that he integrates into Finnish society. Now that I know him better, I'd like to see that he has a better relationship with his girlfriend and son, and that he can live a constructive life in Finland."

Summary of taped material:

After six months:

The sessions continued. He came alone and together with his girlfriend. In the sessions when he came alone, he talked more openly about his past and his hopes for the future in Finland. He wanted to try to make the relationship work. He continues to study. In the sessions when the girlfriend was present, the difficulties of a culturally mixed relationship were taken up by the social worker in simple, often amusing ways, which led to a closer alliance with the couple. The woman became less passive in their conversations. She began to work at her previous job when the child started at a day-care center. They are planning to live together when an apartment becomes available.

Comments of the project leader

The female social worker had long experience, but had never worked with someone of black skin color. She had been meeting the client several months before starting the training program. Because of his aggressive attitude, she had not dared to ask any questions. It is difficult to work with a refugee or immigrant and their family without some knowledge of background factors, especially if the individual/family is behaving in ways which the carer does not understand in the context. Therefore, knowledge of the individual's framework, especially: the *refugee/immigrant situation*, the *reason* and the other aspects should be attained in the first meetings. However, this information can be attained throughout the process, which was the case in this example. In the supervision, the social worker was encouraged to build up knowledge of the individual's way of managing the *refugee/immigrant situation* and the aspects, especially *childhood experiences*, the *reason*, and components within *transition-related conditions*, while working through the *states of being* and the *adaptation cycle*. The supervision was also focused on the social worker gaining insight into the reasons for the individual's aggressive behavior, how to deal with it, as well as comprehension of the transference and counter-transference.

Case 13.6 – child/adult psychotherapy, crisis

Duration: 12 months; psychotherapy to continue

Therapists: Two female psychotherapists, a child psychiatrist, age 39; a psychiatric nurse, age 47

Patients: Two female refugees, mother, age 53, and daughter, age 26, 2 children, 3 and 5 years old

Excerpts from the taped documentation of the supervision

Background to treatment:

Child psychiatrist (T1): "I met the family once. A 3 year old boy and his mother, age 25. They had fled from Somalia. I was asked to assess the mental condition of the child as well as submit my opinion on foster-home placement. Two weeks before, the mother had threatened to kill the child and commit suicide. They came to Finland about a year ago after 2 years in different refugee camps in Africa. The mother was in a bad condition when she arrived in Finland and had made a suicide attempt. She was placed in a psychiatric hospital, and diagnosed there as manic depressive with paranoiac tendencies. She was put in the hospital against her will and released after 2 weeks. A few days later she was admitted again, involuntarily. I was then contacted to assess the child. During the stay at the reception center, the mother had not been taking proper care of the child. A decision was made to place the child in a Finnish foster family until she received a decision on asylum in Finland. The child was there 2 months and became attached to the family. The mother was opposed to the foster-home placement. She feared that the child would like the family more than her. She took the child from them when she was feeling better, even though she still lived at the reception center.

When I met them a year later, they had received refugee status and were now living in a tiny one-room apartment. The child had started to go to a day-care center, but his mother decided against it. The child lived with his mentally ill mother, with no connection with the outside world except for a home assistant coming several times a week. This was the situation when I met them with a male interpreter. She came to my office with the child and the home assistant. They were 20 minutes late. The child was screaming and crying, only wanting to be held by the home assistant. He paid no attention to his mother. She took him from the arms of the home assistant, but he protested. He did not want to be held by her. The situation was terrible. For the first 15-20 minutes, the mother was pacing back and forth with the child in her arms, and he was trying to push himself out of her arms. In this situation, we tried to talk. It was very strange for me. I felt helpless and did not know what to do. Normally, I do. First, I tried small talk. I asked her how the child was developing; what can he do? Does he talk? This was to get some kind of contact with her. Suddenly, she stopped pacing, sat down, and started to talk about him. She calmed down, the child too, and then he started to play with some toys, but not really playing with them, just looking at them, turning them around. He listened to what his mother said, noting the tone of her voice and her reactions. The child seemed very anxious. The mother knew I was a doctor and asked me about certain vaccinations for him. All of a sudden she said, 'Get my mother here.' She explained that she had a mother and another son of 5, 2 years older than the boy with her. They had fled from Somalia over a year ago and were living in a nearby country. She said that

she wanted them to come to Finland, and that that was the only thing that would help her mental condition. She said she has had 'this disease' a long time even in Somalia, and her mother always helped her there. Sometimes she feels so sick, she dislikes and gets angry with everyone. At these times, she just wants to be left alone with her child. She needs him and wants to be left in peace with him, she explained.

I had planned to see the child alone but after this discussion, I decided against it for the time being. I proposed a second meeting. She didn't want to come. I told her that if I could find a way to help her mother get to Finland, I would. I didn't know how to do it, but I understood it was the only solution for her mental welfare. I felt confused and anxious, making her a promise that I wasn't sure that I could fulfill. The session ended that way. The child wanted to stay and play. The mother tried to get him to leave the toys and go with her. It was a hard battle.

Afterwards, I spoke to the social worker and the psychotherapist (T2) working with the mother, and we wrote to government officials encouraging them to allow her mother and older son to enter Finland. The child was never allowed to see me again. The mother refused. However, I recently heard that the grandmother and the other son have now arrived. I am still worried about the child. I never got him out of my mind, that is why I am talking about him now. The child was very anxious and I believe that his development was in great danger because of the symbiotic relationship. He was only there for his mother. He was not able to live for himself. He was not being allowed to develop like a normal child. He was an object for her. That was my impression from that meeting. I think she did not come back because she was afraid I was going to take her child from her." S1: "She was right to be. Isn't that so?" T1: "Yes, I was asked to give my opinion about him and eventual foster-home placement. I had to think in those terms." S1: "Perhaps she felt that. I mentioned that I was to assess the child's mental condition and how he was doing in Finland, but I don't know how she interpreted that statement."

The conceptual framework:

T1: "After the first seminar on the framework and after learning more about the different aspects and how each one can influence the individual's and the family's symptoms, I decided to advise the other workers on the case that we should wait until the grandmother comes and see if her presence would ease the symbiotic situation and the child's development. If not, we had to do something about it. Should we have placed this child in a foster home? This is my part of the case. My colleague will take over now." S1: "Were there any particular components of the framework that you took into consideration?" T1: "I had received almost no background information on the mother or the child when I was asked to assess them. However, I did try to think about using the framework with regard to the *refugee/immigrant situation*. She is a young, black woman in a white world – that could cause suspicion and paranoia, if she did not understand our way

of life. She seemed to be going through several *states of being*. I am not sure if they were based on reality, an exaggerated feeling of it or fantasy. It seemed to be a mixture, but I met her only once. I considered that she was going through *the stranger, loneliness, separation and loss, rootlessness* and *suspicion*. In terms of the *adaptation cycle*, she was still in the *arrival* stage. As to her *childhood experiences*, I was given no information about her background. I learned about it months afterwards. As for the *relevant background conditions*, I had little information about these. She was wearing Western clothes when she came to see me. At that time, I did not know very much about the *reason* she was seeking asylum or what she had gone through in the refugee camps before she came to Finland, that is, almost nothing about the sixth aspect, the components of *transition-related conditions*. I would now ask to be given as much information as possible about the child's and parent's frameworks before I meet them."

Psychiatric nurse/psychotherapist working with the mother (T2): "The reception center for asylum seekers contacted me regarding the mother. They explained that she was not taking proper care of her child. She goes out and leaves him alone for many hours, or leaves for several days and asks someone to look after him. Nobody knows where she goes."

The first session:

"I had organized an interpreter for the first meeting, but she said there was only one that she trusted. I tried to get that one, but it was impossible. She refused anyone else, so we decided to speak English that first time, and she wanted to continue without an interpreter. I felt I had gained quite good contact with her. She seemed to accept me quite easily. The language difficulty limits us, but now we get by pretty well. The woman explained that she comes from a large family of 11 children. She left Somalia at 17 years to work in a neighboring country and returned to marry a couple of years later. When the war began, she had 2 small sons. Her husband became a soldier. One night terrorists came into their home and killed her husband and burned his body in front of her eyes. Then they raped her and burned parts of her body. She fled to refugee camps in neighboring countries and then to Finland. 'I am here to find out if you can help me get my mother and son to Finland', she said. We discussed this. I asked why she wanted her mother to come. She explained, 'I have a sickness. Sometimes I get very depressed. I don't eat. I don't drink. I just stay in my room. There is no medicine that can help me. Only my mother can take care of me, or other Somalians'. She seemed okay at that session. I tried to make another appointment with her. She got angry, 'If you don't help me get my mother here, I don't need you'. She got up and left. A few weeks later a social worker at the reception center contacted me and said that the woman was willing to come again."

The following sessions:

"She was open and explained why she was depressed. Shortly after that the social worker called again and said that the woman was

threatening to kill herself and the child. She was staying with a Somalian family. I made a home visit. She was sitting in a corner wearing black Somalian clothes and scarf. The other times we had met she wore Finnish clothes, white slacks and a blouse. She had not eaten or drunk anything for several days. It was as if she was in mourning. No-one could make contact with her. I felt she needed to be in a hospital. I sat down next to her. We sat in silence a long time. Then she said, 'I don't remember when I ate last. I am very sad.' I told her I was there to help her. I said I felt she needed to go into a hospital. I had an interpreter with me, but I talked English with her. We talked for about an hour and she finally agreed to admit herself to the hospital. When she got there, she did not want to go in but finally was involuntarily admitted and sedated. I was worried that our therapeutic relationship would be destroyed. I went to visit her the second day she was in the hospital. She was glad to see me, hugged and touched me, even clung to me saying thank-you. It seemed to me that she was happy to be in there. She remained there about 10 days and then was released. I have been seeing her regularly 2-3 times a month since then."

S1: "Did she talk about her child?" T2: "She talks about her time at the hospital without him. She said that she needs him to be with her when she feels ill. During the period she isolated herself with him, I tried to tell her how important it was for him to be at the day-care center and to play with other children so as to be able to develop normally. But she disregarded my advice 'No. No. I need him to stay with me when I am feeling bad'."

Information about the components of the individual's framework continues to be gathered and considered through the sessions:

S1: "Have you thought about her in the context of the *refugee/immigrant situation* and the aspects of the framework?" T2: "Yes. But I wish the workers involved with her case had known about and considered the framework on her arrival in Finland. I think we would have been able to be more understanding of her behavior and the situation. As far as the *traumatic experiences* she went through in Somalia and the *refugee/immigrant situation* are concerned, I agree with my colleague. Being a black woman in Finland is not easy. She is stared at and can be treated harshly just because of her skin color. Her way of life in Somalia was very different from life here. Living-in at the reception center while waiting for asylum is being left outside life in Finland. The *states of being* she is going through are: *the stranger, loneliness, missing, longing, guilt, separation and loss, sorrow, rootlessness, suspicion*. Most of these are based on reality, except *suspicion*. She is both in and out of the *arrival* stage of the *adaptation cycle*. Sometimes she opens herself to the *confrontation* stage, but then she falls back to *arrival* again. I have spoken about her *childhood experiences*. I know only the outer circumstances surrounding it, and can only imagine how it feels to be one of 11 children in a simple home, leaving her country at 17 to find work. She says the depressions

started after the birth of her sons. I have learned little about her background. She went to school until l7, and does not seem to be political in anyway. She fled because her husband had been killed and she was raped. She says little about how life was in the refugee camps in Africa, other than that it was horrible. The *transition-related conditions* I have considered are the *traumatic experiences* surrounding the killing of her husband, her rape and torture, loss of family, friends and possessions." S1: "Were the children present when her husband was killed and she was raped?" T2: "I don't know."

Goals of the treatment:

S1: "What are the goals of your work with her?" T2: "At this point, I don't know. There are so many difficulties." S1: "To sum up, it was suggested that it would be best to wait and see what happens. I agree, because both of you are working with different family members. I hope you will try to learn the mother's actual feelings about her children. It doesn't sound psychologically adequate when she says she needs her child when she is sick – but it could sound worse than it is because of her way of expressing herself in English, or because of her *refugee/immigrant situation*, that is how different and isolated she feels and is in Finland. This will change now because the mother and son have been granted asylum and are on their way here. That is why I would wait."

The symptoms recede after reunification with other family members:

A few weeks later:

T2: "Her mother arrived recently. I met her when they came to my office together. She was shining with happiness. 'This is my mother!' she said. She seemed like a nice older woman, but she was not happy. 'Why did I have to come to Finland just to help my daughter?' she asked me. 'I have 11 children in the United States, Germany, and some still in Somalia. Why do I have to come here just for my daughter?' I noticed that the older boy related to the grandmother as his mother. We did not talk very much about that. But the situation is not good. She seems calmer and happier, but her mother is unhappy. The younger child is now open, and happy about having both mother and grandmother here, but the older son was passive and is treated by both of them as the bad one." S1: "How old is this boy?" T2: "About 6. He was very still and passive, staring at the older woman. Now my patient leaves all the responsibility for both children to her mother. She leaves them and travels all over Finland to visit other Somalians. She explained 'This is the month that bad things happen and usually every year at this time I get bad'. 'What bad things?' I asked. It was during this month that her husband was killed and she was raped."

Traumatic experiences, the *refugee/immigrant situation* and the *reason* in the context of the individual's symptoms and behavior:

Gm: "It feels chaotic." S1: "How long ago was her husband killed?" T2: "Three years ago." S1: "We can assume that all the time she was in

Finland she was trying in any way she could to get her mother and son out of the refugee camp. She succeeded in the almost impossible feat of getting her family members permission to reside in Finland. Of course, she has neurotic problems and may be manic-depressive. However, she was telling the truth when she explained that she felt that her situation could not get better until her mother and son were in Finland. We must now see what happens to her and the rest of the family." S2: "To understand the situation we must regard her present family difficulties as stemming from the past. It feels as if she wants to flee from everything – past and present." S1: "We must look at the woman's behavior at different levels. When you are unsure of how to go about working with people from other cultures, you can try to put yourself in their place. How would you feel being alone in a foreign country, where much of the outer life is different; the color of your skin and your traditions are different. In your homeland, you witnessed your husband being killed and burned in front of your eyes. You were raped and tortured by his killers and had to flee your country, live in refugee camps in different countries under difficult conditions, and finally reach Finland. She is 25 years old in a strange country. She wants her mother and child here, knowing the conditions they live in a refugee camp somewhere in Africa. She is seen as a manic-depressive by Finnish professionals and has even explained to them that she was that way in Somalia. So her present behavior may relate to her past psychological profile. She has tried to convince others of her need to have her mother come to Finland with the only the power she had in the new country, expressing her feelings of desperation to the people around her. She was going to kill herself and her child if her mother and other son were not allowed to come. On a conscious or unconscious level, she used the only maneuvers or strategies available to her to get what she wanted. Actually, she shows great strength and will."

The role of the therapist:

S1: "With regard to your role as therapist, have you defined the goal of your work with her? Does she understand your role? Is she avoiding her children to try to escape from the memories of her own traumatic experiences? She leaves her children and goes off to the comfort of friends. Is that so unusual? Isn't it something that a Finn might do, too?"

The process of reunification considered in context to the *reason*:

S1: "Her older 6 year old son doesn't recognize her as his mother. There has been a separation of over 3 years. A boy of 6 may well not at first recognize his mother after a 3-year separation. Nothing so far is showing me a neurotically confused family, but rather a family that has been separated traumatically and finally reunited. The psychological complications of reunification are evident. I would like to mention here that in many cultures, it is not unusual that the grandmother brings the children up. Wasn't it like that in Finland in the past? I believe that the carer must always try to look at and understand the refugee family in a

wider perspective in the first place, only thereafter psychologically. Is it a symbiotic relationship that went on in the homeland and continues in exile, or does it look symbiotic because the mother is unsure of herself in the new country and is compensating for her loss of family? The *traumatic experiences* that she endured 3 years ago may be affecting her maternal role as well as her present behavior. At the time, she was 22 years old. How would you feel if you had seen your husband killed and burned in front of you, and if you were then raped by his murderers? It is not an easy experience at any age. I think we should be very generous with her. I would try to make her see what she can make of her life in Finland, regardless of her past life. Of course she will feel paranoiac and psychotic at times, after what she has experienced. If she was a depressive person before her husband's execution and her rape, these events could afterwards lead to even more severe depression. Being a child in a family of 11 children in a poor economic environment is not easy in any country. How much attention can any parent give 11 children? Perhaps all this is coming up now, when she and her mother have so little to keep them occupied in Finland." T2: "Yes. I agree. She hasn't even got started with her life here yet."

The *relevant background condition: education*:

S1: "Does she have any education?" T2: "She went to school until she was 17 years old." S1: "Is there anything she wants to do?" T2: "I don't know. She went to Finnish language courses but she could not concentrate, so she stopped." S1: "It is often difficult for refugees who have experienced severe trauma to concentrate on language studies when they come to the new country. She is young and seems intelligent and resourceful. Part of our work as psychotherapists/support workers is to encourage refugees to use our societies in constructive ways – such as continuing their education. You could make that a goal while you work on the trauma and the mourning process surrounding it, as well as on her relationship with her mother and children."

Dealing with the *transition-related condition: traumatic experiences* of the adult and the child:

S1: "At the initial phase, I would try to define for myself and the patient what we will be concentrating on. It is painful for her to go into the mourning process on the anniversary of the death of her husband. She visits friends instead. Is she able to talk about those experiences with them and get solace? Or is she running away from her memories? As far as the children are concerned, I would wait to see what happens. Perhaps the seemingly symbiotic relationship with the youngest son was more to compensate for the loss of her other family members. The 6 year old has just arrived. His passivity may change when he feels more at home with his family and the new outer environment. I would give them time to reunite and see what happens." Gm: "Is she going around Finland because she is looking for a man to get married to again?" S2: "I thought that too.

It was like that at the refugee center in Malawi. The women whose men had been killed were looking for husbands – perhaps to avoid the mourning process or to find someone to support them economically." S1: "I have met women from many different countries, including Somalia. When they see the life women are able to have in the Scandinavian countries and Europe, they are not sure they want to go back to their traditional woman's role again. As a therapist, you will be the person she shares these things with. Perhaps, as some participants suggest, she could be running away from her mourning or trying to meet a man. All this will come out in the therapeutic work. A lot of women choose not to marry again after being widowed or divorced. They decide to get an education or find employment. Especially when an individual/family goes into therapy, he/she usually learns to define what he/she wants and begins to understand that there are many different opportunities and choices. Through psychotherapy, the person may learn what she wants in her life in Finland and that she has choices. It is not always certain that an individual from a different culture wants to continue the way of life in which she has lived. The goal of therapy is to motivate the patient to use the therapeutic situation to allow him/herself to find his/her own answers. 'Am I going to follow my culture and get married again as soon as possible, or do I want to do something else, like start an education?' She has a great deal of strength and will. She got the Finnish authorities to allow her mother and son to come here – that shows enormous will power!" S2: "The first goal then is to motivate her to go into therapy so she can learn to make choices." S1: "Yes, and it seems to me that you (T2) are doing that, as the woman trusts you and the working alliance seems to have been formed." T2: "Yes, I have worked to gain her confidence. She is beginning to express her feelings openly, in her own way."

The treatment continues at the end of the supervision and training program:

T2: "I have been seeing the woman twice a month. It is more support work than psychotherapy, at this point anyway. It is a help, she says, to meet this way. Later on, as she gets on with her life in Finland, she wants to come more often. Right now, she doesn't want to. She is studying Finnish every day at school. She often talks about how she was when we first met, almost a year ago when her mother and son were not here. She did not trust anyone and was misunderstood by everyone. 'You and the child psychiatrist (T1) were the only ones who seemed to understand my predicament. I was not crazy. I was worried about my son and my mother'." S1: "It is not unusual that traumatized refugees are wary of deep and ongoing contact. The alliance between you has, over the years, grown in to a trusting relationship, of a kind she has tested so many times. What language are you speaking with her now?" T2: "We speak English and some Finnish." S1: "You showed respect for her and the way she experiences her reality right now, even if it may be paranoiac. That is important. Do you feel good about it?" T2: "Yes, I am very glad that she

trusts me." S2: "Have her symptoms improved?" T1: "Greatly. She has not shown signs of depression or paranoia for several months." S1: "At the beginning of your work with her, you reflected on her *refugee/immigrant situation* and the aspects of the framework, especially the *transition-related condition: past traumatic experiences*. Have there been any changes?" T1: "Sharing her *traumatic experiences* with me I believe has helped her psychological recovery and allowed her to see what she has in life, not only what she has lost. Listening to what a young girl has gone through has not been easy for me, even though I have worked with refugees for a long time. I am better able to contain these experiences and empathize without feeling sorry for her. That is important. She must live on in spite of them. She did not believe she could; that is why she attempted suicide several times.

With regard to her *refugee/immigrant situation*, she and her mother, I am told by her, are doing much more in the outside world – shopping, taking buses and trains alone to different places. They mostly meet other Somalian families here, but she is learning Finnish and trying to help her mother to try to learn it. Her mother cannot read or write. The young woman is friendly with the people in my office now. Before she was aggressive and suspicious. She describes life in Finland in a more positive way than before. During our meetings, I have tried to work through the *states of being* she is going through, especially: *guilt, separation and loss, sorrow, rootlessness* and *suspicion*. There seems to be improvement in all of them. She is definitely more in the *confrontation* stage of the *adaptation cycle* than when she started meeting me, and now she has even touched the *flashback* stage as regards her husband and past life."

Realization of the goals of the treatment:

The adult: S1: "Are you of the opinion that the goals of the treatment have been realized?" T1: "The situation was so chaotic when I started working with her that I could not even imagine a goal for the work, other than trying to calm her down. Now I can state that my goal in my work with her, which is also hers, is to continue life in Finland with all the rights and opportunities of any woman in Scandinavia."

The children: S1: "How are the children now?" Child psychiatrist (T1): "I have no further direct contact with them, but I supervise the personnel at their day-care center. The boys both seem happy, play with other children and have learned Finnish. The grandmother brings them everyday, and the mother picks them up when she comes from school and they seem glad to see her. The youngest boy no longer seems abnormally attached to his mother. The personnel describes the family as 'normal'." S1: "I still wonder if the children saw their father killed, and mother raped and tortured? If so, it must be worked through." T2: "I could ask". T1: "Yes, and I would be willing to work these events through with them. I have now worked with other refugee children in play therapy combining it with consideration of the *refugee/immigrant situation* and aspects of the framework, and also treating

traumatic events and intertwining all this knowledge, and I have been successful in both short-term and long-term child psychotherapies.

Comments of the project leader

This is a case of a troubled mother and child that were dealt with and diagnosed at first by carers who did not understand the inner consequences of war trauma and torture experiences, and how they can be acted out in diverse behavior by a desperate person living in exile. It was when both of these therapists became involved that the family's symptoms and behaviors were understood. Although one of the therapists admitted she was confused by the family members' behavior, she adhered to the woman's pleas and appealed to government officials to permit her mother and older son to reside permanently in Finland. When they arrived a year after that appeal, the family members' symptoms were eased and then disappeared. By mapping out the frameworks of each family member, the symptoms became comprehensible. In the supervision, each one's *refugee/immigrant situation* and aspects of the framework, and *traumas* was discussed as regards the past and the present. The supervisors and group members were positive to the therapists' reactions to the individual's desperate attempt to get her family reunited, by respecting it and writing a joint appeal. The significance of such actions and their consequences for the improved mental states of the family members was discussed in this supervision. The need for mental-health carers to learn to write proper written appeals and certificates was taken up.

Example 13.1 – women's group: support work, time-limited

Duration: A term

Support workers: Female social worker, age 31; female psychiatric nurse, age 34

Participants: Seven female refugees, age range from: 20-33 years, from different countries

A social assistant and a psychiatric nurse organized a female refugee group of different ages and from several different backgrounds and countries. The framework was used in planning and carrying out the group work. The group was conducted in Finnish. There were nine meetings, once every 2 weeks for 2 hours, for 1 term. Each meeting took up a theme chosen by the group members. The meetings consisted of:

1st meeting: Explanation of the goals; presentation of the group members and leaders; childhood memories; how Finnish people are experienced by foreigners.

2nd meeting: Missing family and friends; Finnish people's attitude to their parents and the older generation.

3rd meeting: Sharing of household chores in Finland; marriage; the qualities of a good husband; how weddings are arranged in different countries; cooking in different countries.

4th meeting: Children; the choice and meaning of names in different cultures; conditions in the homeland.

5th meeting: Finnish legislation; the rights and opportunities a woman has in Finland.

6th meeting: Religion; what is permitted, especially in the Islamic and Christian religions; pilgrimages; voluntary and forced behavior with regard to religion, war and its atrocities.

7th meeting: Fear of meeting new people; the future in Finland; home, study and work.

8th meeting: Requested lecture and discussion: Opportunities and limits for a woman in Finnish society; discussion on women's status in different societies.

9th meeting: Requested lecture and discussion: Equality and upbringing of children in Finnish society; discussion on thoughts the lecture provoked.

Group leaders' remarks: Because we chose to speak Finnish and not use an interpreter, we had to be clear, exact and simple in our formulations. Group continuity and a secure feeling within the group was difficult to achieve because of the group members' varied backgrounds. However, even though the group members came from very different backgrounds and circumstances, it worked anyway. As an experience, it was worthwhile and rewarding. We both realized how much all women have in common.

Comments of the project leader

After a lecture on group work using the framework, two participants planned and conducted the meetings of this women's group. In supervision, the goals, contents and organization, and their roles in it were discussed. They were encouraged to map out for themselves the framework of each group member as they got to know them. They listened and, to some extent, shared their own feelings, but focused on clarifying misconceptions about Finnish society, rather than offering interpretations or advice.

Example 13.2 – youth group: support work, time-limited

Duration: One term

Support worker: Male psychologist, age 28

Participants: Five unaccompanied male refugee adolescents, age range 17-21 years, from different countries

During a supervision, a psychologist working at the employment office discussed starting a group with male refugee youths who were making decisions about their future in Finland with regard to education and/or employment. The size of the group, its goal and theme were discussed. The support worker wanted the group members to have a forum to talk about difficulties in their lives in Finland. The framework would be used as the point of reference. The language spoken would be Finnish. The group leaders would be the psychologist and a social assistant. The goal of the group was formulated as "towards a constructive adaptation to life in Finland".

In supervision, the psychologist discussed the following: the type of youths suitable; how the support workers could interest the youths in taking part in the group. To what extent should the group leaders encourage the youths to go into their backgrounds? How should other carers working with these youths be involved? Also taken up were the resources necessary with regard to finance and time; how to set up the group: timescale, location, etc.

In another supervision, the various ways in which to motivate the youths were discussed. It was suggested that the support workers meet with each youth individually and as simply as possible explain the meaning and goals of such a group.

Afterwards, the psychologist contacted possible group participants. He also contacted the schools and social offices involved, and discussed their part in supporting the youths in applying for their educational or employment choices.

The group consisted of 5 youths. Three took part in it continuously. The support workers mapped out the framework of each participant and focused the group work on their collective difficulties. They met once every 2 weeks (1½ hours). The group work lasted for one term. The psychologist expressed the view that it was constructive for the youths to get to know each other, share their lives in Finland and discover the similarities between them, even though they were from different backgrounds. One of the youths started as an apprentice in a small construction company, and 2 others went on to vocational-training programs.

Comments of the project leader

The supervision focused on the outer components of a support group offered at a government employment agency and what could be taken up and what should be avoided. The framework of each participant was considered. Although the adolescents came from different countries and backgrounds, sharing their experiences about life in Finland created closeness and generated catharsis. The carer's experience of counter-transference were dealt with, especially with regard to the group

members' similar experiences of prejudice and difficulties in being accepted in Finnish society.

Discussion

Because of Finland's strict entrance and asylum regulations, persons who seek or have received refugee status have complex backgrounds and severe traumatic homeland experiences. By contrast, the few immigrants that live in Finland are highly educated and/or married to a Finn. One case illustrates an immigrant living five years in the country. During the training program, the participants worked with twenty-two difficult cases referred to them from all over Finland by institutions working with these groups (including hospitals, mental-health centers and the government health-insurance authorities). The refugee/immigrant adults, adolescents, children and families came from different parts of the world, had varied and complicated symptoms and problems, and were treated in various types of psychotherapies and support work (see table 13.1).

The project leader (author) had the following viewpoints on how well the casework sample fully enabled the participants to utilize the framework. Some of the similarities and differences between the refugee and the immigrant – as taken up throughout part 1 (chapters 3-11) of this dissertation – were illustrated. However, most of the cases were of refugees, and entrance and asylum seekers. Accordingly, the long-term effects on the inner and outer worlds of both these groups were referred to extensively in the lectures and literature on the framework, and in other material. Participants worked with one or two cases, and described these continuously throughout the program. The goal of applying the framework is to facilitate the carer in his/her psychotherapy and support work with these groups. During the training program, the participants learned to notice, and also to map out the components of the framework in their cases – so as better to be able to understand, focus on and work through presented symptoms and difficulties. However, it is always more difficult to supervise participants of a training program when they are involved in complicated cases.

In this chapter, eight examples of the casework are documented in some detail to illustrate the application of the framework to the refugee and the immigrant in work with the adult, adolescent, child and family. They were selected to depict the ways in which utilization of the framework may facilitate treatment, care and preventive work.

Case 13.1 provides an example of time-limited psychotherapy. The psychotherapist was experienced, but had never worked with a traumatized refugee. Use of the framework enabled the unsure, but otherwise qualified therapist to map out the individual's most severe problems (in the context of presented symptoms) and work through them. The symptoms for which the individual sought help appeared to be alleviated.

Case 13.2 offers an example of psychotherapy with a traumatized refugee. Her symptoms and difficulties were difficult to understand and decipher. Were they somatic, psychosomatic or psychic? Application of the components of the framework helped the therapist to organize and focus treatment in this complex case. By the end of the treatment, the individual's symptoms seemed to have been alleviated.

Case 13.3 documents psychotherapy with a tortured refugee. The mental nurse/psychotherapist was hesitant to take the case as she had never worked before with victims of torture. Application of the framework enabled the therapist to differentiate between symptoms caused by the effects of torture and those resulting from problems of life in exile. She was able to comprehend and work through the torture experiences and the ways in which these caused the individual's symptoms. At the same time, the therapist could work on the individual's present life difficulties. By the end of the treatment, the individual had worked through and learned to deal with the memories of previous homeland experiences and seemed better able to function constructively in her life in exile.

Case 13.4 deals with an immigrant in psychotherapy with a psychoanalyst who had never worked with a refugee/immigrant. The framework enabled the psychoanalyst first to investigate the common components of the individual's behaviors and problems, and then to focus on the specific difficulties of being an immigrant. The case illustrates the anxiety the refugee turned immigrant has in making the choice to stay in another country or return to the homeland (which the refugee or asylum seeker does not have). By the end of the psychotherapy, the individual showed greater apparent understanding of himself, and seemed able to make significant life choices.

Case 13.5 provides an example of long-term support work. The experienced social worker had never worked with people of different races,

cultures and backgrounds. Through the process supervision, she learned to accept and deal with the kinds of transference/counter-transference that arise in work with individuals from these groups. The case illustrates how a support worker with limited knowledge of the individual's past and homeland experiences can gradually map out significant components of the framework as trust in the working alliance builds up. In the view of the social worker, the individual's behaviors and symptoms could then be better understood and worked through.

Case 13.6 offers an example of child/adult support work and psychotherapy with two psychotherapists – the one treating the adult; the other, the child. The case seemed chaotic and complicated. Mapping out the frameworks of the adult and the child allowed the psychotherapists to understand symptoms and difficulties relating to the past and present respectively. Some of the acute and severe psychotic symptoms of the adult appeared to be alleviated when the therapists made a joint effort to help to reunify the family (by writing an appeal to explain the situation to the government authorities). Afterwards, the two patients were able to work through the past traumatic experiences that affected their lives in exile in separate therapies.

Examples 13.1 and 13.2 depict one-term group work with women and youths. Both groups had curative and preventive goals. The support workers used the framework as a basis to map out difficulties of life in exile and to focus on the issues that the group members wanted to take up.

Although the examples are of a varied and complex group of individuals, the documentation of the participants' treatment and care illustrates the ways in which the application of the conceptual framework may facilitate work with the refugee and immigrant.

14. RESEARCH EVALUATIONS OF THE TRAINING PROGRAM

This chapter depicts research evaluations of the training program. The conceptual framework itself is consistently in focus. Graphic summations of the evaluations and excerpts from the written and oral comments of the participants are provided. The chapter concludes with a discussion of results.

Participants' evaluations are considered with regard to: (1) The training program as a whole; (2) The conceptual framework; (3) The supervision; (4) The casework; (5) The lectures, seminars and literature.

Graphic summations of the written evaluations and a sample of excerpts from the written and oral comments of the participants are presented. The material was collected by the project leader (author) from the participants' oral and written reports, tape-recorded material and three questionnaires (see Appendix 5).

Thirteen of the fifteen participants were present at a final seminar that completed the training, and filled in questionnaire 1. Eleven participants responded to questionnaires 2 and 3, administered one month and six months respectively after the end of the training program. Note that, except in the case of responses to the final-seminar questionnaire (see figure 14.1), the graphic summations are based on the responses of the nine participants who completed *all* questionnaires (the horizontal scales of the graphs encompass all fifteen participants, i.e. include non-respondents). From oral reports received, these evaluations did not seem to differ in any systematic way from those of the additional four participants who answered questionnaire 2, and the two others who answered questionnaire 3.

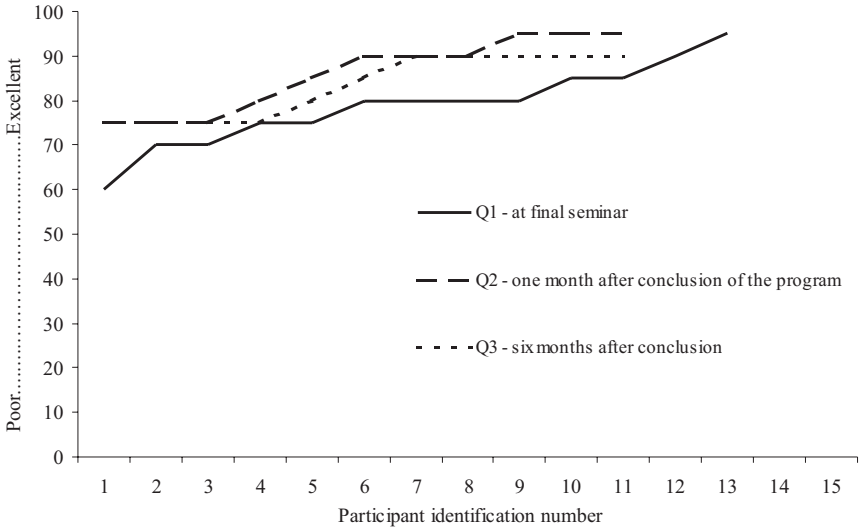
The training program as a whole

Taking the three written questionnaires as a whole, the training program was rated at a total mean value of 80.9 on the scale 0-100. There follows further information on ratings of the program by occasion of evaluation. (See figure 14.1.)

Questionnaire 1 – at the final seminar on completion of the training

The complete training program was rated as having an average value of 77.0. Positive and negative evaluations and comments, and suggestions for improvement were as follows.

1. Positive evaluations: The question "What was most positive in the training program as a whole?" elicited a range of responses. Participants stated that "it was a new sphere and showed a practical



Q 1 – mean rating: 77.0 n = 13 (non responding n = 2); Q 2 – mean rating: 84.0 n = 11; (non responding n = 4); Q 3 – mean rating: 81.7 n = 11 (non responding n = 4) Overall rating: 80.9 (giving equal weight to responses in all three questionnaires).

Figure 14.1. How do you rate the training program as a whole? Ratings by participants on a scale 0 to 100 (poor to excellent) on three occasions.

way of working", "provided an opportunity to become absorbed in the inner world of the refugee/immigrant", and "enabled understanding of their feelings and looking at them as individuals". Several most appreciated having "a practical framework to work with". Nine of the participants rated the supervision as the most positive factor in the program, and stated that through it they had found new methods of working. Favorable comments included "the framework has augmented my ability to work with refugees and immigrants"; "the heterogeneous group has widened my perspectives"; "that the training was a year long was important because it leaves time for reflection and digesting impressions"; "the way theory and personal insight were intertwined with each other was particularly important"; "large-group supervision gave opportunities to gain insight into the casework of others".

2. Negative evaluations: The participants were posed the question "In your opinion, what should be modified or changed?" There were desires for even more structure, and more work with the whole group, and greater personal involvement with the process. One particular comment was as follows: "Instead of concentrating so much on individual psychotherapy/support work, the family's role in different cultures and family therapy should have been extended; the program should be extended to include this." Nine of the participants commented negatively on the literature seminars.
3. Suggestions for improvement: These included having a more homogeneous group, a smaller group, and changes to practical routines. With regard to content, some participants suggested concentrating more extensively on support work, and the ways in which a new culture affects the individual, and family systems.

Questionnaire 2 – one month after conclusion of the training program

The training program was rated by the participants at 84.0 on a scale of 100 one month after its conclusion. Positive and negative evaluations and comments, and suggestions for improvement were as follows.

1. Positive evaluations: The participants were asked "In what way did the program fulfill your needs?" One was especially favorable, writing "1. Theory on how it is to be a refugee, the outer difficulties of life in exile and especially the inner ones. 2. The group supervision made it possible to see the framework applied in practical ways. 3. Own supervision for the questions and cases in point; the program gave me information about the universal feelings of refugees/immigrants and a method for understanding them. I gained an improved basis on which to understand what my clients went through in their lives, and their difficulties in adjusting to life in Finland." Others referred to "increased understanding of refugees/immigrants and a way to map out and understand their symptoms and crises", "a framework to utilize and start from", "a way of dealing with specific problems, e.g. torture", "new ideas concerning activities at the institution where I work"; "deeper client contact; fulfilled what I lacked in knowledge on a theoretical level". Several participants stated that the program gave them security in psychotherapy/psychoanalysis with the refugee/immigrant, and that they had gained confidence and belief in working therapeutically with these groups.

2. Negative evaluations: The participants were asked "In what way did the program not fulfill your needs?" Responses included "we should have studied everything more deeply than the time limit made possible", "maybe I had unrealistic expectations about personal supervision", "the framework's application to social work could have been more extensively dealt with", and "everything was too short; in practice, everything should have been studied in greater depth, but we were restricted by time".
3. Suggestions for improvement: The participants were asked "On what would you have liked to have focused more intensively?" Two referred to doing psychotherapy/support work with an interpreter. The direct question "Do you have any suggestions for improvement?" elicited a number of comments with regard to content: "extended time for discussion", "concentrating even more on similarities and differences in psychotherapy with different cultures and their effects on the process, especially with regard to transference/counter-transference", "questioning the dynamic outlook on mankind".

Questionnaire 3 – six months after conclusion of the training program

The training program was rated 81.7 on a scale of 100. Positive and negative evaluations and comments, and suggestions for improvement were as follows.

1. Positive evaluations: Participants were asked "What has been most positive?" and "What should be used in the future?" Over three-quarters referred to the framework and various lectures about it, and the supervision. Other aspects of the program favorably received were the other theoretical knowledge it provided, the guest lecturers, the seminars, group work on own background and war traumas, own personal prejudices, culture presentations, and refugee laws and policies. One participant replied: "The cultural aspect; you notice that what is *universal* on a psychological level is, paradoxically, what is most important".
2. Negative evaluations: One participant stated that the program had too great an emphasis on therapeutic treatment at the expense of support work. The large-group supervision, the literature seminars, and the organization of individuals for treatment came in for some criticism.

3. Suggestions for improvement: The participants were asked about the focus of the training program in the future. Three responded that it should be exactly the same or similar. Four wanted the current focus to be maintained, with even more of it on the framework. Four participants wanted more supervision. The participants were also asked "What should be added to the program?" They suggested greater focus on what happens within the therapist/support worker working with the traumatized or tortured refugee, and even more stress on cross-cultural knowledge from the perspective of the social worker and other support workers.

Summation of evaluations of the training program as a whole

1. Positive evaluations: The most positive factors reported were: process learning of the framework and how it is applied in treatment and care in curative and preventive programs; supervision and having it in a heterogeneous professional group; that the theoretical part of the program and the supervision were intertwined in a process; the framework and the ability to focus more efficiently on the symptoms and difficulties of the refugee/immigrant; and other theoretical knowledge specific to refugees and immigrants. Also, in psychotherapy and support work: the realization and utilization of universality of feelings between people of different cultures; the understanding of how one's own culture and own cultural attitudes can affect work with refugees/immigrants; and how one's own unaware and aware prejudices can affect one's work in psychotherapy/support work with these groups; increased understanding of the difficulties of life in exile, or living in another country; which made possible a deepened contact in psychotherapy and support work; increased self-confidence in psychotherapy, support work and research in the field.
2. Negative evaluations: the large group and difficulties in expressing oneself openly in it; the casework and the emphasis on psychotherapy rather than support work; insufficient time allocated to children and families; not enough discussion; practical difficulties in traveling to different cities for each meeting; and compact three-day weekends; need to extend the process supervision/education.

3. Suggestions for improvement: that the training program should be more than two terms, and regarded as a specialized program in psychotherapy and support work for refugee/immigrants; greater concentration on supervision; greater focus on the application of the framework in social and support work, and in work with children and families; increased knowledge of different cultures; building networks on a local, national and international level; history of refugee/immigrant laws and policies; and more extensive work on the use of an interpreter; make literature seminars voluntary or exclude them altogether.

The conceptual framework

The participants were asked to rate the framework in both its theoretical and practical aspects both during and after the program. The framework was evaluated in three questionnaires (see Appendix 5) – at the final seminar, one month after conclusion of the program, and six months after its conclusion.

Questionnaire 1 – at the final seminar on completion of the training

1. Positive evaluations: On being asked "What has been most positive about the training program?", seven of the participants commented on the framework and the lectures surrounding it. "Paved the way to wider and deeper perspectives on the refugee and immigrant", "very worthwhile in practical work", "it helps you to focus faster, better, on the special problems of refugees – from chaos to order" were some of the comments.
2. Negative evaluations: One participant stated that the framework "may be too intra-psychically directed".
3. Suggestions for improvement: One participant suggested "more practical solutions in relation to the different components of the framework".

Questionnaire 2 – one month after conclusion of the training program

1. Positive evaluations: Participants generally stated that the framework, used as the basis for the program, was very important – providing a good foundation for one's own work, and clear and precise. On being asked about the framework's use in psychotherapy/support work, the following comments were received: "easy to comprehend and apply", "increased understanding of refugees and immigrants and a way to map out and

understand their symptoms and crises", "well structured and suits reality", "a good and flexible basis to start from and work with", "a simple method to focus on the most elementary things in different phases of psychotherapy".

2. Negative evaluations: One participant stated "I cannot approve of the framework without first accepting its underlying ideology, i.e. heredity/environment, instinct/learning, childhood/manhood, trauma + different cultures – and their connection to dynamic psychology".
3. Suggestions for improvement: To the question "What would you have liked to focus on more deeply with regard to the framework?" The participants referred to use in one's own work, work with children, the framework's application to social work and other support work, and networking. One participant suggested focusing to a greater extent on how the framework is utilized in the treatment process.

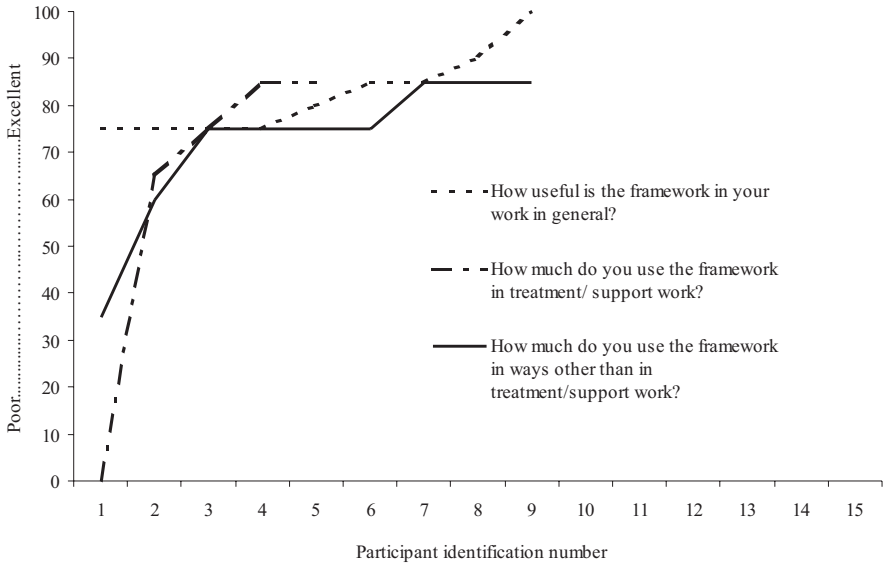
Questionnaire 3 – six months after conclusion of the training program

1. Positive evaluations: Seven of the participants evaluated the framework and the lectures and supervision based on it as the most positive part of the program, and stated that these should be included in the future, but with an even greater focus on processes of psychotherapy/support work.
2. Negative evaluations: The framework's application to social work could have been more extensively dealt with.
3. Suggestions for improvement: Four participants stated that there should be even greater focus on the framework in application to psychotherapy and support work.

The participants were asked to rate several aspects of utilizing the training. Figure 14.2 shows the results of the participants' evaluations.

Utilization of the conceptual framework

1. In your work in general – mean rating: 83.3: The participants made various comments on the way in which they utilized the framework in their work in general: "of great importance when one works with foreigners generally and individually", "increase knowledge among my team colleagues, at other institutions and privately – in my research and giving lectures on cross-cultural psychology".



(1) In your work in general – mean rating: 83.3; (2) In treatment/support work – mean rating: 62.0; (3) In other ways – mean rating: 72.2; Overall rating (giving equal weight to responses in all three questionnaires): 72.5

Figure 14.2. To what degree has the supervision affected you in your work? Ratings by participants on a scale 0 to 100 (poor to excellent) on three occasions.

In direct psychotherapy and support work: “better understanding of how the refugee/immigrant can think and feel and an increased readiness to listen without getting angry, disappointed or too critical”, “not to be used systematically but, for example, when planning methods to help my clientand in contact with my colleagues”, “most concretely in social work with refugees and immigrants”. One went as far to state “the framework made it possible for me to understand better what a refugee/immigrant goes through and the different ways of working with and handling a situation. I also have a better picture of the dynamics in a refugee family. I can now fully comprehend what a refugee endures in the homeland, and the protracted consequences these experiences have”.

Responding to a question on utilization of the framework in work in general, the participants referred to its use in psychotherapy/support work – explicitly and implicitly in treatment, in consultation, and in

assessing the difficulties of the refugee individual/family at the beginning of psychotherapy and during its course. The comments of others were as follows: "A good structure to start from and follow, as it enables you to get into the client's background in a natural way; it helps you to see the entirety, and parts of it can be considered and utilized when needed"; "the clarity and detail are a great help both theoretically and in reality"; "I use the framework in crisis work among persons seeking asylum, and in discussions together with other staff members (social workers, doctors and nurses and others), in going over cases to form an opinion based on the framework"; "A check-up list. Forming an opinion that is, so to speak, approximate, and a method to gather my thoughts"; "The framework became a sort of continuation and intensification into the psychodynamics of the individual and the process of psychotherapy – a natural and good continuation to 3-year long psychotherapy training. I use it all the time on a conscious level in psychotherapy and in support work. Now even when I am not always aware of it, I am utilizing the framework to understand my clients".

2. In treatment/support work – mean rating: 62.0: Four participants answered this more specific question about the use of the framework in treatment (on the second part of the third questionnaire). This will be taken up separately below.
3. In other ways – mean rating: 72.2: The participants described use of the framework in other ways, e.g. in discussions with public officials about refugee matters: "I use it to be able to react to plans and decisions about refugees; I've lectured about the framework to therapists on two occasions".

Summation of evaluations of the conceptual framework (questionnaires 1, 2 and 3)

1. Positive evaluations: In oral and written evaluations, the participants were positive to the framework. Several stated that it was the most positive part of the program. In psychotherapy and support work, the framework was commented on as: "a good foundation"; "precise and easy to apply"; "helps to focus in a quicker, more effective way on the special problems of the refugee/immigrant"; "useful to integrate into the different phases of psychotherapy/psychoanalysis"; "for assessment, especially at the start of the treatment/support work,

helps to see the entirety, and when needed, its parts can be considered and utilized"; "useful in crisis work among asylum seekers for going over cases and forming an opinion, in planning methods to assist clients, in contact with colleagues". Participants were also asked in what ways they utilized the framework and referred to implicit and explicit levels in psychotherapy/support work, in consultation, in research, in giving lectures, in discussions with colleagues, public officials and others, and in responding to political, state and municipal planning in relation to refugees/immigrants.

2. Negative evaluations: One participant questioned the ideology of the framework and its connection to dynamic psychology. Another stated that the framework's application to social work might have been more extensively dealt with.
3. Suggestions for improvement: One participant suggested more practical solutions in relation to the different components of the framework. To the question "What would you have liked to focus on more deeply with regard to the framework?", participants referred to use in one's own work, work with children, application to support work, and networking. One suggested focusing to a greater extent on how the framework is utilized in different phases of psychotherapy/psychoanalysis and support work processes.

The supervision

Supervision was evaluated by the participants in oral and written reports during and after the program. Assessment was performed using the three written questionnaires (see Appendix 5). Questionnaire 1 asked for descriptions of experiences, and these are summarized immediately below. Questionnaires 2 and 3 asked for value ratings, the results of which are depicted in a summation graph (figure 14.3 overleaf).

Questionnaire 1 – at the final seminar on completion of the training

1. Positive evaluations: Nine of the participants felt that the supervision was the most positive component of the program. As to its contents, five stated that it was good, and that the training program had a connection with practical work. Four participants commented on the large-group supervision: "with a functioning team, it really worked!"; **"**learnt much concerning both my own work and that of others"; "gave strength and security to dare to work

in psychotherapy with refugees." With regard to work in general, participants commented "it opened my mind enormously"; "to dare to encounter difficulties, and not look upon refugees as 'different' people"; "easier to approach an agonizing trauma"; "helped to work with crises".

2. Negative evaluations: Negative comments were largely concerned with doubts about large-group supervision. Shyness had to be overcome, and work failures and defects were hard to discuss. One person even began to feel that individual supervision would have been better. It was felt that too many cases were sometimes introduced in one day.
3. Suggestions for improvement: A smaller group, a homogenous group, greater focus on the transactional processes, more practical solutions.

Questionnaires 2 and 3 – one and six months after the conclusion of the program

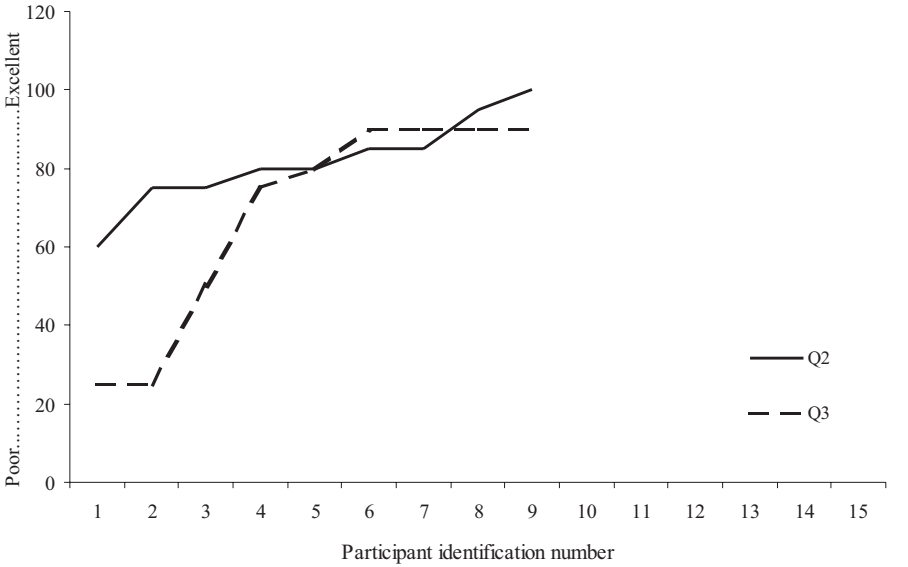
In questionnaire 2, participants were asked to rate the supervision; and, in questionnaire 3, to rate the supervision's influence on their work. Results are depicted in a summation graph (figure 14.3):

On questionnaires 2 and 3, the supervision was rated at a total mean value of 78.9 on the scale 0-100.

Questionnaire 2 – one month after the conclusion of the training program

The supervision was rated by the participants at 82.2 on the scale 0-100.

1. Positive evaluations: When asked to explain the evaluation of the supervision, most participants replied that it was positive with a heterogeneous group, and that they learned from others' methods of working. The putting-together of people from different professions was instructive since it gave insight into the difficulties of refugees and immigrants from different angles. When asked "In what ways has the supervision affected your client work?", five participants responded increased self-confidence in work with these groups.



Q2 – mean rating: 82.2, n = 11 (non responding n = 4); Q3 – mean rating: 75.6, n = 11 (non responding n = 4).

Figure 14.3. Graphic representation of the participants' evaluations of the supervision and the extent to which it has affected them in their work.

2. Negative evaluations: Three participants commented that the group was too large, that they felt hampered, and that they would have liked to see more activity. Two other participants stated that a whole day of supervision was tiring, and that social work and other support work was not always prioritized. One support worker found it difficult to take up the content of her work. Language difficulties were sometimes regarded as a barrier activities. "Too much exposure at expense of depth", was one comment.
3. Suggestions for improvement: three participants proposed smaller groups.

Questionnaire 3 – six months after the conclusion of the training program

The supervision was rated by participants at 75.6 on the scale 0-100.

1. Positive evaluations: As on the previous occasions of evaluation, the participants declared that supervision in a large group, with other case studies, gave deeper insight into their own work.

2. Negative evaluations: Several of the participants still regarded the group as too large, and supervision as too infrequent; one other wanted a more homogeneous group. Two stressed the necessity for more structure.
3. Suggestions for improvement: Participants responded that even greater emphasis should be placed on the supervision and the framework's application to treatment/support work – with more casework in smaller/more specialized groups.

Summation of evaluations of the supervision (questionnaires 1, 2 and 3)

The participants regarded the supervision as an integral part of the program, and considered that in future it should be included in the same way – intertwined with the framework and the other theoretical parts of the training.

1. Positive evaluations: The supervision provided a solid base from which to understand the refugee/immigrant in application of the framework, new angles, and the opportunity to share work and learn by one's own case supervision and that of others. The supervision enabled the participants' work to be better equipped to understand the inner world of the refugee/immigrant; be more efficient in assessment and diagnosis of the adult, the child and family, and facilitated the comprehension of trauma's effect on everyday life. This reflected itself in less client drop-out, longer periods of treatment, and personal strength and security. Participants themselves gained through the supervision, in terms of self-confidence, increased self-reliance, and less burnout. During the program, most of the participants became positive to the heterogeneous large-group supervision.
2. Negative evaluations: hesitancy about large-group supervision; three participants stated that they would have preferred a smaller group. Some felt that a large group required more structure. It was difficult to speak openly, and that led to passivity. Others felt that the meetings were too infrequent, and that too many cases had to be considered in one day. One participant stated that the organizers of the training should provide individuals/families for treatment and support work during supervision, and that the appropriate authorities for obtaining such persons should have been informed well in advance.

3. Suggestions for improvement: Some participants recommended an additional focus on the application of the framework in casework, extended supervision, and more casework (in smaller, and perhaps more specialized, groups).

The casework

The treatment and support work was also evaluated by the participants in oral and written reports during and after the program. Again, assessment was performed using the three written questionnaires (see Appendix 5).

Questionnaire 1 – at the final seminar on completion of the training

1. Positive evaluations: The participants were asked "In what ways has the training program affected your work?" Responses included "deepened knowledge and capacity to work with refugees and immigrants", "a precondition for being able to do this work", "gained better understanding and became more open to these groups", "saved me from burnout", "convinced me that it's useful and necessary to do psychotherapy with these groups", "insight and deeper understanding", "affected me unconsciously by giving self-confidence, courage and security in my casework", "increased the depth and understanding of what my work really is about." More specific comments were that "being a refugee and living in exile doesn't feel peculiar to me anymore, but a most human and traumatic life situation", "I do not feel that unfamiliar, insecure and helpless when confronted by this kind of work in psychotherapy", "I've learnt a lot and I feel more confident inside", "I haven't worked with refugees before. I feel that I have gained insight and better conditions to work with refugees/immigrants thanks to the program. Anyway, I'm not as scared as before to work with them", "I have a clearer, more direct view of traumatized and tortured refugees' inner and external reality. The training gave knowledge of the meaning of trauma to the individual's life. I can work with trauma now."
2. Negative evaluations: There were too many cases in individual psychotherapy, not enough cases in child and family therapy. There was too little focus on the application of the framework and each of its components. More time should have been allotted to support work and social work rather than to psychotherapy. Some of the participants felt that discussion of the cases should have been more extensive.

3. Suggestions for improvement: Individuals for psychotherapy and support work should be sought by the institution organizing the program.

Questionnaire 2 – one month after the conclusion of the training program

1. Positive evaluations: Participants were asked to answer the question "Has the training program fulfilled the needs you have in your treatment and support work with refugees/immigrants? In what ways?" The program was rated on the scale 0 -100 (poor to excellent) at an average of 83.1. Participants' responses were similar to those from questionnaire 1.
2. Negative evaluations: "I didn't acquire very many practical, new methods to approach my clients and their problems." "My work is partly pedagogical, and therapeutical thinking is not enough." "Sometimes I had difficulties keeping up as a result of too little experience."
3. Suggestions for improvement: Each participant should be obliged to work with two cases in individual and family therapy and/or support work continually through the program.

Questionnaire 3 – six months after the conclusion of the training program

The casework was rated on a scale 0 – 100 (poor to excellent) at an average of 84.0.

1. Positive evaluations: Most of the participants commented on their casework in a similar way as in questionnaires 1 and 2. Three participants stated that the application of the framework to their cases had facilitated assessment. It gave better understanding of the symptoms and problems of the individual/family; and allowed them to be focused on more effectively.
2. Negative evaluations: Two participants stated once again that there was too much focus on individual psychotherapy.
3. Suggestions for improvement: Two participants recommended once again that, before the start of the program, individuals and families for the casework should be arranged by the organizers.

<u>Evaluation of specific psychotherapies and support work</u>

In the second part of questionnaire 3, the participants were asked to describe and evaluate the specific psychotherapies and support work carried out during and, in some cases, continuing after the program. Four

participants answered this part. Three participants worked with individual psychotherapy, one with family therapy. Several questions were posed:

For what reason/s did the individual/family seek treatment?

> Participant 1: – Crisis followed by deep depression after separation from fiancée.
>
> Participant 2: – Depression, fear, headache, sleeping problems, nightmares, anguish, difficulties in concentrating, physical weakness, throwing-up, gets irritated easily.
>
> Participant 3: – The family was in a crisis. The mother was psychotic, prone to suicide, persecution mania. The children were isolated and may have been battered. The whole family felt persecuted.
>
> Participant 4: – Anguish, depression, headache. Gets angry with her child easily. Worried over the family in the home country. Difficulties between wife and husband.

The participants were also ask to describe current symptoms: a. Constant; b. New ones have appeared; c. Fewer; d. None. *Responses:* c. Fewer – 75% d. None – 25%.

> At the start of the treatment, how did the individual/family function in the new society?
>
> Participant 1: – Functioned badly because of depression.
>
> Participant 2: – Learning difficulties in school.
>
> Participant 3: – Very bad. Conflicts with the staff, other persons seeking asylum, surroundings.
>
> Participant 4: – The husband, active, extrovert. The child did okay in school. The boy had difficulties at first, but then everything worked fine. The woman had difficulties from the beginning, was sad and cried easily, and filled with anguish.

How does the individual/family function now? a. The same; b. Improved; c. Worse. *Answers*: b. Improved – 100%.

Had the individual or the family members experienced trauma/s caused by outer violence in their homeland? Yes/No. *Reponses:* Three participants answered Yes; one No.

Have the trauma/s been worked through? Yes/No. *Responses:* Two participants answered Yes; two No.

Has the individual/family gained better understanding of how the trauma/s affected the symptoms. Yes/No. *Responses:* Two participants answered Yes; two No. *Explain:*

> Participant 2: – Knows of the connection, when she gets scared and feels uncomfortable when she suddenly sees a policeman. She knows why she gets in a state of anxiety (that it has to do with the torture).

Participant 3: – Well, no deep working-through and insight during the first part of the treatment. The insights are growing now during the middle of it.

Participant 4: – Partly, the client understood the parallel – how she had felt in her home country, during the escape and now. At the same time she has somatic problems.

Considering the components of the framework: Does the individual/family have a better understanding of how the trauma(s) affected life in and attitude to the new country? There were four alternatives: a. Constant; b. complications have been added; c. Better; d. Worse. *Responses:* Three participants answered Better; one gave no response.

How does the individual/family function now? a. Better; b. Returned to the usual pattern; c. New problems. *Responses:* Three participants answered Better; one gave no response. *Describe:*

Participant 1: – Much better. Is working well and objectively. Has a new relationship, which is realistic. Is happy, enterprising, progressive and content with his life.

Participant 2: – Is looking for and will eventually find a place in the society. Difficulties still exist, and they can't always be solved. Is learning the language actively.

Participant 3: – The mother does not talk of suicide anymore and is less depressed, and therefore the whole family has improved.

Participant 4: – Probably better than at the beginning of the treatment. She was looking forward to moving to another city, but could also talk about her and her family's fear of the new.

Summation of evaluations of the casework (questionnaires 1, 2 and 3)

Throughout the program and afterwards, the participants were asked in different ways to assess their casework and whether it had improved because of the supervision, the framework and the theoretical part of the program.

1. Positive evaluations of the oral and written evaluations of the casework showed increased understanding, depth, insight and self-confidence in the ability to work with, heal and support refugees/immigrants in psychotherapy/support work; the application of the framework to their cases had facilitated assessment, better understanding of the symptoms/problems of the individual/family, greater capacity to focus on these, and also a realization of personal influence in starting projects within institutions and out in society; encouraging change in policies and laws; the importance of networks; and less burnout.

2. Negative factors were that there was too much emphasis on individual psychotherapy; not enough cases with family and children or support work; or with practical solutions; not enough focus on the application of the framework; or the different phases of treatment and support work.
3. Suggestions for improvement: The participants recommended that in future training programs each participant should be obliged to work with two cases in adult/child and family therapies and/or support work continually through the program. Before the start of the program, the individuals and families for the casework should be arranged by the institution organizing the program.

In the second part of the final questionnaire, the participants were asked to assess the specific psychotherapies and support work each one had carried out during and after the program. Examples of four psychotherapies show that the individual/family's symptoms had improved; three participants responded that the individual/family's insight into the ways in which past homeland traumatic experiences influence their lives in the new country had increased; two participants answered that the traumas had been worked through, two participants stated that they had not yet been; three of the four participants felt that the individual/family functioned better.

The lectures, seminars and literature

In oral and written reports during and after the training program, the participants rated the lectures, seminars and literature. The purpose of this was to determine whether these were pertinent to the casework and supervision based on the framework.

The written questionnaires (see Appendix 5) were completed at three points in time: 1 the final seminar; 2 one month after conclusion of the program; 3 six months after conclusion.

Written summations of the evaluations follow. The lectures and seminars are documented first, followed by documentation of the literature seminars and the literature.

Questionnaire 1 – at the final seminar on completion of the training

The participants were asked to give their opinions on the structure and contents of A. The lectures; B. The seminars; C; The literature seminars; D: The literature. Note that value ratings were not requested.

A. The lectures:

1. Positive evaluations: Six participants described the lectures positively: comprising important subjects; opening the way to wider perspectives on the work. Specific positive opinions were also expressed by four participants about the lectures on the framework.
2. The negative evaluations: Two participants expressed the view that the tempo was too intense (even more focus was needed on aspects of the framework). Four stated that there was too much concentration on psychoanalytic psychotherapy with adults, and further emphasis should be placed on psychotherapy with refugee children and groups.
3. Suggestions for improvement: more specialization; further lectures on work with the refugee/immigrant family, child and group; with some lectures given by guest therapist and others working with these groups.

B. The seminars:

1. Positive evaluations: The participants evaluated the seminars positively. Nine described them as excellent and informative, with a suitable choice of themes. It was much appreciated that participants' own experiences and cases were always considered and referred to. Five participants were most positive to the invited lecturers, six to the seminar on treatment of tortured refugees, five to the dream seminar, two to working with an interpreter in treatment and support work, and two to the seminar on refugee law and policies.
2. Negative evaluations: The participants commented on the practical difficulties of having the seminars on weekends, that these were too intense, and there was not enough time for discussion.
3. Suggestions for improvement: Several participants suggested an extended program; in which the topics of the seminars could be studied in depth.

Questionnaires 2 and 3 – one and six months after the conclusion of the training program

The participants were asked to rate the lectures and seminars on a scale 0-100 (poor to excellent). Questionnaire 2 had a mean rating of 84.4, and questionnaire 3 a mean rating of 73.3. The four weekend seminars were rated as follows: 1. The introductory seminar: mean rating = 77.5; 2. Treatment of tortured refugees; working with an interpreter: mean rating = 87.2;

3. Dreamwork; support therapy with refugees: mean rating = 90.0;
4. Networking – the Finnish identity: mean rating = 77.1.

On questionnaires 2 and 3, when asked about the positive and negative factors and suggestions for improvement with regard to the lectures and seminars, the participants responses were similar to those of questionnaire 1. On questionnaire 3, the participants recommended the following: additional lectures and seminars on our attitude towards other nationalities, and on international and national refugee/immigrant policies, conventions and laws. Three participants suggested further knowledge on how to organize and work in networks, to set up projects, influence policies, etc., on building up contacts and working on a macro level (e.g. with national and international organizations and institutions working with refugees).

C. The literature seminars:

Questionnaire 1 – at the final seminar on completion of the training

All the participants stated that the literature seminars were the least positive part of the program.

1. Positive evaluations: Two participants described them as "okay"; the literature was interesting but there was not enough time to go through it all.
2. Negative evaluations: Comments included "a failure", "not enough structure", "too slow-moving". One even went so far as to describe them as "worthless".
3. Suggestions for improvement: The participants recommended that the seminars should be voluntary, with more structure, and held locally in smaller groups. They felt that needed time to go through the literature together. This could have been done in small groups locally without a supervisor. This might have liberated time for more fruitful discussion at the large-group meetings.

Questionnaires 2 and 3 – one and six months after the conclusion of the program

The participants rated the literature seminars on a scale 0-100 (poor to excellent) Questionnaire 2 had an average of 43.3. In questionnaire 3, the participants rated the literature seminars as having a value of 52.7. On questionnaires 2 and 3, the positive and negative evaluations were similar to those of questionnaire 1. In addition, they gave more extensive and concrete suggestions for improvement and change of the literature seminars. In particular, there were desires for more structure and detailed

instructions on how the literature could be referred to, to cut down on the obligatory material, and to arrange preliminary small-group discussion prior to considering the literature in the larger group.

D. The literature

On each questionnaire, the literature was evaluated. The participants were asked about its structure and contents, and for suggestions for improvement.

Questionnaire 1 – at the final seminar on completion of the training

1. Positive evaluations: Most of the participants were positive to the choice of literature.
2. Negative evaluations: Several of the participants complained about the volume. Two reported language difficulties.
3. Suggestions for improvement: "cut the volume", "fewer themes".

The mean rating was 76.8 on questionnaire 2. On questionnaire 3, the mean rating was 63.3. The choice of literature was valued 13% lower in questionnaire 3 than in questionnaire 2. Most of the participants did not explain why they rated it lower than before. Perhaps the explanation lies in the words of one participant: "a good choice, but some difficulties in understanding the language". The participants proposed that more time be allotted to reading the literature, alternating it with suitable novels and poetry, and that participants' language comprehension was taken into account.

Summation of the evaluations of the lectures, seminars and literature

There was considerable variation in the results of the participants' evaluations of the lectures, seminars and literature.

1. Positive evaluations: The lectures and seminars rated most positively were on the framework, dreamwork, and torture. Most of the participants were positive about the choice of literature.
2. Negative evaluations: The literature seminars were considered the least positive part of the program. The negative evaluations about the literature concerned its volume and language difficulties.
3. Suggestions for improvement: The participants recommended more specialization in the lectures, and further ones on therapeutic and support work with the refugee/immigrant family, child and group; for the seminars, several participants proposed an extended program, in which the topics of the lectures and seminars could be studied in depth. The participants recommended that the literature

seminars, be excluded, or be voluntary; and held locally; that the volume of literature should be cut and more time allotted to reading it; and that the participants' comprehension of different languages in the obligatory literature should always be considered.

Summation – of each participant's evaluation of the components of the training program

In the final questionnaire (3), six months following the conclusion of the training program, participants were requested to rate essential parts of the program. The instruction was as follows: "You have 100 points to rate the training program. Distribute your points to illustrate what you value most and value least." The parts that were rated are listed to the left in figure 14.4.

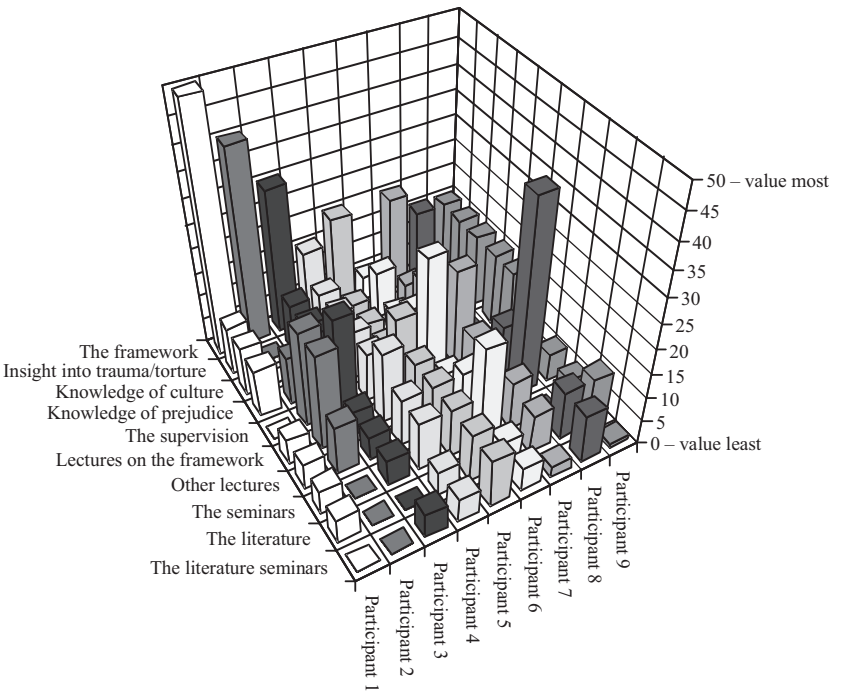


Figure 14.4. Nine participants' point-distribution ratings of the training program (100 points in total).

The points distribution is also shown in table 14.1.

Table 14.1. Summation of parts of the training program based on nine participants ratings on a 100 points scale (1 = low value 100 = high value).

Summation of parts of the program	Total points
The framework/working model	210
The supervision	125
Other lectures	101
The seminars	85
Lectures on the framework	83
Knowledge of prejudices	80
Knowledge of cultures	75
Insight into traumas, war experiences, torture	70
The literature	63
The literature seminars	28

The table illustrates that the participants vary widely in rating the different parts of the training program. Group-level analysis shows that highest ratings were received by the framework/working model and the supervision. The lowest ratings were for the literature and the literature seminars.

DISCUSSION OF RESULTS OF THE EVALUATIONS

The training program as a whole

In the participants' oral reports and the written evaluations, there were considerable variations in how the training program and it contents were received. On the three questionnaires, it was given an overall mean rating of 80.9 on the 0-100 scales.

One of the main goals of the research aspect of the training program was to attempt to show that it is essential to have a special program in psychotherapy/support work for the refugee/immigrant that intertwines actual case supervision and theoretical studies in a process. In the oral and written evaluations during and after its conclusion, this element was evaluated by the participants as one of the most positive elements in the program.

A further goal of the training program and research project was to construct a process education containing theory that would correspond to the supervisory process, built upon the needs of the particular group and group member. This type of process supervision was rated the second most positive component of the program (after the conceptual framework).

An additional purpose was that the participants should have an active role in the development of the training program. In setting it up, it was the view of the project leader (author) that it would be advantageous to start out at "core-theory" level based on the framework. This theory should then be added to as the program evolved according to the particular needs of the participants. This mode of building up the training program was met positively by all but one participant, who felt that the program lacked structure.

The conceptual framework

The framework is the core of the research project. An essential purpose of its utilization as a base for a program of training in psychotherapy/support work for refugees/immigrants is to allow professionals to add to and more efficiently utilize their previous training and knowledge, and enable them to apply it to the refugee/immigrant – adult, adolescent and child. Therefore, one of the most significant goals of the training was to educate the participants in how the components of the framework can be utilized to focus on therapeutic and support-work processes, and also to show how the framework can be used in preventive and curative projects. The results illustrate that the framework, the lectures on its application to psychotherapy, support work, and in its use in curative and preventive ways were evaluated positively throughout and after the program. In the final questionnaire, the framework was rated the most important component of the program.

As the program progressed, it was noticed that the participants gained increased understanding and confidence in utilization of the conceptual framework. There was added structure and depth to the supervisory sessions as a result of the collective language it provided. The participants would have liked even more focus on the framework's application in practice at different phases of the therapeutical process, and in support work and networking. A more extensive program of training would make this possible.

Although the participants were positive to the lectures on the application of the framework, they would also have liked them to be combined with guest lectures from professionals working with children, families and groups. Due to a limited budget and lack of time, this was not possible.

The supervision

The supervision was a principal part of the training program. One purpose of the research project was to evaluate whether the case supervision combined with the theoretical studies based on the framework improved the participants' skills in psychotherapy and support work with refugees and immigrants.

Large-group supervision

The group consisted of fifteen participants of varied professions and work experience and two supervisors. In the original research plan, the intention was to have smaller groups (five to ten participants). Due to the limited financial resources available to the program, this was not possible. In the evaluations, most of the participants were satisfied with supervision in the large heterogeneous professional group. The negative evaluations stated that it led to passivity and difficulties in learning. However, few participants could decide whether the large group should have been split up into smaller, more specialized ones. The issue is debatable.

Own supervision

On the final questionnaire, the participants' own supervision was rated the second most positive component of the program after the framework. They stated that it had augmented self-confidence, self-esteem and self-reliance, that it was now easier to work with refugees and immigrants and their traumas and crises, and that burnout was prevented. Educational, curative and preventive projects that the participants were planning or had started to work on were taken up and analyzed. All participants regarded this as an important part of the supervision.

The principal negative evaluations were that the supervision should continue longer than two terms; a few participants had difficulties sharing their cases and feelings about them in the large group.

The results of these evaluations seem to support the hypothesis that within this type of training program the supervision should be intertwined with theoretical knowledge (about the framework and its utilization in this case). This combination adds to and progressively builds up capacities in psychotherapy/support work, and also in the ability to create and organize varied projects for refugees and immigrants and to influence and create change in policy and decision making.

The casework

The cases in the training program were broadly representative of the population of refugees, entrance or asylum seekers, and immigrants in Finland. Most were refugees, asylum or entrance seekers, but there was only one immigrant. Finland has one of the most restrictive immigration policies in the world.

The cases were not selected, but referred at random from institutions all over Finland. Each case was complicated, most concerning people with difficult backgrounds and severe traumatic homeland experiences. To teach and supervise when casework is complex is always difficult. Despite this, the evaluations of the casework were for the most positive.

In oral reports during the supervision and the classwork, no negative results of the psychotherapy and support work carried out by the participants were reported. The written results recorded six months after the conclusion of the program show that the participants continued to note improvement in their cases, and perceived themselves to have added ability to deal with new ones. The principal negative evaluations of the casework concerned the focus on psychotherapy rather than crisis and support work. During the program, this was taken into account. In the supervision, the schedule was altered to give equal time to psychotherapy and crisis/support work.

The similarities and differences of the inner and outer world of the refugee and the immigrant could be discussed to a certain degree in the casework supervision. To compensate for the relative lack of immigrants in the casework, psychological and outer similarities and differences between refugee and immigrant were taken up in the lectures and literature on the framework, and in other parts of the program.

The case sample did not include refugees or immigrants who had resided in the new country for more than a few years. Therefore, the long-time inner and outer effects of life in the new country as a refugee and/or immigrant were taken up during the program in the lectures and literature on the framework and in other material.

The lectures, seminars and literature

There was considerable variation in the results of the evaluations of the pre-planned lectures and seminars and the ones that evolved during the program. On questionnaires 2 and 3, the lectures were attributed an overall value of 78.9; the seminars were rated at 83.0. The lectures and

seminars rated most positively were on the framework, dreamwork, and torture.

The participants rated the literature seminars as the least positive element in the program. (In two training programs that followed, these were excluded.) In future programs, voluntary study groups might be formed at the start to analyze the literature.

In the oral and written evaluations, there was considerable variation in the participants' approval of the choice of literature. In the final two questionnaires, the literature was rated at an average value of 70 (scale 0-100). The principal negative evaluations concerned its volume and language difficulties.

15. CONCLUDING REMARKS

This final chapter summarizes the procedure adopted in the writing of the dissertation, considers some aspects of theory and methodology, and discusses evaluation of both the conceptual framework and the training program.

In sum, the procedure adopted was as follows. What in chapter 2 was described as a "qualitative-clinical approach" was adopted to formulate a conceptual framework designed specifically to aid caring professionals in their work with refugees, tortured/traumatized refugees, immigrants and their children. Development of the framework and the concepts within it took place over a lengthy period of time (more than 25 years). The developing framework was constantly in clinical use over this period. An attempt was then made more formally to validate or evaluate the concepts that had emerged in conjunction with a training course held in Finland in 1992/93. Accordingly, the work described here naturally falls into two parts. The concepts emerged during extensive clinical practice. They were then evaluated in a case-study or transactional manner of the kind described by House (1980). There is a distinct switch – from induction to transactional evaluation, albeit both with a case-study foundation – when moving between the two parts of the dissertation.

The overall project – which, as stated, lies at the interface between clinical psychology and pedagogic – had two principal purposes: 1) to describe and illustrate the components of a framework for understanding of the inner and outer world of the refugee and the immigrant, whose practical application should provide improved comprehension in psychotherapeutic and related support work of the refugee, the immigrant and their children, and 2) to utilize the outcome of a training program as a means of evaluating and validating the framework.

In part I the processes and experiences of the refugee and immigrant are described theoretically and in illustrative case studies in an attempt to provide guidelines, gathered in a conceptual framework, for utilization in treatment and support work. The concepts have been formulated on the basis of case material from 903 individuals that seem to verify that the common and specific problems faced by these groups in the new country lead to certain shared psychological and existential experiences.

General methodological background

Since the beginning of the century, the study of human behavior has been influenced by many conceptions of scientific understanding – from the positivist to the postpositivist.

Positivism and postpositivism

The positivist view of scientific knowledge came to be questioned and reassessed early in the century by students of human behavior. They maintained that much of what was central to human experience had to be neglected if investigation was limited to those areas that were susceptible to research tools designed to produce certainty. Rather than setting up criteria for the human sciences that are appropriate only for the physical sciences and building deductively generated theoretical networks, it was regarded as necessary to recognize the probabilistic nature of conclusions in this field. The validity of tests and measuring instruments are sometimes regarded as limited in the human sciences due to the human capacity to make meaningful and personally valid conceptual distinctions that incorporate the ever-changing contextual dimensions of experiences. In contrast to positivism, this view does not propose a unified conception of scientific investigation hinging on a previously agreed set of propositions.

Pragmatism

As early as in the 18th century Peirce (1877) argued that science does not develop *truths*. Rather, it develops *knowledge* upon which choices are made. It requires decisions to be made between alternatives, none of which provide absolute certainty. If such decisions are to be accepted, they should be based on the common human trait of learning from experience. Campbell (1921) and Toulmin (1972) presented a similar outline of scientific development – learning from mistakes and being able to assess evidence, i.e. the ability to decide when evidence supports or contradicts a generalization. The research involved in the formulation of the components of the framework, and the building-up of the training program, was based on a pragmatic model of investigation.

Pluralism

In a work first published over one hundred years ago, but one that still attracts interest, Ogilvy (1897) maintained that the loci of truth were various communities of like-minded interpretations. Knowledge claims

are submitted to validation tests within various separate communities. Only if knowledge itself admits the plurality of many truths can corresponding patterns of valuation be confirmed. There is not *one truth* that corresponds to *reality*. Rather, there are *some truths* which hold within communities. *Objectivity* is a construction – a kind of commitment for which an ultimate ground is sought. But the ground does not exist beyond a particular perspective; it is the multiplicity of various perspectives itself. *Truth* is a construct which, on examination, reveals itself to be something like an onion – layers of perspectival understanding can be peeled away until there is nothing left at the core. On this particular perspective, *reality* is a view, not any kind of *thing* that lies behind views and are their causes.

On this view, knowledge is seen as the best understanding we have been able to produce thus far, not a statement of what is ultimately real. The knowledge claims that a community accepts are those that withstand the test of practical argument and use (Polkinghorne, 1986). Comparison and interaction assume a kind of reasonableness which emerges when a researcher is confronted with differences. The acceptance of possible alternatives places one's assumptions in question. A point of view is transformed from *the* way of knowing into *one* way of knowing – a context within which alternatives are admitted. Out of the interaction between various positions, a fuller understanding arises. Because knowledge is not automatically the result of direct experience, but is a human construct, the comparison of various constructs can lead to an increase in depth of understanding. Accordingly, the science of the human realm should be directed towards refining its assertions according to their fruitfulness (Polkinghorne, 1983).

The structure of the framework was conceptualized and formulated according to pluralistic reasoning. The purpose of this study was to attempt to determine the ways in which the inner world of an individual is affected by the outer change of leaving one country for another by will or by force. But, during years of clinical work, fuller knowledge of the psychology of the refugee and immigrant emerged from a specific interactional context in which various alternative positions were available (Polkinghorne, 1983, 1986). The components of the framework and its applications emerged as the author was confronted with similarities, and also differences, between refugee/immigrant groups. The framework and its key

dimensions, the *refugee/immigrant situation* and six aspects, were conceptualized in an attempt to apply a structure to the individual's personal view of reality. The framework is not meant to be regarded as a statement of what is ultimately the individual's reality, but as a structure that includes several constructs that can lead to an increase in depth of understanding.

Scientific evaluation and applied research methods

Patton (1980) stated that the purpose of applied research and evaluation in the human sciences is to inform action, enhance decision making, and apply knowledge to solve human and societal problems. In research into and evaluation of the components of the framework, adhering to this perspective was essential. Patton stressed that basic research is judged by its contribution to theory and explanations of why things occur as they do. Applied evaluative research is judged by its usefulness in making human actions and interventions more effective, and also by its practical utility.

Formulation of the conceptual framework, the training program based on the framework and the other segments of the education and its evaluation, all represent an attempt to utilize an applied evaluation-research approach.

Reliability and validity

Is it possible to attain validity and reliability in the human sciences? An instrument is valid if it actually measures the concept it is supposed to measure, and the instrument is reliable if it is consistent and gives the same measurement under the same conditions (Lewin, 1979). Polkinghorne (1986) argues that in refining a system of knowledge designed to uncover the fullness of human existence, borrowing ideas from traditional notions of research design must be undertaken with great caution.

Qualitative and quantitative research

Westlander (1993) explains:

> *"The expression qualitative analysis must refer to something in addition to allocating someone/something one or several properties. We always do this, even in quantitative analysis. If qualitative analysis is to be genuinely different from quantitative analysis, determinations must be made of several research objects, which are distinguished by the presence and composition*

> *of various attributes. ...Accordingly, qualitative analysis requires attention to be drawn to possible dissimilarities. ...In this way qualitative analysis can generate a new theory that can provide the foundation for a formal point of departure in a following study" (author's translation of extract from Westlander, 1993, p. 22).*

According to Westlander (1987, 1993), determination of context is a central issue in qualitative analysis:

> *"The meaning of context shall be determined by either the perceiving individual or by an outside observer with a relevant way of observing what is relevant". ... [For example], Mead (1934) ... strongly emphasized that social reality can only be defined by the individual himself, and that this definition will change continuously in the course of interaction with other people. ...An outside observer can only access the context by endeavoring to understand the phenomena to which the individual gives context and meaning" (op. cit., p. 112).*

In this context, Westlander poses a question of key relevance to this study:

> *"Should the investigator describe [the individual's] contextual content on the basis of the criteria of the perceiving individual or of those of the outsider, i.e. should an empathic or formal point of departure be adopted?" (op. cit., p.113).*

The method employed in this study has been largely empathic rather than formal, although this may be a matter of degree. Mainly qualitative techniques have been utilized, based largely on clinical case description. The key dimensions of the framework, the *refugee/immigrant situation* and the six aspects, emerged out of the data over a long period of clinical work and supervision, and were conceptualized and constructed in an endeavor to systematize the knowledge acquired.

Perhaps the most common concern about qualitative methods is the subjectivity of the evaluator. Science places great value on objectivity, and the charge is made that qualitative methods are subjective, the antithesis of scientific inquiry. However, Scriven (1967) has pointed out that quantitative methods are no more synonymous with objectivity than qualitative methods are with subjectivity.

In research, validity hinges to a great extent on the individual researcher (Patton, 1980). In discussing the researcher's role, Polkinghorne (1983) stressed that reasoning as a scientific method in the pursuit of knowledge is a creative quest to enhance comprehension of reality. Guba and Lincoln (1981) stated that the human factor has negative consequences for qualitative research. However, far outweighing these are the positive consequences of flexibility and insight, and the ability to build on tacit knowledge, which may not be possible in more formal types of research.

Reliability and validity in qualitative research

There is an ongoing debate on the question of reliability and validity in qualitative research. One of the principal difficulties in the reliability and validity of qualitative research methods is that each individual in treatment is unique. Inner change resulting from treatment cannot always be measured or repeated. For ethical reasons, a clinician can usually test only predictions based on interventions considered constructive to the patient (Schein, 1989). Wertz (1986) questioned the possibility of utilizing the terms reliability and validity in psychological research.

Cronbach (1971) and Salner (1986) stressed that validity in qualitative research can be attained by a developing process of improved interpretations of observations. To validate should be synonymous with to investigate.

Kvale (1987, 1989) defined two validity criteria applicable to qualitative research: communicative and pragmatic validity. Communicative validity is a credibility test of a study's claims to knowledge and occurs through dialogue. The pragmatic criterion is defined by a method that functions or has effects. It is built on a normative model, the basis of which is to function; i.e. to lead to results in the form of improvement. This view entails that validity in psychotherapy is defined by its goal and the final result of the process. According to Schein (1989), the most significant criterion of pragmatic validity is that the person becomes well, or that his/her problems are alleviated. He pointed out that if improvement is not utilized in a test of validity, the cause of, or reason for the interventions and the recovery cannot be related to this improvement.

Clinical research

The current project is based on clinical research methods. A situation involving human behavior is to be investigated. Information is collected and applied to the problem (Berg and Smith, 1985). Berg Brodén (1992) points out the necessity for the clinical researcher to adopt methods or accepted strategies for generating clinical knowledge. In this type of research, both qualitative and quantitative data can be collected and applied in the same study.

The researcher is him/herself a clinician or helper (which was the case in this project). Accordingly, the research relationship is dependent on both the helper (therapist/supervisor) and the helped (client/student), an exchange which consists of some form of action in which both subjects are involved (Berg and Smith, 1985). Patton's, Guba and Lincoln's and Polkinghorne's remarks about the qualifications of the researcher are especially significant in the comprehension and acceptance of the double role of clinician/researcher.

One of the most serious criticisms of this double role is that it is easy for the clinician/researcher to become ensnared in the study object. There is always a risk of transference and counter-transference because the researcher is part of the process.

Berg Brodén (1992) pointed out that, as clinicians, we react from implicit knowledge of a situation. As researchers, we must reflect over what has occurred and our observations of the situation. To contemplate the situation properly, we must retreat from it and establish time between observation and reflection. This helps the researcher to create necessary distance to the material and be able to critically examine it. To counteract the consequences of the double role, the clinical researcher must have special training (or go through a training program) that promotes awareness of his/her own influence on the process. The researcher must be well versed in the area of study and its characteristics, and also in the research process and how results should be evaluated.

At the start of this project, like Berg Brodén, the author was aware of the difficulties that the double role of clinician/researcher can bring to such a study. She attempted to overcome these difficulties in several ways. In psychology-research training (at both Lund and Stockholm universities), an attempt was made to acquire the ability to understand and analyze the research process and the pitfalls created by this double role.

Long time periods between observations and reflections over the conceptualization of the different parts of the framework and its utilization, and finally, the organization of the training program based upon it, were established. The considerable time elapsing between the different phases of the project allowed the author, as well as others, critically to scrutinize the study.

Lowman (1985) pointed out that the clinical researcher has an inductive starting-point and makes assessments based on interaction between researcher and the study object. A theory's value lies in the effects of its influence on the interactive process between the therapist/supervisor and the client/student. The clinical researcher's conclusions are therefore related to his/her skill, intuition and competence.

Case studies

Throughout the study, cases were employed to describe the components of the framework and to illustrate the underlying theoretical reasoning.

Positivists insist that case-study material is subjective, anecdotal, defectively defined, and generally without scientific value. The results obtained are not representative, as they cannot be neutralized or replicated. House (1980) pointed out that there is a lack of methodological development in case-study research. Yin (1989) maintained that the case-study approach lacks scientific stringency. Cases are difficult to generalize and time consuming to collect and document. He points out that it is difficult to carry out good case studies.

Eisenhardt (1989) pointed out that case studies, as they illustrate contradictions, can provide the basis for a new theory. In doing so, this type of research encourages new thought patterns that can lead to further development. Yin (1989) suggests that the case-study approach has a significant place in applied research. Eisenhardt (1989) maintained that the case-study method is the preferred research method when there is limited knowledge of the phenomena that one wants to study and when prevailing research perspectives are insufficient, due to limited empirical substance or because they are in conflict with each other. Utilization of case studies is valuable when a new research area is to be mapped out, or at an early, exploratory phase.

House (1980) explained that a well-constructed case study provides a most forceful evaluative method. He contended that the case-study approach to evaluation of human behavior and actions allows diverse

perspectives in complex situations to be presented. Therefore, it is one of the most democratic and beneficial approaches to develop. However, House pointed out that the case-study approach can result in problems of confidentiality and equity. He discussed whether the case-study researcher should draw conclusions or make recommendations on the basis of such a study, or that these should be left to the recipients. He concluded that either position can be endorsed, but that the preferred one should be determined by the recipients.

In part I of this dissertation, the case-study approach was utilized to conceptualize and formulate the framework and to illustrate its practical application. Case studies were used to depict the theoretical reasoning of the key dimensions of the framework: the *refugee/immigrant situation* and the six aspects, and their practical application. The key dimensions and each component of the second aspect, the *states of being,* were portrayed with three cases from the refugee and immigrant population. During the long-term study, the similarities and differences of these groups emerged from the research data, and were also represented in the case studies. The components of the framework evolved to become, as Polkinghorne termed it, the composite of a "structure of constructs" (1983, p. 56) or a "context that contains the alternatives out of the interaction of various positions" (1986, p. 15). The large population of casework (903 cases) allowed the author to collect and present diverse perspectives in complex situations, which were used to evolve, conceptualize, and formulate the components of the framework.

In part II, twenty-two cases were used in the clinical work and supervision of the training program. These were allocated to the participants at random. Eight case studies are presented in detail to assess the practical application of the components of the framework in process terms.

Evaluation of the training program

The second principal purpose of this dissertation was to evaluate the framework on the basis of a training program. Both qualitative and quantitative research tools were utilized. In the formulation and evaluation of the program, a transaction model (House, 1980; Stake, 1978) was applied, employing both a formative and summative approach.

Stake (1978) focused on perception and knowing as a transactional process in the evaluation of a program. Franke-Wikberg and Lundgren

(1979) and House (1980) described the transaction model or case-study approach to evaluation. The aim of the latter is to improve the understanding of the recipients, primarily by showing them how others perceive a program. In Stake's responsive evaluation, the evaluator usually negotiates with the client regarding what is to be done. He/she responds to what different persons want to know.

A principal goal of the training program was that the participants, as well as the supervisors, took part in its development. Before the start of the program, the supervisors collaborated in considering the themes most significant to take up. Then, in discussions with the participants, the themes most important to them were chosen. Throughout the program, the participants' suggestions for improvement were encouraged and utilized. Their recommendations were incorporated into the two training programs that followed.

For many years, the author had been of the opinion that a training program of this type, for psychotherapists and support workers, was necessary in order to learn, or re-learn, the use of "already existing instruments". In doing this, it was hoped that the caring professional would become better equipped fully to comprehend theoretical knowledge of the psychology of the refugee and immigrant, and also to be able to assist the individual/family to deal with and work through their difficulties of living in exile, and/or torture and war trauma experiences. Information was provided on possible counter-transference as a result of these, and advice was given to carers with regard to the burnout syndrome. For the most part, the results of the data collected (utilizing the transactional approach) indicated that the principal goals of the training program had been achieved.

The conceptual framework and the training program

What influence did the framework have on the participants and their casework, on the supervisors, and on the program as a whole?

From its start, the training program was influenced by the structure and contents of the framework. The data indicate that the simultaneous process of combining theoretical studies about the framework and other relevant knowledge led to effective learning experiences and improvement in the participants' casework.

Throughout and after the program, in the oral and written evaluations, the framework had been assessed in terms of processes to verify its practical function. Results designated the framework and learning its

applications as the most positive segment of the program, and also confirmed the significance of utilization of the framework in the training program and supervision.

The participants reported improvement in their abilities in psychotherapy and support work with these groups. Implicit and explicit knowledge, and application of the framework and the other theoretical material, allowed the participants and the supervisors to use their professional instruments more constructively in treatment and care, and also in varied preventive and curative measures out in society.

Both the supervisors also learned from the experience. At the start of the program, the author's colleague, Kristina Saraneva, an experienced psychologist/psychoanalyst, had not previously supervised people working with refugees/immigrants. As the program progressed, Saraneva became more confident in utilizing psychoanalytic thought in discussing cases. Her questions and ideas connecting psychoanalytic thought to the psychology of the refugee, the immigrant and their children during the supervision and training program added to the collective dialogue and led to further development of the program as well as the research project.

For many years, the author has been a supervisor of psychotherapists and support workers involved with refugees, immigrants and their children individually and in groups, but had never worked simultaneously as an educator and supervisor in a process training based on the framework.

The training program confirms the benefit of utilization of the framework simultaneously in training and supervision. Theoretical studies, in conjunction with supervision, allow a unified, structured approach in this complex problem area. Because of this experience, the framework can be used explicitly in supervision and teaching with a greater degree of confidence.

Due to the training program, conception and comprehension of the components of the framework and its utilization have deepened. It was conceived and built up on clinical experience and supervision, and formulated to facilitate work with refugees, immigrants and their children. This program and the others that followed tend to show that what had been an instrument first constructed for the author's own use has been generalized to become one that can be utilized and verified by others. Naturally, this claim will obtain further validation only after the

conceptual framework has been put to use extensively in clinical practice and on further courses.

Two further year-long training programs have followed the first one in Finland. Given that Finland has one of the strictest asylum and entrance policies in the world, most of the persons waiting for asylum, or those who have received it, have some of the most tragic destinies the author has encountered. Great pressure is placed on the carers who attempt to patch up or heal the inner and outer scars of past experiences, and support individuals and families in starting life anew in a strange country. Therefore, it is significant that this project was carried out in Finland. At the time of writing, nearly every person who took part in the training has gone on to achieve significant advances in their work with refugees and immigrant in treatment and care, and in organizing projects for asylum seekers and for refugees/immigrants in different communities, in supervision and consultation, in teaching, in lecturing in schools and other institutions, in research work, and in confronting, influencing and changing decisions and policies about refugees and immigrants in their respective institution, community or city (and even on a national level).

After many years of being faced with the inner and outer difficulties of these groups, caused partly by their past outer circumstances, but also by their present ones in the new country, the author came to realize that there was an urgent need to form interest and policy-making networks to promote the needs of these groups. These could be organized with professionals from the same and different sectors. One goal of the training program in Finland was to create networks of people where members would get to know and respect each other's competence, share experiences and be able to plan and organize projects together in their institutions, communities and cities, and on a national level. At the time of writing, six years after its conclusion, several participants continue to meet with each other on a professional and informal basis in the three largest Finnish cities, and also with participants on the following two programs. Network meetings have been attended by participants from all over the country. Several projects within institutions and in the community in these cities and on a national level have been started.

Further areas of utilization

Perhaps the framework and its goals could also be utilized in different ways in society. For example, it might be adapted for use anywhere and with all

age groups where knowledge of the refugee/immigrant is necessary in the neighborhood, community or country, and incorporated into existing programs, services and courses of training. Perhaps, the framework might act as a tool to enable understanding in a structured way of the many and at times complicated differences between people. At the same time, it stresses the similarities between human beings, regardless of background. In furthering understanding of the inner and outer world of the refugee/immigrant, it may help to prevent and counteract discrimination, prejudice and racism. The framework could offer a collective language for medical, psychological, social, educational and other support workers in different institutions and organizations, and thus enable them to discuss and plan for the needs of the refugee/immigrant – adult, child, adolescent and/or family and group.

In chapter 3, an overview was submitted of other models/frameworks for working with these groups, and other programs offering different types of training. However, none of these models were based on long-term clinical research. Subsequently, it seems difficult to compare these models with the conceptual framework or its purpose in qualified psychotherapeutic and related support work and training. The author's purpose in constructing the framework was to create a clear structure that can be applied to and utilized in methods of treatment, support work and educational, curative and preventive projects and programs. The goal of the training program was to create a high quality, low-cost process education on a difficult, distressing, sometimes tormenting theme that influences the worker as well as everyone else involved, even in their daily personal lives.

In concluding, the author likens the conceptual framework to a basic and usable recipe. Like all recipes for preparing a particular dish, it is learned by the creative cook. First explicitly and then implicitly, the framework can be enhanced by extra spices and ingredients. The clinician or support worker, and the supervisor or educator, can all improve it by adding their own personal experience and insight.

A negative consequence is that the conceptual framework could become another psychological "truth" to follow, administer and adhere to, like so many other ones before it. This is not the intention. The framework was formulated as an open theoretical structure that permits the incorporation of additions. It should not be regarded as a fixed structure, but one that should continue to encompass further insight, experience and research.

REFERENCES

Abel, T. (1956). Cultural patterns as they affect psychotherapeutic procedures. American Journal of Psychotherapy, 10, 728-739.

Aberbach, D. (1989). Surviving trauma: loss, literature and psychoanalysis. Yale University Press, Connecticut.

Abrams, D. and Hogg, M. (eds.) (1999). Social identity and social cognition. Blackwell Publishers, Malden, Massachusetts.

Ackerman, N. (1958). The psychodynamics of family life. Basic Books, New York.

Adler, A. (1927). Understanding human nature. Fawcett Publications, Greenwich Connecticut, 1954.

Adler, A. (1954). Social interest: a challenge to mankind. Capricorn Books, New York.

Adorno, T., Frenkel-Brunswik, E., Levinson, D. and Sanford, N. (1950). The authoritarian personality. Harper, New York.

Agger, I., Duarte, A., Genefke, I. and Lunde, I. (1985). Torturofre: om psychoterapi af flygtninge, der har vaeret udsat för tortur (Torture victims: On psychotherapy of refugees who have been submitted to torture). Nordisk Psykologi, 37 (3), 177-192.

Agger, I. and Jensen, S. (1989). Traume, mode og mening: Centrale begreber i transkulturel psykoterapi for politiske flygtninge (Trauma, meeting and meaning: Significant concepts in transcultural psychotherapy for political refugees). Nordisk Psykologi, 41 (3), 177-192.

Ahearn, F. and Athey, J. (eds.) (1991). Refugee children: theory, research, and services. Johns Hopkins University Press, Baltimore, Maryland.

Ajdukovic, M. and Ajdukovic, D. (1998). Impact of displacement on the psychological well-being of refugee children. International Review of Psychiatry, 10 (3), 186-195.

Al-Issa, I. (ed.) (1995). Handbook of culture and mental illness: an international perspective. International Universities Press, Madison, Connecticut.

Allodi, F. and Rojas, A. (1985). The health and adaptation of victims of political violence in Latin America. In Pichot, P., Berner, R., Wolf, K. and Thau, F. (eds.) Psychiatry: the state of the art. Plenum Press, New York.

Allotey, P. (1999). Travelling with "excess baggage": health problems of refugee women in Western Australia. Women and Health, 28 (1) 63-81.

Allport, G. (1954). The nature of prejudice. Addison-Wesley, Cambridge, Massachusetts.

Allwood, C. M. (in press). Kulturell och social påverkan på individen – förutsättningar för psykologers arbete i det mångkulturella samhället (Cultural and social influences on the individual – prerequisites for the work of psychologists in a multicultural society). In Allwood, C. M. and Franzén, E. (eds.) Grundbok för psykologer och socialarbetare (Cross-cultural meetings. Basic book for psychologists and social workers). Natur och Kultur, Stockholm.

Almqvist, K. and Brandell-Forsberg, M. (1995). Iranian refugee children in Sweden and the effects of organized violence and forced migration on preschool children. American Journal of Orthopsychiatry, 65 (2), 225-237.

Almqvist, K. and Broberg, A. (1999). Mental health and social adjustment in young refugee children 3 1/2 years after their arrival in Sweden. Journal of the American Academy of Child and Adolescent Psychiatry, 38 (6), 723-730.

Altemeyer, R. (1993). Reducing prejudice in right-wing authoritarians. In Zanna, M. and Olson, J. (eds.) The psychology of prejudice: the Ontario symposium, 7, 131-148. Erlbaum Associates, Hillsdale, New Jersey.

Altfeld, D. (1999). An experiential group model for psychotherapy supervision. International Journal of Group Psychotherapy, 49 (2), 237-254.

Altman, I. and Rogoff, B. (1987). World views in psychology: trait, interactional, organismic, and interactional perspective. In Stokols, D. and Altman, I. (eds.) Handbook of environmental psychology. Vol. 1, 7-40. Wiley, New York.

Atman, N. (1995). The analyst in the inner city – race, class, and culture through a psychoanalytic lens. Analytic Press. Hillsdale, New Jersey.

Amnesty International (1975). Report on torture. Farrar, New York.

Amnesty International (1984). Torture in the eighties. Amnesty International, New York.

Amnesty International (1987). Examining torture survivors. Amnesty International, Copenhagen.

Angel, B. and Hjern, A. (1992). Att möta flyktingbarn och deras familjer (Meeting refugee children and their families). Studentlitteratur, Lund.

Anthony, E. (1986). Children's reactions to severe stress. The response to overwhelming stress: some introductory comments. Journal of the American Academy of Child Psychiatry, 25, 299-305.

Apitzsch, H. (1985). The repeated trauma: the effects of extreme trauma on the second generation. Stockholm County Council, Stockholm.

Apitzsch, H. (1987). Tortyrens väsen (The nature of torture). Psykisk Hälsa, 4, 259-272.

Apitzsch, H. (1995). Posttraumatiska drömmar – "en kungsväg till det omedvetna" (Post-traumatic dreams – "a royal road to the unconscious"). PsykologTidningen, 18, 7-10.

Apitzsch, H. and Ramos-Ruggiero, L. (1994). Bedömning av psykiska traumaskador. Klinisk-psykologisk undersökning av 45 asylsökande till Sverige (Evaluation of psychological trauma: a clinical-psychological investigation of 45 asylum seekers to Sweden). Nordisk Psykologi, 46 (2), 108-123.

d´Ardenne, S. and Mahtani, J. (1989). Transcultural counseling in action. Sage, London.

Axelsen, E. and Sveaass, N. (1994). Psychotherapeutic understanding of women exposed to sexual violence in political detention. Nordisk Sexologi, 12 (1), 1-12.

Baker, R. (ed.) (1983). The psychosocial problems of refugees. The British Refugee Council and European Consultations on Refugees and Exiles, London.

Barna, A. (1973). Stumbling blocks in intercultural communication. In Ruitenbeek, H. (ed.) Varieties of modern social theory, 35-46. Dutton, New York.

Barth, F. (1994). Enduring and emerging issues in the analysis of ethnicity. In Vermeulen, H. and Govers, C. (eds.) The anthropology of ethnicity: beyond ethnic groups and boundaries, 104-120. het Spinhuis, Amsterdam.

Barudy, J. and Vieytes, C. (1985). El dolor invisible de la tortura (The invisible pain of torture). Franja, Brussels.

Basoglu, M. (ed.) (1992). Torture and its consequences: current treatment approaches. Cambridge University Press, Cambridge, England.

Bauer, G. and Kobos, J. (1987). Brief therapy: short-term psychodynamic intervention. J. Aronson, Northvale, New Jersey.

Beaglehole, E. (1939). Culture and psychosis in New Zealand. Journal of Polynesia Society, 48, 144-55.

de Beauvoir, S. (1953). The second sex. Jonathan Cape, London.

Becker, E. (1962). The birth and death of meaning. Free Press, New York.

Becker, E. (1973). The denial of death. Free Press, New York.

Becker, E. (1975). The structure of evil. Free Press, New York.

Bellak, L. and Small, L. (1978). Emergency psychotherapy and brief psychotherapy. Grune and Stratton, New York.

Bemak, F., Chung, R. and Bornemann, T. (1996). Counseling and psychotherapy with refugees, 243-265. In Pedersen, P., Draguns, J., Lonner, W. and Trimble, J. Counseling across cultures (4th. ed.). Sage Publications, Thousand Oaks, California.

Ben-Menachew, E. and M. (1970). Swedish citizens – a social psychological investigation of immigrants in Sweden. Research Report, 1. Department of Psychology, University of Uppsala.

Bendler-Lindqvist, M. and Palm, T. (1988). Psykoterapeutiskt arbete med flyktingbarn och deras familjer (Psychotherapeutic work with refugee children and their families). Swedish Save the Children, Stockholm.

Berg, D. and Smith, K. (1985). Exploring clinical methods for social research. Sage, London.

Berg Brodén, M. (1992). Psykoterapeutiska interventioner under spädbarnsperioden (Psychotherapeutical interventions during the infancy period). Förlagshuset Swedala, Trelleborg.

Berger, R. (1996). Group work with adolescent immigrants. Journal of Child and Adolescent Group Therapy, 6 (4), 169-179.

Berry, J. (1997). Immigration, acculturation, and adaptation. Applied Psychology: An International Review, 46 (1), 5-34.

Berry, J. (1997). Constructing and expanding a framework: opportunities for developing acculturation research. Applied Psychology: An International Review, 46 (1), 62-68.

Berry, J. and Dasen, P. (1974). Introduction. In Berry, J. and Dasen, P. (eds.) Culture and cognition, 1-20. Methuen, London.

Berry, J. and Kim, U. (1988). Acculturation and mental health. In Dasen, P. (ed.) Health and cross-cultural psychology: toward application. Sage, London.

Bettelheim, B. (1943). Individual and mass behavior in extreme situations. Journal of Abnormal and Social Psychology, 38, 417-452.

Bettelheim, B. (1960). The informed heart. Free Press, Glencoe, Illinois.

Bettelheim, B. and Janowitz, M. (1950). The dynamics of prejudice: a psychological and sociological study of veterans. Harper, New York.

Bibring, E. (1953). The mechanism of depression. In Greenacre, P. (ed.) Affective disorders, 13-45. International University Press, New York.

Bibring, E. (1968). The teaching of dynamic psychiatry. International University Press, New York.

Bion, W. (1961). Experiences in groups. Basic Books, New York.

Bion, W. (1962). Learning from experience. Basic Books, New York.

Bion, W. (1970). Attention and interpretation. Basic Books, New York.

Blanck, G. and Blanck, R. (1974). Ego psychology: theory and practice. Columbia University Press, New York.

Bleichrodt, N. and Drenth, P. (1991). Contemporary issues in cross-cultural psychology. Swets and Zeitlinger, Amsterdam.

Blos, P. (1962). On adolescence – A psychoanalytic interpretation. Free Press, New York.

Bollas, C. (1987). The shadow of the object. Psychoanalysis of the unthought known. Free Association Books, London.

Bollas, C. (1989). Forces of destiny: psychoanalysis and human idiom. Free Association Books, London.

Bowlby, J. (1969). Attachment: attachment and loss. Vol. I. Basic Books, New York.

Bowlby, J. (1973). Separation: anxiety and anger. Vol. II. Basic Books, New York.

Bowlby, J. (1980). Loss: sadness and depression. Vol. III. Basic Books, New York.

Boyd Webb, N. (ed.) (1991). Play therapy with children in crisis: a casebook for practitioners. Guilford Press, New York.

Brandell-Forsberg, M. (1991). Flykt, exil, tortyr: medicinska och psykologiska aspekter på flyktingar (Flight, exile, torture: medical and psychological aspects of refugees). Weeth Nordiska, Sollentuna.

Brody, E. (1967). Transcultural psychiatry, human similarities and socioeconomic evolution. American Journal of Psychiatry, 124 (5), 616-622.

Brown, C. and O'Brien, K. (1998). Understanding stress and burnout in shelter workers. Professional Psychology: Research and Practice, 29 (4), 383-395.

Brown, L. (ed.) (1993). The new shorter Oxford English dictionary on historical principles. Clarendon Press, Oxford.

Bucci, W. (1997). Psychoanalysis and cognitive science: a multiple code theory. Guilford Press, New York.

Budman, S. (ed.) (1981). Forms of brief therapy. Guilford Press, New York.

Bustos, E. and Ramos Ruggiero, L. (1984). Exilungdomars frigörelseprocess (Exile youth and the process of adolescence). Stockholm County Council, Stockholm.

Bustos, E. (1987). Psykisk traumatisering hos flyktingar (Psychic traumatization in refugees). Psykisk Hälsa I, 24-34.

Bustos, E. (1989). Dealing with the unbearable: reactions of the therapist and therapeutic institutions to victims of torture. In Suedfeld, P. (ed.) Psychology and torture, 143-163. Hemisphere Publications, New York.

Bustos, E. (1992). Psychodynamic approaches in the treatment of torture survivors. In Basoglu, M. (ed.) Torture and its consequences: current treatment approaches, 333-347. Cambridge University Press, Cambridge, England.

Callao, J. (1973). Culture shock – west, east, and west again. Personnel Guidance Journal, 51 (6), 78-83.

Cameron, G., Vanderwoerd, J. and Peirson, L. (1997). Protecting children and supporting families: promising programs and organizational realities. Aldine De Gruyter, New York.

Camilleri, C. and Vinsonneau, G. (1996). Psychologie et culture: concepts et méthodes (Psychology and culture: concepts and methods). Armand Colin/Masson, Paris.

Campbell, J. (1970). Myths, dreams and religion. Dutton, New York.

Campbell, N. (1921). What is science? Dover, New York, (1953).

Cannon, A. (1977). Mental health programs for minorities? Conference of mental health programs for minorities. Howard University, USA.

Carrillo, C. (1976). Chicano psychotherapy. Mimeograph.

Caruth, C. (1995). Trauma. Explorations in memory. Johns Hopkins University Press, Baltimore, Maryland.

Casement, P. (1982). Some pressures on the analyst for physical contact during the reliving of an early trauma. International Review of Psycho-Analysis, 9, 279-86.

Casement, P. (1982). Samuel Beckett's relationship to his mother tongue. International Review of Psycho-Analysis, 9, 35-44.

Casement, P. (1984). The reflective potential of the patient as mirror to the therapist. In Raney, J. (ed.) Listening and interpreting: the challenge of the work of Robert Langs, 125-151. J. Aronson, New York.

Casement, P. (1985). Learning from the patient. Guilford Press, New York.

Cernovsky, Z. (1997). Traumatization in refugees. In Miller, T. (ed.) Clinical disorders and stressful life events, 71-85. International Universities Press, Madison, Connecticut.

Chambon, A. (1989). Refugee families' experiences: three family themes-family disruption, violent trauma and acculturation. Journal of Strategic and Systemic Therapies, 8, 3-l3.

Cherniss, G. (1995). Beyond burnout. Routledge, London.

Chester, B. (1992). Women and political torture: work with refugee survivors in exile. Women and Therapy, 13 (3), 209-220.

Coles, R. (1964). Children of crisis. Delta, New York.

Coles, R. (1986a). The political life of children. Houghton Mifflin, Boston, Massachusetts.

Coles, R. (1986b). The moral life of children. Houghton Mifflin, Boston, Massachusetts.

Coll, C. and Magnuson, K. (1997). The psychological experience of immigration: a developmental perspective. In Booth, A., Crouter, A. and Landale, N. (eds.) Immigration and the family: research and policy on U.S. immigrants, 91-131. Lawrence Erlbaum, Mahwah, New Jersey.

Cooley, C. (1902). Human nature and the social order. Scribner's Sons, New York.

Condon, J. and Fathi, Y. (1975). An introduction to intercultural communication. Bobbs-Merrill, New York.

Cornell, S. (1996). The variable ties that bind: content and circumstances in ethnic processes. Ethnic and Racial Studies, 19, 265-289.

Crafoord, C. (1988). En bok om borderline (A book on borderline). Natur och Kultur, Stockholm.

Crits-Christoph, P. and Barber, J. (eds.) (1991). Handbook of short-term dynamic psychotherapy. Basic Books, New York.

Cronbach, O. (1971). Test validation. In Thorndike, R. (ed.) Educational Measurement. American Council of Education, Washington, D.C.

Cullberg, J. (1990). Kris och utveckling (Crisis and development). Natur och Kultur, Stockholm.

Cunningham, M. and Cunningham, J. (1997). Patterns of symptomatology and patterns of torture. Australian and New Zealand Jounral of Psychiatry, 31 (4), 555-565.

Cwik, M. (1996). The many effects of rape: the victim, her family, and suggestions for family therapy. Family Therapy, 23 (2), 94-116.

Dahl, H. and Kächele, H. (1988). Psychoanalytic process research strategies. Springer Verlag, Berlin.

Daneshpour, M. (1998). Muslim family and family therapy. Journal of Marriage and family counseling, 24 (3), 355-368.

Darwin, C. (1872). The expression of emotions in man and animals. John Murray, London (1987).

Davidson, L. (1987). The cross-cultural therapeutic dyad. Journal of Contemporary Psychoanalysis, 23 (4), 659-675.

Deane, W. (1957). The culture of the patient: an underestimated dimension in psychotherapy. Journal of Mental Science, 3, 285-292.

Deaux, K., Dane, F. and Wrightsman, L. (1993). Social psychology in the ‘90s. Brooks/Cole, Pacific Grove, California.

Deutsch, H. (1945). Psychology of women. Vols. I and II. Grune and Stratton, New York.

Deutsch, S. and Won, G. (1956). Some factors in the adjustment of foreign nationals in the US. Journal of Social Issues, 2, 205-218.

Devereux, G. (1953). Cultural factors in psychoanalytic therapy. International Journal of Psychoanalysis, I, 629-653.

Devereux, G. (1956). Normal and abnormal: the key problem of psychiatric anthropology. In Casagrande, J. and Gladwin, T. (eds.) Some uses of anthropology: theoretical and applied, 3-48. Anthropological Society of Washington, Washington, D.C.

Devereux, G. (ed.) (1956). Culture and mental disorders. Thomas, London.

DeVos, G. (1983). Ethnic identity and minority status: some psycho-cultural considerations. In Jacobsson-Widding, A. (ed.) Identity: personal and socio-cultural. Almqvist and Wiksell International, Stockholm.

Dewald, P. (1964). Psychotherapy. A dynamic approach. Blackwell Scientific Publications, Oxford.

Dewald, P. (1987). Learning process in psychoanalytic supervision: complexities and challenges. International University Press, New York.

Diaz-Guerrero, R. (1975). Psychology of the Mexican. University of Texas Press, Austin.

Dinnen, A. (1977). No speak much English: or how I stopped worrying about the theory and began treating the indigent Greek. Mental Health and Society, 4 (1-2), 26-35.

Dollard, J., Doob, L., Miller, N., Mowrer, O. and Sears, R. (1939). Frustration and aggression. Yale University Press, New Haven, Connecticut.

Donovan, J. (1998). Brief couples therapy: lessons from the history of brief individual treatment. Psychotherapy, 35 (1), 116-129.

Durham, W. (1991). Coevolution: genes, culture, and human diversity. Stanford University Press, Stanford, California.

Durkheim, E. (1968). Självmordet (Suicide). Argos Förlags, Uppsala.

Edgerton, R. and Karno, M. (1971). Mexican-American bilingualism and the perception of mental illness. Archives of General Psychiatry, 24, 286-290.

Eisenberg. N. and Cialdini, R. (1984). The role of consistency pressures in behavior: a developmental perspective. Academic Psychology Bulletin, 6, 115-126.

Eisenhardt, K. (1989). Building theories from case study research. Academy of Management Review, 14, (4), 532-550.

Eitinger, L. (1960). The symptomatology of mental disease among refugees in Norway. Journal of Mental Science, 106, 947-966.

Eitinger, L. (1964). Concentration camp survivors in Norway and Israel. Universitetsförlaget, Oslo.

Eitinger, L. and Grünfeld, D. (1966). Psychoses among refugees in Norway. Acta Psychiatrica Scandinavica, 42, 365-383.

Ekman, P. (1972). Universals and cultural differences in facial expressions of emotion. In Cole, J. (ed.) Nebraska symposium on motivation. Vol. 19. University of Nebraska Press, Lincoln, Nebraska.

Ekman, P. (ed.) (1982). Emotion in the human face. Cambridge University Press, Cambridge, Massachusetts.

Ekman, P. and Friesen, W. (1975). Constants across cultures in the face and emotion. Journal of Personality and Social Psychology, 17, 124-129.

Ekman, P., Friesen, W., O'Sullivan, M., Chan, A., Diacoyanni-Tarlatzis, I., Heider, K., Krause, R., LeCompte, W., Pitcairn, T., Ricci-Bitti, P., Scherer, K. and Tomita, M. (1987). Universals and cultural differences in the judgments of facial expressions and emotion. Journal of Personality and Social Psychology, 53, 712-717.

Ekstein, R. and Wallerstein, R. (1958). The teaching and learning of psychotherapy. International University Press, New York.

Eleftheriadou, Z. (1997). The cross cultural experience – integration or isolation? In du Plock, S. (ed.) Case studies in existential psychotherapy and counseling, 59-69. Wiley, Chichester, England.

Ellemers, N., Spears, R. and Doosje, B. (eds.) (1999). Social identity. Blackwell, Oxford.

Epstein, H. (1979). Children of the holocaust: conversations with sons and daughters of survivors. Putman, New York.

Erikson, E. (1950). Childhood and society. Norton, New York.

Erikson, E. (1968). Identity: youth and crisis. Norton, New York.

Erikson, E. (1974). Dimensions of a new identity. Norton, New York.

Erikson, E. (ed.) (1976). Adulthood. Norton, New York.

Esman, A. (ed.) (1975). The psychology of adolescence. International Universities Press, New York.

Fairbairn, D. (1943). The repression and the return of bad objects. British Journal of Medical Psychology 19, 327-341.

Fanon, F. (1967). Black skin, white masks. Grove Press, New York.

Farber, B. (1980). Introduction: a critical perspective on burnout. In Farber, B. (ed.) Stress and burnout in the human service professions, 1-20, Pergamon Press, New York.

Feinberg, R. (1996). Use of reminiscence groups to facilitate the telling of life stories by elderly Russian Jewish immigrants. Smith College Studies in Social Work, 67 (1), 39-51.

Feldstein, S. and Costello, L. (eds.) (1974). The ordeal of assimilation. Anchor books, New York.

Fenichel, O. (1946). The psychoanalytic theory of neurosis. Routledge and Kegan Paul, London.

Figley, C. (ed.) (1985). Traumatic stress theory, research and intervention. Vols I and II. Brunner and Mazel, New York.

Fitzpatrick, J. (1975). The role of white ethnic communities in the urban adjustment of newcomers, Working Papers, 2. Institute on Pluralism and Group Identity, New York.

Fleming, J. and Benedek T. (1966). Psychoanalytic supervision: a method of clinical teaching. Grune and Stratton, New York.

Florsheim, P. (1990). Cross-cultural views of self in the treatment of mental illness. Disentangling the curative aspects of myth from the mythic aspects of cure. Psychiatry, 53 (3), 304-315.

Franke-Wiberg, S. and Lundgren, U. (1979). Att värdera utbildning Del 1. En introduktion till pedagogisk utvärdering (Evaluation of education Part 1. An introduction to pedagogic evaluation). Wahlström and Widstrand, Stockholm.

Frankl, V. (1959). From death camp to existentialism: a psychiatrist's path to a new therapy. Beacon Press, Boston.

Frankl, V. (1963). Man's search for meaning. Pocket Books, New York.

Frankl, V. (1976). Psychotherapy and existentialism. Simon and Schuster, New York.

Freeman, P. (1998). Ethnopsychiatry in France, Transcultural Psychiatry, 34 (3), 313-319.

Freire, P. (1972). Cultural action for freedom. Penguin, Middlesex, England.

Freud, A. (1937). The ego and mechanisms of defense. Hogarth Press, London.

Freud, A. (1965). The writings of Anna Freud. Vol. VI. International Universities Press, New York.

Freud, A. and Burlingham, D. (1943). War and children. Hogarth Press, London.

Freud, S. (1915). The unconscious. Standard Edition, 14, 159-215.

Freud, S. (1915). Repression. Standard Edition, 14, 143-158.

Freud, S. (1917). Mourning and melancholia. Standard Edition, 19, 3-66.

Freud, S. (1921). Group psychology and the analysis of the ego. Standard Edition, 18, 67-143.

Freud, S. (1930). Civilization and its discontents. Standard Edition, 21, 59-145.

Fromm, E. (1941). Escape from freedom. Holt, Rinehart and Winston, New York.

Fromm, E. (1959). The sane society. Routledge and Kegan Paul, London.

Fromm, E. (1973). The anatomy of human destructiveness. Holt, Rinehart and Winston, New York.

Fromm-Reichmann, F. (1959). Principles of intensive psychotherapy. University of Chicago Press, London.

Gaines, A. (1998). Mental illness and immigration. In Loue, S. (ed.) Handbook of immigrant health, 407-421. Plenum Press, New York.

Gans, H. (1962). The urban villagers. Free Press, New York.

Garza-Guerro, A. (1974). Culture shock: its mourning and the vicissitudes of identity. Journal of American Psychoanalytic Association, 22-29.

Gaw, A. (1976). Mental health care for the Boston Chinese community. Paper presented at the conference on ethnicity and the delivery of mental health services. Institute on Pluralism and Group Identity, New York.

Geertz, C. (1973). The interpretation of cultures. Basic Books, New York.

Gelfand, D. (1976). Ethnicity, aging and mental health. Paper presented at the conference on ethnicity and social welfare. Institute on Pluralism and Group Identity, New York.

Giordano, J. (1973). Ethnicity and mental health. Institute on Pluralism and Group Identity, New York.

Glazer, N. and Moynihan, D. (eds.) (1975). Ethnicity, theory and experience. Harvard University Press, Cambridge, Massachusetts.

Goin, M. and Kline, F. (1974). Supervision observed. Journal of Nervous and Mental Diseases, 158, 208-213.

Gonzalez-Roma,V., Ripol, P., Caballer, A., Ferreres, A., Gil, P. and Peiro, J. (1998). Comparación de modelos causales sobre la experiencia de burnout: un estudio mulimuestra (Comparison of causal models on the burnout experience: a multi-sample study). Ansiedad-y-Estres, 4 (1), 81-95.

Greenson, R. (1950). The mother tongue and the mother. International Journal of Psychoanalysis, 31, 540-552.

Greenson, R. (1967). The technique and practice of psycho-analysis. Hogarth Press, London.

Grinberg, L. (1990). The goals of psychoanalysis: identification, identity and supervision. Karnac Books, London.

Grinberg, L. and Grinberg, R. (1989). Psychoanalytic perspective on migration and exile. Yale University Press, New Haven, Connecticut.

Gruenbaum, L. (1998). Psychotherapy with children in refugee families who have survived torture: containment and understanding of repetitive behavior and play. Journal of Child Psychotherapy, 23 (3), 437-452.

Grundin, I. (1994). Att vara både flyktingbarn och fosterbarn (To be both a refugee and foster child). Rinkeby Local District Administration, Stockholm.

Guba E. and Lincoln, Y. (1981). Effective evaluation: improving the usefulness of evaluation results through responsive and naturalistic approaches. Jossey-Bass, San Francisco.

Guerin, P., Fay, I., Burden, S. and Kautto, J. (1987). The evaluation and treatment of marital conflicts: a four-stage approach. Basic Books, New York.

Guntrip, H. (1961). Personality structure and human interaction. International Universities Press, New York.

Gustafsson, L. and Lindkvist, A. (1987). Barn i krig, röster och fakta (Children in war, voices and facts). Verbum Gothia, Stockholm.

Gustafsson, L. and Lindkvist, A. (1989). Våga lyssna: att möta flyktingbarn (Daring to listen: meeting refugee children). Utbildningsradion, Stockholm.

Haasen, C., Lambert, M., Mass, R. and Krausz, M. (1999). Impact of ethnicity on the prevalence of psychiatric disorders among migrants in Germany. Ethnicity and Health, 3 (3), 159-165.

Haavio-Mannila, A. and Stenius, K. (1973). Immigration and mental health. Institute of Sociology, University of Helsinki.

Haley, J. and Hoffman, L. (1967). Techniques of family therapy. Basic Books, New York.

Hallowell, I. (1934). Culture and mental disorder. Journal of Abnormal Social Psychology, 29, 1-9.

Hallowell, I. (1936). Psychic stresses and culture patterns. American Journal of Psychiatry, 1292-1310.

Handelman, D. (1977). The organization of ethnicity. Ethnic Groups, 1, 187-200.

Handlin, O. (1951). The uprooted. Grosset and Dunlap, New York.

Harris, M. (1999). Theories of culture in postmodern times. AltaMira, Walnut Creek, California.

Hartog, J. (1971). Transcultural aspects of community psychiatry. Archives of General Psychiatry, 55, (1), 35-44.

Hathaway, J. (1991). The law of refugee status. Butterworths, Toronto.

Hawkins, P. and Shohet, R. (1994). Supervision in the helping professions: an individual, group and organizational approach. Open University Press, Bristol, Pennsylvania.

Heidegger, M. (1949). Existence and being. Henry Regnery, Chicago.

Henle, P. (ed.) (1972). Language, thought and culture. University of Michigan Press, Ann Arbor, Michigan.

Herman, J. (1992). Trauma and recovery. Basic Books, New York.

Hjern, A. (ed.) (1995). Diagnostik och behandling av traumatiserade flyktingar (Diagnosis and treatment of traumatized refugees). Studentlitteratur, Lund.

Hoffman, J. and Zak, I. (1969). Interpersonal contact and attitude change in a cross-cultural situation. The Journal of Social Psychology, 78, 165-171.

Hollis, F. (1964). Casework – a psychosocial therapy. Random House, New York.

Holloway, E. (1995). Clinical supervision: a systems approach. Sage, London.

Horenczyk, G. (1997). Immigrants' perceptions of host attitudes and their reconstruction of cultural groups. Applied Psychology: An International Review, 46 (1), 34-38.

Horowitz, M. (1993). States, schemas, and control: general theories for psychotherapy integration. Journal of Psychotherapy Integration, 1, 85-102.

Horowitz, M. (1997). Stress response syndromes: PTSD, grief, and adjustment disorders. J. Aronson, Northvale, New Jersey.

House, E. (1978). Assumptions underlying evaluation models. Educational Researcher, 7, 4-12.

House, E. (1980). Evaluating with validity. Sage, London.

Hsu, J. and Tseng, W. (1972). Intercultural psychotherapy. Archives of General Psychiatry, 27, 700-705.

Hughes, E. (1994). On work, race and the sociological imagination. University of Chicago Press, Chicago.

Hulewat, P. (1996). Resettlement: a cultural and psychological crisis. Social Work, 41(2), 129-135.

Hunter, D. (1964). The slums. Free Press, New York.

Husemann, K. (1997). Discussion on paper by Raymond Battegay and Ali Tarik Yilmaz. Group Analysis, 30 (2), 228-232.

Jaco, E. (1939). Mental Health of the Spanish-American in Texas. In Opler, M. (ed.) Culture and mental health, 215-225. Macmillan, New York.

Jacobson, E. (1943). Depression: the Oedipus conflict in the development of depressive mechanisms. Psychoanalytic Quarterly, 12, 541-560.

Jacobson, E. (1961). Adolescent moods and the remodeling of psyche in adolescence. Psychoanalytic Study of the Child, 16, 164-183.

Jacobson, E. (1964). The self and the object world. International Universities Press, New York.

Jacobson, E. (1971). Depression. International Universities Press, New York.

James, W. (1890). The principles of psychology. Vols. 1 and 2. Holt, New York.

Jenkins, R. (1996). Social identity. Routledge, London.

Jenkins, R. (1997). Rethinking ethnicity. Sage, London.

Johnson, P. (1959). Psychology of religion. Abington Press, New York.

Jones, J. (1997). Prejudice and racism. McGraw-Hill, New York.

Josephson, E. and Josephson, M. (eds.) (1962). Man alone: alienation in modern society. Dell, New York.

Jung, C. (1917). On the psychology of the unconscious. Two essays on analytical psychology. Routledge and Kegan Paul, London (1953).

Jönsson, K. (1995). Asylrätt i teori och pratik (Right to asylum in theory and practice). Swedish Save the Children, Stockholm.

Kagitcibasi, C. (1997). Whither multiculturalism? Applied Psychology: An International Review, 46 (1), 44-49.

Kalmanowitz, D. and Lloyd, B. (1999). Fragments of art at work: art therapy in the former Yugoslavia. Arts in Psychotherapy, 26 (1), 15-25.

Kaplan, B. (1961). Studying personality cross-culturally. Peterson, Evanstone, Illinois.

Kareem, J. and Littlewood, R. (1992). Intercultural therapy. Themes, interpretations and practice. Blackwell Science, Oxford.

Kernberg, O. (1972). Early ego integration and object relations. Annals of the New York Academy of Science, 193, 223-247.

Kernberg, O. (1975). Borderline conditions and pathological narcissism. J. Aronson, New York.

Kernberg, O. (1976). Object relations theory and clinical psychoanalysis. J. Aronson, New York.

Kernberg, O. (1984). Severe personality disorders. Yale University Press, New Haven, Connecticut.

Kiev, A. (1972). Transcultural psychiatry. Free Press, New York.

Kihlström, J. and Cantor, N. (1984). Mental representatives of the self. Advances in Experimental Psychology, 17, 2-47.

Kinzie, D., Fleck, J., Leung, P., Bui, A. and Ben, R. (1988). Group therapy with Southeast Asian refugees. Community Mental Health Journal, 24 (2), 157-166.

Kirk, J. and Miller, M. (1986). Reliability and validity in qualitative research. Sage, Beverly Hills, California.

Klain, E. (ed.) (1992). Psychology and psychiatry of a war. Faculty of Medicine. University of Zagreb, Croatia.

Kleber, R., Figley, C. and Gersons, B. (eds.) (1995). Beyond trauma: cultural and societal dynamics. Plenum Press, New York.

Klein, M. (1932). The psycho-analysis of children. Norton, New York, (1989).

Klein, M. (1948). On the theory of anxiety and guilt. In Riviere, J. (ed.) (1952) Developments in psychoanalysis, 271-291. Hogarth Press, London.

Klein, M. (1957). Envy and gratitude. Basic Books, New York.

Kohut, H. (1977). The restoration of the self. International Universities Press, New York.

Kristal-Andersson, B. (1975). Svenska för invandrare. Dikter (Swedish for immigrants. Poems). Invandrarförlaget, Borås.

Kristal-Andersson, B. (1976). Kan encounter-grupper lösa kulturella motsättningar? (Can encounter groups help to solve cultural conflicts?). PsykologTidningen, 1, 76, 6-8.

Kristal-Andersson, B. (1978). Psychotherapy and social change – can they be integrated? Parts I and II, Report for clinical psychology examination (M.A.). Department of Psychology, University of Stockholm.

Kristal-Andersson, B. (1980). Psykoterapi och social förändring – går det att integrera? (Psychotherapy and social change – Can they be integrated?). Wahlström and Widstrand, Stockholm.

Kristal-Andersson, B. (1981). Mot förståelsen av invandrarens och flyktingens inre värld (Towards understanding the inner world of the immigrant and refugee). Socialmedicinsk tidskrift, 10. 542-573.

Kristal-Andersson, B. (1986). Mot förståelse av flyktingens inre värld (Towards understanding of the refugee's inner world), Tidskrift för Psykoterapi, 10, 7-25.

Krystal, H. (1988). Integration and self-healing, affect, trauma and alexthymia. Analytic Press, New Jersey.

Kvale, S. (ed.) (1987). Validity in the qualitative research interview. Psykologisk skriftserie, 12 (1).

Kvale, S. (1989). Issues of validity in qualitative research. Studentlitteratur, Lund.

Ladany, N., Lehrman-Waterman, D., Molinari, M. and Wolgast, B. (1999). Psychotherapy supervisor ethical practices: adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. Counseling Psychologist, 27 (3), 443-475.

Laing, R. (1961). The self and others. Tavistock, London.

Lambert, M. (1980). Research and the supervisory process. In Hess, A. (ed.) Psychotherapy supervision: theory, research and practice, 125-136. Wiley, New York.

Langs, R. (1978). The listening process. J. Aronson, New York.

Langs, R. (1979). The supervisory experience. J. Aronson, New York

Lavik, N., Nygård, M., Sveaass, N. and Fannemel, E. (eds.) (1994). Pain and survival – human rights violations and mental health. Scandinavian University Press, Oslo.

Lewin, K. (1936). Principles of topological psychology. McGraw-Hill, New York.

Lewin, K. (1938). The conceptual representation and measurement of psychological forces. Contrbutions to psychological theory, 1, 4, 532-641. Duke University Press, Durham, North Carolina.

Lewin, M. (1979). Understanding psychological research. Wiley, New York.

Lichenstein, H. (1977). The dilemma of human identity. J. Aronson, New York.

Lidz, T. (1968). The person: his development throughout the life cycle. Basic Books, New York.

Lindholm-Jakobsson, M. (1987). Några tankar efter ett års klinisk erfarenhet med torterade flyktningar (Some thoughts after one year's clinical work with tortured refugees). Psykiska Hälsa, 2. 102-108.

Lindholm-Jakobsson, M. (1990). Överförings- och motöverföringsaspekter i psykoterapi med tolk. Den terapeutiska "triaden". (Transference and counter-transference aspects in psychotherapy with an interpreter. The therapeutic "triad"). Mimeograph. Swedish Red Cross.

Lindholm-Jakobsson, M. (1991). Behandlingsarbete med tolk vid Röda korsets center för torterade flyktingar (Treatment work with an interpreter at the Red Cross Center for tortured refugees). Mimeograph. Swedish Red Cross.

Lowman, R. (1985). What is clinical method? In Berg, D. and Smith, K. (eds.) Exploring clinical methods for social research, 90-102. Sage, London.

Luborsky, L. (1984). Principles of psychoanalytic psychotherapy. Basic Books, New York.

Luthman, S. and Kirschenbaum, M. (1974). The dynamic family. Science and Behavior Books, Palo Alto, California.

Maas, H. (1956). Cultural elements in group psychotherapy: Some problems for study. Mental Hygiene, 40, 44-52.

MacDonald, B. (1975). Evaluation and the control of education. In Tawney, I. (ed.) Curriculum evaluation today: trends and implications, 150-166. MacMillan, London.

Mahler, M., Pine, F. and Bergman, A. (1975). The psychological behavior of the human infant. Basic Books, New York.

Maini, M. and Nilsson, A. (1983). Process and outcome as viewed by the client, the therapist and a significant other. Project Report. University of Lund.

Malan, D. (1959). On assessing result in psychotherapy. British Journal of Medical Psychology, 32, 86-105.

Malan, D. (1976). The frontier of brief psychotherapy. Plenum, New York.

Malan, D. (1976). Toward a validation of dynamic psychotherapy. Plenum. New York.

Malan, D. (1979). Individual psychotherapy and the science of psychodynamics. Butterworths, London.

Malmström, K., Ramos-Ruggiero, L. and Søndergaard, H. (eds.) (1997). Med livet i behåll (With life left intact). Centrum för Behandling av Tortyrskadade (CTD), Stockholm.

Malzberg, B. and Lee, E. (1956). Migration and mental disease. A study of first admissions to hospitals for mental disease. Social Science Research Council, New York.

Mann, J. (1973). Time-limited psychotherapy. Harvard University Press, Cambridge, Massachusetts.

Markus, H. (1977). Self-schemata and processing information about the self. Journal of Personality and Social Psychology. 35, 63-78.

Markus, H. and Kitayama, S. (1991). Culture and the self: implications for cognition, emotion, and motivation. Psychological Review, 98, 224-253.

Markus, H. and Kitayama, S. (1994). The cultural construction of self and emotion: implications for social behavior. In Kitayama, S. and Marcus, H. (eds.) Emotion and culture: empirical studies of mutual influence, 89-132. American Psychological Association, Washington, D.C.

Markus, H., Kitayama, S. and VandenBos, G. (eds.) (1996). The mutual interactions of culture and emotion. Psychiatric Services, 47 (3), 225-236.

Markus, H. and Nurius, P. (1986). Possible selves. American Psychologist, 41, 954-969.

Markus, H. and Zajonc, R. (1985). The cognitive perpective in social psychology. In Lindzey, G. and Aronson, J. (eds) Handbook of social psychology, 3rd ed.,Vol.1, 137-230. Random House, New York.

Marlin, O. (1994). Special issues in the analytic treatment of immigrants and refugees. Issues in Psychoanalytic Psychology, 16 (1), 7-16.

Marsella, A, DeVos, G. and Hsu, F. (1985). Culture and self: Asian and Western perspectives. Tavistock Publications, New York.

Martinez, C. (1973). Community mental health and the Chicano movement. American Journal of Orthopsychiatry, 12, 220-229.

Masterson, J. (1967). The psychiatric dilemma of adolescence. Linda Brown, Boston.

May, R. (1967). Psychology and the human dilemma. Van Nostrand Reinhold, New York.

May, R. (1967). The art of counseling. Abingdon, Nashville, Tennessee.

May, R. (1967). Man's search for himself. New American Library, New York.

May, R. (1967). Existence: a new dimension in psychiatry and psychology. Simon and Schuster, New York.

May, R. (1969). Existential psychology. In May, R. (ed.) Studies in psychology, 2nd rev. ed.,10-40. Random House, New York.

May, R. (1972). Power and innocence. A search for the sources of violence. Norton, New York.

May, R. (1977). The meaning of anxiety. Norton, New York.

May, R. (1983). The discovery of being. Norton, New York.

McDougall, J. (1969). Theaters of the mind. Free Association Books, London.

McDougall, J. (1989). Theaters of the body. Free Association Books, London.

McGoldrick, M. (ed.) (1982). Ethnicity and family therapy. Guilford Press, New York, (1996).

McWilliams, N. (1994). Psychoanalytic diagnosis: understanding personality structure in the clinical process. Guilford Press, New York.

Mead, E. (ed.) (1990). Effective supervision. Bruner/Mazel, New York.

Mead, G. (1934). Mind, self and society. University of Chicago Press, Chicago.

Mead, M. (1947). The implications of culture change for personality development. American Journal of Orthopsychiatry, 17, 636-645.

Meissner, W. (1991). What is effective in psychoanalytic therapy: the move from interpretation to relation. J. Aronson, New York.

Messer, S. and Warren, S. (1995). Models of brief psychodynamic therapy: a comparative approach. Guilford Press, London.

Mezey, A. (1960). Personal background, emigration and mental disorder in Hungarian refugees. The Journal of Mental Science, 1, 106-113.

Miller, A. (1983). For your own good. Farrar, Straus, and Giroux, New York.

Milliken, R. (1965). Prejudice and counseling effectiveness. Personnel and Guidance Journal, 710-712.

Minuchin, S., Montalvo, B., Guerney B., Rosman, B. and Schumer, F. (1967). Families of the slums. Basic Books, New York.

Minuchin, S. and Fishman, H. (1981). Family therapy technics. Harvard University Press. Cambridge, Massachusetts.

Mirkin, M. (1990). The social and political contexts of family therapy. Allyn and Bacon, Boston.

Miserez, D. (ed.) (1987). Refugees: the trauma of exile. Martinus Nijhoff, Vitznau, The Netherlands.

Mitchell, S. and Black, M. (eds.) (1995). Freud and beyond. Basic Books, New York.

Mollica, R. and Caspi-Yavin, Y. (1996). The assessment of events and their related symptoms in torture and refugee trauma. In Miller, T. (ed.) Theory and assessment of stressful life events, 273-293. International Universities Press, Madison, Connecticut.

Montgomery, E. (1998). Refugee children from the Middle East. Scandinavian Journal of Social Medicine, suppl. 54, 1-152.

Mostwin, D. (1976). Uprootments and anxiety. International Journal of Mental Health, 5 (2), 205-211.

Moynihan, P. (1975). Ethnicity theory and experience. Harvard University Press, Cambridge, Massachusetts.

Murphy, H. (1934). Culture, society, and mental disorder. Journal of Abnormal Social Psychology, 29, 1-9.

Murphy, H. (1964). Cross-cultural inquiry into the symptomology of depression. Transcultural Psychiatric Research, 1, 5-21.

Nesdale, D., Rooney, R. and Smith, L. (1997). Migrant ethnic identity and psychological distress. Journal of Cross Cultural Psychology, 28 (5), 569-588.

Nichols, M. and Schwartz, R. (1995). Family therapy concepts and methods. Allyn and Bacon, Boston.

Novak, M. (1971). The rise of the unmeltable ethnics. MacMillan, New York.

Obradovic, B., Kanazir, V., Zalisevskij, G. and Popadic, K. (1993). A threat to mental health of children and young people in exile. Psihijatrija-Danas, 25 (1-2), 91-98.

Ochberg, F. (ed.) (1988). Post-traumatic therapy and victims of violence. Brunner/Mazel, New York.

Offer, D. (1971). Rebellion and antisocial behavior. American Journal of Psychoanalysis, 31, 13-19.

Offer, D. (1973). Psychological world of the teenager: a study of normal adolescent boys. Harper and Row, New York.

Ogilvy, J. (1897). Many dimensional man: decentralizing self, society and the sacred. Oxford University Press, New York.

Opaku, S. (ed.) (1998). Clinical methods in transcultural psychiatry, 391-411. American Psychiatric Press, Washington, D.C.

Osofsky, J. and Fenichel, E. (eds.) (1994). Caring for infants and toddlers in violent environments: hurt, healing and hope – zero to three. National Center for Clinical Infant Programs, Arlington, Virginia.

Oxford Dictionary (1961). Oxford University Press, London.

Parlett, M. and Hamilton, D. (1973). Evaluation as illumination: a new approach to the study of innovatory programs. In new trends in evaluations. Material for a conference on educational evaluation held at the Department of Education, University of Gothenburg, 22-23 October 1973, 55-70. Department of Education, University of Gothenburg.

Patton, M. (1980). Qualitative evaluations and research methods. Sage Publications, Newbury Park, California.

Peterson, K., Prout, M. and Schwarz R. (1991). Posttraumatic stress disorder, a clinicians' guide. Plenum, New York.

Peterson, R. (1967). Rehabilitation of the culturally different: a model of the individual in cultural change. Personnel and Guidance Journal, 1001-1007.

Piaget, J. (1929). The child's conception of the world. Routledge and Kegan, London.

Piaget, J. and Weil, A. (1951). The development in children of the idea of the homeland and of relations with other countries. International Social Science Bulletin, 3, 570.

Peirce, C. (1877). The fixation of belief. In Buchler, J. (ed.) Philosophical writing of Peirce. Dover, New York, (1955).

Pick, S. (1997). Berry in Legoland. Applied Psychology: An International Review, 46 (1), 49-52.

Polkinghorne, D. (1983). Methodology for the human sciences. State University of New York Press, Albany, New York.

Polkinghorne, D. (1986). Changing conversations about human science. Saybrook Review, 6, (1), 1-32.

Polkinghorne, D. (1986). Conceptual validity and nontheoretical science. Journal of Phenomenological Psychology, 17, (2), 129-150.

Postero, N. (1992). On trial in the promised land: seeking asylum. Special issues: refugee women and their mental health: shattered societies, shattered lives. Women and Therapy, 13 (1-2), 155-172.

Price-Williams, D. (1969). Cross-cultural studies. Penguin Books, Middlesex, England.

Priebe, S. and Esmaili, S. (1997). Long-term mental sequelae of torture in Iran – who seeks treatment? Journal of Nervous and Mental Disease, 185 (2), 74-77.

Proshansky, H. (1978). The city and self-identity. Environment and Behavior, 10, 147-169.

Proshansky, H., Fabian, A. and Kaminoff, R. (1983). Place identity: physical world socialization of the self. Journal of Environmental Psychology, 3, 57-83.

Ramirez, M. (1999). Multicultural psychotherapy: an approach to individual and cultural differences. Allyn and Bacon, Needham Heights, Massachusetts.

Reich, W. (1946). The mass psychology of fascism. Noonday Press, New York, (1972).

Reissman, F., Cohen, J. and Pearl, A. (1964). Mental health of the poor. Collier-Macmillan, London.

Reynolds, B. (1942). Learning and teaching in the practice of social work. Rinehard, New York.

Richter, E. (1974). The family as patient. Farrar, Strauss, and Giroux, New York.

Roche, J-L. (1987). Multidimensional approach to exiles: persecution experiences. In Miserez, D. (ed.) (1987) Refugees: the trauma of exile, 223-235. Martinus Nijhoff, Vitznau, The Netherlands.

Roeder, F. and Opalic, P. (1997). A psychotherapy group for Turkish patients using an interpreter. Group Analysis, 320 (2), 233-240.

Roth, G. and Ekblad, S. (1993). Migration and mental health: current research issues. Nordic Journal of Psychiatry, 47 (3), 185-89.

Rousseau, C., Said, T., Gagne, M. and Bibeau, G. (1998). Resilience in unaccompanied minors from the north of Somalia. Psychoanalytic Review, 85 (4), 615-637.

Ruszczynski, S. (ed.) (1993). Psychotherapy with couples. Theory and practice at the Tavistock Institute of Marital Studies. Karnac Books, London.

Ryle, A. (1997). Cognitive-analytic therapy: active participation in change. A new integration in brief psychotherapy. Wiley, New York.

Saegert, S. and Winkel, G. (1990). Environmental psychology. Annual Review of Psychology, 41, 441-477.

Salner, M. (1986). Validity in human science research. Saybrook Review, 6 (1), 107-131.

Sandler, J., Dare, C. and Holder, A. (1992). The patient and the analyst. Karnac Books, London.

Sartre, J-P. (1962). Existential psychoanalysis. Henry Regnery, Chicago.

Scarry, E. (1985). The body in pain: the making and unmaking of the world. Oxford University Press, New York.

Schein, H. (1989). The clinical perspective in fieldwork. Sage, London.

Schlapobersky, J. and Bamber, H. (1987). Rehabilitation work with victims of torture. In Miserez, D. (ed.) Refugees: the trauma of exile, 206-222. Martinus Nijhoff, Vitznau, The Netherlands.

Schoenpflug, U. (1997). Acculturation: adaptation or development? Applied Psychology: An International Review, 46 (1), 52-55.

Scriven, M. (1967). The methodology of evaluation. In Tyler, R., Gagne, R. and Scriven, M. (eds.) Perspectives on curriculum evaluation. AERA Monograph, Series on Curriculum Evaluation, 1, Rand McNally, Chicago.

Searle, H. (1962). Problems of psycho-analytic supervision. Science and Psychoanalysis, 5, 157-166.

Searle, H. (1965). The informational value of the supervisor's emotional experiences. In Searle, H. (ed.) Collected papers on schizophrenia and related subjects, 135-146. International Universities Press, Madison, Connecticut.

Segall, M., Lonner, W. and Berry, J. (1998). Cross-cultural psychology as a scholarly discipline. American Psychologist, 53 (10), 1101-1110.

Seguin, A. (1956). Migration and psychosomatic disadaptation. Psychosomatic Medicine, 18, 404-409.

Shrestha, N-M., Sharma, B., Van-Ommeren, M., Regmi, S., Makaju, R., Komproe, I., Shrestha, G-B. and de-Jong, J. (1998). Impact of torture on refugees displaced within the developing world; symptomatology among Bhutanese refugees in Nepal. Journal of the American Medical Association, 280 (5), 443-448.

Shweder, R. and Sullivan, M. (1993). Cultural psychology: who needs it? Annual Review of Psychology, 44, 497-527.

Sifneos, P. (1972). Short-term psychotherapy and emotional crisis. Harvard University Press, Cambridge, Massachusetts.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. Journal of Nervous and Mental Disease, 187 (4), 200-207.

Sluzki, C. (1979). Migration and family conflicts. Family Process, 18, 370-383.

Solomon, S., Greenberg, J. and Pyszczynski, T. (1991). A terror management theory of social behavior: the psychological functions of self-esteem and cultural worldviews. In Zanna, M. (ed.) Advances in experimental social psychology, 24, 93-159. Academic Press, San Diego, California.

Somnier, F. and Genefke, K. (1986). Psychotherapy for victims of torture. British Journal of Psychiatry, 149, 323-329.

Stake, R. (1974). Program evaluation, particularly responsive evaluation. Department of Education, Report, 35, University of Gothenburg.

Stake, R. (1978). The case study method in social inquiry. Educational Researcher, 7, (2), 5-8.

Stake, R. (1978). Case studies in science education. Circe. University of Illinois.

Stenlund, G. (1996). Dynamisk korttidsterapi. En utfallsstudie (Dynamic short-term therapy. An outcome study). Rapportserie: Psykologi i tillämpning, Lund University, 14 (3).

Stewart, E. (1971). American cultural patterns: a cross-cultural perspective. Intercultural Communications Network, Pittsburgh, Pennsylvania.

Stover, E. and Nightingale, E. (eds.) (1985). The breaking of minds and bodies. Freeman, New York.

Streit, U. (1998). Nathan's ethnopsychoanalytic therapy: characteristics, discoveries and challenges to Western psychotherapy. Transcultural Psychiatry, 34 (3) 321-343.

Suedfeld, P. (1990). Psychology and torture. Hemisphere Publications, New York.

Sullivan, H. (1947). The psychiatric interview. Norton, New York, (1970).

Sullivan, H. (1953). The interpersonal theory of psychiatry. Norton, New York, (1971).

Sundquist, J. (1994). Refugees, labor migrants and psychological distress: a population-based study. Journal of Social Psychiatry and Psychiatric Epidemiology, 29 (1) 20-24.

Sylvander, I. (1982). Identitetsutveckling – ungdom i riskzon (Identity development – adolescents in the risk-zone). National Board of Health and Welfare, Stockholm.

Szecsödy, I. (1974). Handledning i psykoterapi (Psychotherapy supervision). Psykisk Hälsa, 1, 23-32.

Szecsödy, I. (1981). The supervisory process. Theory and research in psychotherapy supervision (A research project). Report 3, Department of Psychotherapy, Karolinska Institute, Stockholm.

Szecsödy, I. (1990). The learning process in psychotherapy supervision. Doctoral dissertation. Department of Psychiatry, Karolinska Institute, S:t Görans Hospital, Stockholm.

Tabora, B-L. and Flaskerud, J. (1997). Mental health beliefs, practices, and knowledge of Chinese American immigrant women. Issues in Mental Health Nursing, 18 (3), 173-189.

Tajfel, H. (1978). Differentiation between social groups. Studies in the social psychology of intergroup relations. Academic Press, London.

Tajfel, H. (1981). Human groups and social categories. Cambridge University Press, Cambridge, England.

Tajfel, H. (1982). Social psychology of intergroup relations. Annual Review of Psychology, 33, 1-39.

Terr, L. (1988). What happens to early memories of trauma? Journal of the American Academy of Child and Adolescent Psychiatry, 27, 96-104.

Terr, L. (1989). Treating psychic trauma in childhood: a preliminary discussion. Journal of Traumatic Stress, 2, 3-20.

Terr, L. (1991). Childhood traumas: an outline and overview. American Journal of Psychiatry, 148, 10-20.

Thomas, A. (1961). Pseudo-transference reactions due to cultural stereotyping. American Journal of Psychology, 894-900.

Ticho, G. (1971). Cultural aspects of transference and counter-transference. Meninger Clinic, 35, 530-541.

Tillich, P. (1972). The courage to be. Yale University Press, New Haven.

Toulmin, S. (1972). Human understanding: the collective use and evolution of concepts. Princeton University Press, Princeton, New Jersey.

Trankell, A. (ed.) (1971). Fem IMFOstudier (Five studies from the IMFO group). IMFO-gruppen, Department of Education, University of Stockholm.

Triandis, H., Lambert, W., Berry, J., Lonner, W., Heron, A., Brislin, R. and Draguns, J. (eds.) (1980). Handbook of cross-cultural psychology. Allyn and Bacon, Boston.

Triandis, H. (1989). Self and social behavior in differing cultural contexts. Psychological Revew, 96, 269-289.

Triandis, H. (1997). Where is culture in the acculturation model? Applied Psychology: An International Review, 46 (1), 55-58.

Tsung-Yi, L. (1953). A study of the incidence of mental disorder in Chinese and other cultures. Psychiatry, l6, 313-336.

Tyler, T., Kramer, R. and John, O. (1999). The psychology of the social self. Lawrence Erlbaum, Mahwah, New Jersey.

Ullman, M. and Limmer, C. (eds.) (1987). The variety of dream experience. Continuum Publishing, New York.

Ullman, M. and Zimmerman, N. (1979). Working with dreams. Delacorte Press, New York.

UNHCR (United Nations High Commissioner for Refugees) (1979). Handbook on procedures and criteria for determining refugee status. Office of the High Commissioner for Refugees, Geneva.

Vahia, N. (1962). Cultural differences in the clinical picture of schizophrenia and hysteria in India and the United States. Report. Postgraduate Center for Psychotherapy, New York.

Van der Veer, G. (1992). Counseling and therapy with refugees. Wiley, New York, (1998).

Vargás, R. (1977). Mental health needs of the Hispanic community. Testimony before the President's Commission on Mental Health, Washington, D.C.

Vargás, R. (1977). Policy and intent statement regarding mental health services to minorities. California Conferences of Local Mental Health Directors. Mimeograph.

Vontress, C. (1969). Cultural barriers in the counseling relationship. Personnel and Guidance Journal, 11-17.

Vontress, C. (1970). Counseling blacks. Personnel Guidance Journal, 40, 9, 713-719.

Wallerstein, R. (1981). Becoming a psychoanalyst. A study of psychoanalytic supervision. International University Press, New York.

Webster's Dictionary (1974). Ottenheimer Publishers, New York.

Webster's New World Dictionary (1984). Warner Books, New York.

Weinberg, A. (1949). Psychosociology of the immigrant: an investigation into the problems of adjustment of Jewish immigrants into Palestine. Social Studies 2, Institute of Folklore and Ethnology, Jerusalem.

Weinberg, A. (1961). Migration and belonging. A study of mental health and personal adjustment in Israel. Martinus Nijhoff, Hague.

Weine, S., Becker, D., McGlashan, T. and Vojvoda, D. (1995). Adolescent survivors of "ethnic cleansing": observations on the first year in America. Journal of the American Academics of Child and Adolescent Psychiatry, 34 (9), 1153-1159.

Weine, S., Kulenovic, A., Pavkovic, I. and Gibbons, R. (1998). Testimony psychotherapy in Bosnian refugees: a pilot study. American Journal of Psychiatry, 155 (2), 1720-1726.

Wertz, F. (1986). The question of the reliability of psychological research. Journal of Phenomenological Psychology, 17 (2), 181-206.

Westermeyer, J. (1989). Psychiatric care of migrants: a clinical guide. American Psychiatric Press, Washington, D.C.

Westermeyer, J. and Wahmenholm, K. (1989). Assessing the victimized psychiatric patient. Journal of Hospital and Community Psychiatry, 40 (3), 245-249.

Westermeyer, J. and Williams, C. (eds.) (1986). Refugee mental health in resettlement countries. Hemisphere Publishing, Washington, D.C.

Westin, C. (1971). Invandrares problem belysta av invandrare i svårigheter. Rapport Nr. 1. Diskussion av anpassningsbegreppet. Bakgrund och teoretisk referensram (The problems of immigrants elucidated by immigrants' difficulties. Report No. 1. Discussion on the concept of adaptation. Background and theoretical framework). Department of Education, University of Stockholm.

Westin, C. (1975). Existens och identitet (Existence and identity). Bokförlaget Korpen, Gothenburg.

Westin, C. (1989). Tortyr och existens (Torture and existence). Bokförlaget Korpen, Gothenburg.

Westlander, G. (1987). Kontextorienterad ansats i organisationspsykologisk forskning. En metod diskussion (Context-oriented approaches in research on organizational psychology. A discussion of methods). Nordisk Psykologi, 39, 2, 104-114.

Westlander, G. (1993). Socialpsykologi: tankemodeller om människor i arbete (Social psychology: thought models on people at work). Akademiförlaget, Gothenberg.

Wilson, C. (1956). The outsider. Delta, New York.

Winnicott, D. (1958). Collected papers. Through pediatrics to psychoanalysis. Tavistock, London.

Winnicott, D. (1965). The family and individual development. Tavistock, London.

Winnicott, D. (1971). Playing and reality. Tavistock, London.

Winnicott, D. (1988). Human nature. Free Association Books, London.

Wong, T. (1962). Racial prejudice, interpersonal attraction and assumed dissimilarity of attitudes. Journal of Abnormal and Social Psychology, 65, (4) 246-254.

Wurmser, L. (1994). Aggressionens ursprung (The roots of aggressivity). SFPH monografiserie, 38.

Yin, R. (1989). Case study research. Design and methods. Sage, London.

Young, M. (1998). Psychological consequences of torture: clinical needs of refugee women. In Opaku, S. (ed.) Clinical methods in transcultural psychiatry, 391-411. American Psychiatric Press, Washington, D.C.

Zanna, M. (1994). On the nature of prejudice. Canadian Psychology, 35, 11-23.

Zung, K. (1969). A cross-cultural survey of symptoms in depression. American Journal of Psychiatry, 126, 1, 155-158.

APPENDIX 1. ABOUT THE AUTHOR AND HER CLINICAL WORK

The author was born and raised in a multinational/multicultural neighborhood in Brooklyn, New York. Her parents were children of refugees, and her interest in migration, exile and its consequences began as a child due to the people she grew up with and their experiences as refugees and immigrants in the United States. She came as an immigrant to Sweden in 1966, and has lived and worked in several countries. She has also written about her experiences in poetry collections and fiction, theater and film, and non-fiction anthologies and books.

Countries of origin of refugees/immigrants receiving treatment from the author or other persons supervised by the author (1976-1998).

Refugees (74 countries)

Afghanistan	Estonia	Pakistan
Albania	Ethiopia	Peru
Algeria	Gambia	Poland Rumania
Angola	Germany	Rwanda
Argentina	Ghana	Russia
Armenia	Greece	Senegal
Bangladesh	Hungary	Serbia
Bhutan	India	Sierra Leone
Bolivia	Indonesia	Somalia
Bosnia-Herzegovina	Iran	South Africa
Bulgaria	Iraq	Sri Lanka
Burundi	Israel, the Occupied Territories	Sudan
Chad	Jordan	Syria
Chile	Kenya	Tanzania
China	Laos	Thailand
Congo	Latvia	Tunisia
The CongoDem.Rep. (Zaire)	Lebanon	Turkey
Columbia	Liberia	Uganda
Croatia	Libya	Ukraine
Cuba	Malawi	Uruguay
Czechoslovakia	Morocco	United States of America
Egypt	Mozambique	Vietnam
El Salvador	Namibia	Yugoslavia (former)
Eritrea	Nigeria	Zambia

Immigrants (54 countries)

Algeria	Holland	Peru
Austria	Honduras	Philippines
Australia	Hungary	Poland
Bahamas	Iceland	Russia
Barbados	India	Senegal
Belgium	Iran	South Africa
Canada	Iraq	Saudi Arabia
Chile	Ireland	South Korea
Cuba	Israel	Sweden (returnees)
Denmark	Italy	Spain
Egypt	Jamaica	Switzerland
England	Japan	Thailand
Finland	Lebanon	Trinidad
France	Malaysia	Turkey
Gambia	Mexico	United States of America
Germany	Morocco	Venezuela
Greece	Nigeria	Yugoslavia (former)
Haiti	Norway	Zambia

Persons with refugee and/or immigrant status (18 countries)

Chile	Iran	Russia
Cuba	Iraq	Senegal
Gambia	Morocco	South Africa
Germany	Nigeria	Turkey
Greece	Peru	United States of America
India	Poland	Yugoslavia (former)

APPENDIX 2. SCHEDULE OF THE TRAINING PROGRAM

Meeting 1	Three-day introductory seminar	Psychology of the refugee, the immigrant and their children – a framework and its application to psychotherapeutic and related support work
	presentation	– of participants/supervisors
	lectures	– the framework and its use
		– inner and outer qualities necessary
		– trauma
		– prejudice, discrimination, racism
	groupwork	– our culture and its influence on us
		– our conscious and unconscious prejudices and their effects
Meeting 2	supervision	
	lecture	– assessment/evaluation utilizing the framework
Meeting 3	literature seminar	
	supervision	
	lectures	– using the framework at the beginning phases of psychotherapy and support work
		– using the framework in work with children and adolescents
Meeting 4	three day seminar	
	literature seminar	
	supervision	
	lecture	
	seminar	– treatment of tortured refugees
		– using an interpreter
Meeting 5	literature seminar	
	lecture	– cultural differences in psychotherapy
	supervision	
	lecture	– using the framework in work with traumatized refugees
Meeting 6	supervision	
	lecture	– using the framework in limited therapy and support work
Meeting 7	literature seminar	
	lecture	– a psychological theory of exile
	supervision	
	lecture	– using the framework in the middle of the psychotherapeutic process
Meeting 8	three-day seminar	
	supervision	
	culture presentations	
	lectures and seminars	– dreamwork
		– support work
		– the therapeutic process – transference/counter-transference and other components
Meeting 9	supervision	
	lecture	– using the framework at the end of the psychotherapeutic process
Meeting 10	literature seminar	
	lecture	– example of support work in a third-world country
	supervision	
	lectures	– using the framework in family therapy
		– in group therapy
Meeting 11	supervision	
	lecture	– using the framework at the final stage of the psychotherapeutic and support-work process
Meeting 12	lecture and seminar	– refugee/immigration laws and policies
	culture presentations	
	supervision	
	questions/discussion	– on the framework
Meeting 13	three-day seminar	
	culture presentations	
	supervision	
	lecture and seminar	– on networking and use of the framework in society
	lecture	– Finnish identity and self-esteem

APPENDIX 3. COMPULSORY LITERATURE IN THE TRAINING PROGRAM

Books

Bettelheim, B. (1985). Det upplysta hjärtat (The informed heart). Norstedt, Stockholm.

Cullberg, J. (1990). Kris och utveckling (Crisis and development). Natur och Kultur, Stockholm.

Frankl, V. (1986). Livet måste ha en mening (Man's search for himself). Natur och Kultur, Stockholm.

Fromm, E. (1982). Det glömda språket (The forgotten language). Natur och Kultur, Stockholm.

Grinberg, L. and Grinberg, R. (1989). Psychoanalytic perspectives on migration and exile. Yale University Press, New Haven, Connecticut.

Kristal-Andersson, B. (1990). Psychology of the refugee, the immigrant and their children – A framework and its application to psychotherapeutic and related support work. Manuscript.

Kristeva, J. (1991). Främlingar för oss själva (Strangers to ourselves). Natur och Kultur, Stockholm (1992). Muuklaisisa itsellemme (Strangers to ourselves). Karisto, Helsinki.

Krystal, H. (1988). Integration and self-healing, affect, trauma and alexthymia. Analytic Press, New Jersey.

Suedfeld, P. (1990). Psychology and torture. Hemisphere Publishing, New York.

Ullman, M. and Limmer, C. (eds.) (1989). Drömmen löser problem (The variety of dream experience). Natur och Kultur, Stockholm.

Ullman, M. and Zimmerman, N. (1981). Använd dina drömmar (Working with dreams). Natur och Kultur, Stockholm. (1982). Paljastavat unet (Working with dreams). Karisto, Helsinki.

Westermeyer, J. (1989). Psychiatric care of migrants: A clinical guide. American Psychiatric Press, Washington, D.C.

Articles

Kristal-Andersson, B. (1981). Mot förståelse av flyktingens och invandrarens inre värld. Ur antologin: Att leva med mångfalden (Towards understanding of the inner world of the refugee and immigrant. From the anthology: To live with diversity), 134-173. Liber Förlag, Stockholm.

Kristal-Andersson, B. (1985). Mot förståelse av flyktingens inre värld. Ur antologin, Eriksson, L-G. (red) Att ta emot flyktingar (Towards understanding of the inner world of the refugee. In the anthology, Eriksson, L-G (ed.) The reception of refugees), 101-126. The Swedish Immigration Board, Norrköping.

Kristal-Andersson, B. (1985). Att möta och arbeta med flyktingar. Ur antologin, Eriksson, L.G. (red) Att ta emot flyktingar (Meeting and working with refugees. In the anthology, Eriksson, L-G. (ed.) The reception of refugees), 140-160. The Swedish Immigration Board, Norrköping.

Kristal-Andersson, B. (1993). Flyktingens och invandrarens inre och yttre värld – referensram för psykoterapeutiska samtal (Refugees and immigrants inner and outer world – a framework for psychotherapeutic work). Mimeograph.

Lindblom-Jakobson, M. (1988). Att arbeta med tolk i psykoterapi på psykoanalytisk grund, erfarenheter från Röda korsets center for torterade flyktingar (Working with an interpreter in psychoanalytic psychotherapy, experience from the Red Cross Center for tortured refugees). Psykisk Hälsa, 1, 57-66.

Lindblom-Jakobson, M. (1990). Överförings-och motöverföringsaspekter i psykoterapi med tolk. Den terapeutiska "triaden" (Transference and counter-transference aspects in psychotherapy with an interpreter. The therapeutic "triad"). Mimeograph. Swedish Red Cross.

Lindblom-Jakobson, M. (1991). Behandlingsarbete med tolk vid Röda korsets center for torterade flyktingar (Treatment work with an interpreter at the Red Cross Center for tortured refugees). Mimeograph. Swedish Red Cross.

APPENDIX 4. THE SESSION REPORT FORMS

Here follow examples of the three forms used by the participants to report on the sessions: form 1 – the introductory session; form 2 – account of the second and following sessions; form 3 – account of the third and final sessions. Please note that on the original forms extra space was available for each answer.

FORM 1 – SCHEDULE FOR THE INTRODUCTORY SESSION

Please write your remarks down immediately after the session and send the completed form to the given address.

I. Referral by:

II. See below: information on "client variables"

III. The client:

Client's description of his/her problems (now and earlier):

Client's behavior:

Client's background and reason for seeking therapeutical help (motivation):

Client's description of him/herself (even healthy characteristics):

Client's description of others:

IV. The therapist – client relation:

Therapist's/support worker's behavior towards the client:

Client's behavior towards the therapist/support worker:

V. Noteworthy incidents (statements) during the conversation:

VI. Indications of need for time-limited psychotherapy/support work:

Indications against need for time-limited psychotherapy/support work:

VII. Any further information:

VIII. The therapist's/support worker's expectation of the outcome of psychotherapy/support work:

Client variables (information to be acquired in the introductory session):

Sex:

Age:

Education:

Occupation:

Civil status:

Home country:

Arrival:

Reason:

When the current symptoms/difficulties were first observed:

Earlier seeking out help for the same difficulties:

If yes, in what way does the client describe the contacts he/she made?:

Client's expectation of treatment/support work:

Client's perception of his/her situation if treatment/support work cannot be carried out:

Client's expectation and aim of the treatment/support work:

Client's perception of the therapist's role in the treatment/support work:

Client's perception of the importance of his/her contribution to the treatment/support work:

FORM 2 – SECOND AND FOLLOWING SESSIONS

Please fill in this information immediately after the session and send it to the given address.

I. Frame divergences; for example, if the client arrives late, etc.:

II. Client's condition at the start of the session – the therapist's observation:

III. Atmosphere during the session (course of events, fluctuations, ability to fantasize – concrete level), dependent on:

The client:

The therapist:

IV. Theme or focus:

IVa. In what ways are the symptoms, difficulties and problems for which the client sought help taken up in the session?

How are they expressed or affected by:

The *refugee/immigrant situation*?

The aspects:

1. The *states of being*? Which one(s)? Based on reality, an exaggerated feeling of reality or fantasy?
2. The *adaptation cycle*?
3. The *childhood experiences*?
4. The *relevant background conditions*? Which one(s)?
5. The r*eason* for exile/immigration?
6. The *transition-related conditions*? Which one(s)?

V. The therapist's/support worker's interventions:

VI. Transference:

VII. Counter-transference:

VIII. The therapist's thoughts immediately after the session:

IX. Expectation and prediction of the next session:

X. Hypotheses on the "core problem":

FORM 3 – THIRD AND FINAL SESSIONS

Please fill in the form immediately after the third and final sessions. Mail to the given address.

I. The core problem of the neurotic complex:

A. Basic wish/fear:

B. Organization of self-integrating defenses which contribute to the maintenance of self-esteem:

C. Feelings/affects experienced by the client and verified by the therapist:

D. What effect has the client's *refugee/immigrant situation* had on the neurotic complex (according to the B K-A definition):

E. Which one(s) of the six aspects of the framework are affecting the core problem? In what way(s)?:

F. How are the client's previous traumatic experiences in the homeland affecting the *refugee/immigrant situation* and the six aspects of the framework? In what way(s)?:

II. Effect criteria (cf. Malan); that is, observed effects in relation to the core problem are noted as well as "semblance effects". Diffuse descriptions such as "feel better" are not reported. The description is made in accordance with the five-point scale below:

0. The core problem has gotten worse.
1. "Semblance relief"; substitute symptoms have arisen.
2. The symptoms have improved without alleviation of the core problem.
3. "Standard relief" has occurred; that is, symptom improvement has taken place combined with a certain change in the core problem.
4. "Recovered": that is, symptom-free and relief of the core problem.

III. Expectation of the therapy/support work. Evaluate. 0 1 2 3 4

APPENDIX 5. THE OUTCOME EVALUATION QUESTIONNAIRES

QUESTIONNAIRE 1 – THE FINAL SEMINAR

1. How do you rate the training program as a whole? Mark the line at an appropriate point – scale 0-100 (poor to excellent).
2. Give your reason(s) for this evaluation:
3. What has been positive, and what would you like to keep in the training program?
4. What do you find most important to change?
5. Give your opinions with regard to the contents and extent of:
   a. The supervision:
      - the large-group model:
      - your case supervision:
      - its effects on your work:
      - being able to take part in other participants' casework:
   b. The lectures:
   c. The seminars:
   d. The literature:
   e. The literature seminars:
   f. The culture presentations:
6. In what way(s) has the training program affected your work with refugees and immigrants?

QUESTIONNAIRE 2 – ONE MONTH AFTER THE CONCLUSION OF THE PROGRAM

<u>The training program as a whole</u>

Please rate the following questions on a scale 0-100 (poor to excellent).

- How do you rate the training program as a whole?
- Has the program met your expectations?
- Has the program fulfilled your needs with regard to your work with refugees/ immigrants?

Please answer the following questions more extensively.

- In what way(s) did the training program fulfill your needs? Explain:
- In what way(s) did the training program <u>not</u> fulfill your needs? Explain:
- What has been positive, what would you like to retain?
- What should be changed?
- Should the training have lasted longer than two terms? Explain your answer:

<u>The supervision</u>

Please rate the supervision on a scale 0-100 (poor to excellent).

Please explain your evaluation of the supervision:

- What is your view on the large-group model?
- Did the model meet your needs or not? Please explain:

- In what way(s) did the other participants' cases influence you?
- In what way(s) has the supervision affected you in your client work?
- What have you gained from the supervision?
- Should supervision have extended over more than two terms?
- What should be changed?

The seminars

Please rate the seminars on a scale 0-100 (poor to excellent).
Please explain the reasons for your evaluation:

- Which seminar(s) were most positive?
- Which seminar(s) would you like to see changed?
- Give your opinions on the content and scope of the seminars:
- Which themes would you have liked to study more intensively?

Seminar 1 – The introductory seminar

Please rate the following on a scale 0-100 (poor to excellent).

- the seminar as a whole:
- your presentation of yourself:
- the lecture on prejudices:
- group work on prejudices:
- group work on your own culture:
- Give your opinion on the content and scope of the introductory seminar:
- What would you have liked to focus on more extensively?

Seminar 2 – Treatment of tortured refugees. Using an interpreter

Please rate seminar 2 on a scale 0-100 (poor to excellent).

- seminar 2 as a whole:
- treatment of torture:
- using an interpreter:
- Give your view on the content and scope of seminar 2:
- Which themes would you have liked to study more intensively?
- What should be changed?

Seminar 3 – Dreamwork. Support therapy with refugees

Please rate seminar 3 on a scale 0-100 (poor to excellent).

- dreamwork seminar as a whole:
- lecture on dreamwork:
- group work:
- lecture on transference/counter-transference:
- lecture on support work:
- group work:
- Give your view on the content and scope of seminar 3:

- What would you have liked to focus on more extensively?
- What should be changed?

Seminar 4 – On networking. The Finnish identity

Please rate seminar 4 on a scale 0-100 (poor to excellent).

- seminar 4 as a whole:
- lecture on networking:
- group work:
- lecture on the framework and society:
- lecture on the Finnish identity:
- Give your view on the content and scope of seminar 4:
- What would you have liked to focus on more intensively?
- What should be changed?

The lectures

Please rate the lectures as a whole on a scale 0-100 (poor to excellent).

- Rate the lecture on…given by…:
- Give your view on the content and scope of the lectures:
- What would you have liked to focus on more intensively?
- What should be changed?

The literature

Please rate the compulsory literature of the training program as a whole on a scale 0-100 (poor to excellent).

Give your opinion of the contents of each book and paper on the compulsory reading list.

- Which books/papers were most useful? Please explain:
- Which one(s) were least useful? Please explain:
- What should be changed?
- Give suggestions for literature that you would like to see in the program:

The literature seminars

Please rate the literature seminars as a whole on a scale 0-100 (poor to excellent).

- Which seminar(s) were most positive?
- Which seminar(s) were most negative?
- What should be changed?
- Give your view on the content and scope of the literature seminars:

Culture presentations

Please rate the culture presentations as a whole on a scale 0-100 (poor to excellent).

- What was most positive?
- What was most negative?
- What you would to have focused on more intensively?
- What should be changed?

Practical arrangements

Please rate the practical arrangements as a whole on a scale 0-100 (poor to excellent).

- Please explain your evaluation:
- What has been positive?
- What has been negative?
- What should be changed?

Please give examples of the ways in which you would have liked the practical arrangements to have been organized:

General:

Please comment freely on the training program as it is now, and how you would improve it for the future:

QUESTIONNAIRE 3 – SIX MONTHS AFTER THE CONCLUSION OF THE PROGRAM

This questionnaire is in two parts: Part I – Evaluation of the training program as a whole; Part II – Evaluation of the casework.

Part I – Evaluation of the training program as a whole

Six months have gone by since you participated in the first 13-month specialist training program for psychotherapists and support workers working with refugees, traumatized refugees and immigrants, based on Kristal-Andersson's framework and working model, organized by the Centre of Extension Studies at Åbo Akademi University.

On separate sheet/s of paper, please reflect on and respond to the following questions using Swedish, Finnish or English:

Write (as much as you want, but at least a page) about your reflections on, and opinions of, how the training program has helped you in your work with, and attitude to, refugees and immigrants on an individual, one-to-one basis, at your institution, as well as out in society. When you answer this question, please consider the following:

- First, how the *refugee/immigrant situation* and six aspects of the framework have influenced your work with refugees and immigrants.
- Second, the ways in which you have been influenced or changed in your work with refugees/immigrants as a result of the seminars, lectures and literature as a whole. Specifically, your insight into traumas, torture and war experiences; your attitude to your own and other cultures; and your own prejudices and the prejudice of others.
- Third, the ways in which the group supervision of yourself and others have assisted you in your professional development.

Please give some examples:

- What within the program made the deepest impression on you? Why?
- What made the least impression?
- What could be added to the program to improve it?
- What should the training program focus on in the future: Please explain:
  a. What is most important for it to include?
  b. What should be added?

c. What should be excluded?

Please rate the following questions on a scale 0-100 (poor to excellent).

The training program

- What is your evaluation of the training program as a whole?
- Has understanding of and insight into your own and your family's traumas due to war experiences influenced your work with refugees?
- Have any understanding and insights you gained during the program with regard to your own culture influenced your work?
- To what extent has any insight you gained during the program about your own and others' conscious and unconscious prejudices affected you in your work?

The framework

- How often do you use the framework?
- How useful is the framework in your work?
- How much do you use the framework in treatment?
- How much do you utilize the framework in ways other than in treatment? Give examples:
- To what extent have the lectures on the framework contributed to your understanding?
- To what extent would you estimate the lectures on the framework to have influenced your work?

The supervision

- To what extent has supervision of your cases during the training affected you in your work?
- To what extent has the supervision of other participants in the group affected you in your work?

The seminars and lectures

- How do you rate the seminars and the lectures?
- Which one(s) made the deepest impression on you? Explain:

The literature seminars

- Six months after completion of the training program, how would you now rate the literature seminars? Explain:
- Which one(s) made the deepest impression on you? Why?

The literature

- What do you think of the literature as a whole?
- Which book(s) and/or article(s) made the deepest impression on you? Why?
- Which book(s) and/or article(s) did you find the least important? Why?

Group heterogeneity

- Please give your evaluation of participation in a training program which included participants with different educational backgrounds, work experiences and professions?

- Please discuss the positive and negative aspects of this for your work:

Duration of the training program

- What is your opinion of the length of the program, that is one-year? (on a scale 0-100; too short-too long):
- If longer, how long should the training program be?:
  1.5 years 2 years 2.5 years 3 years 3.5 years or longer
- Why?
- If shorter, how long should the training program be?
  2 months 3 months 6 months 8 months 10 months
- Why?

Finally, you have 100 points to rate various components of the training program. Distribute the points between the following segments of the program to illustrate what you value the most and the least:

- the framework/the basic working model:
- insight into traumas, war experiences and torture:
- knowledge of cultures:
- knowledge of prejudices:
- the supervision:
- lectures on the framework:
- other lectures:
- the seminars:
- the literature:
- the literature seminars:

Part II – Evaluations of the casework

- For what reason/s did the individual/family seek treatment/support?
- What were the symptoms of the individual/family at the start?
- The symptoms are (underline the appropriate response): a. unchanged; b. new ones appearing during treatment; c. fewer; d. none. Explain!
- At the start of treatment/support work, how did the individual/family function in this new society?
- How do they function now?: a. the same; b. improved; c. worse. Explain:
- Had the individual/family members experienced trauma(s) caused by outer violence in their homeland. Yes/No. Describe:
- Has the trauma(s) been worked through. Yes/No. Describe:
- Has the individual/family gained better understanding of how trauma(s) have affected their symptoms? Yes/No. Explain:
- In considering the *refugee/immigrant situation* and the six aspects of the framework, has the individual/family now a better understanding of how the trauma(s) affected life in and attitude to the new country? a. unchanged; b. new complications have arisen; c. better; d. worse. Describe:

- How did the individual's/family's *refugee/immigrant situation* influence her/him/them at the start of treatment/support work?
- How is the *refugee/immigrant situation* now? a. unchanged; b. new complications; c. better; d. worse. Describe:
- Which of the *state(s) of being* applied to the individual/family members at the beginning of the treatment/support work?
- After the treatment/support work the *state(s) of being* are: a. unchanged; b. new complications have been added; c. fewer; d. non-existent. Explain:
- What stage of the *adaptation cycle* did you estimate that the individual/family members was at? Explain:
- At what stage are they now? a. unchanged; b. improved; c. worse. Explain:
- At the beginning of the treatment/support work, was the individual/family aware that their *childhood experiences* might affect their lives in and attitude to the new country? Yes/No. Explain:
- Is the individual/family more aware now of *childhood experiences* and its influence in the new country? a. unchanged; b. improved; c. worse. Explain:
- When the treatment/support work began, were any of the *relevant background conditions* causing or complicating the symptoms, the *refugee/immigrant situation* or any of the aspects of the framework? Yes/No. Which one(s)?
- Has the individual/family gained better understanding of this now? a.unchanged; b. new complications have occurred; c. improved; d. worse.
- Did the *reason* affect the symptoms, the *refugee/immigrant situation* or any of the aspects of the framework? If so, in what way/s?
- During the course of the treatment/support work was the *reason* worked through? Yes/No. Explain:
- At this time, is the individual/family aware of how the *reason* might have influenced him/her/them in life in the new country? Yes/No. Explain:
- At the start of treatment/support work, which of the following component(s) of the *transition-related conditions* was affecting the individual/family? Underline the *transition-related conditions.*
- a. experiences of *oppression*, physical and/or mental *torture, imprisonment, death or disappearance of experiences family, friends, colleagues, loss of property*; b. *ambivalence*; c. *waiting for asylum*; d. *lowered self-esteem*; e. *loss of society*; f. *dream of return*.
- In what way(s) did these *transition-related conditions* cause, influence or complicate the symptom(s)? Explain:
- The *refugee/immigrant situation*: Yes/No.
- The aspects of the framework: Yes/No. Which one(s):
- Has the individual/family gained better insight into how the symptoms, the *refugee/immigrant situation* and aspects have affected life in the new country? Yes/No. Describe:

- Were the goals of the treatment/support work attained? a. The goals of the individual/the family; b. The goals of the psychotherapist/the support worker. Explain:
- Did the individual/family arrive at any solutions concerning their difficulties after the therapy/support work? Explain:
- How does the individual/family function now? a. better; b. they have gone back to their ordinary pattern of behavior; c. they have new problems. Please describe.