CSVR

Centre for the Study of Violence and Reconciliation

Guidelines for clinical work with migrant African families affected by complex and continuous traumas

Acknowledgements

Recognising that the CSVR is a learning organisation, these guidelines should be recognised as having developed over many years of working with families. This includes acknowledging past authors, interpretors, clinical team members, supervisors as well as consultants who contributed to the previous version of the family guidelines; namely, CSVR's Guidelines for Improving Family Outcomes. This includes Monica Bandeira, Nataly Wollett, Ashleigh Kater, Boitumelo Kekana, Celeste Matross, Gezina Hoxobes, Gugu Shabalala, Jacqui Chowles, Marivic Garcia, Malose Langa, Sumaiya Mohamed, Thembisile Masondo, Helena Lund, Judy Ramsden, Laila Jacobson, Sophia Combrink, Tina Ammundsen, and Vinitha Jithoo.

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The Centre for the Study of Violence and Reconciliation has worked with families since the early 1990s. Whilst great learnings and changes have occurred in its work with families, it is only in the last few years that CSVR has attempted to document the ways in which its clinicians have worked with migrant families affected by complex and continuous traumas.

These guidelines provide an overview of the history of CSVR's work with families, its overall process of working with families, as well as the broader themes that have emerged in working with different family members. While these guidelines were developed as a means of capacitating incoming psychosocial professionals (clinicians), it is hoped that the guidelines can also be utilised by those who offer mental health and psychosocial support (MHPSS) services to other vulnerable groups affected by complex and continuous traumas. This could include groups affected by the intersection of vulnerabilities such as nationality, poverty, health status, inequality, marginalized gender or sexual identities, educational outcomes and so forth.

Furthermore, as a learning organization, it is hoped that these guidelines take on the form of a living document, which can be revised as new learnings and themes emerge in CSVR's work with families.

1. About CSVR

CSVR was established in 1989, initially under the name of 'Project for the Study of Violence'. CSVR is a multi-disciplinary institute that seeks to understand and prevent violence, heal its effects, and build sustainable peace at community, national and regional levels. It does this through collaborating with and learning from the lived and diverse experiences of communities affected by violence and conflict. Through its research, interventions, and advocacy, CSVR seeks to enhance state accountability, promote gender equality, as well as build social cohesion, integration, and active citizenship. While primarily based in South Africa, it works across the African continent and globally through collaborations with community, civil society, state, and international partners.

2. CSVR clinic history

Whilst attempting to understand and engage with different forms of violence, CSVR initially focused on the political violence and trauma that was prevalent as South Africa transitioned to democracy. Recognizing the effects of this violence and trauma, trauma experts from the University of the Witwatersrand were approached to work with youth in Soweto, Johannesburg, who were either involved in or experienced political violence. The CSVR clinic was established to work with these youth, through school-based youth programmes, as well as individuals who had experienced high levels of violence within their communities. CSVR's understanding of trauma developed through this work and contributed to the organization supporting those who testified during the country's Truth and Reconciliation Commission (TRC).

As this clinical work progressed, CSVR recognized that South Africa (SA) was also a major destination for those fleeing from the political violence and other human rights violations that were happening across Africa in the 1990s – particularly the Great Lakes region. Recognizing the high levels of trauma and difficulties experienced by this vulnerable and marginalized population, the Rehabilitation and Research Centre for Torture (RCT, now the Danish Institute Against Torture, DIGNITY) supported CSVR in conducting an epidemiological study of torture in South Africa as well as the organisation's needs. The results of this research culminated in RCT funding CSVR's direct service provision, to victims of torture, from 2002 to date.

3. CSVR clinical work with families

While offering school-based youth programmes and individual counselling to those affected by political violence and torture, CSVR could not overlook the systemic nature of violence and torture; that is, how trauma proliferates from the individual level of the victim or perpetrator, affecting families, friends, communities, and broader society across time. At the time, CSVR clinicians often received requests for counselling and support from parents, whose children were reached through school-based youth programmes, as well as individual clients, who asked clinicians to work with other family members.

Having clinicians from diverse disciplines, whose training included working with families, CSVR worked with couples as well as families with children of different ages. CSVR clinicians would often work in teams to conduct family and play therapy, with their work being supervised by psychologists and social workers experienced in approaches such as conjoint[i] as well as structural family therapy[ii].

The process of developing and documenting CSVR's guidelines for working with families commenced in 2015 and included collecting, analyzing, and integrating information from interviews with clinicians and family work supervisors, documents on CSVR's clinical work, as well as all family intervention process notes compiled by clinicians since 2014. The process culminated in the development of the 2018 report entitled, Centre for the Study of Violence and Reconciliation (CSVR): *Guidelines for Improving Family Outcomes*[iii]. This report highlighted important key considerations in working with families, themes which emerged through process notes, the identification of four subgroups for family work (children under the age of six, working with teens through groups, individual parents, and parental couples), evidence-based approaches as well as content for working with these subgroups.

Whilst many of these aspects were important, the CSVR clinical team noted that these guidelines required some revisions. This included the need to reduce the number of recommended materials for working with different subgroups to those that were more contextually viable – including considerations around client population, budget, and training requirements. The sections that follow include an integration of aspects from these initial guidelines for improving family outcomes as well as new additions.

4. Revised guidelines for clinical work with families

Before moving into the revised guidelines, it seemed important to provide readers with a sense of the demographics or characteristics of the families that CSVR clinicians have worked with as well as details around CSVR's clinic and clinicians.

4.1. CSVR family clients: Demographics

CSVR recognizes that there are multiple definitions and variations of what or who constitutes a family. Factors such as nationality, culture, religion, socioeconomic status and so forth influence levels of collectivism and identified boundaries or notions of family. CSVR recognizes that many clients may align with more collectivistic, extended definitions of family but that trauma, violence, and torture within their countries of origin, as well as forced migration, often results in the fragmentation of families. Most of the families that CSVR has worked with include parents and their children, which is more aligned with the definition of a nuclear family.

CSVR has completed several detailed overviews of its clinical work with families. This included an analysis of clinicians' intervention process notes (IPNs) completed between 2014 and 2017. These guidelines include an analysis of family IPNs collected between January 2018 and September 2019. CSVR worked with seventeen families during this period. This represented between 10 to 20% of CSVR's overall caseload.

In terms of their country of origin, fifteen of the families originated from the Democratic Republic of Congo, two families originated from Somalia and one family originated from Burundi. Related to reason for referral or presenting concern, many of the families presented with concerns related to previous war or forced migration trauma (such as war trauma, torture, sexual torture, or being wanted by the authorities for political reasons) and subsequent current stressors (unemployment, difficulties with documentation, housing, living conditions, safety concerns including experiences of xenophobia).

The number of family members in each family case varied between two and five family members. Forty-four percent (n= 7) of the families that CSVR worked with included work with two family members. This included work with parent-child dyads (for example, child play therapy and parental support) or parental couples work. A third of CSVR's family work (n= 5) included work with families with a total of four family members. In these family cases, the clinical work was likely to include working with a mother/ female caregiver and her children. The absence of fathers or male caregivers in work with children could be attributed to several factors. These include fathers not being able to attend sessions as readily, due to their attempts to find part-time or piecemeal employment; fathers not attending due to challenges with finding enough transport money for the whole family[1]; fathers missing or deceased; fathers potentially abandoning their

1. While CSVR attempts to subsidise family members' transport to and from the areas in which they live, there are times where families have no consistent income and are potentially forced to use whatever money they may have to meet their basic needs. This may contribute to some and perhaps not all family members being able to attend family sessions.

families due to the pressures and shame associated with not being able to provide for their families or fathers viewing difficulties with children's psychological well-being as being outside of their gender role expectations.

Related to types of interventions or work with caregivers, close to half (47%, n=9) of the adult/caregiver cases included couples counselling. This often involved working with couples on challenges in their relationship, which in turn, may have affected their relationships or ability to meet their children's psychological needs. Sixty percent of these interventions involved three or more sessions.

A quarter of sessions with caregivers included providing feedback on their children's counselling processes and working with emerging themes, whereas another 26% of sessions included working with caregivers through a holistic family approach, where caregivers received individual or couple's sessions in conjunction with their children's play therapy. As with couples counselling, 60% of parental work involved three or more sessions whereas family work often included more than eight sessions. Families involved in more holistic family work were more likely to be involved in more long-term interventions.

Focusing on work with children, CSVR worked with 21 children between 2018 and 2019. Two of these children were younger than 3 years of age, with the youngest being a 6-month-old involved in parent-infant psychotherapy. Half of the child clients (47%, n= 10) were adolescents whereas 43% (n= 9) were aged between 3 and 12. Overall, CSVR worked with an equal amount of male and female children.

CSVR clinicians have noted how caregivers often bring their children to the clinic due to a lack of childcare resources (basic needs or child-minding), behavioural or academic difficulties. Reasons for seeking support have rarely included considerations around how previous or current traumas have affected children's behaviour or well-being – with parents often viewing their children as being too young to understand or be affected by such traumas.

Related to number of sessions, the average number of sessions with children was nine sessions, with number of sessions ranging from 1 to 29 sessions. A comparison of age category and number of sessions highlighted that 33% of children aged 3 – 12 and 50% of adolescents were likely to continue play therapy or counselling for more than 8 sessions.

The number of children and adolescent clients, included in the above statistics, was based purely on counselling or clinic sessions. It should be noted that CSVR has developed mental health and psychosocial services (MHPSS) for working with children. This includes a 3-day holiday programme with children (6 – 9- and 10-14-year-old age groups) and adolescents (14-18 years of age), where topics such as emotional regulation and trauma are explored using techniques such as film, books, as well as children's yoga.

4.2. CSVR clinic: Current context

The CSVR clinic initially operated in Braamfontein, Johannesburg and expanded to include a satellite clinic in Pretoria in 2015 and Marikana in 2018. The clinic programme is overseen by a MHPSS programme manager. Six full-time clinicians or psychosocial trauma professionals and either one or two counselling psychologist interns offer clinical services such as screenings, intake assessments, counselling as well as trainings. Entry-level clinicians see 6 to 12 clients a week whereas more senior clinicians see between 15 to 20 clients a week. This caseload may include children between the ages of 2 and 12, adolescents, individual parents, couples or individual adult clients.

Aligned with CSVR's diverse client population, CSVR trained and currently works with nine sessional interpreters who, collectively, can interpret languages such as Amharic, French, Kirundi, Kinyarwanda, Lingala, Somali, Swahili, and Tigrinya. Interpreters also receive twice-monthly group supervision as a means of debriefing and discussing challenges or revisions needed in their work.

4.3. Broader themes in working with families

CSVR's 2018 guidelines for improving outcomes for clinical work with families included an analysis of themes emerging across family intervention process notes (IPNs), compiled between 2014 and early 2018. This included an analysis of 91 IPNs, covering 29 families, with 17 of the families being Congolese, 5 Somalian, 4 Ethiopian, 2 Burundian and 1 family of Rwandese origin.

In considering the broader themes that may emerge in working with families, it is also important to consider migrant (asylum seeker, refugee, and undocumented political migrants who may be undocumented due to challenges at the Department of Home Affairs) families' journeys. This includes thinking about family members' earlier experiences in their countries of origin, from their relationships with parents, siblings, peers and community members, through to their experiences with state institutions (schools, colleges, hospitals, police, other departments), officials and the state more broadly.

Considering families' journeys also includes considering the more proximal push and pull factors that contributed to their decisions to leave their home countries and travel to South Africa. Push factors may have included direct or vicarious experiences of state violence – such as political intimidation or imprisonment, torture or marginalization due to identity (e.g. ethnicity, religion or sexual orientation), civil violence or war, as well as unemployment and the economic consequences of decades of violence and political unrest. Pull factors may have included their expectations of greater safety and economic opportunities in South Africa, given that the country has one of the strongest economies in Africa and a stable, democratically elected government.

However, it is also important to acknowledge the positive or important resources that families may leave behind in their countries of origin. This can include social resources such as direct family members, in cases where one family member (often a husband or father) leaves for South Africa before the rest of the family or they are missing or murdered, extended family (such as parents, grandparents, siblings, aunts, uncles or cousins), close friends, neighbors or community members. These resources also include physical, political and economic resources such as university qualifications, land, citizenship and forms of identity such as culture or nationality.

Following pre-migration experiences, family members' experiences of fleeing or moving from their countries of origin to South Africa is another important aspect of their journeys. For many families, the migration experience may have involved a partner or parent fleeing or leaving for South Africa, not hearing from this family member for weeks or months and potentially only seeing this family member again after years. For other families, the decision to move may not have been one for which they had a great deal of time to prepare, perhaps fleeing from civil war or imminent political persecution with little to no money and just the clothes on their backs. The journey from their countries of origin to South Africa may have taken many days, weeks or months and due to their vulnerability, may have involved exposure to additional traumas, such as physical and sexual violence or other forms of exploitation.

When entering through any of South Africa's ports or borders, all asylum seekers would need to apply for asylum seeker status. After receiving a section 23 permit, an asylum seeker would then have up to 14 days to report to the nearest refugee reception area (designated Home Affairs office) and apply for asylum seeker status. Whilst certain identifying documents may be required, those seeking asylum in South Africa are often provided with asylum seeker status (a section 22 permit) which provides them with up to 6 months whilst a decision around refugee status is being determined. However, due to the high number of refugee applications, the backlog with processing applications (close to 250,000 waiting for refugee application interviews or appeals), as well as corruption within the Department of Home Affairs, many migrants have been forced to renew their asylum seeker permit, every six months, for multiple years.

Due to South Africa's non-encampment policy, those who have attained asylum seeker status are then seemingly free to find work and a place of residence. Whilst many family members may have heard of the promises of South Africa and its major cities, they often enter a country and cities that require a great deal of adjustment and acculturation. This can include family members adjusting to being surrounded by people who speak multiple and vastly different languages and a need to adjust their expectations of their lives in South Africa against the realities of being an asylum-seeker in a country that has many of its own challenges.

Whilst some asylum seeker family members can find more regular sources of income in South Africa, many more struggle to find employment, often due to their asylum seeker status. Whilst South Africa's constitution provides asylum seekers the right to work in South Africa, there is a great discrepancy between what the country's laws state and what asylum seekers

experience when seeking employment. Whilst this may be due to a lack of awareness around the law amongst employers, high levels of unemployment contribute to xenophobic attitudes towards non-nationals competing for unskilled and semi-skilled forms of labour. Without access to regular, formal, and regulated employment, many migrant job seekers are exposed to unregulated and often exploitative labour practices – where migrants are paid well below South Africa's minimum wage of R17 (1USD) an hour or not paid at all. Furthermore, without strong social networks or capital, many migrant families face regular and repeated current stressors. The first of these current stressors includes extreme poverty, with families living on less than or close to 2USD a day. In major cities such as Johannesburg or Pretoria, this means that many migrant families do not have the means to meet their most basic human needs for food, shelter, security, education, or healthcare – with a basic single room dwelling alone costing about 2USD a day. Whilst some migrants receive financial support from family in their country of origin, this is not the norm. In fact, many migrant job seekers may be further stressed by the expectation of sending money back home, given that they have moved to the "New York of Africa".

Another current stressor that migrant families experience is that of safety concerns. This includes concerns about being mugged on the streets or when using trains. Whilst South African citizens are also likely to be victims of such crimes, migrant family members are more likely to be targeted and treated more aggressively due to xenophobia – where non-nationals are viewed as stealing South Africans' jobs or partners. A recent men's safety group, held at CSVR, suggested that migrants may be victims of such crimes on a monthly basis. However, concerns around safety are often a concern for all family members and often contributes to or exacerbates symptoms of post-traumatic stress – such as hypervigilance, re-experiencing, avoidance, and difficulties with sleeping. Whilst the symptom of hypervigilance might be considered abnormal, it can perhaps also be viewed as an adaptive response, given the contexts and high levels of crime to which family members are exposed.

Institutional xenophobia and a difficulty accessing important services is an additional current stressor faced by many migrant families. This includes instances of failing to receive timely, rigorous or quality healthcare at clinics or hospitals due to their being viewed as draining or burdening an already strained healthcare system. Poor service delivery or xenophobic remarks may also be experienced when attempting to report crimes. In such instances, family members may experience secondary victimization and traumatization following their being victims of crime.

When migrant family members come to hear about the CSVR clinic through CSVR community outreach or awareness-raising events, community screenings, strategic partners or referral networks or through word of mouth. These initial meetings often highlight the high levels of anxiety, frustration, hopelessness, and other difficult emotional states that many family members, especially caregivers, experience. CSVR clinicians have noted how these current emotional responses to current stressors are often tied to the interaction between previous unresolved traumas as well as current traumas – where previous unresolved traumas may make it more difficult for family members to cope with, manage or solve select current stressors. Psychological conditions such as complex post-traumatic stress, major depression, personality organisation and psychotic symptoms have also been noted. Family members' emotional and psychological well-being affects their levels of functioning or ability to carry out different roles and responsibilities in their lives. This, in turn, affects other family members, family functioning, and the roles and responsibilities that need to be fulfilled.

Additional areas of family functioning affected by family members' physical and psychological well-being include frustration tolerance, communication, mentalisation, and discipline. Parents or children who are struggling with their psychological well-being may find it more difficult to regulate their emotions, deal with frustration or stress. This can contribute to a difficulty in mentalising[2], recognizing family members' psychological state or needs, increased levels of conflict within the home and challenges with discipline.

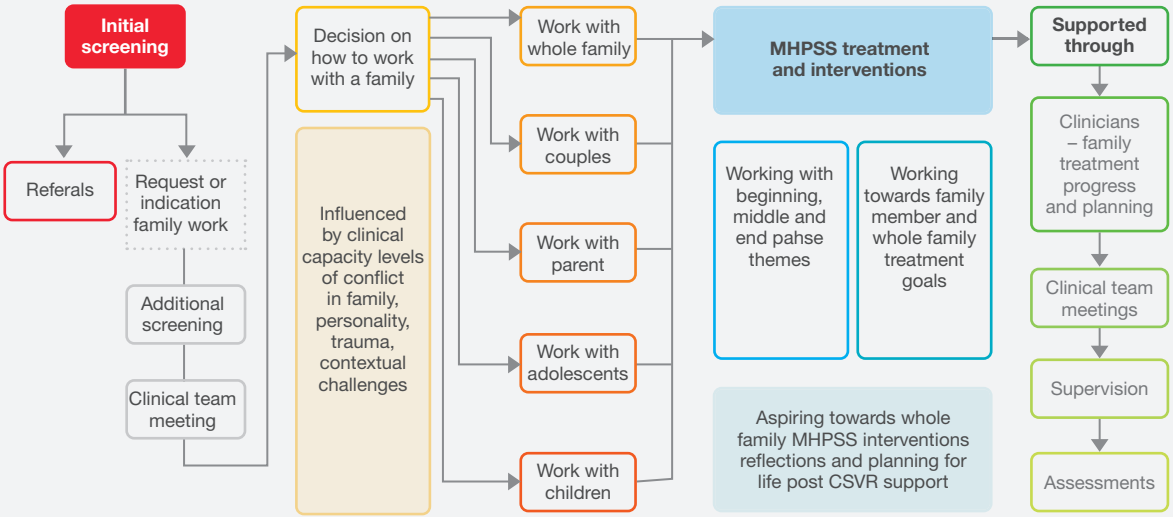
Whilst discussing the challenges that families experience, CSVR clinicians have also noted family members' resilience or the resilience and resources within families. Families' current stressors may ebb and flow over time, which contributes to periods of improvement in individual and family functioning. These better periods as well as the often inextinguishable hope to which some family members hold, assists families in getting through the much more difficult times that they experience. Whatever social capital or relationships that family members may have outside of the home also represents a valuable means of coping with periods of far greater stress. This social capital can include CSVR clinicians and the other service providers that families may turn to when crises arise in their lives. Finally, as is noted across the world, some family members' spirituality or religious beliefs and their connections with people who share such beliefs, also represents a great source of hope and promise.

2. Greater details around how family members' psychological well-being affects family functioning as well as the concept of mentalisation are provided in section 4.7.2.

4.4. Overall process of clinical work with families

Figure 1 highlights the different considerations as well as phases in working with families. The first step of working with families is to conduct an ***initial screening***. This screening (see appendix A for screening form) aims to collect information on a client's personal details, family details, referral details, presenting concerns (historical background), current stressors, as well as any history of trauma or torture. The screening is also utilised to clarify expectations around the services that CSVR provides as well as determine whether an individual meets CSVR criteria for clinical services. This decision is often based on whether the potential client directly or vicariously experienced torture, either in their country of origin or in South Africa, as well as any experiences of xenophobic or other forms of collective violence in South Africa.

Figure 1. CSVR overall process for clinical work with families



During this screening, it may emerge that a client's needs do not meet those which CSVR can attempt to meet; in which case, CSVR will refer the client to partner organisations – linked to the client's needs. When a client does meet the criteria, the client may request MHPSS interventions for multiple family members. In some instances, a client may not request family services but it may be apparent that the requesting client's challenges may have a more systemic concern or that there is a more familial concern that requires broader intervention. In such instances, the clinician may share thoughts around the systemic nature of the client's presenting concern or the potential for broader work with the family. The clinician also endeavors to provide the client with a sense of what such work could look like and that there will be a need to discuss the possibility of family work within a team meeting.

Whether the presenting client requests or a clinician suggests broader family work, the next step would be for the clinician to ask the presenting client to invite the other members of his/her family for ***additional screenings***. These additional screenings are held with each attending family member and are scheduled to meet both the clinician(s) and family members' schedules.

Details from the family screenings are then taken to a ***clinical team meeting***. During this meeting, a clinician will present the results of the family screenings and the clinical team will assist in discussing what may be the best ways of working with the family. This could include working with the whole family or splitting the family into sub-units to work with the children or adolescents in the family and/or work with a couple or single parent. Such decisions are influenced by the information attained from the family screenings, the clinical team's human resource capacity to work with different sub-units, levels of conflict within the family, family members' personality types and levels of functioning, family members' levels of trauma (for example, experience of physical or sexual torture) as well as the contextual challenges experienced by the family – where challenges such as a lack of finances, childcare support, work or school commitments may prevent some family members from attending MHPSS interventions.

If a decision is made to work with different sub-units or members of the family, each sub-unit will be allocated to a clinician. The clinicians working with the different family members will then form a team, which meets regularly to plan and discuss the potential systemic nature of family members' challenges or a family's progress towards family treatment goals. As confidential material is likely to be discussed in this space, it is important that clinicians discuss the roles of this team with family members. This includes that confidential material from individual sessions is only raised when it is thought to be important to assisting the family in moving towards its treatment goals.

Individual and collective family treatment goals are developed in the beginning phases of counselling and are also revisited every six sessions. Examples of individual or collective family treatment goals may include reduced levels of familial conflict, improved family functioning (e.g. roles and responsibilities), reduced levels of symptomatology or greater levels of perceived familial support.

Clinicians working with a family need to balance individual family member and collective family treatment goals, with the broader family treatment goals of improving family functioning, cohesion and flexibility being important guiding treatment goals. It is also important to note that these goals should be developed in a collaborative manner. In some instances, family members may have different treatment goals in mind and clinicians may have to work towards shared goals. A clinician may also view some areas of functioning (e.g. traditional gender roles) as a concern within the family but family members may not identify these areas as concerns or treatment goals. It may only be important to raise these concerns with a family or family members if it has a clear link to the challenges experienced in the family (for example, rigid

or traditional gender roles preventing a female partner from taking up more accessible work opportunities in a time where finances is a great concern for the family).

Another important aspect of the newly formed team is to carry out additional assessments to identify potential themes or concerns, as well as plan, monitor and evaluate progress towards collective family treatment goals. Whilst CSVR's individual assessment tool (IAT) may be useful, clinicians have noted how different assessments are also required in working with families. This might include utilising projective tests in working with children (e.g. the Draw a Person test or Kinetic Family Drawing to assess family dynamics), the Family Tree to assess communication, genograms to understand family history and patterns of interaction, family observations to assess family interactions, and so forth. Joint family sessions may also be held with a family, after every six sessions, as a means of assessing and discussing progress towards family treatment goals.

While the ***MHPSS interventions and support*** offered to families may vary, CSVR clinicians have noted important beginning, middle and end phase themes in working with families. The beginning phase of working with families continues to include initial relationship building with family members and working through themes encountered in early MHPSS interventions. As most migrant families are not familiar with counselling, themes in the early phases of working with families include an orientation to counselling that assists in clarifying roles and expectations as well as further discussing treatment goals.

In relation to client's expectations of counselling, clinicians have found that whilst they may spend time providing details around what services CSVR can and cannot provide, clients (caregivers) may continue to attend counselling in the hope that CSVR will directly or indirectly, through referrals, provide them with the resources that they require. This can contribute to clients feeling that clinicians are withholding resources or refusing to assist them and clinicians feeling frustrated with their clients' apparent resistance or unwillingness to explore other themes (e.g. torture or trauma impacts, impact of current stressors on emotional wellbeing).

A central theme of early sessions includes working with the current stressors or crises that caregivers are experiencing. This includes unemployment, extreme poverty, hunger, a lack of or poor accommodation, difficulties with documentation and related difficulties with access to services (e.g. schooling for children). Clinicians work with this theme in different ways. This includes sitting with or holding clients using microskills (see section 4.5) and reflections. Clinicians also work to determine if clients have experienced these stressors or how they may have managed them in the past. Where possible, clinicians will also refer clients to partner organisations that provide social, legal or other rehabilitation services.

It has been noted how clients may continue to focus on current stressors, which is understandable, given the fact that it is often difficult for CSVR, partner organisations or the South African government to assist with some of these stressors (e.g. extreme poverty, unemployment or

accommodation difficulties). CSVR clinicians identified two ways in which they attempt to work with clients who continue to bring these current stressors to counselling.

The first approach includes being mindful of client transferences or clinician countertransferences. Transference refers to instances where a client may unconsciously or unknowingly experience feelings associated with a previous person or experience but attributes or projects these feelings to the therapist (his/her demeanor, appearance, or actions). Countertransference refers to instances where a counsellor or therapist unconsciously or unknowingly experience feelings associated with a previous person or experience but attributes or projects these feelings to the client. This mindfulness may include reflecting on the client's helplessness and potential frustration with the clinician who appears to be withholding or not doing anything. It may also include the clinician's sense of being overwhelmed, exhausted, and frustrated with the client or the client's attempts to avoid sessions. Clinicians may reflect on these transferences in sessions or find appropriate times to share these observations with the client; for example, "maybe this is not something that you have said but sometimes it feels like you want me to help you get more money or a job."

These reflections also include the clinician's attempts to not get caught up in content but to continuously reflect on the therapeutic process or the potentially deeper, more symbolic meaning of the theme or transferences. Essentially, it includes an attempt to see the links between past experiences or traumas and current experiences and finding an appropriate means of sharing these links with the client.

An alternative approach identified for working with clients includes using much more structured sessions from the outset of counselling. This would include having 10-15 minutes to discuss continued or new current stressors, 30 minutes to focus on themes related to treatment goals and then 5-10 minutes allocated to any exercises or tasks for the week ahead.

The *middle phase* of working with families is considered to represent the period where the clinician(s) are working more closely on the individual and collective family treatment goals. Whilst not exclusive, this might involve working with previous traumas, the interaction between past and present experiences or symptoms, safety concerns, family dynamics, communication, parenting, discipline, and identity.

During the middle phase, clinicians working with a family may continue to meet with each other – personally or via team meetings – to share treatment updates, challenges, and goals. Clinicians also receive individual ***supervision*** from an external consultant – who has additional expertise in the areas of trauma, couples counselling, working with families or children – once to twice a month. These supervisions support clinicians in thinking about how to approach difficult themes (theoretically or practically) that may emerge with different clients or family members as well as offer a space for clinician debriefing and support. New insights developed through supervision can then be incorporated into a family member's case formulation, treatment plan

as well as the interventions utilized to support the family member and family. A clinician then provides an update on family clients, once a month, via a ***clinical team meeting***. The length of this update may depend on the case's complexity.

Whilst clinical team meetings represent a space to provide case updates, it is important to recognise the important multiple functions or roles served by this space. Clinical team meetings also represent a "holding space" for both clients and clinicians. Working with migrant families can bring about a sense of helplessness and feeling stuck which can, in turn, contribute to clinicians feeling overwhelmed or burnt out. Team meetings represent a space where clinicians are not alone in their work but rather have a space where they can draw on the diverse training, knowledge and experiences of other clinicians, to think about (mentally hold) their clients. By normalizing the challenges of this work, clinicians can also openly express their challenges without feeling a sense of inadequacy, judgment, or shame.

An analysis of recent family MHPSS interventions (particularly counselling) noted that the duration of the middle phase of working with families can vary greatly – with an average of eight sessions and up to over 50 sessions. Factors that influence the duration of treatment have included families' contextual challenges, expectations, as well as satisfaction with counselling and CSVR. Contextual challenges may include a client not having enough money to attend counselling (where transport money provided by CSVR may be used to meet basic needs), a lack of childcare services (where parents cannot transport their dependent children to counselling), a clash between a session date and a piecemeal job, or a client being physically unable to attend a session due to the physical and psychological effects of a recent attack (mugging).

The end phase of working with families may include decisions to discontinue interventions with family members who may have achieved individual treatment goals and perhaps continuing with other family members. This phase also strives towards reuniting sub-units of the family in whole family interventions that may focus on collective family goals that may require further attention.

In considering the discontinuation of MHPSS interventions, it may be important to recognise the recurrence of themes such as unresolved trauma, loss, hopelessness, and regression in terms of individual and family functioning. It can be important to discuss these with family members and reflect on potential ups and downs experienced in their progress towards treatment goals, what they may have learned from these experiences and how they can manage similar challenges in the future. Therapeutic tools such as family vision boards can assist in this process of looking back, looking forward, as well as identifying individual and familial strengths that may assist with future challenges.

4.5. Risk assessment and management

Assessing for and managing risk is an important aspect of working with families. The different forms of risk that clinicians have worked with include the risk of violence posed by a family member to themselves (e.g. self-harm or suicide), the risk of violence by a family member to other family members or others (e.g. gender-based violence, child abuse, femicide, filicide, homicide), as well as the risk of violence from others to a family member or the family. The latter form of risk has been noticed in instances where a family member or families continue to experience threats emanating from their ethnicity, former involvement in politics or journalism. The clinical team has utilised several tools or resources in their assessment and management of risk. Details of these tools or resources is included below:

- Suicide risk assessment training: This training is provided by the training institutions at which clinicians were trained as well as trainings provided to clinicians (interns) by internal supervisors at CSVR. This training includes suicide risk assessment, which assist clinicians in gauging whether clients are at low, moderate, or high risk. Low risk clients include those who report recent suicidal ideations with no specific plans or intent to act on their suicide plans. Risk factors may be low and protective factors high. These clients also have no history of previous suicide attempts; Moderate risk clients include those who have suicidal ideations and a plan but no intent to act on that plan. It is important to explore previous suicide attempts and risk factors; High risk clients include those who have suicidal ideations, a plan and intent to act on that plan, previous suicide attempts, behavioural characteristics such as impulsivity and a previous history or current state of psychosis with several risk factors and few protective factors.
- Psychotherapy/ counselling: The information or lived experiences that family members share through counselling often provide ample opportunities to assess for and manage risk. While the level of structure in sessions may vary, sessions may be structured to include regular assessments of risk when threats of violence are suspected.
- Team meetings and supervision: Section 4.4. highlighted the central role that team meetings and supervision play in case management. The central role that these spaces can play, in terms of identifying or managing risk, has also been noted by clinicians.
- Family consultations or assessments: In some instances, CSVR clinicians have noted that it can be beneficial to get a family member's permission to talk to other family members about the identified risk, behaviours or other factors. This can include bringing in a client's husband to see how he understands or may have responded to the risk (e.g. attempted suicide or GBV). Such sessions may also provide a sense of levels of support within the family, family functioning, current stressors, additional risks, and so forth.
- Safety planning: CSVR's individual African torture rehabilitation model[iv] highlighted eleven aspects to consider in working with families to respond to threats of violence. These aspects include working with family members/ families to identify different ways of assessing and minimizing risks, as well as different ways of responding to threats.
- Psychiatric consultations or assessments: The CSVR clinic has an established relationships

with WITS' Department of Psychiatry, community clinics as well as state hospitals. Through screenings and counselling, clinicians often refer family members for psychiatric assessments when it appears that they may benefit from medication for the treatment of conditions such as major depressive disorder, anxiety disorders, bipolar mood disorder, psychosis, or schizophrenia.

The CSVR clinical team identified several cases where multiple tools or resources were utilised to identify, assess, and manage risk. The first case included that of a male client, in his mid-forties, who received individual counselling at CSVR. After several sessions, the CSVR clinician noted that the client was struggling with severe major depressive disorder, which likely stemmed from multiple pre-migration traumas and current stressors such as unemployment, inconsistent piece jobs, chronic poverty, poor living conditions, and frequent muggings or assaults. During these episodes, there were instances where he was physically abusive towards his wife and would also experience suicidal and homicidal ideation. Part of this ideation related to his belief that death would be a kinder, easier path for himself and his family, given the huge, persistent challenges that they confronted.

Whilst initially reluctant, the clinician had developed a good-enough level of rapport with the client for him to recognize that a psychiatric assessment could be useful. A combination of medication and continued counselling, where the client also identified different coping mechanisms, assisted in reducing the frequency and severity of the depressive episodes. However, the client maintained that the medication increased his libido, which resulted in his wife falling pregnant, and so he discontinued the medication.

Current stressors persisted and the clinician suggested that his wife attend couple's sessions as a means of supporting his well-being and his family more broadly. The client refused, likely in fear that she would highlight his violent episodes, which would lead to him being arrested. His wife then approached CSVR, out of her own volition, mentioning the violent episodes as well as suicidal and homicidal threats. The clinician assessed these risks through a session, discussed safety planning, and then attempted to reassure the husband that they (husband, wife, and clinician) could work together to address challenges such as current stressors and mental health. However, the husband decided to discontinue counselling.

The clinician met with the wife for one session where she mentioned the ethical dilemmas/ conflict of interest in seeing her individually. The clinician mentioned that she would be able to see them for couple's counselling if they both agreed. Six months passed and the husband consented to couple's counselling. As the former clinician had moved into a management position, a new clinician was appointed to work with the couple. The clinician noted that conversations around the husband's mental health and threats of violence were taboo topics – where on one occasion the husband got visibly anxious and irritable when his wife mentioned these topics. Whilst recognizing the seriousness of the threats, the clinician aimed to explore how the couple understood the violence, what it meant, and how it made each of them feel. Whilst initially

difficult for the husband, the approach likely contributed to his feeling less demonized. The joint space also created a platform to explore some of the factors that contributed to familial stress, some of which CSVR could assist. These included an exploration of how gender roles and expectations, as well as difficulties with their children's education (registration), contributed to stress and conflict.

The clinical team noted several factors that need to be considered when assessing for and managing risk. The first of these is context. This includes the need to be particularly sensitive to the lived experiences of the families with which CSVR works and how these experiences influence their mental health, family functioning, as well as risks of perpetrating or experiencing violence. This includes being aware of factors such as institutional xenophobia and how such experiences may influence family members' perceptions of or ability to access services. In some instances, parents have been wary of accessing basic resources through social workers or through organisations where they may interact with social workers. This reluctance often stems from the fear of being viewed as neglectful or abusive parents and subsequently having their children taken away. It also includes being aware of the lack of social support or support with childcare that some families experience and how this may make it difficult for parents to access services such as counselling or in-patient treatment (e.g. a psychiatric evaluation).

Clinicians have noted how it is important to sensitize service providers to such lived experiences. Clinicians have facilitated such sensitization training or awareness-raising workshops with lawyers, nurses, social workers, and other service providers.

4.6. Monitoring family therapeutic outcomes

As a learning organization, establishing, monitoring, and evaluating families' progress towards desired therapeutic goals or outcomes is an important goal for CSVR. Whilst the screening and initial assessments provide valuable information around family demographics, background, previous traumas, social networks (capital), potential levels of depression and anxiety as well as coping, CSVR has also moved towards working with family members and families to identify individual and collective treatment goals.

It is hoped that this collaborative or participatory aspect to monitoring and evaluation can assist in clarifying the purpose of counselling, roles and expectations, as well as developing realistic expectations of what may be achieved through counselling. It is also hoped that such collaboration can contribute towards greater buy-in and family autonomy.

Detailed efforts at conceptualizing individual and collective treatment goals can assist in operationalizing these goals – that is, making it easier to track changes or progress towards goals over time. An example of a jointly developed goal could be that, through counselling, the clinician and family members would like to see less physical and verbal conflict in the home. A deeper discussion around what it would be like at home, if there was less conflict, could help to

identify the outcomes and indictors of progress towards this goal. The clinician and family could also discuss the steps that they could take, on a daily or weekly basis, to reach this goal. This could include efforts to develop more open communication (such as having family meetings once a week or parents setting aside 5 minutes a day to talk to each other and their children), setting up more time for family activities (such as playing cards or having storytelling time) as well as a list for family responsibilities (e.g. older children sweeping the house, doing homework or so forth). A clinician or member of the KLME team could then assist in developing a tool with a timeline and response scale (for example, in the last month, how often did you…) that families could complete once a month.

4.7. Overarching therapeutic approaches

4.7.1. Microskills

Microskills are the basic, practical techniques that form part of good communication in all relationships. Clinicians utilize these skills to support a client in feeling heard, understood and respected, which in turn contributes to building trust (therapeutic rapport) and assisting a client in sharing difficult experiences. These microskills are common across all different therapeutic approaches (for example, cognitive behavioural, person-centered, existential or psychodynamic therapy) and can be applied to work with both children and adults. These microskills, as outlined by Brems[v], are briefly discussed below:

- *Attending skills:* Attending refers to the focused attention that a clinician places on a client or clients during counselling or another psychosocial intervention. A clinician can convey this attention through both verbal and nonverbal cues and can focus on the same cues, expressed by a client, to better understand what a client may be experiencing. For example, clinicians can sit in an attentive manner or express themselves verbally, by saying “mmm”, as a way of showing attentiveness. Other attending skills include focusing on verbal and non-verbal congruity or confirmation where, as an example, a client will cry or appear sad when talking about a sad experience rather than incongruence or contradiction, where a client might laugh or appear unaffected when talking about a fearful or sad experience. Clinicians should also be aware of these same congruencies or incongruences, within themselves, during sessions.

- *Listening skills:* This includes listening in a way that provides clients with the sense that a clinician’s full attention is on them whilst the clinician also tries to pay attention to his/ her thoughts and feelings (self-awareness). Further details of barriers or ‘roadblocks’ to active listening are highlighted by Egan[vi].

- *Questions:* Open-ended questions as well as systemic inquiry assist in facilitating communication, assisting clients in sharing their experiences, clarifying assumptions or understandings as well as in developing new insights or understandings. Brems provides

examples of questions that can either facilitate or hinder clinicians and clients in these processes.

- *Responding:* Whilst clinicians do well to actively listen to clients, the ways that they verbally respond to their clients is another important part of clarifying information and assisting clients in feeling heard or validated. These response types include encouraging phrases (oh, alright, and then…), paraphrasing and restatements (summarizing what a client has shared), and reflections (which include summarizing what the client has said whilst also including observations on meta-communications such as body language or potential underlying emotions). All three response types can be powerful therapeutic tools though it is important that clinicians are comfortable with and can utilize all three at different points in treatment.

- *Empathic skillfulness:* A clinician's ability to develop empathy with a client does not rely purely on affective or emotional awareness but also cognitive and behavioural awareness. Brems' focus on clinician empathy helps to distinguish empathy from other traits such as sympathy, identification or 'warm fuzzy' clinicians and also highlights the skills and phases that can assist in developing empathic skillfulness. These distinctions between sympathy and empathy is important for CSVR's work and all practitioners who work with individuals, families and groups affected by multiple stressors and traumas. Whereas the sympathetic clinician would focus on or be consumed by removing pain and suffering, the empathic clinician would offer initial practical support (e.g. referrals where possible) but then focus on remaining emotionally present and working with such experiences therapeutically. For example, "When you came to South Africa five years ago you hoped that you would have a better life. The ways things are now maybe make you feel so disappointed and frustrated."

- *Working with thoughts and cognitions:* Whilst this section includes a great deal of detail, Brems highlights skills such as psychoeducation as well as reflecting on patterns or themes as important therapeutic skills. Reflecting on patterns or themes can include themes within a session or between sessions. For example, "two weeks ago you mentioned that it was so difficult to not be able to provide for your family. It seems like this is something that worries you quite a lot?" The clinician could then work to exploring this theme of financial provision or being the breadwinner in greater depth.

- *Working with affect and emotion:* Brems distinguishes between emotional awareness, experience, and expression and outlines the importance and potential processes that could be utilised in working with clients to improve emotional or affect awareness, experience, and regulation.

4.7.2. Psychoanalytic concepts

Sigmund Freud's collection of work can be viewed as a catalyst for theory and practiced within the fields of both psychiatry and psychology. In his theorizing on the development and structure of the psyche (mind), Freud[vii] introduced the concepts of the id, superego, and ego.

The id was thought of as the first part of the psyche and includes two opposing primitive, innate drives or impulses. These include the death drive, which includes the uncontrollable drive to destroy, as well as the life drive, which includes the drive for self-preservation or nurturance. Expressions or acts associated with the death drive include acts of violence whereas acts associated with the life drive include meeting basic needs[3] (eating, sleeping, finding shelter), childcare, and cooperative behaviour. The superego is thought of as the part of the psyche that has internalized social norms or standards learned first through interactions with primary caregivers and then through other individuals (e.g. teachers, peers…).

The ego develops almost in conjunction with the superego and acts as the mediator between the id and superego, searching for socially appropriate means of satisfying impulses emanating from the id. The ego can also utilize different defense mechanisms to manage intense anxiety stemming from conflict from the different parts of the psyche (internal conflict).

A person's impulse control, emotional regulation, decision-making, reality testing, work performance and quality of relationships would thus be viewed as an indication of a person's *ego functioning* or *ego strength*. Poor impulse control, decision-making and so forth could suggest the ego's difficulty in finding suitable opportunities for drive satisfaction (excessive drive frustration), a potentially weak or strict superego or the rigid use or lack of defense mechanisms to manage internal conflict.

CSVR has noted the application of the concepts of psyche and ego functioning in several cases. The first would be a family presenting with current socioeconomic stressors such as chronic poverty and underemployment. The real-world stressors experienced by this family contributes to reality anxiety (safety concerns) as well as neurotic anxiety, or the fear of self-preservation or survival (id – life drive) and potentially moral anxiety, stemming from social expectations or understandings of their current struggles. For a father, this might include moral anxiety, stemming from the superego, about not being able to meet the expectations of being a provider and protector for his family.

A difficulty in changing these socioeconomic circumstances may contribute to increased or prolonged anxiety (inner conflict) as well as a weakening of the family members' ego strength or functioning – especially if the family finds it difficult to change their circumstances or have inadequate coping or defense mechanisms. CSVR clinicians would work with such a family to explore these anxieties, including making them more conscious, as well as in developing healthy and diverse means of managing or defending against these anxieties. These coping mechanism

3. Meeting basic needs such as eating, drinking, and sleeping can be viewed as a part of self-preservation, especially when considering a stronger death drive and a person's lack of drive to meet these needs when suffering from depression.

or defenses may include containment, cathartic release (finding appropriate times to make the unconscious more conscious), reframing (developing different ways of understanding the difficulties – not as representing an internal flaw or failure), assistance with problem-solving (which can be hampered by poorer ego functioning), as well as referrals to organisations that may be able to assist with socioeconomic difficulties.

The clinics understanding of ego strength and functioning also assists in thinking about the therapeutic approaches that can be utilized with family members. Clients with weaker ego strength may struggle with depth approaches or techniques (e.g. interpretation), potentially showing resistance or difficulty with insight. Clinicians may be frustrated by this apparent resistance or lack of insight, but these can be viewed as the ego's way of protecting itself from information that could contribute to a psychotic break (close to complete loss of ego functioning).

The psychoanalytic concepts of transference and countertransference were also previously mentioned in the overall process of working with families. It can be important for therapists to recognize or be more conscious of these unconscious processes as making these processes more conscious can assist a client/ family member to work through previous unresolved traumas that may continue to impact different areas of the family member's life (e.g. relationships, self-esteem, mood and so forth). Likewise, counsellors who are attuned with their countertransferences may use these to better formulate/understand their clients or to work on their own unconscious, unprocessed traumas, or significant relationships.

4.7.3. Attachment theory

Attachment theory was proposed by John Bowlby[viii] in the late 1960s and focuses on the quality of the emotional bonds that a person has with other people. The drive for connectedness or an emotional bond (attachment) was thought to be innate and a part of our survival instincts. The reported or observed quality of a person's attachments to significant others (family and friends) was thought to develop from birth and was also strongly linked to a person's earliest relationships (parents or caregivers). Research contributed to the identification of four attachment styles including secure attachment, anxious-preoccupied, dismissive-avoidant, and fearful-avoidant.

Mary Ainsworth's[ix] strange situation test assisted in identifying toddlers' attachment styles to their primary caregivers. In this test, a toddler and primary caregiver went in to a strange or new room together. The toddler would be allowed to play freely or lead what happened in the room for up to twenty minutes. Thereafter, a stranger (usually a women) would come into the room and interact with the caregiver for up to 10 minutes. The caregiver would then visibly leave the room. The level of distress experienced by the toddler whilst the caregiver was out of the room (for up to 5 minutes), together with the toddler's response to the caregiver when he/she returned, assisted researchers in determining what type of attachment style the child had with his/her caregiver.

CSVR clinicians utilize attachment theory in their attempts to understand both children and adult clients' relationships as well as parent-child relationships. It is held that the attachment style or the quality of relationship between parents and their children can help to understand children's as well as parents' presenting concerns, risk, and resilience.

4.7.4. Psychodynamic concepts

The theory and practice of Donald Winnicott, Melanie Klein and Wilfred Bion is considered to fall within the broader psychodynamic or object-relations approach. Like Freud, these clinicians presented theories on the development of the human mind, all of which had a strong focus on early caregiver-child relationships and how these affect later personality development, relationships, and psychological functioning.

Whilst their theories present multiple concepts, CSVR clinicians often utilize Winnicott's[x] concept of *holding*, Klein's[xi] concept of *splitting* and Bion's[xii] concept of *containment* in their work with different family members. Holding refers to the physical and psychological acts performed by primary caregivers – from pregnancy, through birth and childhood – that contribute to a person's sense of internal and external experiences or stressors as being manageable. Whilst Bion's concept of containment is considered similar to that of holding, it focused more on how infants' project or put in to their mothers (primary caregivers) emotions which are intolerable. A containing caregiver should, in turn, take in and experience these emotions, attempt to understand these emotions or experiences and then give them back to the infant in a way that makes these emotions more tolerable.

CSVR's clinicians understand that clinical work often involves their conscious and unconscious willingness to take in, sit with, process and give their clients' experiences back to them in more manageable doses. This involves attempts to create a holding or containing environment (safe counselling space), being physically and psychologically present in their sessions, reflecting and working with clients to process their experiences and accompanying emotions. Examples of such holding could include gently and regularly reflecting on a child's play, body language or emotions during a session or a client simply feeling held by a clinician's ability to recall discussions from previous sessions and mentally connect these with content discussed in a current session.

Klein's concept of splitting essentially relates to a client's difficulty to integrate good and bad experiences or the good and bad parts of the self and others. This splitting is noted in many conditions including depression, anxiety, bipolar and psychosis. In the context of CSVR's work with families and victims of torture, this can include a difficulty in sitting and working with the positive and negative aspects of the self, partners or children, the idealization or denigration of the self and others (including clinicians), as well as a difficulty taking responsibility for one's actions.

4.7.5. Systems theory concepts

Ecosystemic or cybernetic as well as structural family therapy principles have also proven to be valuable in working with migrant families. These concepts include trying to understand behaviour or 'pathology' not at the level of the individual but rather as originating within the patterns of interactions between family members. Furthermore, given the levels of change and adjustment required by these families, the principles of feedback, rules and boundaries are also important. These concepts suggest that families may be resistant to change but that the contexts within which they find themselves require adjustment and the development of new roles, rules, boundaries or expectations.

An example of adjustments required by families include instances where a partner/ husband/ father has not been able to find employment and a partner/ wife/ mother then takes on the role of supporting the family financially. In CSVR's experience, gender roles and expectations can often make this switching of roles more difficult for families, especially in cases where these gender roles have largely contributed to men or women's identity or sense of self.

4.7.6. Concepts related to play therapy

Play involves any type of activity that an individual or individuals carry out for enjoyment. Play is often spontaneous (cannot be forced) and contributes to many areas of development or life – for example, cognitive, social, physical or psychological development or maintenance. As early as 1932, Mildred Parten identified different types of play, with more symbolic types of play commencing from about the age of two. Through symbolic types of play, children from as young as two can consciously or unconsciously communicate important information about their inner experiences or how they may have internalised traumas, relationships or other experiences.

There are several important concepts utilized in play therapy. The first is following the child's lead. Aligned with non-directive play therapy, the clinician should be directed by the child and his/her play; allowing children to name toys or objects, as objects can take on different uses and meanings. The second is that of tracking, where the clinician describes child-toy interactions, children's emotional state during play, their behavior, as well as sequences of play. A third concept is that of setting limits. These include communicating that children cannot harm themselves or the clinician or intentionally damage toys during play. These limits might be communicated where boundaries are close to being violated. When a toy could be broken, a clinician might offer alternative ways of playing with the toy as well as options – e.g. if you carry on hitting that toy against the floor it might break. Remember, toys are not for breaking. You can play with that toy in another way or I will have to take that toy away.

A fourth concept of play therapy involves returning responsibility or attempting to encourage children in their attempts to take on difficult tasks (e.g. opening a jar or container) and asking children if they would like to be helped rather than simply helping the child. This concept

relates to the concepts of scaffolding as well as building children's autonomy and sense of self-confidence.

Another concept relates to dealing with children's questions. Children can ask clinicians different types of questions prior to, during or after sessions. Whilst children's questions might seem naïve or simply curious, it is important for clinicians to consider underlying themes that might relate to these questions. For example, if children ask, "do other children play here" or "do you have your own children" could relate to children's sense of sibling rivalry, needing to compete for the clinician's attention, feeling special or important.

Similarly, the concept of assessing patterns in children's play suggests that many questions or types of play may not initially seem meaningful but keeping track of types of play, emotions or behavior may assist clinicians in identifying themes, within or across sessions, which may be more clinically meaningful. Different theories (e.g. object relations or Gestalt) can also be utilized to understand the potential origins and means of working with these themes. See Blom's[xiii] *Handbook of Gestalt Play Therapy* for a more detailed account of working with children from a Gestalt perspective.

4.7.7. Cognitive behavioural concepts

As with other psychological theories, cognitive behavioural therapy (CBT) emerged from Aaron Beck's dissatisfaction in working with depression from a psychoanalytic approach. Whilst CSVR clinicians do not work primarily from a CBT approach, CBT principles have been integrated in to work with children, adolescents and caregivers. CBT concepts that have proved to be useful have included the negative cognitive triad, cognitive schemas, core beliefs, intermediate and automatic thoughts as well as cognitive distortions.

The negative cognitive triad suggests that clients, who are struggling with depression, have negative views of themselves, their future and the world in general. Early difficult or negative experiences may contribute to an individual developing a negative self-schema, where the individual is prone to take in information that is likely to conform with or support existing negative views of the self to the exclusion of information that does not fit with this view of the self.

Core beliefs are strongly tied to cognitive schemas and include the early basic central ideas that an individual developed of him/herself, others, and the world (for example, I am worthless or unlovable or people are only worried about themselves). Intermediate thoughts include the attitudes, rules and assumptions that an individual utilizes when confronted with a situation (for example, I will be rejected or I should not ask for help). Automatic thoughts refer to the more spontaneous thoughts that arise when a person is confronted with a situation. These thoughts are often brief but also can be more conscious to an individual (for example, this is too difficult; this person does not care).

Automatic thoughts can be categorized within different cognitive distortions, which refer to common ways in which people may interpret situations or process information. There are up to fifteen cognitive distortions, some of which include polarized thinking ("things never go my way", "I cannot do anything right"), overgeneralization ("I could not get this right and I will never be able to get things right", "I did not get the job so I might as well stop trying), as well as personalization ("this is all my fault", "this would not have happened if I did not…").

Another important aspect of cognitive behavioural therapy and the cognitive triad is the belief that it is not the situation itself that affects how we feel and respond (behave) but rather the way that we think about a situation that affects how we feel and respond. This can be noted in the fact that people do not respond to the same situation in the same way. For example, while one client may think, "I am unemployed because I do not have the right documentation and no one will hire me with asylum seeker status", another client – with the same skills – may think, "having asylum seeker status is a challenge but I have found work before and I have skills that people need".

Identifying and working with the way that a client may think about and make meaning of a challenging situation requires balancing empathy, sitting with or holding (acknowledging) the real challenges associated with being a migrant, recognizing times where the situation has been different as well as the internal and external resources that the client has utilised in the past. This represents a potentially healthier means of thinking about a difficult situation.

4.7.8. Solution-focused concepts

Solution-focused therapy can be viewed as falling within the broader field of positive psychology – which includes more of a focus on resilience and protective factors rather than deficits. Compared to psychodynamic approaches, the approach focuses a great deal more on a client's present and future circumstances, goals and potential solutions rather than past experiences – unless these past experiences provide examples of resilience and strength. The approach is also viewed as goal-oriented and more collaborative. It also believes that clients often have the tools to address the challenges that they face and that directed conversations can assist clients in identifying these tools. Therapists may also adopt a more complimentary approach, in that they may work with clients to identify and affirm the tools and strengths that clients possess or have developed.

In the context of CSVR's work with migrant families, the solutions-focused approach has been useful in working with depressive episodes and recurrent patterns of hopelessness. Sessions may include efforts to identify, recall and explore different options or approaches to a difficult situation that seems immovable and therefore generates a sense of hopelessness. This could include the situation of unemployment, where difficulties with documentation make it exceptionally difficult for migrant families to find decent, stable employment. Part of a solutions-focused approach would be to reflect on the situation, what may have worked in the past, what

may have changed, and which approach or mindset may be the best way of approaching the situation.

4.7.9. Developmental considerations

CSVR understands that children, adults, and families often experience normal developmental challenges at different points in their lives. This includes the physical, cognitive, verbal, emotional, and social changes experienced from birth, early and late childhood, adolescence, as well as early through to late adulthood. Whilst attempting to be sensitive to the diversity of its clients, CSVR clinicians draw on developmental theories, such as Erikson's[xiv] psychosocial stages of development, as well as McGoldrick's[xv] work on the family life cycle, to try and understand and potentially normalize the challenges that some families may experience.

These developmental considerations could include working with parents to better understand how children around the age of 18 months to 3 years of age often have a growing desire for autonomy, to explore or try different things by themselves. Such developmental understanding may help to reframe or reinterpret instances of a child's stubbornness and tantrums. Similarly, adolescence represents a period of great physical, cognitive, psychological, and social changes in our lives. It can also be helpful to work with parents to understand how they may need to adopt more open forms of communication with their adolescent children, that their children's attempts to spend more time with their friends is normal but that it is important to jointly develop rules, boundaries or expectations around socializing and time outside of the home.

4.7.10. Therapeutic tools

CSVR clinicians noted that practical, more visual and experiential tools or activities represent an important means of developing therapeutic relationships, exploring difficult themes and working with clients who may find pure talk therapy as a bit more daunting. Clinicians have identified the use of genograms as an important tool in working with couples. Genograms represent a visual way of representing each partner's family history and the potential qualities or characteristics of these relationships. This, in turn, can assist partners in thinking about how these relationships may have shaped their current relationships.

The River of Life is another tool that can be useful in working with different families. In working with couples, this tool can also facilitate conversations around the successes and challenges or difficulties experienced by each partner at different points in their lives. Reflecting on partners' responses to each other's narratives can also assist in generating important conversations.

The selection of the tool that you want to use is dependent on the purpose of the intervention and the outcome that the clinician wants to achieve for the client group/entire family system and sub-systems that they are working with. As such, these tools can be used for individuals and whole families as well. The process is more important than the tool that you use.

4.7.11. Psychoeducation

Psychoeducation refers to the different ways that clinicians may educate or provide clients

with information related to their mental health or other areas of their lives. For CSVR clinicians, this has often involved having discussions with clients and communities around trauma, what it is, symptoms of trauma and PTSD. This has, in many instances, assisted in reducing stigma around symptomatology (e.g. hypervigilance, paranoia) and in helping clients and their family members in understanding how trauma or other conditions may affect their thoughts, feelings, behaviour and relationships.

4.7.12. Psychopharmacology

Psychopharmacology includes medication that can be used to affect changes in a person's mood, thinking and behaviour. Linked to the need for a holistic approach to wellbeing, CSVR recognizes that there are instances where family members, both adults and children, require medication as a means of symptom reduction or to improve overall functioning. CSVR clinicians attempt to assess family members' symptoms, level of functioning and attitude towards medication prior to referring clients to a psychiatrist who has consulted with the organization for many years. These consults also assist in determining whether there are other physiological or neurological explanations for a client's symptoms. Conditions that have required medication in the past have included major depression, PTSD, psychosis as well as schizophrenia.

4.7.13. Referrals and partnerships

CSVR has developed a network of partnerships and referral organisations across Johannesburg and Pretoria in a means to assist families with needs or concerns that fall outside of CSVR's experience and expertise. This includes organisations that provide legal assistance (often for documentation purposes), social assistance (with basic needs), medical services, physical rehabilitation, as well as assistance with skills development and job seeking.

4.8. Working with children

Section 4.3 of these guidelines provided an overview of the themes that may emerge in working with families. Many of these themes may also be present when working with children; subsequently, this section focuses on themes that may be more unique to working with children and their parents. It also highlights points which may be important to consider when working with children.

4.8.1. Therapeutic considerations in working with children

- Clinicians should attempt to create an environment that encourages a sense of safety and the child's permission to express different emotions.
- Feelings that children can engage with and identify from as young as 3 years old include angry, happy, scared, and sad. It is important that clinicians have these four faces visible on for example cue cards; pictures on the wall etc. so that children can point at them during the session, they can learn them, and that they know that expressing any of these in this space is accepted and normal.
- Clinicians should always look at the emotions linked to the play or emerging from the play and

use this in therapeutic ways and for therapeutic goals.

- Getting to a child's level – sit on or play on the floor if the child is doing so. Be directed by the child. Be expressive in your voice and use your body.
- Engage with children in their world (work with their fantasies, using materials as props to explore this). The clinician will take on multiple roles in the play; they may also be the "naughty" or bad one.
- Children should not feel like therapy is "work".
- Very angry children may have learnt that anger is dangerous and that their anger is scary to themselves and others. They may have also not been able to manage their anger (both the feeling and the behaviour). It is crucial that these children get to express their anger and learn the skills of emotional containment and regulation within therapy. This includes learning that they can be angry, express it safely; that there are good reasons for being angry but that nobody has to get hurt when they get angry. They can control their anger.
- As with adult counselling, it is important for a clinician to model containment and maintain healthy boundaries in play. Children can often find it easier to act out rather than verbally expressing their emotions. An example of this could include a clinician observing that a child may be getting close to hurting him/herself, the clinician or breaking a toy, whilst experiencing an emotion such as anger. Instead of allowing a child to break a toy, within a resource constrained context, a clinician could offer the following reflection and redirection; "It looks like you are quiet angry when you are pulling on that doll… [allow pause to see how child reacts] … how about you come tear this paper with me or let's see how hard you can throw this ball against the wall?" The clinician can then gradually attempt to probe around the anger.
- It is not helpful to ask "why" in play, as most children cannot answer this question. Clinicians can attempt to reframe a "why" in to a what, how, when… type question; for example, "what made you angry" versus "why were you angry". A clinician may offer an interpretation of a child's behavior, based on observations and stronger themes that have emerged through therapy. For example, "You told me that you were bullied at school yesterday. Maybe that is something that you are still angry about". Such interpretations may be accepted or rejected but can assist a child with internalizing this curious voice, assist in developing their inner voice or self-talk.

4.8.2. Themes in working with children

In addition to the overall themes in working with families, there are a number of themes that are more unique in working with children. The presence of these themes may depend on the unique context, culture, age, nationality, gender and family dynamics (birth order, child-headed households, parentified children etc.) and so forth of each child and family.

- **Intergenerational trauma:** The concept of intergenerational trauma suggests that trauma and especially the effects of unresolved trauma can be passed from one generation to the next. In working with families, this may include children displaying signs of avoidance and mistrust following observations of a parents' behaviour (e.g. symptoms PTSD) which may stem from their own, parents' or collective experiences of war trauma, torture or other traumas. Working with this theme may require working with parents' unresolved trauma and depending on a child's age, reflecting on how their behaviour may relate to their parents' behaviour or experiences. Occasionally, the traumatic experiences are not acknowledged or

verbalized within a family but children feel a tension that they do not understand. This often causes distress and is also a vehicle for the transmission of trauma. It is sometimes more distressing because they cannot name the cause of these feelings. Children often internalize and blame themselves for these unidentified feelings or tensions. This distress and blame may be intensified in instances where parents believe that their children are too young to be aware of or affected by the struggles or tensions within the family and thus do not require emotional support in this regard.

- **Effects of parental functioning on children:** This theme suggests parents' physical and mental well-being can affect the different areas of children's lives (emotional, psychological, physical, social, cognitive, academic etc.). Parents' who may be struggling with mental health conditions can potentially find it more difficult to tolerate what may be normal children's behaviour and may also find it difficult to sit with, hold or manage their children's psychological needs. Perhaps also not having their emotional or psychological needs met as regularly, children may act out as a means of gaining their parents' attention as a way of being held in their parents' minds.

  In addition, the aspects of support that parents prioritise are usually directed at the physical/ basic needs of their children rather than their emotional needs. This may be linked to either cultural norms around parenting or the vast lack of resources available to families, which results in a preoccupation with needs linked to survival.

  Furthermore, due to practical reasons, such as parents who do not speak a South African language, children often step into unexpected roles; for example, managing the family's finances, managing the household needs, dealing with landlords around late payment of rent, renewing document and permits and so forth. Where a parent or no other parent or caregiver can fulfill certain roles, it may contribute to children having to take up or occupy these roles. This relates to the parentification of children, where children parent themselves and/or act as caregivers to their siblings or even parents. This may include the seemingly understated role of providing emotional or psychological support to a parent, parents or siblings through to other household responsibilities such as cooking, cleaning or childcare.

  This theme represents one of the reasons why CSVR clinicians may work with different members of the family. Parents may need to receive psychosocial or other forms of support to improve their overall levels of functioning whereas play therapy and other interventions represent a space where children can express different needs or parts of themselves – including those needs or parts which may be more difficult to fulfill or express at home.

- **Acculturation and identity:** All members of the family experience this theme. For younger children, being a non-national may not always be a barrier to socializing or developing relationships with other children but there are times where differences in language or nationality may contribute to exclusion and othering. This othering based on nationality is likely an attitude and behaviour that children pick up from the significant adults within their lives (e.g. parents, family members, teachers etc.).

  This exclusion and othering may contribute to non-national children being victims of school

violence or bullying. Aspects such as poverty, parental functioning and children's psychological well-being may also represent a buffer against or risk factor for bullying – e.g. where more uncontained parents and children, with greater psychological difficulties, may be more likely to be perpetrators or victims of bullying. Instances of xenophobia, bullying and othering also contribute to children experiencing low self-esteem as well as symptoms of anxiety and depression.

Considering these factors, the themes of identity, bullying and low self-esteem have been worked with using different approaches. These include the child voice toolkit, projective exercises such as the photo assessment, emotional regulation techniques such as the use of a punching bag, meditation and breathing exercises, body mapping, the Draw-a-Person test as well as the Kinetic Family Drawing.

- **Learning difficulties:** it has been noted that previous trauma, parental and child psychological well-being as well as current stressors (e.g. poverty, hunger, and poor accommodation) can negatively affect children's capacity to learn and meet their full academic potential. In particular, clinical observations have quite strongly linked a child's ability to thrive to their nutritional deficiency. Nutritional deficiency has been noted as an Adverse Childhood Experience (ACE) factor that affects long-term development. These learning difficulties have also been noted through psychoeducational assessments completed by interns working within the CSVR clinic.

  As the factors that contribute to these learning difficulties are multi-faceted, treatment approaches to learning difficulties often also require more holistic interventions. This could include the use of play therapy and other psychosocial interventions to support children's psychological well-being, providing parents with psychoeducation regarding learning difficulties, providing parents' with psychosocial support, as well as referring children to other professionals (e.g. therapists, interns or students in the fields of occupational therapy, speech therapy, audiology or optometry).

  Whilst recognizing the learning difficulties that some children experience, CSVR clinicians often also point to children's resilience and ability to thrive at school despite the challenges that they may be experiencing in other areas of their lives. This suggests that well managed classrooms or schools can represent a coping mechanism or buffer against such challenges.

- **Parental feedback sessions:** These sessions form an important theme or part of working with children. Recognizing the need to maintain trust with children, clinicians may discuss with children the themes or points that they might want to raise with their parents. This also provides children with the opportunity to assess what information or how information is shared with their parents.

  Parental feedback sessions should occur after 3-4 sessions with a child. The space represents an opportunity for both parents and clinicians to think about the themes emerging in their children's play. These discussions also represent a form of holding or mentalisation, where parents can hold their children in their minds – which may not always be an easy activity given the level of functioning or stressors that parents may experience. This space also represents a

space for psychoeducation, learning and knowledge exchange where clinicians and parents can attempt to better understand children's difficulties or how to implement changes at home (e.g. changes in communication, parenting techniques, discipline).

4.9. Working with adolescents

Many of the themes from working with children also apply to working with adolescents. This includes considering intergenerational trauma, how parents' physical and psychological well-being affects children's psychological well-being, bullying, learning difficulties and parental feedback sessions. The section that follows represents an integration of therapeutic considerations as well as themes more specifically related to working with adolescents:

- **Building trust or rapport:** Whilst building trust and a therapeutic relationship with clients of all ages is important, CSVR clinicians have noted how there may be some initial challenges in this regard when it comes to working with adolescents. This may include adolescents being slightly more closed or resistant to talk therapy in the initial phases. Considering this point, some CSVR clinicians have found that using a combination of more practical or experiential tools or tasks with talk therapy can be an effective means of building more open communication with adolescents. This could include tools that make it easier for adolescents to share information about their everyday lives.

- **Identity and belonging:** Aligned with Erikson's theory of psychosocial development, clinicians have noted how adolescent clients may grapple more strongly with individuation, questions of who they are and developing a sense of self. The broader themes of adjustment and acculturation as well as parents' psychological well-being play an important role in this theme.

  In terms of adjustment and acculturation, clinicians have noted how there can be a tension between parents who were raised and grew up in a different context and era and their children, who are growing up in a context where they are exposed to different traditions, cultures, and ways of being. For parents, there may be a sense of wanting to raise their children in a way that their children can also identify with the customs and practices of their country of origin; however, their children may not identify with these practices and may rather identify as being South African.

  Adolescents may also find it difficult to develop a true sense of self if their parents' lower levels of psychological well-being made it difficult for them to express parts of themselves or to have certain psychological needs met by their parents. In such instances, the clinician can provide a space where adolescents can express and explore these parts of themselves, which may assist with the identity exploration suggested by Erikson, assist with greater integration of the self and easing of potential underlying tensions.

- **Depression:** An increased likelihood of experiencing depression during adolescence is perhaps easier to understand when considering the hormonal, physical, cognitive and social changes that adolescents experience during this period. For adolescents in migrant families, these normal difficulties are intensified by the previously mentioned themes of intergenerational

trauma, parental psychological well-being, and current stressors. Depression has many faces within this age group. Children may present differently, with violence or aggression versus only a low mood and lethargy. It is important to be aware of this and look for depression in behaviour that may be experienced as violent, anti-social, conduct oppositional, ADHD etc. There is often the temptation to treat with only medication and overlook the psychosocial and emotional counselling aspect. A more complimentary approach to treating psychiatric diagnoses is needed. Given the potentially complex nature of depression, clinicians may work with adolescents to become more attuned with their emotional state, the factors that may contribute to this, as well as means of managing symptoms associated with depression.

- Communication: Clinicians have noted that communication in the families that they have worked with can be more closed or avoidant. Whilst being a concern for children, it is also a concern for families with adolescent children, as more open communication and negotiation around roles and expectations is a developmental requirement for both adolescent children and their parents. Clinicians may attempt to work with both adolescents and their parents to explore different ways of communicating and resolving conflicts. This can include conversations around conflict with adolescents and their parents, clinicians modelling good communication skills in these conversations, more explicit conversations around communications skills as well as communication traps such as criticism, contempt, stonewalling, bulldozing, debating and a lack of accountability.

4.10. Working with parents

The section that follows commences with a theme that also relates to therapeutic considerations in working with parents. It then moves on to discuss prominent themes in working with parents:

- **Empathy and building rapport:** Clinicians have urged that it is important to recognize that parents are often giving their utmost to support their families and children in what are difficult circumstances. It is important to consider this when thinking about some parents' actions. For example, one may view a parent leaving young children at home as neglectful but the realities of poverty, needing to find employment, a lack of familial or social support, unsafe neighborhoods or not being able to access a child care grant, may make leaving children at home the only or most rational option in the situation.

  Recognising or reflecting on physical and psychological demands of parenting can provide parents with a sense of validation, which is important considering the challenges that they face as well as the sense of inadequacy and guilt that so many parents experience. This empathy can also make it easier for parents to see the clinician in the light of a co-parent or an ally in parenting rather than a professional such as a social worker – with some parents often mentioning their concern about their children being taken away given their occasional inability to provide adequate food or shelter.

- **Negotiating safety through the therapeutic frame and boundary setting:** There may be times where the content or themes emerging in sessions make it unsuitable for children to be included in sessions or waiting for their caregivers just outside a counselling room. However, these cases may be unavoidable due to a lack of childcare services during these times.

In these instances, clinicians may need to work with caregivers to think of alternatives; for example, delaying this content until a caregiver can be found, asking a CSVR staff member to look after the child for the duration of the session or, if the child is older and the parents feel comfortable, leaving a child in the waiting room while this sensitive content is being discussed.

- **Adjustment and acculturation:** Partly related to previous traumas, many migrant parents find themselves in contexts that may be vastly different to the ones in which they were raised. This includes differences in language, culture, social norms, parenting practices, relationships, social status and potential socioeconomic status. Some aspects of parents' parenting practices may replicate their experiences of being parented. Given the different context in which they find themselves, some of these practices may not be applicable or acceptable – where physical punishment is illegal or children's exposure to other narratives of parenting (e.g. from the school environment) may contribute to greater resistance or dissatisfaction with certain parenting practices.

Parents who may be struggling to adjust to their new context, who may be finding it difficult to develop new relationships or who may have security concerns, may also be more hyper-vigilant and mistrustful of others. This can contribute to more restrictive parenting practices, where children are more limited in terms of their movements or relationships with other children.

- **Identity and belonging:** A related theme is that of identity and a sense of belonging. Where nationality and culture are important aspects of identity for parents, they may attempt to transfer or hope that their children also identify with these aspects. This is a way of managing the multiple losses of being forced to leave their country of origin and may be seen as a way of retaining some of that which was lost.

  Clinicians have noted how parent-child conflict may arise when this is not the case. Having conversations with parents around this topic can assist them in exploring their own ambivalence or the emotional tensions they may experience around identity and belonging, what makes it important for them that their children have a shared identity, as well as how to express this importance to their children. Alternatively, elements of psychoeducation can also be utilized to help parents consider how identity is a formative process and how the aspects of the self (identifiers) that children find important may change over time (as is the case with adults).

  In addition, forming an identity that is acceptable to the host country can be a form of survival/safety. Children are often bullied and ostracized at school for being different (being foreigners, talking or looking different). This is largely due to the xenophobic narratives spread by South African community members and government representatives. Choosing to celebrate what makes them unique and different may expose them to increased levels of violence and isolation. Unfortunately, they can experience this from both their communities and their families, who each have competing ideas of the types of people that children should be, the accepted ways in which they should express themselves and should "be" in the world.

- **Intergenerational and previous trauma:** In addition to their own traumatic experiences, parents may also carry their parents', communities' or countries' traumas. As with most people, parents are often unaware of how these traumas may affect their mental well-being

as well as their relationships with their partners and children. Part of working with parents may be to support them in unearthing or considering the factors that may contribute to some of the behaviour or actions that may negatively affect their children or broader family dynamics.

- **Mentalisation:** This theme refers to a parent's ability to recognise, think about, attempt to understand, and potentially resolve their child's feelings and experiences. As noted, previous traumas and current stressors can reduce parents' capacity to mentalise or tolerate their children's more psychologically demanding states. These difficulties can contribute to children's psychological needs being unmet, which can in turn contribute to difficulties such as a failure to thrive (infants), depression, anxiety, and behavioural difficulties.

  Working with parents on this theme often requires providing them with a space where they can unpack their own mental burdens and create greater space to contain or hold their children's psychological well-being in mind. Clinicians may also use parental feedback sessions as a space to mirror or model this mentalising, where a parent or parents are posed with (empathic) questions that facilitate their thinking about the factors that may underlie their children's difficulties.

  As has been noted, it is important to approach such conversations with empathy, recognising parents' difficulties, otherwise parents may experience a greater sense of inadequacy and guilt in not being able to meet their children's physical or psychological needs.

- **Communication:** Both children and adults rely on their interpretation of previous experiences as well as other sources of information (such as parents, siblings, peers, teachers, the media) to make sense of or interpret new experiences. Clinicians have noted how there are many themes that come up in working with families that require more open communication for children to interpret these experiences in healthier or more constructive ways.

  For example, clinicians have found that it can be valuable to work with parents, struggling with their mental health, to find age-appropriate ways of talking to their children about their mental health, how it affects them and how they may be trying to manage these concerns. Similarly, parents can be assisted in talking to their children about their previous traumas and how certain situations or factors may trigger symptoms such as re-experiencing, hypervigilance or avoidance. This might help children understand that their parents' behaviour is not because of them or their fault. Knowing that their parents are getting support could perhaps also relieve the sense of responsibility that children have for their parents' happiness or well-being.

- **Psychoeducation:** Having conversations with parents about the challenges that they or their children' may be experiencing can also assist parents in understanding what may be developmentally appropriate behaviour or how to best manage or support their children. Clinicians have found that there are various topics that emerge in working with parents and children that can require psychoeducation and that clinicians may need to turn to their peers or other professionals to find additional information on some of these topics.

- **Supporting parents who have children living with chronic physical illnesses or psychological conditions:** Between late 2016 and early 2018, CSVR carried out individual

and group work with parents whose children experienced physical and psychological conditions such as cerebral palsy, heart conditions and autism. Work with parents often involved providing a space for parents to share their thoughts and feelings regarding their children's conditions and possibly normalizing thoughts and feelings which may have been viewed as socially unacceptable – for example, the sense of loss or grief associated with having a child who struggles with a physical or psychological condition. This sense of loss can be made more complicated by aspects of African culture, where having children means having someone to carry your name and taking care of you in your old age. There is also increased guilt because the child's special needs or health challenges are often attributed to being cursed or something that the parents did or failed to do. At a time when social support is most needed, parents often face social isolation because of these reasons.

This work often also required clinicians to consult with other professionals and conduct further readings to answer some of the questions that parents may have had as well as a means of providing appropriate psychoeducation.

4.11. Working with couples

In the context of these guidelines, couples work includes work with a married or cohabiting couple who may or may not have children. Couples work often occurs when initial assessments highlight high levels of parental or couples conflict or the need to strengthen the spousal (couple) dyad as a means of strengthening the broader family. Clinicians identified the following themes in their work with couples:

- **Adjustment, roles, and responsibilities:** Echoing a theme mentioned throughout these guidelines, couples are often faced with the need to adjust to current stressors and other contextual changes. This may include the need to adjust roles and responsibilities within the family given a partner's physical or mental health or employment status. Clinicians noted how traditional gender roles often represented a barrier to adjustment in roles and responsibilities where, in some instances, a female partner would perhaps find greater work opportunities but would still need to take on the responsibilities of childcare and household responsibilities such as shopping, cooking or cleaning. Conversations around such difficulties may highlight a male partner's potential shame in not being able to meet traditional role expectations.

  In such instances, a clinician may work with a couple to explore themes related to identity, traditional gender roles, status, and concepts of partnership in the hopes of reducing stigma and shame and improving cooperation and partnership.

- **Religious beliefs:** Linked to gender roles, social norms and expectations are often also shaped by religious beliefs. Each partner's identity may also be shaped by these beliefs to the same or to different extents. Conflict may arise when partners have different ideas around the extent to which these beliefs should shape their lives and relationship. Furthermore, linked to acculturation, partners and especially women may be exposed to different religious beliefs and the implementation thereof within their communities, social circles or through media.

  Clinicians have noted how this theme is often interlinked with the themes of gender,

culture, acculturation, and others. MHPSS interventions may include developing a deeper understanding of how such beliefs emerged, the meaning that they hold, how differences in beliefs play out in their lives and what their relationship and lives may look like if they were to consider accommodating changes.

- **Coupling and partnership:** In working with couples, clinicians may find the need to explore each partner's understanding or perceptions of the concepts of partnership and being a couple. These conversations can help to identify attitudes and beliefs that may hinder a couple's ability to adjust and support each other in difficult times. These conversations may move around traditional roles and expectations as well as more unique or idiosyncratic roles or needs that partners occupy or require from each other given the contextual challenges they experience.

- **Communication:** As previously mentioned, cultural and traditional patterns of communication, whereby patriarchal ways of being are upheld, often contribute to avoidance or a difficulty in talking about topics that may contribute to conflict or relationship difficulties (such as difficulties with intimacy). Such avoidance and communication difficulties are amplified for couples where a partner or both partners have experienced previous traumas such as physical or sexual torture – traumas that may contribute to a sense of shame or fear or rejection.

  In such instances, clinicians would aim to provide a holding space that may help partners make links between previous traumas and current difficulties as well as make it feel a bit safer to share such traumas with a partner. In addition, clinicians will provide options and model more supportive and open patterns of communication.

- **Sexual intimacy and trauma:** Considering the previous forms of physical or sexual torture that clients may have experienced, as well as high prevalence of gender-based violence, clinicians have noted how couples may present difficulties with sexual intimacy in their relationships. In some instances, a partner may have shared details of previous sexual traumas with their partner but in other instances, the potential shame and fear of rejection or abandonment may have contributed to silences around these traumas.

  Previous traumas may not be the only cause of difficulties related to sex. Expectations around a partner's duty to perform sex, especially in marriage, is an issue which abounds across the globe. Such expectations may develop through culture, religion, peer social groups, ideas around masculinity, the media as well as a partner's means of coping or emotional regulation (where sex can represent a means of emotional regulation).

  As with other themes, clinicians often approach this topic by using a combination of unpacking the theme, attempting to develop a deeper understanding of the meaning of the topic and potential psychoeducation – where expectations around what is normal can be discussed or compared to literature around sexuality or the role of sex in relationships or links can be made between previous traumas and sexual difficulties.

- **Psychoeducation:** As with all work with different family members, psychoeducation represents an important theme as well as tool when working with couples. A broad range of

topics can include aspects of psychoeducation, from conversations around gender roles and expectations through to conversations around previous traumas and parenting practices.

4.12. Working with the whole family

As suggested in section 4.4 (the overall process of working with families), it can be beneficial to work with the entire family but factors such as presenting concerns, family members' level of functioning, levels of parental conflict, previous traumas and socioeconomic concerns may make this type of intervention more difficult. In addition to the themes discussed for different family members, clinicians have identified the following considerations and themes in working with the entire family:

- **The identified patient:** From a systemic understanding, problematic behaviours or challenges within the family should be understood as being systemic rather than individualistic. Thus, the identified symptoms or concerns placed on a family member should be viewed as representing symptoms of broader difficulties within the family.

  Working with the broader family on challenges or difficulties could involve developing a better understanding of how each family member thinks about or understands the challenges that the identified patient or family are experiencing. These understandings often locate the problem within the individual and the clinician's role would be to work with the family towards more systemic understandings of their challenges – how problems can be located between family members or in patterns of interaction.

- **The identified hero:** Clinicians have also noted how a family member may also be identified as the family's hero or savior. This may include a father who may save the family through gaining a good job or employment and lifting the family out of poverty or a child who is doing well academically and may also save the family, from their current situation, through his/her academic exploits.

  Whilst such hope can represent an important means of coping for some family members, it may also be important for the family to recognize and discuss this hope, to discuss the pressures that may be experienced with it and what might happen if this family member (hero) was not able to succeed. For some family members, their entire identities may be wrapped around being the family savior, which may have different effects on their mental health or well-being.

- **Family observations:** Observations of family interactions before, during and after sessions represent an important source of information for clinicians. Observations by the clinician, co-therapist or other clinicians (via a one-way mirror) can assist in working with family members to reflect on patterns of interaction, unspoken rules or boundaries that may relate to the presenting concerns or other areas of family functioning.

  The importance of such observations was noted in the case of Grace (pseudonym), a two-year-old girl who was the youngest child of three children. Through individual and team reflections, it was noted how it was often difficult to remember what Grace was doing in

sessions, where she was located, or where she was referenced in conversations. These observations assisted the clinician and family members in recognizing that the parents did not display mentalisation for this child and as such, where her physical and emotional needs often went unmet. When she was given attention, it was usually negative or disparaging as she was labelled as the "naughty" child. Her parents viewed her natural need for sustenance as selfishness and greed, as she knew that the family could not afford food. This child became the receptacle for the family's displaced anger and frustration. These observations made it possible to reconceptualise the challenges experienced within the family and revise their treatment plan.

- **Therapeutic tools:** As previously mentioned, clinicians have emphasized the value of finding existing and potentially creating activities, exercises or tools that can provide families with more tangible, concrete, practical or visual ways of exploring different topics. Tools such as genograms and the River of Life have already been noted. Additions to these include the Tree of Life, which can assist the family in thinking about their strengths, challenges, weaknesses and opportunities; the Family Vision Board, which can assist families in thinking about where they are currently situated, their strengths and challenges, the future that they envision for themselves and the different ways that they anticipate moving towards this vision; the My World exercise from the Child Voice Toolkit, which asks children to orientate themselves according to their perception of their place and importance within their world; as well as the use of imagery and metaphors, which can often be easier for family members to recall. Such tools also help clinicians in identifying further family interactions as well as potential themes.

5. Conclusion

This document represented an attempt to highlight the ways in which CSVR clinicians have worked with migrant African families affected by complex and continuous traumas. This included an overview of CSVR's overall process in working with families. A central aspect of this process included a decision-making matrix or an outline of how clinicians approached the complexities that often emerged in working with families who experienced multiple, complex, and continuous traumas.

Whilst these guidelines have not encapsulated all the themes that clinicians experience in working with families, it is hoped that these guidelines, together with CSVR's African torture rehabilitation model, provide a solid foundation for future learnings and revisions. The need for constant reflection and documentation is likely vital, given the constantly changing world in which we live and all hope to thrive.

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