



Original Article

A Culturally Informed Trauma Therapy Approach for Muslim Refugee Families

Emel Genç¹

Bartın University

¹ Emel Genç, Ph.D., Bartın University, Department of Psychology, Kutlubey- Bartın, Turkey. E-mail: gncemel@hotmail.com

Abstract

Refugees arriving in western countries from predominantly Muslim countries, who have already been exposed to severe traumatic experiences in their country of origin, experience further stress during the resettlement process in the host country. Although the number of Muslim refugees is increasing in the U.S. and Europe, the existing literature is not yet adequate to determine which treatments are effective for traumatized Muslim refugee families. Since inappropriate treatment approaches for this population may result cause ineffective or even negative therapy outcomes, this study aimed to develop a culturally responsive treatment model. Specifically, it offers an integrated family-based therapy approach for refugee families, which is influenced by narrative, art, and narrative exposure approaches. This integrated family therapy model consists of 12 weekly sessions in four phases: a) diagnostic interview; b) narration of the life story; c) exposure to the trauma; and d) re-narration and reprocessing of the traumatic events. Future studies should test the feasibility and effectiveness of this integrated model with randomized controlled trials as the implementation of such treatment models is essential for developing a culturally sensitive treatment model for Muslim refugees.

Keywords:

family therapy • Muslim refugees • narrative exposure therapy • refugee trauma • trauma treatment.

Müslüman Mülteci Aileler için Kültürel Olarak Bilgilendirilmiş Bir Travma Terapi Yaklaşımı

Öz

Ağırlıklı olarak Müslüman ülkelerden gelen mülteciler, ülkelerinde ciddi travmatik deneyimlere maruz kalmaktadırlar. Ayrıca göç ettikleri ev sahibi statüsündeki ülkelerde yeniden yerleşim sürecinde yaşadıkları stres devam etmektedir. Amerika Birleşik Devletleri ve Avrupa'da, Müslüman mültecilerin sayısı artsa da, mevcut alanyazın, travma deneyimi olan Müslüman mülteci ailelere yönelik tedavinin etkinliği hakkında bir sonuca varmak için yeterli değildir. Bu popülasyon için yetersiz ruh sağlığı desteği yaklaşımı, olumsuz veya etkisiz ruh sağlığı hizmetleri ile sonuçlanabilir. Bu nedenle, bu çalışmanın amacı Müslüman mülteci ailelere yönelik kültürel olarak duyarlı bir tedavi modeli geliştirmektir. Bu amaçla, bu çalışma mülteci aileler için öyküsel, sanat ve öyküsel maruz bırakma yaklaşımlarından etkilenen sistematik bir aile temelli terapi yaklaşım modeli sunmaktadır. Önerilen bu aile terapisi modeli, haftalık 12 seans ve 4 aşamadan oluşmaktadır: a) tanışıl görüşme, b) yaşam öyküsünün anlatılması, c) travmaya maruz kalma ve d) travmatik olayların yeniden anlatılması ve yeniden işlenmesi. Müslüman mültecilere yönelik kültürel açıdan duyarlı tedavi modellerinin geliştirilmesi onların travma tedavilerinde ve ruh sağlığını ele almak gerekli olduğundan, gelecekteki çalışmalar randomize kontrollü denemeleri kullanarak bu çalışmada önerilen entegre modelin etkinliğini test etmelidir.

Anahtar Kelimeler:

aile terapisi • Müslüman mülteciler • mülteci travması • öyküsel maruz bırakma • travma tedavisi.

Corresponding author:

Emel Genç, Ph.D.

E-mail:

gncemel@hotmail.com

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Refugees are groups of people forced to flee from their countries to escape human rights abuses and physical and emotional distress (United Nations High Commissioner for Refugees [UNHCR], 2006). There is an increasing number of refugees who have experienced traumatic incidents during persecution within their country of origin, migration, and resettlement process in the host countries. Refugees' basic rights are violated in several countries, and many refugees have been exposed to one or more horrific traumas, such as rape, war, terrorism, persecution, political repression, ethnic cleansing, abject poverty, starvation, and genocide (Lies et al., 2020). Currently, more than 35 million displaced and stateless people are seeking asylum (UNHCR, 2019). These include many asylum seekers from predominantly Muslim countries fleeing from civil war or persecution. Currently, there are 25.8 million Muslim refugees in Europe, and this number is expected to grow in future years (Pew Research Center Report, 2017).

Muslim refugees from non-western countries like Iraq, Syria, Afghanistan, and Palestine suffer from prolonged trauma as a result of exposure to warfare, political torture, displacement, and separations from family members before migrating (Matos et al., 2022; Spaas et al., 2022). Although resettlement seems the best option to provide a safe environment, many refugees pay high costs, including the stress of adjusting to a new country, discrimination, financial insecurity, and educational and occupational struggles (Shedlin et al., 2014; Spaas et al., 2022). Refugees also face loneliness and a lack of social support, which may lead to mental health issues (Liang et al., 2019). Moreover, in most western countries, refugees are not always treated with respect. Instead, they may be confronted with racial prejudice, xenophobia, or islamophobia (Cratsley et al., 2021; Fozdar, 2012). Due to such stressors, Muslim refugees often suffer mental health disorders, including sleeping problems, stress-related disorders, anxiety, depression, substance abuse, paranoia, and personality change (Lies et al., 2020; Müller et al., 2019; Shedlin et al., 2014). These psychological problems are usually compounded by the challenges of acculturation and adjustment to the host country (Tonui & Mitschke, 2022), as well as the added trauma of discrimination, racism, and Islamophobia (Fozdar, 2012). In short, all these factors can add to the stress of migration to make refugees more vulnerable to mental health issues.

Various treatment models have been developed to work with PTSD in refugees. Several qualitative and single-case research studies confirm the effectiveness of these models. However, not enough studies have focused on Muslim refugee families. Therefore, although some evidence-based treatment models have been culturally adapted for this population, there is not yet enough evidence to determine whether such treatments are effective for traumatized Muslim refugees. While working with this population, a lack of information about their beliefs, culture, and values may lead to ineffective or even negative therapy outcomes and increased stress or severity of trauma (Tanhan, 2019). Thus, there is an urgent need to develop effective culturally sensitive treatment models for Muslim refugees that integrate their cultural values and past experiences with their present reality.

Treatment of Refugee Trauma

Many trauma interventions have been developed to reduce post-traumatic stress symptoms, such as trauma-focused cognitive behavioral treatment (TF-CBT), narrative exposure therapy (NET), eye movement desensitization and reprocessing (EMDR), and testimony therapy (e.g., Nocon et al., 2017; Pfeiffer et al., 2019). However, these approaches are not specifically developed for refugees and do not overtly discuss the role of culture during trauma treatments (Genç, 2022). This is problematic because refugees seeking asylum in western countries encounter not just trauma but also problems due to their legal status, such as uncertainty, discrimination, struggles with acculturation, loss of social status, and language obstacles (El Baba & Colucci, 2018; Dhalimi et al., 2018; Schmitt et al., 2014). These treatment modalities also fail to include the client's families or communities in the therapy (Voulgaridou et al., 2006). Therefore, new and more effective integrative services are needed for refugees to provide for their unique needs. Effective treatment models should incorporate relevant cultural features while new intervention programs should be developed to meet the specific needs of refugees by including the family and/or community in therapy.

In response to the lack of effective trauma models for refugee families, this study proposes an integrated family-based therapy approach, influenced by narrative, art, and narrative exposure (NET) approaches. These therapy modalities are driven by a cognitive-behavioral, testimony, and social constructionist theoretical framework. Specifically, NET draws on the trauma-focused cognitive-behavioral and testimony therapy model, specifically traumatic stress disorders (Schauer et al., 2011). NET aims to construct a detailed autobiographical demonstration of traumatic incidents to lessen trauma symptoms by confronting the traumatic memories and facilitating the emotional processing of traumatic memories. NET enables individuals to reconstruct their traumatic memories by developing a new narrative of past events. NET was developed by White and Epston (1990) from the social constructionist assumption that people construct knowledge and reality based on their experience, values, and culture. Accordingly, NET insists on exploring clients' subjective realities, meanings, and cultural discourse. Through this exploration, people reconstruct oppressive realities and formulate alternative stories. This gives individuals a chance to share their experiences and thoughts while others are listening, which allows all family members to be included in a family narrative. They can then construct a new narrative of their life story together.

The integrated family-based therapy for refugees proposed here includes the following themes: current conditions, previous life conditions before experiencing trauma in the country of origin, and escape from the home country. In the session, the clients discuss each family member's point of view, role changes, social network, and thoughts of the future, and coping strategies in the family. Such family sessions enable all family members to participate and share their experiences and thoughts in front of

the whole family. Another goal of therapy is to help the family construct a narrative of their life story. Considering the increasing number of refugees, their living conditions, and the challenges of being Muslim in non-Muslim host countries, a culturally adapted treatment approach is a need for this population. To provide a guide and help mental health workers working with Muslim refugee families, the current study proposes a culturally informed trauma therapy approach for this population.

Integrated Therapy Approach Phases

Phase 1 (Establishing therapeutic alliance and assessment). This phase focuses on the diagnostic interview, psychoeducation and developing a working relationship, and helping the family feel safe. The therapist's role in this phase is to establish rapport and be effective (Bemak et al., 2002).

This phase also includes psychoeducation, normalization of the family's experience, and explaining the therapy process. In psychoeducation, the therapist explains normal common reactions to trauma, the nature of PTSD, and the reasons for the symptoms. The therapist then describes the therapy process and what the client should expect. This phase prepares the clients for the stress and arousal that they may encounter during the treatment.

Several gender-based cultural issues affect treatment with this population. First, Muslims, particularly males, generally act to maintain a positive family identity. Thus, displaying fragility or vulnerability may be seen as a sign of profound personal weakness (Genç & Baptist, 2019). Second, Muslim families are often patriarchal, so the father is seen as the leading authority figure in the family. Accordingly, it is critical to gain his trust and support to treat family members in sessions. If the father becomes withdrawn or feels isolated, he may withdraw therapy for the whole family. Therefore, the therapist must treat the father or oldest male in the family with respect and include them in all family discussions.

In this session, the therapist could apply the *Naming and validating the effects of trauma* technique with the family. Internalizing trauma narratives can lead to feelings of inadequacy, inability to cope, and incompetence. Naming and affirming the physiological and psychological impacts of trauma can help to combat these sentiments. It is a relief for people to understand that supposedly 'abnormal' feelings like frustration, irritability, numbness, being easily startled, over-protectiveness, nervousness, agitation, or specific concerns are associated with a trauma-stress response (van der Kolk, 2000). This factor influences how therapists approach the interpreting process by identifying the significance of particular words. The family reconstructs their own past while in the host-country environment by recounting unpleasant situations, events, thoughts, worries, and expectations with well-chosen

words and phrases. Various words can be used as cultural keys, particularly names that explain certain situations, life events, conventions, and behaviors. These elements may elicit emotional and linguistic responses from family members, which can help with therapeutic communication.

While doing therapy with Muslim families, the therapist should consider that Allah is the final arbiter of truth and wisdom, so it is to Him that one should turn for help and guidance. That is, Allah is seen as the ultimate helper (Sabry & Vohra, 2013). In Islamic cultures, individuals struggling with their parents or spouse can benefit from consulting a sheikh, so a mullah or imam (Islamic scholar) can be invited to the therapy session. The Islamic scholar's presence can help families construct their narrative by expanding family members' perceptions of reality in helpful ways (Genc & Baptist, 2020). Hadiths (i.e., religious statements, actions, and traditions of the prophet Muhammed) can also facilitate a shift in the family's epistemology. However, before integrating religious teaching into therapy, the therapist should learn how religious the family is, how they practice their religion, and whether the family believes there is a link between the presenting problem and their sinfulness or lack of faith (Hedayat-Diba, 2000).

Therapist role. It is important to note that the therapist should build a consistently warm, trusting, and positive relationship with family members before starting treatment (Genc, 2021). When working with Muslim families, the therapist may need to spend extra time and energy creating a therapeutic alliance with each family member. Therefore, before asking about family and personal problems, the therapist should first build a rapport. As Abi-Hashem puts it, "Inquire gently! Be patient. Do not demand information or put pressure on them to quickly disclose their issues or to completely describe their pain, needs, etc." (Abi-Hashem, 2011, p. 165).

Phase 2 (Focusing on trauma and autobiography). This phase begins the narration of the life story, which begins at birth and continues through the earliest traumatic incident to further sessions dealing with subsequent events. The goal is to learn about the different types of traumatic incidents and gain an overview of the family's life, which provides sufficient distance and space to reflect on both happy and terrible times. During this phase, the therapist uses the NET-based "Lifeline" exercise (Schauer et al., 2011). According to NET, survivors of complex trauma usually seem lost and have difficulty remembering traumatic events. The lifeline tool enables them to talk about distressing content.

For this exercise, the therapist rolls out a long piece of rope, ribbon, or string for each family member, with one end representing each family member's birth and the other end representing their future life. Each family members place two kinds of objects (stones and flowers) on the table to symbolize various moments in their lives. The flowers represent happy memories whereas the stones reflect humiliating,

challenging, and especially traumatic memories. By completing the lifeline exercise, family members symbolically present the emotional highlights of their life. They then write and read aloud a biographical and chronological overview of the timeline to the other family members.

Therapists must understand that although Muslim clients generally have a strong sense of family connectedness and unity, family members may feel embarrassed and uncomfortable expressing their concerns with other members of the family present in the counseling session due to fear of confrontation. Hence, Daneshpour (1998) suggests having individual sessions with each family member before family sessions in which the therapist can serve as a mediator.

Phase 3 (Telling the trauma story and creating new stories). This phase focuses on telling the trauma story, creating re-exposure to the trauma, and restructuring the story through narrative, art, and NET techniques. Once family members separate the trauma from themselves, the therapist can assist them to reconstruct and author their new story.

For traumatic cases, it is important to process the traumatic memories. NET therefore follows two main strategies. Firstly, the therapist guides the clients in imaginal exposure to the traumatic events and tries to activate the associated fearful memories. This aims to alter emotional and cognitive process through detailed investigations of traumatic events. Secondly, the clients re-evaluate and re-interpret the meanings and patterns of traumatic, negative, and fearful events. In exposure-based interventions, the therapist's role is critical at this point. Therapists must guide and assist the clients to remain emotionally engaged with the traumatic memories through positive regard, validation, encouragement, and emphatic understanding (Bragesjö et al., 2021).

During this phase, family members re-read the preliminary narrations of their life stories to activate traumatic memories and fears related to their trauma. In activating these memories and emotions, the major goal of the narrative and exposure model is to help the clients build new autobiographical memories about the past traumatic events (i.e., cold memories). In this phase, the clients also label and place the fragments of the networks of physical sensations, thoughts, and emotions (i.e., hot memories) until they are able to construct a new autobiographical image of the traumatic event that fits within the larger narrative of their entire life. While new autobiographical memories permeate further contextual information into hot memories, the fearful or traumatic memories progressively cool down. This allows family members to adjust the triggers linked with the hot memories (Schauer et al., 2011) and ultimately process the problematic stories so as to formulate a new story.

In further sessions, the therapist thickens the family's narration with more detail by asking more specific questions about the traumatic experiences. In this way, the

therapist helps the family members turn their memory fragments into words. This generally includes narrating traumatic incidents, re-experiencing emotions and trauma in greater depth, and labeling in more detail. The family members then integrate these details into their narratives. To activate hot memories the therapist uses various NET strategies, including telling stories, using metaphors, or asking direct questions about the client's sensory, cognitive, and emotional experiences during trauma as well as providing feedback on the clients' reactions and responses as they narrate their stories.

The therapist can use various *externalizing the problem* techniques (White & Epston, 1990) with refugee families, particularly art therapy techniques, such as drawing, coloring, and sculpting. Art therapy can also help the family to separate themselves from the problem. For example, directives such as “Draw how the problem looks to you” can encourage sufficient emotional separation for the family to observe and rethink the problem. Once family members can externalize the problem and consider it as a separate entity, they can start to redefine it as well as re-author their life story (White & Epston, 1990). For re-authoring, the family members firstly recognize the influence of their culture on their stories. They then reveal their dominant narratives that explain certain behaviors and thoughts within their culture. After this recognition of the dominant narratives in the family's culture, simple directives may help the family to find alternative meanings, such as “Draw your past, present, and future” or “Draw your ideal world”.

Narrative therapists generally use questions to access alternative meanings and information (Kiser et al., 2010). Through such questions, they how the problem has affected the family subsystems (e.g., couples, parents, and siblings/children) and the relationships and behaviors toward each other. Therapeutic questions also allow the family members to separate themselves from the impact of the traumatic events and form trauma narratives by reconstructing their dominant stories. Nichols and Schwartz (1998) use the following set of therapeutic questions:

- *Deconstruction question*: “What does trauma/stress whisper in your ear?”
- *Opening space questions*: “Has there ever been a time when that stress could have taken control of your relationship, but didn't?”
- *Preference questions*: “Was this way of handling thing better or worse?”
- *Story development questions*: “How is this different from what you would you have done before? “Who will be the first person to notice this positive change in you?”
- *Meaning questions*: “What does it say about you that you were able to do that”
- *Questions to extend the story into the future*: “What do you predict for the coming year?”

These therapeutic questions can be continued through drawing a ‘progressive story’ on the wall or a poster, or by mapping. Through these techniques, the family can visualize the problem, discover unique outcomes, develop a new story from these outcomes, produce negative images of the self and create alternative positive images, and highlight positive changes.

Cultural components of phase 3. While *Storytelling* is a common technique in narrative therapy, it is a particularly characteristic tradition in Islamic culture (Voulgaridou et al., 2006). Muslim refugee families usually recall their homelands with nostalgia while extended family members assemble to tell each other traditional stories. The subjects of these stories are generally people who have led remarkable or instructive lives. That is, they present outstanding life histories as models for overcoming difficult situations and circumstances in life. By using such stories, the therapist may access and activate the family’s resilience and belief that they have the knowledge and ability to control the worries and fears stemming from their own hard times. The therapist can then use *story development questions*. These ask the family members to explain the process and aspects of their experiences and relate them to a timeframe. Through this practice, the family may gain a better understanding of how to challenge the constraints of the chosen story.

Another commonly used technique in narrative therapy sessions is *family-generated metaphor* (Methieson et al., 2018) as a nonthreatening way to talk about emotionally complex issues with Muslim refugee families. The metaphor is a unique linguistic expression that conceals an interior meaning under the surface of language and represents a certain culture. It can represent a request, a plea for sympathy, or listening to a fear or conviction that deepens therapeutic conversation (Kornhaber et al., 2006). Thus, the therapist should be careful not only of the meaning of the metaphors but also of the style in which they are communicated as the problems that families bring into treatment cannot be understood without consideration of their cultural trials.

Therapist role. Throughout the process of reconstructing a narrative, family members must feel supported while re-experiencing and reporting their traumatic experiences. The therapist provides an audience and witness to the family’s ordeals (Schauer et al. 2011) and helps the family to write and/or draw their story, but without developing a new story for them.

Phase 4 (Termination, relapse presentation, and future orientation). The aim of this phase is to narrate and reprocess the events in chronological order by rereading and signing the family members’ narrative documents by discussing their future. The therapists also assist the family members to identify and discuss their present and future worries, hopes, goals, and expectations to create new meanings for their stories while recreating and reframing their past.

While working on future hopes and goals with Muslims, therapists should explore whether future expectations are linked to Islam. Since each expectation or hope has both an enduring inclination and future inspiration, the metaphysical element of the will of Allah is involved in this particular form of imagination. Many Muslims have a fatalistic interpretation of life, based on the belief that everything happens because Allah wills it, as in the Arabic saying “Inshallah” (God willing). The family may thus consider that one must accept life as it is since Allah is responsible for everything. Hence, some clients may think that only Allah can make a difference, and that they are powerless and incapable of making changes to benefit themselves. In this case, the therapist may then question the concept of free choice and self-determination with the family, using the following saying in the Holy Qur’an: “God does not change people until they change themselves”.

In the last session, *Audiencing* (White & Epston, 1990) can be applied, which aims to acknowledge and encourage the family’s efforts. The therapist plays a critical role as an enthusiastic audience, applauding the family members’ efforts, and enacting a preferred story. The therapist also writes letters to each family member, which predict their outcomes, list their accomplishments, and encourage them to take further action. These letters also be used as letters of reference that clients can show to others who are interested. Letters also have a symbolic purpose. That is, they not only record the re-authoring assignment but also provide physical evidence of support and interest.

After giving each family member a copy of their narrative letter, the therapist processes their reactions as well as any feelings about termination. Lastly, the therapist must confirm that the family has achieved closure and that the trauma narrative no longer causes acute emotional arousal.

Implications

The increasing presence of Muslim refugees worldwide requires religious leaders, policymakers, trainers, and mental health providers to respond by designing and implementing appropriate services for this population. The development of culturally adapted evidence-based practice treatment models would help to facilitate healing and trauma recovery. Thus, more practice in the field and experimental studies are needed to evaluate the effectiveness of new models. In addition, it is important to train mental health providers to improve their knowledge about Islam and Muslim culture as well as gain cultural awareness. Relatedly, providing supervision to mental health providers would reduce their anxiety and increase confidence while working with this population. Religious leaders, including imams, priests, or clergy, can play an important role in making this particular population feel accepted into their host society. Specifically, religious leaders and scholars could use the khutbah (the sermon) to draw local people’s

attention to the refugees' problems and inform them about how they treat refugees based on Islamic rules. Lastly, policymakers could introduce more humanitarian policies for this population to improve their living conditions. Finally, laws should protect Muslim refugees from hate crimes, including Islamophobia and xenophobia.

Limitations and Future Directions

While this study provided a model to guide mental health providers while working with Muslim refugee families, there are some limitations. First, the proposed model has not been tested and may not work effectively in practice. Thus, randomized control studies are needed to assess the effectiveness of the proposed model. The second limitation is that the current needs of Muslim refugees were not analyzed before developing the model. Thus, qualitative research using in-depth interviews is needed to explore the unique needs and expectations of Muslim refugees regarding mental health treatment. This would provide more appropriate interventions and better alternative treatment models for this population. Lastly, research is needed to determine the long-term effects and sustainability of the proposed treatment model's interventions. Therefore, future studies should include follow-up sessions.

Conclusion

Trauma therapies have been proven to be effective and expressive therapies have become popular among refugee populations, specifically. However, these existing therapy models should be adapted to Islamic culture to ensure that traumatized Muslim refugees are treated effectively. Within the proposed integrated approach, the family therapist is interested in how the family forms and conceives reality, as well as how family members communicate in their narratives. The therapeutic interventions are also sensitive to the family members' perceptions and beliefs about their own refugee experience. To grasp the complexity of the family system and tie together the family stories, it is vital that the therapist acquires a complete picture of the family and listens to each member's point of view. This can help increase the family members' ability both to cope with their past trauma and adapt to their host society. While we believe this model can usefully be applied in treating refugee families, further studies are needed, specifically randomized controlled trials, to fully investigate the model's effectiveness.

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