Flexibility, creativity and responsiveness in trauma counselling: Working with refugees and asylum-seekers

Teresa Puvimanasinghe
Linley A Denson
Martha Augoustinos
Daya Somasundaram
University of Adelaide South Australia

Psychosocial interventions with refugee and asylum-seeker clients present particular challenges for mental health professionals. Not only do these clients suffer from posttraumatic experiences, they also encounter a plethora of difficulties with communication, social support and resettlement. To address psychosocial distress, interventions must be effective, efficacious, culturally appropriate and acceptable to clients. This study focussed on how service providers assisted their refugee and asylum-seeker clients to recover from psychosocial distress. We conducted semi-structured interviews with 28 professionals from humanitarian agencies serving migrant and refugee people in Australia. Qualitative analysis of interviews demonstrated four prominent themes: establishing safety, trust and connection; talking about trauma; alternatives to ‘talk therapies’; and promoting resilience and growth. Study findings highlighted the complexity of addressing trauma among people from diverse experiential and sociocultural backgrounds. They demonstrate the importance of flexibility, creativity and responsiveness when balancing and integrating individual, group and community modalities, diverse therapies, and evidence-based and client-focussed approaches.

Supporting mental wellbeing, resilience and recovery is central to working with refugees and asylum-seekers. Refugees are people who have fled their country of nationality because of a well-founded fear of persecution and are unable or unwilling to return to that country (UN High Commission for Refugees (UNHCR), 1951). People who have fled their country and have similar experiences to that of refugees but are awaiting their claims to be recognised as refugees are considered asylum-seekers. This study focussed on service providers’ experiences of addressing the psychosocial distress and trauma of their refugee and asylum-seeker clientele, through a multitude of individual and collective therapeutic interventions. As such, this study encapsulates important principles of community psychology - going beyond traditional, individual, psychotherapy to focus on social, cultural, economic and other influences that promote positive change, health, and empowerment of a marginalised group of people.

The introduction contains a discussion of the relevant literature pertaining to the biopsychosocial impact of experiencing trauma, trauma recovery, compounding factors of resettlement stressors, evidence- and practice-based treatment modalities and the Australian context relating to refugees and asylum-seekers.

The traumatic experiences of refugee and asylum-seekers such as threats to life, serious injury, sexual violence, torture, other human rights violations and multiple losses including separation from loved ones, home, community and culture can result in posttraumatic symptoms (e.g. PTSD), depressive, anxiety and psychotic states, substance abuse, existential problems, and identity crises (Drozdek & Wilson, 2004). Higher exposure to traumatic events is associated with more severe distress (dose-effect; Mollica, McInnes, Poole, & Tor, 1998); sometimes persisting for decades (Steel, Silove, Phan, & Bauman, 2002).
Although most cope with and recover from trauma over time (Fazel, Reed, Panter-Brick, & Stein, 2012; Fazel, Wheeler, & Danesh, 2005); with or without formal interventions, some refugee and asylum-seeker adults and children experience serious and ongoing mental health problems. This study explored how those providing services to refugees and asylum-seekers utilised flexible and creative treatment modalities to address the mental health concerns of their clientele, in order to inform future practice.

Before introducing this study of the experiences of people caring for refugees and asylum-seekers, we will briefly review the literature on refugee mental health, and introduce the Australian context. Posttraumatic symptoms include: reliving of past traumas as flashbacks during waking hours and nightmares during sleep; hyperarousal or hypervigilance; avoiding distressing memories or external reminders of trauma including social withdrawal and emotional numbing (Briere & Scott, 2014). People with posttraumatic symptoms may experience intense emotions without a clear memory of any corresponding event; or remember traumatising events in detail without emotions; or be in a continued state of vigilance, irritability or rage without knowing why (Herman, 2015). Although humans are endowed with a complex, organised and well-integrated system to deal with distress encountered in the ordinary course of life, traumatic events can render people helpless and terrified; overwhelming and disorganising this self-protection system (Herman, 2015).

Traumatic experiences also interfere with memory. Although trauma survivors can be frequently reliving their traumatic past (via flashbacks and nightmares), associated memories are usually not integrated into normal memory leaving survivors without a fluid narrative of events that can be assimilated into their life story (Van der Kolk, 2014). Thus trauma not only destroys actual security (e.g. threat to life), but also shatters survivors’ assumptions concerning the safety, predictability of the world, and their trust in others, sense of self-worth and control, as well as their construction of self in relation to others, resulting in alienation and social disconnection (Linley & Joseph, 2004). Accordingly, some trauma experts suggest that creating, retelling and revising trauma stories enables people to integrate their fragmented memories, process their traumas, ameliorate posttraumatic symptoms and reconnect to society (Agger & Jensen, 1990; Drozd & Wilson, 2004; Schauer, Neuner, & Ebert, 2011).

Although recovering from trauma is not a straightforward process, Herman (2015) proposed three stages of trauma recovery: establishing safety and security, acknowledging and consolidating traumatic memories, and moving from isolation to social connection. Highlighting the importance of creating a sanctuary within the therapeutic setting, Van der Veer and Van Waning (2004) identified four aspects of establishing safety—safety from the past, safety in present living conditions, safety in the therapeutic setting and for the therapist to feel comfortable with the client of diverse cultural backgrounds (safety for the therapist). It follows that socioeconomic difficulties in resettlement or the perception of living in an alien culture can perpetuate a sense of insecurity among refugees, maintaining or worsening their trauma. For instance a study by Steel and colleagues (Steel, Silove, Bird, McGorry, & Mohan, 1999) demonstrated how pre-migration trauma interacted with post-migratory stressors to exacerbate posttraumatic symptoms, and worsen settlement outcomes. Silove (1999) has suggested that post-migratory factors impacted on five core adaptive systems including safety, attachment, justice, identity-role, and existential meaning.

People with refugee experiences commonly encounter a plethora of difficulties in resettlement. They must learn a new language, adapt to new cultural values, food, traditions and worldviews, and navigate new systems of healthcare, governance, transport, and trading (Murray, Davidson, & Schweitzer, 2008). Berry
(1997) suggested that migrants including refugee people who were able to interact with the host society by maintaining some of their cultural values while also adopting aspects of the new culture (integration), had better settlement outcomes and higher wellbeing than those whose resettlement experience was one of assimilation, separation or marginalisation. However, learning the language of the host country, vital for successful integration, can be difficult for those suffering from concentration and memory issues (Herman, 2015). They also have responsibilities for family and kin they have left behind who they continue to try to help.

**Evidence-based Treatment Modalities**

For all these reasons, addressing trauma among refugee and asylum-seeker people presents particular challenges for mental health professionals. Most psychological interventions for traumatised people have involved intense exposure to their most traumatising experiences in a safe and secure environment. The primary objectives of exposure treatments are consolidation of memories and development of coherent narratives. Such exposure therapies can also include culturally appropriate components for calming the body and regulating emotions, such as meditation, mindfulness exercises, progressive relaxation, visualisation, and localised rituals. Nevertheless, they require strong commitment from therapists and clients, to undertake and complete the treatment program while working through intense and frightening memories and emotions. Examples of such well-established, evidence-based therapies used with trauma survivors include Culturally-adapted Cognitive Behavioural Therapy (CA-CBT; Hinton, Rivera, Hofmann, Barlow, & Otto, 2012), Narrative Exposure Therapy (NET; Schauer et al., 2005) and Testimony Therapy (TT; Agger & Jensen, 1990).

As an alternative to prolonged exposure, Briere and Scott (2014) suggest that ‘titrated’ exposure within a therapeutic window that is not too emotionally overwhelming or underwhelming to the trauma survivor, might be more effective. There is also support among practitioners for using non-verbal forms of trauma treatments – such as psychomotor, music or relaxation therapies, – based on the understanding that the body encodes and stores memories of trauma, which are then expressed through the body (Van der Kolk, 2014). For refugees and asylum-seekers, group and community interventions have particular advantages; potentially addressing social isolation, loss of trust, and multiple traumatisation, and also being more compatible with collective cultures and identities (e.g. the Den Bosch treatment model; Drozdek & Wilson, 2004). There are few empirical studies supporting these alternative approaches, however, in part because the interventions and their evaluations are more complex.

**The Australian Context**

The present study was conducted in the Australian state of South Australia. Australia is a multicultural society and many residents are first, second or third generation migrants, reflecting active government immigration and refugee resettlement programs throughout the nineteenth, twentieth and twenty first centuries (Hugo, 2011). In June 2018, there were 68.5 million displaced people and 25.4 million refugees in the world respectively (UN High Commission for Refugees (UNHCR), 2018). In 2015-2016, Australia accepted approximately 17,555 humanitarian entrants including 12,000 displaced from conflicts in Syria and Iraq (Department of Home Affairs (DOHA), 2018).

Migrants to Australia often elect to settle in the large cities (Sydney or Melbourne) which offer more employment and training opportunities and have larger migrant communities including people from migrants’ own background, country and ethnicity. Nonetheless, the Australian Government actively encourages settlement in other areas, including South Australia (Australian Bureau of Statistics, 2011). In Australia, there are two main government support programs for refugee people: The Humanitarian Settlement Services program (HSS) offers essential services for the initial
6-12 months; accommodation, household goods, and assistance to register with social security, universal basic health insurance, health services, banks, and schools. The Settlement Grants Program (SGP) affords less intensive support for up to five years after arrival (Department of Social Services, 2016). Humanitarian entrants are offered 510 hours of free English language classes and have access to 24-hour telephone translating and interpreting services (TIS). Although trauma counselling and specialised healthcare services are also available free of charge to humanitarian entrants, eligibility is assessed according to stringent criteria.

In contrast to the humanitarian program, Australia’s policies towards asylum-seekers are particularly harsh, including mandatory detention of adults and children in offshore facilities, extended use of indefinite ‘temporary protection’ visas, and blocking family reunion. Only limited services (e.g. individual and group counselling for past trauma) are available to them. Numerous experts in refugee mental health have documented the devastating psychological impact on already vulnerable adults and children (e.g. Newman, Dudley, & Steel, 2008; Silove, Steel, McGorry, & Mohan, 1998; Steel et al., 2006); posing special challenges to mental health professionals to provide culturally safe, sensitive and competent services to asylum-seekers awaiting their claims to be processed (Khawaja & Stein, 2016).

**Study Aims**

The present study formed part of a larger research project exploring the experiences of healthcare, mental health and resettlement workers, caring for refugees and asylum-seekers in South Australia. This study focussed on the ways in which service providers addressed the psychological distress and trauma of their refugee and asylum-seeker clients, whether through individual trauma counselling or other therapeutic interventions. In order to inform future practice, we aimed to ascertain the extent to which participants used individual, group and community intervention modalities, and to elicit, report, and reflect on their experiences of helping people from refugee backgrounds. Through the qualitative analysis of interviews, we identified four prominent and recurrent patterns relevant to the study aims.

**Method**

**Participants**

Twenty eight service providers, employed by agencies in three sectors (mental health, healthcare and resettlement services) working with people from refugee and asylum-seeker backgrounds were interviewed for this study. They were doctors, nurses, psychologists, counsellors, agency managers, service coordinators, or case workers working in Adelaide, South Australia. Their work experience ranged from 18 months to 30 years with the majority reporting 2-5 years of experience working with refugees. Participants worked at either non specialised or specialised ‘refugee’ agencies. About one third of participants were recent migrants (some from refugee backgrounds), while the remainder were born or had lived more than 10-15 years in Australia.

Because of the relatively small population and number of agencies providing services to refugees and asylum-seekers in South Australia, organisational affiliations and participant descriptions that could potentially lead to identification have been omitted, to ensure participant and organisational confidentiality. Table 1 contains a description of participants. (Further information regarding participants can be found in: Puvimanasinghe, Denson, Augoustinos, and Somasundaram, 2015).

**Data Collection**

Conduct of the study was approved by the Research Ethics Committees of the University of Adelaide and the South Australian Health Department. The first author contacted and met with agency managers or team leaders of relevant organisations and after discussing details of the research study requested permission to interview staff. Most study participants were recruited through a passive snowballing technique. Managers or team leaders circulated an email request to staff members,
Table 1. Characteristics of participants.

<table>
<thead>
<tr>
<th>N=28</th>
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<tbody>
<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Women 19</td>
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<tr>
<td>Men 9</td>
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<tr>
<td><strong>Previous experience working with refugees</strong></td>
</tr>
<tr>
<td>Less than 2 years 3</td>
</tr>
<tr>
<td>2-5 years 10</td>
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<tr>
<td>5-10 years 5</td>
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<tr>
<td>More than 10 years 7</td>
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<tr>
<td>Not specified 3</td>
</tr>
</tbody>
</table>
| **Profession / current position**
  - a Denotes either specialisation (doctor, nurse, psychologist) or current position (e.g. counsellors included people with tertiary qualifications in counselling, social work, nursing or psychology).
| Doctors 2 |
| Nurses 3 |
| Psychologists 3 |
| Counsellors 9 |
| Managers 3 |
| Program officers / case workers 8 |
| **Nature of Organisation**
  - b Denotes the main service provided by the organisation to which a worker was affiliated and not necessarily the worker’s specialisation (e.g. a social worker at a mental healthcare service was considered a ‘mental healthcare worker’).
| Healthcare 5 |
| Mental health 12 |
| Settlement 11 |
| **Background**
  - c Refugee background included workers from South Asia, Middle East and Europe; Recent Migrant/CaLD background included those from South Asia, Europe and South America.
  - d CaLD = Culturally and Linguistically Diverse
| Non-CaLD background or long-term migrant 17 |
| Refugee 5 |
| Recent Immigrant / CaLD d background 6 |
those interested in participation contacted the first author. Two participants who worked as private practitioners were approached directly: they were interviewed in their personal professional capacity notwithstanding any organisational affiliation. Participants were offered the option to be interviewed individually or participate in a group discussion. All participants except two opted for individual interviews. Signed informed consent was obtained from each participant before their interview.

Interviews lasted 1-2 hours and had a semi-structured format comprising several open-ended questions. The interview protocol focused on areas such as: participants’ experiences working with people from refugee backgrounds; challenges faced by clients and service providers; observed strengths and resilience of clients; and recommendations for improving services. All interviews were audio-recorded.

**Qualitative Data Analysis**

Inductive thematic analysis (Braun & Clarke, 2006, 2013) was used to identify prominent and recurring patterns in the data identified at a semantic or explicit level of analysis. The NVivo version 9 qualitative data analysis program was used to facilitate analysis. Data analysis comprised the following stages. First, the audiotaped interviews were transcribed orthographically and checked for accuracy. Second, interviews (including interview notes) were read and re-read to gain familiarity with the data set. Third, interviews were coded, and the initial codes generated were searched for themes which were then reviewed, defined and named. Analysis included moving backward and forward between the data set, the generated codes, analyses being produced, and theoretical concepts (Braun & Clarke, 2013). Interviews and primary analyses were conducted by the first author, then a recent migrant to Australia. All authors participated in subsequent analyses including refining themes and extracts, as well as linking to theoretical concepts. The themes and subthemes identified through analysis together with their relationships with each other are depicted in Figure 1.

**Analysis**

As depicted in Figure 1, we identified four major themes: (1) establishing safety, trust and connection, (2) talking about trauma, (3) alternatives to ‘talk therapies’, and (4) promoting resilience and growth. Detailed analyses are set out below.

**Establishing Safety, Trust and Connection**

Participants described the importance of establishing safety, not only in therapy but in everyday life including easing resettlement stressors. Other than concerns for family and kin left behind, there was consensus that refugees’ primary concerns usually revolved around practical resettlement issues: healthcare, employment, children’s schooling, learning English and, in particular, accommodation. The serious shortage of public housing and affordable private rental properties in South Australia was a major problem. As one agency manager explained, refugee people had already faced multiple displacements, losing homes, families, possessions and livelihoods. Secure and affordable housing was essential for a sense of stability and safety. Thus, most participants’ work included advocating for clients’ resettlement needs, or referring clients to services providing for such assistance. One resettlement worker emphasised the importance of her mediatory role in creating a trusting and confident relationship between her refugee clients and various services (health, housing, social security); another aspect of safety.

Advocating for clients and assisting with practical needs had the advantage of building a trusting relationship between clients and service providers, considered essential to the commencement and progress of therapeutic work. Therapists sometimes needed to spend months or even years developing connections with their clients. One counsellor described creating trust with clients by offering ‘the counselling room as their space and the counselling time as their own pace’ and ‘addressing their concerns at any given time’. Others described visiting clients at home, meeting their families and sharing...
Figure 1. The theme and subthemes revealed by data analysis
food and everyday activities (e.g. cooking or sewing) with them to overcome the barrier of strangeness.

Some mental health workers considered establishing safety, stability and trust with clients as the primary focus of their work—together with addressing clients’ immediate needs and managing current symptoms of traumatisation such as sleeplessness, nightmares, loss of appetite and concentration, nervousness and irritability. According to AB, a mental health worker, restoring safety and trust was more important than processing trauma. He explained:

> We all experience trauma of some kind. I don’t think the magic or the mystery is in being able to process that event as much as the consequences of that event - that is that people don’t feel safe anymore. They don’t feel that the world is predictable, they don’t feel that their rights or the things that they hold really valuable are safe. And it’s those feelings that need to be restored. And we restore them in different ways such as letting people know that …therapy is a choice, that it has a beginning and an end, they can leave any time you know, [and] tell that you are there for them. So, lot of little experiences add up to restore a sense of safety and a sense of trust in people.

CD who worked at a healthcare agency shared a strategy he employed to develop a trusting relationship with clients—to bring himself into the therapy including his personal weaknesses such as feeling angry, nervous or lost. For example, he said:

> …yesterday, a woman I’m working with; I was actually feeling quite angry in some ways because I couldn’t get my point through to her very well. And I said to her at the end ‘We had a bit of a fight today didn’t we?’ and she said ‘Yes we have’. And this was a real opening. We built a bridge, a conduit that we were able to open up to connect much better even if we had to do it through the interpreter. But it really worked very well.

Many participants said that once safety and trust were established, clients usually felt more comfortable and confident to disclose and address past traumatic experiences. Healthcare workers noted clients’ gradual willingness to share more of their history as they progressed through the health assessment. Participants working with asylum-seekers, however, highlighted the difficulty of establishing safety, stability or trust while their clients’ lives were surrounded by uncertainty and instability—as explained by EF, a mental health worker:

> …one of the really important things…before talking about traumatic memories is the idea of safety and stability. And asylum-seekers don’t have that. So because they don’t know when they’re going to be sent back; if they’re going to get their visa, if they’ll be deported, if they’ll be sent to Nauru, even at the moment there is so much uncertainty about where people are gonna go, it’s really hard to establish that sense of safety to be able to start talking about trauma.

Therapeutic progress with asylum-seekers was additionally hindered by the uncertain duration of therapist-client relationships. Mental healthcare workers were reluctant to commence trauma exposure programs with clients who might be deported or transferred at short notice. Hence, they limited their input to support, advocacy and symptom management unless the client actively initiated discussion of his or her past experiences (as described below).

Asked specifically about differences between types of client in their ability to feel safe and build a trusting relationship with service providers, participants providing mental healthcare to their clients were very reluctant to generalise. Some cautiously observed a difference between older women,
who sometimes had difficulty engaging with the counselling process, and younger women – seen as more assertive, articulate and ready to establish relationships. GH, an experienced counsellor, described the challenges of working with a group of older women as follows:

…when we work with [them], it is hard because [they] had come from generations of wars. It’s not just one war; it’s series of ‘wars’…they were kind of forced to get married at 11, 12 years old. And sometimes…they had their husbands being abusive…women who had lived in remote villages…inserted into this society and expected to do many things. And so…it was quite hard to establish that sense of safety and to develop a relationship because they … have confronted so much suffering, so much pain…that once here, some of them initially were paralysed by pain…and [indicated] profound depression and sadness.

Talking about Trauma

The benefits of verbalisation or disclosure of past trauma were acknowledged by the majority of participants who identified three categories of clients depending on their ability and willingness to talk about past traumatic experiences: clients who willingly elaborated traumatic events and experiences; clients who were initially unwilling or incapable of verbalisation, but gradually with time and the establishing of safety and trust wanted to share the traumatic experiences of their lives; and others who never wanted to, could not, or got more disturbed when disclosing past trauma.

Almost all participants indicated that they had encountered clients who readily shared details about past traumas and described how some people would tell their entire life story despite not being required to do so (e.g. during initial assessment). Some participants observed that people told stories not necessarily because they wanted to do so, but because they considered it a ‘necessary evil’ in order to obtain vital practical assistance or because they believed that divulging past trauma would motivate service providers to give tangible assistance, such as writing letters to support their eligibility for public housing or disability payments. According to one counsellor, as a survival technique or active coping strategy used by clients that was ‘not necessarily a bad thing’. A psychologist observed that now he simply asked clients during the first session what agency support letters they wanted, so he could write them and then perhaps begin therapeutic work. Many people declined ongoing therapy once the tangible help was provided, but some of those returned much later, requesting treatment.

Nonetheless, several participants acknowledged that sharing trauma stories was beneficial for trauma survivors because they previously had little opportunity to do so, and they needed validation of their previous traumatic experiences and to find meaning for those events. Even clients who had families and community, refrained from confiding in significant others because they did not want to burden them. These participants believed that the privacy and confidentiality of the counselling room facilitated disclosure. Sometimes trauma narratives occurred spontaneously and briefly, taking service providers by surprise as described by IJ, a counsellor, in the following extract:

So during assessment…someone will just come in and ‘blah’ just tell you everything in the first two hours, absolutely everything, to the point that…I’m not ready and I’m quite upset from what I’m hearing. And when you finish the session, they are visibly quite happy because they’ve purged; just got rid of all this information that they wanted to talk about for so long because no one has ever asked them. And then suddenly you say ‘ok, this is a process that can be ongoing for several months; are you interested?’ ‘Oh no, no; I don’t want to see anyone else again…thank you so much’. And they are gone; because
they’ve done what they wanted to do.

Participants indicated both individual and group differences in clients’ ability and/or capacity to talk about trauma in response to interviewers’ questions, although many said they were reluctant to stereotype clients or be influenced by prior assumptions. When they did identify cultural and other group differences, they emphasised that these were general observations and that individual differences usually surpassed group differences.

According to one mental health worker, if the human rights violations had received international recognition, clients were more inclined to describe the details of their torture and trauma. Another observed that for some clients the experience of torture and trauma had become their predominant identity, impeding their ability to move on, heal and establish a new life. Conversely if survivors’ stories of violation, deprivation and suppression were relatively unknown or had not received public or personal validation (e.g. asylum-seekers), they might be less willing to describe their past. One participant working with a group of young male asylum-seekers observed a slightly different trend among his clientele, most of whom had made dangerous sea journeys to Australia and spent several years in detention before being released into the community. According to him, they were proud to describe their stories of escape, endurance and bravery.

Several mental health and healthcare workers mentioned a distinction they observed between Middle Eastern and Asian women, and their African counterparts. African women were identified as being more articulate, assertive, and willing to engage with the therapeutic process whereas Middle Eastern and Asian women were perceived as more hesitant to share intimate details of their traumatic experiences, possibly because of the stigma attached to such disclosure or they feared ostracization from their families and communities, if what they disclosed became public.

According to one psychologist, sexual traumatisation was the most difficult topic to discuss for both women and men, but for different reasons. For men, sexual violence perpetrated against them brought about a personal sense of shame about masculinity and manhood; whereas in some cultures, sexually abused women were considered to be unclean or to bring dishonour on their families. Hence, he observed, women were doubly traumatised: first by the perpetrators and then by their own families and communities.

In the following extract KL, a counsellor from a culturally and linguistically diverse (CaLD) background shared his opinion of the benefits of culturally appropriate disclosure of past trauma even though silence is a coping strategy in many cultures.

Supressing the issues is one technique and in some communities it’s common… [in] some Eastern or African cultures…one of the conflict resolution techniques…[is] just keep it quiet. It means you don’t disturb the issue; you don’t talk about it. You just keep quiet. But I don’t believe it. We are talking about human beings; culture is second… first is human being. [So] I believe in verbalisation…it is very useful but it has to become part of the culture…if that woman or man is from that culture you can’t expose them to those techniques [immediately]. So you have to be careful.

Most participants agreed that counselling, which involves revealing one’s inner-most personal thoughts and feelings with a stranger (and possibly an interpreter), usually in a counselling room, was a western concept not necessarily familiar or acceptable to people from diverse non-western cultures. Most refugees would understand discussing problems with family, friends, religious leaders, or tribal elders, but western counselling remained an alien concept, with many languages not including a word for ‘counselling’. Settlement workers from two South Asian communities confirmed their communities’ unfamiliarity with the counselling concept and their
discomfort with the practice.

An initial step of mental health work with clients therefore involved informing them about counselling and ascertaining their willingness to participate. One healthcare worker described taking the opportunity to introduce the concept of counselling when clients complained of physical ailments (headaches, backaches, shoulder pain), suggesting that maybe worry and distress was causing the physical pain. However she would refer them for counselling only if she observed willingness in clients because, she explained, counselling was similar to giving up smoking; a client had to be willing to change and to do the hard work involved. Contrastingly a mental health worker said he preferred to ‘give the tablet’ (i.e. refer clients to a General Practitioner - GP or Psychiatrist to obtain medication) most clients expected for their physical pain, so he could focus on the therapeutic process. Although there was never a complete acceptance or understanding of counselling among clients, participants said that increasing familiarity and reduced distress enhanced clients’ willingness to talk and to share. However, when certain clients or groups appeared not to benefit from individual sessions, mental health and healthcare workers were called upon to expand their imaginations and design unique and innovative programs for their clients (detailed in the next section: alternatives to talk therapies).

Most participants mentioned the stigma attached to mental illness in many communities and the barriers to accessing mental healthcare faced by refugees. Sometimes, people were wary to seek assistance for fear of being labelled ‘crazy’ or ‘mad’. Confidentiality was also a concept not totally comprehended despite explanation; people worried that what they disclosed during counselling would reach their communities, through the interpreters or otherwise. Although membership in a close-knit community was considered an important coping strategy (see under ‘promoting resilience and growth’ it also limited the privacy of community members. These perceptions were validated by several workers from CaLD and refugee backgrounds.

Alternatives to ‘Talk Therapies’

Most participants said they had met clients who were reluctant to talk about their difficult experiences. Some declined to return to the darkness of the past, instead focussing on the present and future. For mental health workers, a client-focussed approach was acceptable in these instances and they continued to address clients’ day-to-day needs; giving them information, empowering them to access essential services, making referrals, and otherwise facilitating their resettlement.

Nevertheless, the ultimate goal was to progress through advocacy and the establishment of trust to intervention and recovery: by actively assisting refugee clients to process trauma. With some clients however little progress was made despite months or years of conventional individual treatment. Hence it was imperative to be innovative and introduce culturally more acceptable alternatives for trauma recovery.

In the following extract MN, a counsellor, described how she successfully used non-verbal techniques with people who were unable or unwilling to talk about past trauma:

When there is a block… then the person will just repeat the same thing again and again…So I use relaxation and meditation and visualisation and metaphors…like talking about a tree you know…And it works really well. It works really well. Because it’s a way of expressing differently. I use art therapy as well which is externalisation and metaphors as well.

Observing the lack of progress with groups of clients in individual counselling sessions, mental health workers had initiated group sessions for older women and younger men. For instance, in a women’s group, despite the women’s earlier distrust of counselling and fear that their stories would be revealed to their communities, they actively participated in group sessions, readily taking turns to share their experiences
with each other. These women’s groups were later developed into ‘theatre therapy’ involving women depicting their trauma and distress collectively through body movements without using words. The success of group work was enthusiastically explained by OP in the following extract:

We found that with the group it was fantastic. At [agency name] we started an even more challenging process…We started a theatre group…based on Augusto Boal’s ‘Theatre of the Oppressed’…and this kind of theatre…is more than talking; it is working with the body but to liberate people…women initially were fearful…a woman may sit and talk but will not move the body…During the theatre group the women would do things…like these body movements that were incredible.

The women’s groups organised by settlement agencies were also quite successful in promoting the sharing of coping strategies. Overcoming isolation, they provided a venue for women to learn from each other and for settlement workers to understand the challenges they faced.

Participants working with men reported encountering similar problems. According to mental healthcare workers, among some Middle Eastern and African men, talking about feelings was a weakness; and together with the stigma attached to mental illness, led to reluctance to share traumatic experiences. Unaccompanied young men, without family and sometimes estranged from community, were especially isolated. Hence a young men’s group was established for the men to meet and socialise with each other and with a counsellor in a group setting. This also allowed a counsellor to sensitively monitor any deterioration in clients’ well-being or circumstances.

The flexibility extended to adult clients by professionals and their organisations was also evident in services offered to children. One mental health worker indicated that because some refugee children exposed to trauma had accelerated heart rates, and were quick to react and get angry, they were getting into trouble and being expelled from school. Sitting and talking to individual children about trauma was unproductive, so this worker together with colleagues had started an innovative program to teach children to calm their bodies through drumming. During a lengthy interview, she described establishing a drumming group for children identified by schools as difficult to manage – and with the assistance of an instructor, teaching children to drum to the rhythm of the heartbeat. The results were described by QR as follows:

…I remember doing it once at a school with a group of boys, and they picked all the difficult boys in the school…They were put into this drumming program…as I was watching them drumming, some of them were getting quite glazéd in their eyes and looking a bit tired; and some asked if they could just lie down for a while. It was really funny…because the teacher…said to me: “Oh, this is not good; nobody is participating…and she was panicking because at least five boys were lying on the floor and having a bit of a nap. And I said to her ‘this is fantastic’. Because basically we were seeing right in front of us, all those systems that need to calm down or regulate are actually doing that.

Some mental health workers delivered specific therapies such as Acceptance and Commitment Therapy (ACT), or Narrative Exposure Therapy (NET), whereas others adopted eclectic approaches, for example including narrative and art therapy, writing in journals, relaxation, meditation, or visualisation. Psychologist ST found ACT especially useful for trauma recovery because, he explained, it recognised that people’s thoughts and feelings were not necessarily dysfunctional, unlike ‘pure’ cognitive behavioural therapy. ACT assisted people to accept, tolerate and manage uncomfortable thoughts and emotions. According to him, implying or telling his
clients that they ‘should not feel like that’ would be abusive, because sometimes people were justified in thinking and feeling the way they did, for example the hopelessness felt by asylum-seekers simultaneously dealing with past trauma and brutal immigration department procedures.

**Promoting Resilience and Growth**

The majority of interviewees highlighted the importance of assisting trauma survivors to process their trauma, whether through disclosure and exposure, or non-verbal methods. They also emphasised that people’s ability to feel safe again, sense of predictability in the world, and trust in humanity needed to be restored. According to an agency manager with a refugee background, it was appreciation for freedom and the beauty of life that enabled clients to rebuild their lives, overcome trauma, and continue despite adversity.

Several mental healthcare workers said they utilised a strengths-based approach; not merely to teach clients coping strategies, but also observing and uncovering the strengths clients already possessed; because most refugees had enormous resilience even at times when they could not see beyond their present predicaments. Listening to clients’ stories was a good way of exploring potential sources of strength and resilience and reminding them of their achievements (escaping wars, safeguarding children, overcoming obstacles and surviving). Similarly, participants encouraged clients by giving positive feedback on current achievements (e.g. learning English, getting a job). For most refugees, thinking about their families, financially supporting relatives overseas whenever possible, and maintaining hope for reunion were coping strategies – although official barriers to family reunion produced desperation and hopelessness.

The enormous resilience of clients was readily identified and elaborated by several participants. To them, clients experienced tremendous stressors settling into a new society, navigating through a strange system and, learning an alien language. Simultaneously many were suffering the consequences of past traumas and continuing to be distressed about separation or loss of immediate family members, home country culture and community. Yet they continued to care for their children, educate themselves, and gain employment, much to the admiration of participants who found their clients’ perseverance personally inspiring (how service providers learned lessons from their refugee clients is further described in Puvimanasinghe et al., 2015).

Participants working with asylum-seekers—especially unaccompanied minors—marvelled at the resilience of some clients. They had left their families and made the perilous journey to Australia, endured detention, and were constantly worried about deportation, but still enthusiastically learnt English, used social media, attended school and gym, and engaged in other activities common to adolescent boys.

**Community factors.** Participants in all three categories (mental health, healthcare and resettlement) considered community an important source of strength for refugees to get a sense of belonging, maintain communal identity, associate with others from a similar culture, speak the same language, share food, and prevent social isolation within the new environment. Social networks were particularly important for newcomers to get practical help, receive information and ease the burden of resettlement. For example, a resettlement worker described how the Afghan community in Adelaide came to the aid of asylum-seekers, welcoming and sharing their homes with them. The support received by Tamil asylum-seekers from their community in Melbourne was also described. According to mental health workers, clients’ sense of community enhanced the therapeutic relationship during counselling and workers facilitated the communal spirit in the counselling room by for example, booking the same interpreter for all sessions with a client.

Mental health and resettlement workers facilitating group work described how group members shared their stories and their coping strategies with each other (praying for family overseas, religious rituals, gardening). Resettlement workers explained the benefits
for one refugee community of living in a small country town in South Australia rather than being isolated in the outer suburbs of a city. They described a symbiotic relationship between clients and the town’s inhabitants: the refugee workforce supported a specific local industry; and in return, the local people offered refugee families communal support and friendship. The local health centre organised meetings where older Italian and Greek immigrant women shared their experiences with the newcomer women, giving hope for the future.

According to some participants, however, community was a double-edged sword. Communities could be divided on past ethnic and religious antagonisms; people could be stigmatised for deviating from cultural norms; and inter-generational tensions developed between younger and older generations within communities and families. Some communities were working to unify their diverse members. Nonetheless, some people remained isolated with only agency workers and volunteers to befriend and support them. UV, a nurse, described the twin-edged nature of community as follows:

Some people want to connect to community; and others don’t. And it depends a lot on their circumstances. So sometimes connecting to community can mean…connecting to home; but it can also mean taking the problems from home and planting them in a new country…[they] absolutely don’t want to…meet people here that back home were responsible for the very trauma they have.

Religion and spirituality. Most participants said that religious values and beliefs could be a protective factor, sometimes preventing desperate people from committing suicide (because suicide was against most religious precepts). Some participants made a distinction between religion and spirituality: rigid religious beliefs could defeat the therapeutic objective because people could be resistant to change (e.g. ‘it is God’s will that I suffer’) whereas a personal relationship with a higher power was identified as a consolation in times of need. However, religion and culture intersected in many ways, connecting clients to their past and affording a sense of belonging to a religious community including benefits of socialising at religious festivals and partaking of religious rituals.

WX, a mental healthcare worker, explained the twin-edge of religion as follows:

Though religion was a powerful source, rigid fatalistic religious beliefs are difficult to work with in the counselling room; because sometimes clients’ fatalistic religious beliefs becomes an uphill battle against God.

Organisational support. One agency manager explained that organisational assistance was vital for refugees’ confidence and support. It was a consolation to have a place where they were understood, a place they trusted and could visit and talk to someone and where they got social support (‘my counsellor will come to visit me today and make sure I am alright’). A settlement agency had a volunteer program with around 150 volunteers who assisted newcomers in numerous ways, especially people who had little social support elsewhere. These volunteers provided their clients with the necessary skills and information to be confident and resolve their own resettlement problems.

Sometimes, however, participants explained that some clients indicated no coping strategies or strengths, and had no community supports available. Then, agencies and their workers served as a scaffold for clients to lean on until their situations improved.

Discussion

This study focussed on the ways in which service providers addressed the psychological distress and trauma of their refugee and asylum-seeker clients, whether through individual counselling or other therapeutic interventions. In order to inform future practice, we aimed to (1) ascertain the extent to which workers used individual, group and community intervention modalities, and (2) draw on their experiences
Counselling with refugees and asylum-seekers

of assisting traumatised people from refugee and refugee-like backgrounds to overcome trauma and distress. Through the qualitative analysis of interviews, we identified four prominent and recurrent patterns relevant to the research aims, namely how service providers in South Australia assisted people. The four identified themes were: (1) establishing safety, trust and connection; (2) talking about trauma (3) alternatives to ‘talk therapies’ and (4) promoting resilience and growth.

As emphasised consistently, we found strong support for the importance of establishing safety, stability and trust with refugee clients. Almost all participants considered resettlement issues to be a major obstacle in establishing a sense of safety and stability. Inability to secure essential needs such as housing necessitated participants to spend long hours advocating on behalf of clients to establish a sense of basic security. Sometimes that was the extent of the therapeutic service mental healthcare workers afforded, considering the multitude of needs and the recurring nature of problems clients encountered. Establishing safety and trust and creating a ‘safe therapeutic sanctuary’ is a pre-requisite to any psychological intervention (Van der Veer & Van Wanning, 2004). Considering the first aspect of safety; most refugee clients had achieved safety from past threats—although this did not extend to asylum-seekers who lived in perpetual fear of deportation. Service providers strove to create a sense of safety in the present by advocating for clients’ essential resettlement needs (e.g. affordable housing). Mental health workers were utilising advocacy to build a safe and trusting relationship in the counselling setting. The mostly cooperative relationship between mental health, health and settlement agencies in South Australia described by participants also facilitated the creation of a safety-net and stability for refugees in the present (cf. Vander Veer & Van Wanning, 2004).

According to participants, supporting asylum-seekers was particularly arduous (workers’ experiences of vicarious traumatisation are described in Puvimanasinghe et al., 2015). Clients’ uncertain plight and intense fear of deportation were not conducive to establishing safety and stability. Hence some mental health workers were left with little option but to limit their work to addressing basic needs and managing posttraumatic symptoms. One settlement agency’s use of a volunteer program to assist asylum-seekers’ material and psychosocial needs was especially useful in this regard—mainly because volunteers were not restricted by funding mandates (most of which specifically excluded asylum-seekers). Another important strategy for establishing safety in the present (as well as safety in the therapeutic setting and for the therapist) was to ensure the cultural and language sensitivity of services, because being in a culturally alien place was a potential cause for insecurity and mistrust (Gartley & Due, 2017; Murray et al., 2008). Accordingly, participants from all three categories (mental health, healthcare and resettlement) elaborated the measures they took: to be sensitive to the cultural, conceptual, gender, age and experiential differences of their clients; to accommodate and respond to clients’ differential expectations; and to maintain flexibility in service delivery (Khawaja & Stein, 2016; Puvimanasinghe et al., 2015). Two additional ways of enhancing safety were normalising responses (reminding clients that other migrants and refugees had faced similar situations and survived) and giving control (offering clients choices and opportunities in the therapeutic process) as described by Van der Veer and Van Wanning (2004).

Notwithstanding that most people require a sense of security and stability to share their most traumatic and intimate experiences, some clients made spontaneous disclosures in the midst of instability. This finding supports the narrative impulse of human beings (Bruner, 1990), where people told stories about their lives as an essential exercise of making meaning of otherwise incomprehensible and meaningless occurrences. Apparently, the mere fact that someone was willing to listen, bear witness
and validate clients’ stories was sufficient for some clients to feel the safety and trust required to share their experiences. The benefits of disclosing traumatic experiences in a safe and secure environment as described by participants tends to support the efficacy of culturally modified psychological interventions involving intense detailed exposure to past traumatic experiences (e.g. Agger, Igreja, Kiehle, & Polatin, 2012; Hinton et al., 2012).

The client-focussed approach emphasises the importance of being sensitive to particular individual needs of clients (Joseph, 2004). Many participants advocated this approach as an alternative to exposure-based trauma interventions, because they recognised individual and group differences between clients in their current capacity to feel safe and enter into a trusting relationship and their willingness to share past trauma (e.g. variations in cultural, gender and age, visa status, nature of trauma). Our findings highlighted the adaptability and innovation utilised by participants in designing non-standard therapies and strategies for clients unable to benefit from standard approaches. The benefits of alternative therapies in group settings such as drumming, dancing and art work, to reduce symptoms, increase wellbeing and give meaning to life to traumatised people from refugee backgrounds, has been acknowledged (Dhillon, Centeio, & Dillon, 2019; Marsh, 2012; Rowe et al., 2017).

There was also some evidence that for some clients, verbalising past trauma was not indicated, either because they had not established the basis (safety, stability, trust) for doing so or they had alternative coping strategies to process trauma. Previous research has found kinaesthetic measures and culturally based rituals to be more important for some groups of people than ‘talk therapies’. For example Somasundaram (2010) utilised cultural and religious rituals in therapy to bring about positive remissions in a group of Muslim refugees and asylum-seekers in South Australia. Although Somasundaram measured study outcomes qualitatively, there is potential for study findings to be utilised to develop standalone/adjunct interventions or for adapting established therapies for culturally diverse populations (e.g. CA-CBT; Hinton et al., 2012).

These study findings regarding refugee clients’ differing preferences for and ability to utilise verbal or non-verbal methods are consistent with the findings of a narrative study conducted with former refugees from two African communities also living in South Australia. Whereas members of one community afforded elaborate and evaluative narratives of past traumatic events, members of the other community preferred to maintain their silence regarding painful past events (Puvimanasinghe, Denson, Augustinos, & Somasundaram, 2014).

Most participants utilised what they described as a strengths-based approach that focused on listening to clients’ stories to explore and learn about clients’ resilience and traditional coping strategies. Interviewees identified a range of strengths such as family and community support, spirituality and religious observances and rituals—now well-established in the literature (Goodman, 2004; Khawaja, White, Schweitzer, & Greenslade, 2008; Tempany, 2009). Conversely, however, some potential resources (community, religion) could become stressors for some people. These findings illustrate the complexity and diversity involved in working with people from refugee and refugee-like backgrounds. Although learning about people’s cultural and national backgrounds was important, participants warned against simplistic assumptions. They emphasised the need for openness, on-the-job learning from clients, and the need for flexibility to address complexity.

**Study limitations.** The snowballing technique of participant recruitment through specific agencies and the purposive sampling utilised in the study may have resulted in the findings being unrepresentative of the experiences of the general population of service providers working with people from refugee and refugee-like backgrounds. Participants who worked in these agencies,
and volunteered for interviews, may have had more positive experiences than others who did not. Participants’ attempts to portray themselves in a positive light, especially regarding their commitment to their clients and their work, cannot be discounted. However, we believe the study strategies of using open-ended interview questions; adopting an informal interview that prompted elaboration and discussion of thoughts and ideas; and the request for stories, to some extent, safeguarded against this limitation.

Finally, the exploratory nature of the research precludes us from making causal linkages within our study findings. Nonetheless, the rich data shared and collected; and the insights into the importance of establishing safety and trust, trauma disclosure, and resilience undoubtedly adds to the literature on working with people from refugee backgrounds.

**Conclusion**

The present study explored how mental health, healthcare and resettlement workers in South Australia assisted their refugee and asylum seeking clients; specifically, how they helped them recover from psychosocial distress and trauma. Four prominent themes were identified: establishing safety, trust and connection, talking about trauma, working with silences, and promoting resilience and growth. The study underscored the complexity of working with people from diverse experiential and sociocultural backgrounds, and the flexibility required in this type of trauma work—and also the rewards of such work.

Our findings suggest that key aspects of successful counselling approaches in the refugee context include a strong focus on relationship-building and safety; sensitivity to individual and cultural needs and preferences; responsiveness to settlement needs; and a flexible array of approaches (individual, group and community) including client-focused, exposure-based, non-verbal, and positive (strengths or resilience-based) interventions.

These findings may be utilised when developing training and supervision programs for workers caring for refugees and asylum-seekers, to raise awareness of the skills, commitment, flexibility and reflexivity required to work in this area: Figure 1 provides a possible template. These findings may also inform personnel recruitment, highlighting the personal rewards and social value of this diverse and flexible therapeutic work.

Participants’ accounts provided additional evidence of the inadequacy of asylum-seeker policies in Australia. Traumatic in their own right, they also specifically deny refugee people many potentially therapeutic experiences including security, trauma treatment, and family reunion, all of which promote resilience. Future research could focus on designing larger studies of more agencies, with more representative sampling, including workers who have left the field. Formal evaluation of the flexible and culturally appropriate interventions described here is also imperative if the field is to develop further: it would permit these useful and acceptable psychosocial approaches to be admitted as evidence-based practice.

**References**


Address for correspondence.
Teresa.Puvimanasinghe@unisa.edu.au

Author biographies
Dr. Teresa Puvimanasinghe, BA Hons, PhD, completed her doctoral studies at the School of Psychology, University of Adelaide in 2015. Her research interests include cross-cultural psychology, migrant and refugee mental health, and trauma informed practice. She is currently Research Associate to an Australian Research Council funded project investigating refugee youth transition from school, to further education, training and employment at the University of South Australia.

Dr Linley Denson MPsych, PhD, is a Visiting Research Fellow at the School of Psychology, University of Adelaide and a Fellow of the Australian Psychological Society. Her research interests are in clinical and health psychology, ageing and health service usage. Previously, she was a Senior Lecturer in the School of Psychology at the University of Adelaide, where she coordinated the Clinical Psychology program.

Prof. Martha Augoustinos, BA Hons, PhD, is the Director of the Social and Organisational Unit and a Professor of Psychology in the School of Psychology at the University of Adelaide. Her research interests are in social psychology and discourse. Her published works focus on racial discourse, and more recently on majority group representations of asylum seekers and refugees. She is co-author of Social Cognition: An Integrated Introduction with Iain Walker and Ngaire Donaghe (2014, Sage).

Prof. Daya Somasundaram, MD, FRCPsyCh, FRANZCP was a senior Professor of Psychiatry at the Faculty of Medicine, University of Jaffna, and a Consultant Psychiatrist working in northern Sri Lanka for over three decades. He has worked as a Consultant Psychiatrist at Glenside Hospital and Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) in Adelaide and is currently a Clinical Associate Professor at the University of Adelaide. He has functioned as co-chair of the subcommittee on PTSD under the WHO working group on stress-related disorders during the ICD-11 revision process. His research and publications have mainly concentrated on the psychological effects of disasters, both man-made wars and natural tsunami, and the treatment of such effects. Currently, he is co-chair of the Task Force on Psychosocial Support, Office for National Unity and Reconciliation (ONUR), and on the UN mandated Consultation Task Force on Reconciliation Mechanisms in Sri Lanka.