Journal of Contemporary Psychotherapy, Vol. 29, No. 4, 1999

Rethinking a Familiar Model: Psychotherapy and the Mental Health of Refugees

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This paper examines with a somewhat critical eye the primary role that psychotherapy and other clinic-based services currently play in addressing the mental health needs of political refugees in the industrialized countries. Two factors are considered which suggest that refugee mental health needs might be better served by complementing clinic-based treatments with a variety of community-based interventions. The first factor concerns the pervasiveness of psychological distress within refugee communities, coupled with the reluctance of many refugees to utilize formal psychological and psychiatric services. This calls into question both the adequacy and appropriateness of clinical-based services as cornerstones of our response to the mental health needs of refugees. More precisely, it suggests the need to complement such services with a variety of culturally grounded, community-based strategies that do not require attendance in formal mental health settings. Second, recent findings have shown consistently that a considerable amount of the distress reported by refugees is related not to prior exposure to violent events, but to a constellation of exile-related stressors such as the loss of one's community and social network, the loss of important life projects, changes in socioeconomic status and related concerns about economic survival, the loss of meaningful structure and activity in daily life, and the loss of meaningful social roles. It is suggested that while psychotherapy can play an important adjunctive role in helping people confront these exile-related stressors, they may most effectively be addressed through targeted community-based interventions. Examples of such community-based approaches are briefly described, and suggestions are offered for community-level strategies that might be explored. The paper concludes by emphasizing the complementary nature of clinical and community-based programs, and by suggesting that psychotherapy might best be conceptualized as one component of a more comprehensive approach to addressing the mental health needs of refugee communities.

KEY WORDS: refugees; psychotherapy; community.

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This paper examines, with a somewhat critical eye, the role of psychotherapy in addressing the mental health needs of political refugees. Throughout the industrialized world, and in the United States in particular, it is taken largely for granted that mental health interventions with refugees will primarily involve clinic-based psychotherapy or counseling, often coupled with psychiatric medication, as the primary means of addressing the profound distress that political violence and forced migration so often generate. While not questioning the important role that psychotherapy can play in helping people heal from certain aspects of war and exile-related distress, I do wish to examine more closely the notion that conventional (i.e., Western) mental health services, and psychotherapy in particular, represent an adequate response by the mental health professions to the psychological needs of refugee communities. In the following pages, I suggest that two factors argue strongly for a more comprehensive approach to refugee mental health, one that incorporates ideas and strategies from public health and the ecological model of community psychology (Trickett, 1984; Westermeyer & Williams, 1986).

The first of these factors concerns the pervasiveness of psychological distress within refugee communities, coupled with the reluctance of many refugees to utilize formal psychological and psychiatric services. As I discuss below, this problematic reality raise some important questions regarding both the adequacy and appropriateness of clinical-based services as cornerstones of our response to the mental health needs of refugees. More precisely, it suggests the need to complement such services with a variety of culturally grounded, community-based strategies that do not require attendance in formal mental health settings.

Second, recent findings (e.g., Gorst-Unsworth & Goldenberg, 1998; Pernice & Brook, 1996) have shown consistently that a considerable amount of the distress reported by refugees is related not to prior exposure to violent events, but rather to a constellation of exile-related stressors that lie largely outside the reach of psychotherapy (but very much within the reach of community-based interventions). By exile-related stressors, I refer to variables such as the loss of one's community and social network, the loss of important life projects, changes in socioeconomic status and related concerns about economic survival, the loss of meaningful structure and activity in daily life, and the loss of meaningful social roles.

In discussing the impact of exile-related variables such as these on refugees' mental health, it is not my intent to minimize the highly traumatic nature of war-related experiences such as the disappearance and murder of loved ones, arbitrary detention, physical and psychological torture, and witnessing horrific acts of violence. In my former role as director of the Bosnian Mental Health Program in Chicago, I saw on a daily basis the devastating psychological effects of such experiences, especially among clients who had survived internment in concentration camps. Indeed, the empirical data are consistent on this point: war-related events that entail exposure to extreme violence often generate extraordinary levels

of psychological trauma (Kinzie, Sack, Angell, Manson, & Rath, 1986; Mollica et al., 1998; Weine et al., 1998).

My point here is simply that such experiences are only a part of the picture, and that stressors related to everyday life in exile appear to be just as important in understanding the high levels of distress documented in so much of the research on refugee mental health. Because such exile-related variables lie largely outside the scope of conventional mental health services, including psychotherapy, I suggest that we would do well to complement clinical treatment with a variety of community-level interventions tailored specifically to helping people adapt to and master the numerous challenges of life in exile.

In the remainder of this paper, I discuss in depth these two factors that limit the utility of clinic-based mental health treatment, including psychotherapy, with refugees. Examples of community-based approaches to refugee mental health are briefly described, and suggestions are offered for community-level strategies that might be explored. The paper concludes by emphasizing the complementary nature of clinical and community-based programs, and by suggesting that psychotherapy might best be conceptualized as one component of a more comprehensive approach to addressing the mental health needs of refugee communities.

THE PREVALENCE OF PSYCHOLOGICAL DISTRESS AMONG REFUGEES

Research examining the mental health status of refugees has consistently found high rates of psychological distress, most commonly conceptualized in the diagnostic language of American psychiatry[1] and its Diagnostic and Statistical Manual (American Psychiatric Association, 1994). Numerous studies have documented a high prevalence of both post-traumatic stress disorder (PTSD) and depression in adult refugees as well as children. While epidemiological data are somewhat sparse, research samples have included both clinical and non-clinical community groups, with high rates of distress across both types of settings.

Mollica and his colleagues (1998), for example, found a 90% prevalence of PTSD and a 49% prevalence for major depressive disorder (MDD) in a clinical sample of 51 Vietnamese refugee men, all of whom shared a history of detention and torture in Vietnam. In another clinical study, Weine et al. (1998) found that

[1] In this paper, I use the same language as that most commonly employed in research studies of refugees mental health, namely the diagnostic language of American psychiatry and its Diagnostic and Statistical Manual. However, I both recognize and agree with criticisms that such language is culturally-derived and may be inappropriate cross-culturally, and that both universal and culturally specific forms of distress may result from political violence and exile which do meet the diagnostic criteria spelled out in the DSM (Wessells & Monteiro, in press). My decision to stay with the language of the DSM in this paper reflects a choice of convenience given its prevalence in much of the research cited in the paper.

74% of their sample of 25 adult Bosnian refugees met diagnostic criteria for PTSD. Miller et al. (1999) assessed levels of PTSD and depressive symptomatology in two groups of Bosnian refugee adults—one clinical and the other a non-clinical community sample—and found that mean scores for *both* groups were in the clinical range for both categories of disorder. Michultka, Blanchard, & Kalous (1998) found a 68% prevalence of PTSD in their study of Central American refugee adults, while Allden et al. (1996) found rates of 23% and 38% for PTSD and MDD respectively in their study of Burmese refugees in living in Thailand.

In one of the few randomized community samples involving refugees, McSharry & Kinney (1992) studied the prevalence of psychiatric disorder in 124 adult Cambodian refugees in the United States. Most striking was their finding that 12 to 14 years after resettling in the US, their sample yielded rates of 43% for PTSD and 51% for MDD. While such findings might appropriately be interpreted as reflecting the profoundly psychopathogenic impact of the violence these refugees had experienced while in Cambodia, they also raise the question of whether ongoing stressors in the resettlement environment (i.e., the United States) might have contributed to the persistence of such distress over such a lengthy period of time (an important point to which I return below).

In one of the most oft cited studies of refugee children, Kinzie et al. (1986) found that 50% of the 40 Cambodian refugee youth in their community-cohort study met diagnostic criteria for PTSD, while 53% met criteria for some form of depressive disorder. These children had a history of prolonged detention in Khmer Rouge "re-education" camps, where they experienced beatings, starvation, illness, and separation from family members; in addition, the children had lost an average of three members of their nuclear families. Consistent with clinical observation and empirical data which indicate that psychological trauma may persist unabated in the absence of some form of intervention (Shalev, 1996; van der Kolk, 1996), 3 year follow-up data on these children revealed a 48% prevalence of PTSD, 7 years after their departure from Cambodia (Kinzie, Sack, Angell, Clark, & Ben, 1989). The prevalence of depressive disorders in this group had also remained essentially unchanged at follow-up.

Other studies of refugee children, using both clinical and non-clinical community samples, have yielded varying rates of distress, ranging from 11.5% for PTSD and MDD in a community sample of Tibetan children living in India (Servan-Schreiber, Lin, & Birmaher, 1998), to an approximately 33% prevalence of PTSD among a group of 30 Central American refugee children being treated in a clinic in the United States (Arroyo & Eth, 1986).

What are we to make of these various findings? It is evident that refugees of all ages constitute a population at risk of severe and persistent psychological distress. Findings of clinically significant levels of trauma and depression have been found in numerous community samples as well as in clinical settings, suggesting that the high rates of documented distress are not merely an artifact of

the particular samples that have been studied (i.e., one would expect high rates of distress among those studied in clinical settings; they are, after all, seeking treatment). Although systematic epidemiological data are lacking, the available evidence suggests that symptoms of psychological trauma and clinical depression are widespread among those living in exile. While longitudinal data are comparatively sparse, the few studies that have either included a follow-up component or that have studied refugees several years after their departure into exile, have consistently found that painful symptoms of trauma and depression often persist over periods of many years, suggesting that time does *not* heal all wounds and that timely and appropriate mental health interventions are very much needed.

AN ECOLOGICAL APPROACH TO REFUGEE DISTRESS

If we take as a given that psychological distress, however we wish to conceptualize it, is fairly widespread within refugee communities, the question from a public health perspective is how to most efficiently and effectively reach the largest number of people with our mental health interventions. While psychotherapy may be an effective form of intervention at the individual or small group level, its capacity to reach large numbers of people is limited in part by the number of professionally trained therapists and interpreters available to work with refugees. An example might be helpful in illustrating the problem. The Bosnian Mental Health Program in Chicago, in conjunction with its sister Refugee Mental Health Program, represents one of the largest mental health services in the United States specifically designed to serve Bosnian refugees. With a staff of several psychologists and psychiatrists, 5–6 graduate student trainees, an art therapist, 2 volunteer massage therapists, an interpreter, and 4 mental health counselors/case managers who also provide interpreting for individual and group psychotherapy, the program provides a fairly comprehensive range of services. Caseloads are consistently full, and the program is able to serve a maximum of between 200 and 250 individuals per year. To put this in context, consider that there are an estimated 22,000 Bosnian refugees living in the Chicagoland area (Smajkic, 1999). Given the available data regarding the prevalence of psychological distress among refugees generally, and among Bosnian refugees specifically, it seems reasonable to conclude that the program is serving only a small percentage of those Bosnians who could benefit from some form of psychological intervention.

The issue of access to clinical treatment is complicated by an additional variable. As various authors have noted (e.g., Dragons, 1984; Farias, 1994; Kinzie, 1985; Williams, 1986), psychotherapy is a uniquely Western phenomenon, and though it can certainly be helpful to people from non-Western societies (Singer, 1976; Yamamoto, 1978), there is both empirical and anecdotal evidence which suggests that people from non-Western cultures are not generally inclined to seek

out and utilize formal mental health services, including psychotherapy (Ensign, 1995; Sue & McKinney, 1975). This observation is especially relevant to thinking about mental health work with refugees, who overwhelmingly come from non-Western societies (UNHCR, 1997) with culturally distinct ways of expressing, understanding, and responding to psychological distress (e.g., Farias, 1994; Hiegel, 1994; Saul, 1999). Thus, our public health question now becomes, "How can we reach the greatest number of people most effectively, using interventions that are congruent with the cultural backgrounds of those we wish to assist?"

One answer to this question may be found in the ecological perspective of community psychology (Trickett et al., 1984; Kelly, 1991). The ecological model was developed in the late 1960s and early 1970s by community-oriented psychologists who were seeking an alternative to the medical model of psychiatry and clinical psychology as a framework for understanding and responding to psychological distress. In contrast to the medical model, which focuses on the individual as the unit of analysis and intervention, and which emphasizes the treatment of pathology by highly trained experts, the ecological model emphasizes the relationships between people and the settings they live in; the identification of naturally occurring resources within communities that can promote healing and healthy adaptation; the enhancement of coping and adaptational strategies that enable individuals and communities to respond effectively to stressful events and circumstances; and the development of collaborative, culturally grounded community interventions that actively involve community members in the process of solving their own problems (Rappaport, 1977; Trickett, 1984).

Within an ecological framework, there is an emphasis on addressing individual and community problems by identifying and developing local resources, rather than relying on outside professionals who may be difficult to access and are unlikely to be familiar with local beliefs, values, and practices. An ecological view does not negate the important role that outside professionals can play in addressing salient problems; it does, however, recognize the potential of community members to actively participate in confronting their own difficulties. A common model involves professionals who work collaboratively with local community members to develop contextually appropriate interventions which can be carried out primarily by members of the community. This approach is efficient, in that it maximizes the use of existing local resources, while simultaneously benefiting from, and minimizing dependence on, the expertise of outside professionals. It is empowering in that it helps communities become better able to address their own needs in culturally congruent ways.

One ecological approach to mental health work with refugees involves the training of mental health paraprofessionals, themselves members of the affected community. This approach has its roots in the health promoter model described by Werner & Bower (1990). In their popular book *Where There Is No Doctor*, Werner & Bower aptly note that a wide variety of interventions traditionally performed

by physicians and nurses (e.g., giving immunizations, diagnosing and treating common maladies) can be readily taught to lay health workers. As part of their training, these paraprofessionals can learn to recognize when professional treatment is indicated, as well as when local, lay interventions are adequate. Translating this intervention model to the domain of mental health, we might ask whether many of the basic diagnostic and interventive techniques used by mental health professionals might be effectively taught to non-professionals. The widespread popularity of peer-counseling programs, crisis intervention services, and rape and domestic violence programs which rely heavily on paraprofessionals suggests that it is in fact possible to train people in the basics of mental health intervention, thereby reaching a much greater number of people than could be served by mental health professionals alone (Anderson, 1976; Hoff & Miller, 1987).

The mental health paraprofessional approach has been utilized in the development of community-based interventions in many developing countries where people have minimal access to professional psychological or psychiatric care (Boothby, 1994; Wessells & Monteiro, in press). Community-based mental health projects have been developed in settings as diverse as Angola (Wessells & Monteiro, in press), Mozambique (Boothby, 1994), Mexico (Billings & Saenz, in press; Saenz, 1994), Sri Lanka (Tribe & De Silva, 1999), and Nicaragua (Metraux, 1990), all utilizing the ecological model's emphasis on helping local residents develop the skills needed to address common problems and concerns.

With regard specifically to refugee and internally displaced communities affected by political violence, a number of innovative paraprofessional programs have been developed. For example, Saenz (Saenz, 1994) and her colleagues in Mexico City trained indigenous Guatemalan refugee women to work as *promotoras de salud mental*, or lay mental health workers. The women were trained in the basics of refugee mental health and the fundamentals of the active listening approach to counseling, and were provided ample opportunity to address their own experiences of psychological distress related to the violence in Guatemala and the stresses of life in exile. The *promotoras* subsequently applied the skills they learned in their own communities, where they were able to impact a far greater number of distressed individuals than could ever have been reached through individual or group therapy conducted by the small professional staff of the project.

The *promotora* model just described has the advantage of greatly increasing the availability of formal and informal counseling opportunities within refugee communities by training community members to serve as lay counselors. It may be noted, however, that this approach replicates at a paraprofessional level the utilization of Western therapy and counseling concepts and skills, such as those of active listening, to address individual psychological distress. Other lay mental health projects have sought to more actively integrate local beliefs and practices regarding psychological well-being and distress into the program design, and have emphasized the importance of healing the effects of violence and displacement at multiple

levels, including the individual, family, and community. As the late Salvadoran psychologist Ignacio Martín Baró (1989) noted, political violence has a destructive impact on entire communities, and indeed on the fabric of society as a whole; consequently, mental health interventions should aim to address not only individual trauma, but also the psycho-*social* trauma that political violence engenders. Social relations are fundamentally altered, racist practices become ingrained and legitimized, new social divisions are created or old divisions exploited and reified (e.g., the profoundly destructive exploitation and manipulation of ethnic differences in the former Yugoslavia), and any previously shared sense of community may be diminished or destroyed by the creation of mutual suspicion and the destruction of traditional social ties. As Englund (1998) has noted, the experience of *self* evolves out of, and remains deeply rooted in, a matrix of social relations; from this perspective, much of the distress generated by war and exile may be viewed as the result of the destruction of the social fabric in which people's lives are embedded. Consequently, interventions that focus solely on healing individual distress without attempting to mend or recreate meaningful social networks may be limiting their potential impact.

In the Angola-based mental health project entitled "Province-based War Trauma Team" (Wessells & Monteiro, in press), children displaced and traumatized by the violence of civil war are re-integrated into families and communities by means of a multi-tiered system of local trainers and lay mental health workers ("trainees"). By employing a structure in which locally trained paraprofessional staff work as trainers themselves, the project has been able to train more than 2,000 adults to work with children in several war-affected provinces of the country. Adult trainees are given opportunities during the group trainings to address their own experiences of distress related to the war; in this way, a program that is formally focused on the healing and integration of displaced children is actually facilitating a process of psychological healing among community members of all ages. Traditional local beliefs and practices regarding loss and healing are central foci of group discussions among the trainees, many of whom have limited formal education, and who come from the communities into which the children are being integrated. In total, over 15,000 children have been reached by the program, which utilizes a variety of group-level activities including story-telling, drama, singing, dance, drawings, athletic activities, and discussions to help children heal from the effects of war and displacement. At the community level, trainees lead community discussions focused on the status and needs of the children, help in the development of community projects aimed at assisting the children's integration, and advocate on behalf of policies that might affect the children's well-being.

Lykes (1991) and her colleagues from Argentine and Guatemala have been involved in the development of a similar project with Indian communities affected by the Guatemalan army's genocidal counter-insurgency campaign during the late 1970s and early 1980s. Adapted from work originally done in Argentina,

this program trained local community members (teachers, health promoters, and others) in the use of expressive arts and drama therapy techniques ("*tecnicas creativas*") for use with children in a variety of group settings. Training workshops were held in schools, orphanages, and other community locations. An emphasis was placed on the utilization of locally available resources, and on strengthening social ties both within and between communities affected by the military's genocidal violence. The supportive context of the training provided the adults with opportunities to share and reflect on individual as well as communal experiences of trauma and loss; thus, like the Angolan project described above, this child-focused program was also able to contribute to a process of healing among adults affected by violence and displacement.

It is interesting to note that lay mental health projects such as these have found comparatively little expression in the industrialized countries. While mental health paraprofessionals have been utilized in the context of a few refugee mental health programs (e.g., Kinzie, 1986; Lum, 1985), their role has been primarily adjunctive, supplementing the clinic-based treatment of refugees by professionally trained mental health staff. It may be that the dominance in the industrialized nations of the medical model of psychiatry and clinical psychology has somewhat narrowly defined how we understand and respond to psychological distress; interestingly, it is precisely in those countries where Western-trained psychiatrists and psychologists are scarce that some of the most creative community-based mental health interventions for refugees have been developed.

It might also be argued that unlike in developing countries, where there is often a paucity of mental health professionals (particularly in those areas where refugees are likely to reside), there is no such scarcity in the industrialized countries, and therefore lay mental health programs for refugees are simply not needed. Several factors, however, argue against this notion. First, recent research on the utilization of formal mental health services by refugees (e.g., Strober, 1994; Weine, et al., under review) suggests that existing refugee mental health programs, despite full caseloads, may be merely touching the tip of the iceberg. This idea is supported by the findings of research cited earlier regarding the widespread prevalence of psychological distress among refugees who are *not* receiving mental health treatment. It would seem reasonable to conclude not only that there is a great deal of distress within refugee communities, but that many distressed refugees are neither seeking nor receiving treatment in clinic-based refugee mental health programs. Given the significant (though imprecisely known) extent of unmet need, I propose that rather than pursue more of the same—that is, an increase in clinic-based programs—perhaps we should consider the limitations of existing approaches and explore the role of alternative, complementary strategies in meeting the mental health needs of refugees. Lay mental health programs represent one such strategy, and there is a growing literature on which to draw which can inform the development and implementation of such programs. In the industrialized countries, such programs could work in collaboration with resettlement agencies, mutual assistance associations,

and religious institutions, all of which represent ideal (i.e., non-stigmatized, frequently utilized) settings for such programs. As I discuss below, there is no need to frame such projects as mental health interventions *per se*, and in fact there may be considerable advantages in not doing so. Coming together with others to engage in specific social activities such as weaving, or drinking coffee and discussing politics is likely to be both familiar and comfortable to many people; on the other hand, coming together specifically to address issues of psychological distress is not.

There are a range of other ecological strategies for utilizing resources that exist within refugee communities to address mental health needs. For example, traditional healers, whose healing skills may not be recognized or valued by the host society, may nonetheless be highly regarded by community members and can play an important role in the healing process (Eisenbruch, 1994; Hiegel, 1994). Ensign (1995), for example, noted that while Hmong refugees in California were reluctant to utilize psychotherapy and other Western forms of psychiatric treatment, they were quite willing to seek out traditional Hmong Shamans who used a variety of culturally-specific rituals, corresponding to Hmong beliefs regarding the nature and origins of psychological distress, to ease people's distress. Peltzer (1997) has similarly documented the use of traditional rituals of healing by traditional spiritual leaders in the treatment of traumatic stress among Ugandan refugees.

Religious leaders often have far more influence within refugee communities than do mental health professionals. By collaborating with priests, imams, rabbis, and other spiritual leaders who are themselves members of refugee communities (or who serve such communities), mental health professionals can contribute to the development of psychologically-oriented programs housed in religious settings which lack the stigma of mental health clinics. In addition, religious leaders can also be encouraged to incorporate culturally appropriate mental health themes related to trauma, loss, and healing into their sermons as well as their informal interactions with congregation members. In this way, they can play a powerful role in helping to frame experiences of trauma and loss within a context of shared religious meaning. Eisenbruch (1988) has noted that indigenous spiritual leaders may be able to facilitate processes of psychological healing at the community level by use of traditional religious rituals. In one example, he describes the importance of a traditional Buddhist religious ceremony in helping to calm rising tensions within a Cambodian refugee community reacting to the death of one of its members. By utilizing traditional rituals to facilitate a process of mourning, the leader of this ceremony helped the community engage in a culturally meaningful process of grieving and of honoring the deceased.

Other strategies for addressing refugee mental health needs similarly involve broadening the range of settings in which mental health work can take place. A compelling example of this can be found in recent efforts to incorporate mental health concepts and interventive strategies into the English as a Second Language (ESL)

classroom (Paul, 1987). Most refugees in the United States spend a considerable amount of time in the ESL classroom, making it an ideal, stigma-free setting in which mental health issues can be addressed in non-threatening, normalizing ways. In my own experience with Bosnian refugees, I found that experiences of failure in the ESL classroom were frustrating and embarrassing for previously competent adults whose symptoms of trauma and depression were impairing their ability to concentrate and focus during class. By training ESL teachers to recognize and carefully address experiences of distress common to refugees, it becomes possible to transform the classroom into a safe setting for discussion and normalization of common refugee mental health problems, as well as for communal problem-solving of some of these problems.

The possible range of community-based approaches to mental health work with refugees has only begun to be explored. The point is not that such approaches should replace traditional clinic-based mental health services for refugees; rather, community-based interventions represent a complementary set of strategies for addressing the mental health needs and problems of refugee communities. In addition to greatly expanding the reach of mental health interventions, such programs can also serve as essential sources of linkage to more traditional mental health services for those individuals requiring more intensive psychological and psychiatric treatment.

PSYCHOTHERAPY AND THE STRESSES OF EXILE

Much of the literature on psychotherapy with refugees has focused on clinical strategies for healing psychological trauma related to prior exposure to political violence. This emphasis on psychological trauma is understandable and appropriate, given the salience of traumatic events and post-traumatic symptomatology in refugee populations. At the same time, however, the available data clearly indicate that a considerable amount of the distress experienced by refugees, particularly the high level of depressive symptomatology, is strongly related to ongoing stressors associated with life in exile, rather than to prior (i.e., pre-migration) experiences of violence. While trauma-focused therapy may hold much promise for ameliorating the disabling symptoms of post-traumatic stress reactions, an exclusive or even primary focus on war-related trauma may ultimately limit the overall efficacy of the therapeutic process. One of the few treatment outcome studies involving refugees reached a telling conclusion regarding the importance of addressing exile-related variables in mental health work with refugees:

> Psychotherapy (supportive therapy, networking, individual and group cognitive behavioral therapy, systemic family therapy), together with anxiolytic and antidepressive pharmacotherapy, did not have any significant effects, *unless the therapist was willing to be engaged in exploring and resolving the serious existential-economic problems which are typical in patients with war psychotraumas* (Pejovic, Jovanovic, & Djurdic, 1997; italics added).

In a similar vein, Kinzie & Fleck (1987), based primarily on their work with Cambodian refugees, cautioned that the success of psychotherapy with refugees may be undermined if therapists fail to assist clients in dealing with important social and financial issues. The types of issues that Kinzie & Fleck (1987), Pejovic et al. (1997), and others refer to include, for example, the social isolation that results from the loss of social networks, the loss of personally meaningful social and occupational roles, the loss of environmental mastery (the ability to effectively negotiate one's environment), and the numerous stresses associated with living in poverty. For each of these sources of distress, there is a corresponding psychosocial need: a need for the development of new social networks; a need for the identification and development of new roles that provide a sense of meaning and structure to daily life; a need for the development of skills and competencies that will permit effective negotiation of the new environment; and a need for employment-related opportunities that permit refugees to achieve financial self-sufficiency in the shortest time possible.

While I agree with the authors cited above regarding the importance of psychotherapists helping their refugee clients deal with a broad range of issues related to the experience of exile, I believe there is much to be gained by complementing psychotherapeutic strategies with community-based interventions that are specifically tailored to addressing these issues. In fact, I would suggest that we might best conceptualize psychotherapy and psychopharmocology as playing important though primarily *adjunctive* roles in helping people master the multiple challenges of living in exile. Particularly when symptoms of trauma, pervasive anxiety, or depression interfere with people's basic psychophysiological functioning, their capacity to engage in social interaction, or their ability to concentrate during ESL classes or occupational therapy sessions, traditional clinical services may help to minimize such interference and thereby assist people in taking fuller advantage of the various resources available to them.

In the remainder of this section, I briefly examine the nature of several exile-related stressors, and consider the role of either existing or potential community interventions in helping people address each of these ongoing sources of distress.

SOCIAL ISOLATION

> I cry when I think about my husband (who died). It's difficult as a widow, having to raise my children without the support of a man to bring the wood, help with the work, and to be generally supportive. The kids were young when he died, and they couldn't help, though now they can and do.
>
> —Ana, 32, Guatemalan refugee in southern Mexico[2]

[2] All quotes from Guatemalan refugees in this section come from Billings, D., & Miller, K., Unpublished raw data.

> I have difficulty doing my work in the home because of desperation. I have no-one to talk with . . . I am lonely. I cry when I am alone in my house. I don't have parents or siblings who help me and visit me.
>
> —Katrina, 41, Guatemalan refugee in southern Mexico

Social isolation is result of the rupture of social ties that ensues when an individual or family goes into exile. Friends and other family members are left behind or go into exile elsewhere, and refugees who previously enjoyed regular social contact before going into exile may subsequently find their days devoid of social interaction. In a recently completed study with Bosnian refugees in Chicago (Miller et al., 1999), social isolation was a powerful predictor of depressive symptomatology, and seemed to exacerbate symptoms of PTSD as well. In a similar vein, Silove et al., (1997) found that self-reported levels of loneliness were significantly related to levels of anxiety and depression in their study of 40 refugees of varied nationalities seeking asylum in Australia. Bennet & Detzner (1997) likewise found that loneliness was a central theme in the life histories of the Southeast Asian women they studied, for whom the experience of loneliness was closely tied to the difficult social transitions resulting from going into exile. These findings are consistent with other research on the effects of social isolation and loneliness, which have been linked to a variety of adverse psychological and physical outcomes, ranging from depression (Beach, Arias, & O'Leary, 1986; Chesney & Darbes, 1998) and other types of emotional distress (D'Augelli, 1983) to an increased risk for heart disease (Chesney & Darbes, 1998; Egolf et al., 1992).

Such findings suggest that the initial phase of exile may be a critical time during which to help link refugees to resources that can facilitate the development of new social networks, which can increase the availability of social support while reducing the experience of isolation. One innovative approach in this regard is the CAFES project (Weine, 1998), a community-based intervention for Bosnian refugee families in the Chicagoland area. The CAFES project brings families together in a community setting, utilizes members of the refugee community as programs facilitators, and promotes a process of mutual sharing of experiences and collective problem-solving. In the process, new social networks are formed, and information is shared (often by the participants themselves) regarding important resources available in the community.

Another approach to helping people displaced by violence to develop new social networks while also addressing a range of other psychosocial issues was developed by the Family Rehabilitation Centre (FRC) in Sri Lanka (Tribe & De Silva, 1999). The FRC's intervention was aimed at women who had been widowed by the civil war in their country. The program brought women together for an intensive program lasting several days, and was aimed at promoting a sense of shared experience among the participants, while also helping them gain access to important educational, legal, health, and employment-related resources. An important

feature of this program was the dual emphasis on promoting social support among the women in the group, while also linking participants up with organizations and resources that would assist them in becoming economically self-sufficient despite the loss of their husbands.

Another community-building approach that has been implemented successfully is the utilization of gardening projects (Bogard, personal communication). For refugees from agricultural societies, opportunities to cultivate flowers and vegetables on commonly shared land, even small plots in urban areas, can provide wonderful opportunities to interact socially while engaging in a familiar set of activities that call on areas of competence and expertise. Other approaches to promoting social connection among refugees include the development of drop-in and activity centers which can offer space for socialization, informational and support groups focused on salient exile-related issues, and ESL classes tailored to the psychological capacities of program participants (Robb, personal communication). The role of the mental health professional in such settings is that of consultant, helping to inform the design of specific programs by sharing expertise regarding the special psychological challenges and needs of refugees; further, mental health professionals can offer workshops in such settings on a range of psychological topics, ranging from stress-management, conflict resolution for distressed couples and families, interacting with schools and other social institutions, and the prevention and/or management of secondary trauma among program staff who work with refugees on a daily basis.

Elderly refugees who have lost a spouse may be at particularly high risk of becoming socially isolated in exile (Miller & Worthington, manuscript under preparation). Even when they are living with their grown children, the children are often away during the day and their elderly mothers or fathers may find themselves with little social contact or structured activity for extended periods of time. One possible approach to this problem would entail the development of volunteer-based programs in which younger refugees spend time each week visiting with elderly community members with whom they share a common language and cultural background. Not only would this reduce social isolation among elderly refugees, it would also provide a source of regular, meaningful activity to younger refugees who are unemployed and whose days are otherwise devoid of structure and social contact.

In sum, there are numerous ways of helping refugees develop new social networks, thereby reducing social isolation and increasing the availability of social support. Community-based interventions such as those described have the additional advantage of being based in community settings rather mental health clinics, thereby avoiding the stigma that many refugees associate with receiving psychological or psychiatric assistance. For this reason, such programs have the potential to reach large numbers of refugees who may be experiencing psychological distress, but are not inclined to seek out and utilize formal mental health services.

THE LOSS OF SOCIAL AND OCCUPATIONAL ROLES, AND THE CORRESPONDING LOSS OF MEANINGFUL ACTIVITY

> I worked in one factory, which produced cookies, and I had gone to school for that kind of profession, making candy. I liked my job a lot. I worked three shifts. I was really excited in my factory. When I didn't work, I used to get up in the morning to clean up the home, to cook dinner, to have breakfast, lunch and dinner. Then, I used to go out with my friends. We used to go out to the restaurant or coffee shop, and it happened usually on Saturday or Sunday. Sometimes we used to drive to the countryside . . .
>
> Alma, 46, Bosnian refugee in the United States[3]

> I was very active. I used to go with my friends to hunt, and Sundays, I used to play soccer. I was a professional soccer player for 10 years, and then I was the president of the soccer club for years. And, as I said I was always active . . . I was a civil engineer for 20 years . . . and, for at least 14 years, I was an officer of the court . . .
>
> Ibrahim, age 45, Bosnian refugee in the United States

The various personal and professional roles we play are intimately related to our sense of identity (Heller, 1993), and to our sense of competence and self-esteem (Kivelae, 1997). As people go into exile, they leave behind many of the social and occupational roles they previously played, and from which they derived a sense of purpose, meaning, and structure. Although the impact of this role loss has received little attention in the literature on refugee mental health, psychologists *have* studied the loss of social roles quite extensively among elderly Americans (Heller, 1993). As people approach their senior years, they face the increased likelihood of multiple changes in some of the most fundamental roles they have occupied during their adult lives. Retirement forces the abandonment of occupational roles, while the death of a spouse imposes the transition from the role of marital partner to that of widow or widower. Studies examining the impact of such role loss on the mental health of older adults have found an increased risk for depression (Reker, 1997; Silverman, 1988) and lowered self-esteem (Kivalae, 1994). Ryff & Singer (1998) have conceptualized this loss of personally esteemed roles as a loss of *meaning*, which they regard as etiologically linked to suboptimal psychological and psychophysiological functioning. Alternatively, one might adopt a more socio-psychological perspective, and consider the impact of role loss on the structure and activity level that characterize people's daily lives. Lavik et al. (1996), for example, found that unemployment and a lack of participation in educational activities were positively related to levels of anxiety, depression, and aggressive behavior in their multinational sample of refugees seeking assistance in a mental health clinic in Oslo. The authors concluded that the lack of meaningful daily activity associated with unemployment and/or not being in school was having a significantly adverse effect on the refugees' mental health. A lack of meaningful daily activities was

[3]All quotes from Bosnian refugees in this section come Miller, K., & Worthington, G., Manuscript under preparation.

also a highly significant predictor of depression among Bosnian refugees in the Miller et al. study cited earlier.

These findings have important implications for understanding the experience of refugees, whose departure into exile creates a pervasive disruption of established roles and related activities. People living in exile are frequently at high risk of unemployment (Beiser, Johnson, & Turner, 1993; Lavik et al., 1996; von Buchwald, 1994), and often find themselves without access to the various social relationships and economic structures that gave shape and meaning to their daily lives prior to exile. In addition, the separation from friends and family members that so often accompanies the act of going into exile can have a significant impact on the availability of previously valued social roles.

The loss of social roles is most effectively addressed by linking people with opportunities to both recreate familiar roles and to discover new roles that are personally meaningful and that provide structure and activity to their days. This may entail the creation of settings in which familiar skills can be utilized, such as providing women who are experienced at weaving or sewing with the initial infrastructural resources to produce and market their products. In one such project, a non-profit organization in the highlands of Guatemala helps groups of women who have been widowed by the army's violence to develop weaving cooperatives, which are then linked to international markets through the organization's infrastructure. Profits from the sale of products are fed back into the communities so that the groups become financially self-sustaining. The women are able to assume the role of primary economic provider for their families, a role previously played by their husbands. The skills required to maintain the cooperatives encourage the women to develop new areas of competence and a shared sense of efficacy (billings, personal, communication). The promotion of small business ventures as an approach to addressing poverty-related stressors among refugees is discussed in greater detail below.

For men, who in many societies are expected (and who themselves expect) to provide for the financial well-being of their families, extended periods of unemployment—extremely common in exile—represent the loss of the role of provider and can be highly distressing. Paradoxically, well-intentioned aid programs that provide ongoing financial and material assistance may unwittingly promote a sense of dependence and further erode the capacity of refugees to identify and assume employment-related roles that might help them regain a sense of competence and self-sufficiency (Forbes Martin, 1991; UNHCR, 1997). In contrast, income-generation projects that promote small business ventures among refugees hold considerable promise for helping people create new roles that are both personally meaningful and economically viable. The Austrian Relief Committee, for example, provided skilled Afghan refugees with the tools needed to engage in their crafts, such dress making, carpet weaving, and other handcraft production (Forbes Martin, 1991). For refugees who lack such skills, occupational therapy and job training programs could provide the necessary training.

Of course, social roles are not limited to the domain of work. People occupy a wide range of personally meaningful roles—friend, sibling, grandparent, team member, community activist, etc., all of which may be lost or fundamentally altered as a result of exile. Linking people to organizations and settings that provide opportunities for meaningful role acquisition in *any* domain is likely to be psychologically beneficial. Light (1992), for example, has documented the positive impact of newly acquired social activism on the mental health of Guatemalan refugee women in southern Mexico. *Mama Maquin*, an organization founded by and for Guatemalan refugee women, has provided members with opportunities for collective reflection and social action, leading to the establishment of new roles for women within the camps and a greater degree of power-sharing between the sexes. In a related vein, Aron (1992) has described the psychological benefits for survivors of torture of community-based *testimonio* (Cienfuegos & Monelli, 1983), the sharing of one's experience of torture with fellow community members and other interested groups. The act of *testimonio* transforms the victim of torture into a vocal activist, opposing and exposing those responsible. The active nature of the role attained by means of giving public testimony acts as a therapeutic antidote to the feelings of powerlessness and vulnerability generated by the experience of torture.

In sum, the loss of valued social and occupational roles represents a significant source of ongoing stress for people living in exile. Community-based projects that provide opportunities for the rearticulation in exile of traditional social roles, as well as the identification and/or development of previously unfamiliar roles, may hold great potential for helping refugees create more meaningful lives in their new environment.

THE LOSS OF ENVIRONMENTAL MASTERY

> It is very difficult. It's very difficult when you go out and you are not able to communicate—when you go to the doctor or when you go shopping, and you are not able to communicate. Life was very hard... We got just a little help—social support for just two months, and after that we were on our own... My husband worked, and I worked too for a while, until I burned my hand. I was supposed to work in one hotel, but in order to reach there, I was supposed to take three buses, and I didn't know how to do that. So, I used to sit down and cry.
>
> —Asima, age 50, Bosnian refugee in the United States

Regardless of where they settle—refugee camp, informal settlement, or country of permanent resettlement—refugees face a daunting series of tasks related to negotiating their new environment successfully (Hinton et al., 1997). For many, this includes learning a new language in order to gain access to better educational and employment opportunities. It may also involve developing new work skills that correspond to the types of employment available in the new setting. Unfamiliar sociocultural values and practices are likely to be encountered in exile,

and traditional practices from the homeland may be discouraged or misunderstood by members of the host culture (McGoldrick, 1982). Also, basic setting-specific skills such as negotiating the local bus or subway system may mean the difference between staying home or being able to take advantage of local services and employment opportunities.

The following clinical example illustrates the powerful psychological impact of a simple behavioral intervention that helped a Bosnian refugee woman gain greater mastery of over one important aspect of her new setting, the local bus system:

> Mrs. L., a 64 year old Bosnian refugee, was referred for a mental health assessment because of her severe depression. A survivor of domestic violence as well as the recent war in Bosnia, she had left everything behind to go into exile with her son and daughter in law. They both worked, leaving her alone during the day, and in the evening they were tired and not inclined to accompany her on errands. Afraid of taking the bus, and unable to speak more than a few words of English, she quickly came to feel like a prisoner in the family's small apartment. During the assessment, the severity of her depression and sense of helplessness was immediately apparent. Believing that at least some of Mrs. L.'s depression was related to her sense of helplessness and confinement in the apartment, her therapist spent the next few sessions riding the bus with Mrs. L. to and from the clinic as well as to other parts of the city. Within a few weeks, the client was riding the bus to the clinic and to other appointments by herself. This achievement was accompanied by a marked attenuation of her depressive symptomatology. Her "imprisonment" in the family's home had effectively ended (Worthington, 1999).

As this example illustrates, refugees can be successfully assisted in learning to effectively negotiate their environment in the context of a psychotherapeutic relationship. The essential point, as Kinzie & Fleck (1987) and Pejovic et al. (1997) have noted, is that psychotherapists must be careful to address a broad range of adaptational issues, including those related to the development of basic environmental mastery, as well as focusing on the more traditionally "psychological" phenomena such as psychological trauma and unresolved grief.

From the perspective of community intervention, comprehensive orientation programs could be developed that utilize refugees who already have some history living in the setting of exile, and who have learned to effectively negotiate the local environment. These individuals could lead orientation and mutual support sessions for recently arrived individuals and families, helping people learn how to use the local public transportation system, as well as how to access important social, medical, legal, mental health, and educational resources. This approach is nicely exemplified by the CAFES project discussed earlier (Weine, 1998), which makes use of the experience and knowledge of group facilitators, themselves members of the refugee community. Furthermore, as program participants acquire their own knowledge and experience in dealing with their new environment, information regarding available resources and opportunities is shared with other group members. One staff member noted that in a recent CAFES group, only member had gainful employment at the start of the program; 6 weeks later, 8 members of

the group had found employment through the connections provided by this one individual (Kulauzovic, personal communication).

THE LOSS OF MATERIAL AND FINANCIAL RESOURCES

> I had everything there. I have nothing here . . .
>
> —Alma, 38 years old, Bosnia refugee in the United States

> I cry because of what we suffer *here*. We feel very sad, we had all our lands there. Sometimes we run out of food and our land is so far away. I cry when I want to work and plant crops and we can't. How are we going to eat? I feel sad because of our poverty. Sometimes I'd rather die because I can't work. I can't buy medicine, I can't earn money to buy medicine . . .
>
> —Catarina, 48, Guatemalan refugee in southern Mexico

It is widely recognized that refugees experience a marked decline in their material and financial well-being as they move into exile (Sinnerbrink, 1997; UNHCR, 1997). While it is true that many of the world's refugees come from materially impoverished settings, the conditions in refugee camps are almost always invariably worse. Personal space and privacy in such settings are scarce, as are land for building homes and growing crops, nutritional resources, and basic medical care (Hitchcox, 1990; Lundgren & Lang, 1989; Miller, 1996, 1994; UNHCR, 1997). For refugees who are resettled in industrialized countries, a lack of financial resources and a variety of barriers to employment often lead to an existence at or below the poverty level, with income barely sufficient to meet basic living expenses (Beiser, Johnson, & Turner, 1993; UNHCR, 1997). The adverse and often complex impact of poverty on mental health has been documented in numerous studies (McLoyd, 1990; Paltiel, 1987). For many refugees, the experience of poverty is colored by a previous history of self-sufficiency, access to land or other forms of employment and subsistence, and home ownership. Suddenly confronted with the overcrowded and extremely basic conditions of refugee camps, or with the recurrrent prospect of eviction from small, crowded rental apartments due to a lack of income for rent, basic survival issues may take on considerable salience (Hitchcox, 1990; Lundgren & Lang, 1989; UNHCR, 1997), and a powerful sense of loss may ensue as previous conditions of life are compared to those in which refugees currently find themselves (Von Buchwald, 1994).

Interventions that address issues related to poverty are the same as those already mentioned with regard to gaining environmental mastery and the development of new social and occupational roles. Job training programs, income generation projects, and occupational therapy for psychologically impaired individuals who wish to work but feel unable to do, all represent promising strategies. It is essential that we regard employment-related issues as pertinent to our work as mental health professionals; otherwise we risk overlooking the important role we can play in helping connect people to important job-related resources, as well as

helping to tailor existing employment-related programs to the specific psychological needs and challenges common to refugee populations. Given the significant impact of poverty and unemployment on mental health, efforts to link refugees to employment-focused resources should be regarded as falling very much within the domain of mental health professionals.

SUMMARY AND CONCLUSIONS

Psychotherapy can play a potentially powerful role in the healing process of those refugees who have access to it, when it is conducted in culturally sensitive ways that respect the particular belief systems and rituals of healing that people bring with them into exile. My point in this paper is simply that by itself, psychotherapy represents an inadequate response to the magnitude of the problem of psychological distress within refugee communities. Community-based interventions that make use of existing resources within refugee communities, and which are located in settings that lack the stigma of psychiatric clinics, hold great promise for extending the reach of mental health interventions. Such community-based programs in no way negate the value of traditional clinic-based services, and indeed can function as essential sources of linkage to such services for individuals and families requiring more intensive treatment. Particularly for survivors of torture who are initially reluctant to utilize Western mental health treatment, community-based programs may represent a critical first step in the difficult journey of psychological healing.

The other main point of this paper has been to highlight the essential role that community-based interventions can play in helping refugees manage the highly stressful constellation of exile-related variables that impact their well-being on a daily basis. In this regard, clinic-based services such as psychotherapy and psychopharmocology can play an important adjunctive role, helping highly distressed individuals to more effectively engage in community programs by reducing the painful and intrusive symptoms of trauma and depression.

The ongoing stressors of exile create very real and often very persistent distress, and it is therefore essential that we not limit our focus to healing those wounds rooted in the violence and destruction of the past. By complementing traditional clinical strategies with community-based interventions such as those described in this paper, I believe we can develop a more comprehensive approach to refugee mental health, one that neither negates the value of psychotherapy and other clinical services, nor places them at the center of our intervention model.

ACKNOWLEDGMENTS

The author wishes to express his appreciation to Stevan Weine, MD, and Ira Moses, Ph.D., for their invaluable feedback on an earlier version of this manuscript.

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