Training Burmese refugee counsellors in India

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Since 2007, the Centre for Refugee Rights (Australia) has provided workshops on community development and refugee rights to refugees from Myanmar (Burma). Described herein is one, five-day counselling training programme, which was one component of the workshops, developed for participants from community based refugee organisations who were living in New Delhi and in Aizawl, Mizoram. The author presents an approach to teaching counselling, both within a workshop format, and a refugee context. The components of the counselling workshop are outlined, followed by the author's reflections on providing a counselling training in this context.

Keywords: community development, counselling workshop, refugees from Myanmar (Burma) in India

Background

Each year, since 2007, staff and students from the Centre for Refugee Research[1] (CRR, University of New South Wales, Australia) have visited India in order to provide training for refugee communities from Myanmar (Burma). Counselling training was one component of a suite of workshops that was requested by this group of refugees on community development and the enhancing of refugee rights. In this paper, aspects of the five-day counselling programme are outlined and discussed. These are followed by the author's reflections on providing counselling training to refugee participants who live in impoverished urban environments. The paper also highlights the difficulties faced by refugees from Myanmar who work as counsellors within this context.

Refugees from Myanmar resident in New Delhi

For decades in (present day) Myanmar, the military government persecuted the country's ethnic minorities, including: the Chin; Karen; Karenni; Rohinga; and Katchin. Many of these minority populations fled into neighbouring countries to escape torture, rape, murder and the burning of their villages. Having arrived in camps and cities in India, Thailand and Bangladesh, these refugees remain stranded in protracted situations, and face extreme adversity with little hope of resettlement. It is estimated that there are currently 100,000 refugees from Myanmar in Mizoram and Manipur (Human Rights Watch, 2009) and between 7,000 and 10,000 in New Delhi (Basavatavna and Fernandez, 2010).

In New Delhi, refugees from Myanmar face extreme hardship, as work opportunities are limited. Most refugees receive less than half the wages of the local population, while many are not able to find any work at all. They are frequently the target of discrimination and abused by employers, landlords, rickshaw drivers, neighbours and people on the street. Their most pressing concern is the risk of violence, closely followed by poor health care, insufficient food and water, limited opportunities for children to attend school and crowded living conditions. It is

common for several people to live and sleep together in dwellings the size of a small bedroom. While the United Nations High Commissioner for Refugees (UNHCR) and nongovernmental organisations (NGOs) have attempted to address these concerns, the vast majority of refugees continue to live in these situations of extreme adversity. Despite these conditions, the refugees have developed durable community organisations and liaised with UNHCR (and its implementing partners) in order to provide some support to vulnerable individuals and families. Although many refugees from Myanmar have been resettled over the decades, in recent years, overseas resettlement opportunities have been significantly reduced. This is because resettlement countries such as the USA, Canada and Australia have given priority to refugees from countries other than Burma, especially in light of the current rapprochement between Burma and western nations. Those remaining in New Delhi still want to be resettled, and do not foresee ever returning to Myanmar.

The Centre for Refugee Research

The Centre for Refugee Research[1] is an interdisciplinary advocacy organisation funded through grants and consultancies. The Centre conducts research into issues relevant to refugees and provides training to refugee communities. It aims to investigate the conditions of refugees in countries of first asylum, as well as identify gaps and needs in situations of forced migration, and develops tools and supports innovative laws to address the gaps identified. The Centre works closely with community based refugee women's organisations in India and Thailand. This is an ongoing collaboration that began with researching and documenting the systematic use of rape by the Burmese military (Karen Women's Organisation (KWO), 2004). Since 2005, these organisations have commissioned the Centre to provide training in areas such as; advocacy, human rights, managing community based organisations, livelihoods, women's leadership and counselling. The sponsoring organisations decided that the training topics and workshops should be offered as *'training of trainers'* (ToT) workshops, so that participants could train others within their own communities. Although the training was sponsored by women's organisations, men were usually invited to participate, excluding topics such as women's leadership training and the counselling workshops that were considered to be gender based. These were segregated.

In the most recent visit to New Delhi (2011), the organising committee requested two or three-day workshops in refugee rights, community responses to violence, women's leadership and counselling. These workshops ran concurrently for two weeks, drawing over 100 participants. Groups within the community nominated individuals who were then invited to participate in the workshops, usually choosing those already working in leadership or helping roles[2].

This paper draws on the author's experience of conducting six counselling workshops for refugee women from Myanmar, between 2008 and 2011, in New Delhi and Aizawl.

Counselling training: literature

Teaching counselling within a refugee context requires examining the appropriateness and relevance of Western approaches to counselling, and to mental health. Within Western mental health frameworks, evidence based models of trauma counselling are inseparable from psychological assessment and diagnosis of *'pathology'*, and these dominate the fields of psychiatry and

psychotherapy (Gozdziak, 2004; Summerfield, 2001).

A psychiatric diagnosis tends to focus on symptoms within an individual, rather than looking at problems within a social context. A psychiatric diagnosis may, perhaps, open doors to treatment in Western environments, but it generally does not do so for refugees in India. Traumatic experiences are ubiquitous, and therefore many people in the community could be *'diagnosed'* with a psychiatric disorder. However, as there are no treatment options within this context, trauma related diagnoses would be of very limited use. The label of posttraumatic stress disorder (PTSD) and its associated symptoms (hyper-vigilance, avoidance and intrusive thoughts) fail to capture the experience of refugees who have suffered overwhelming loss of family, community and country. They experience somatic symptoms, anxiety and depression complicated by malnutrition, substance abuse and exposure to ongoing stress (Summerfield, 2001). Trauma interventions attempt to reduce symptoms, such as hyper-arousal. However, this may not be an achievable goal for refugees in New Delhi and Aizawl as they, like other survivors of collective violence in low income settings, are not only faced with overwhelming stress (as listed above), but also exposed to danger on a daily basis (Miller, Fernando & Berger, 2009).

Individually oriented counselling approaches, such as psychotherapy and trauma counselling, may fail to conceptualise the importance of a client's connection to his or her family, or community. Within refugee contexts, it is often relationship conflict, or breakdown, that contributes most to an individual's distress. According to research on resilience, adults and children who feel loved and supported within their families and communities recover from trauma more quickly than those who are isolated and unsupported (Walsh, 2007; Herman, 1997). Counsellors who facilitate relationships within families and communities help promote resilience, and thereby reduce the severity of symptoms (Yule, 1998; Gorst-Unsworth and Goldenberg, 1998).

Criticisms of dominant Western approaches have resulted in the development of *'ecological'* frameworks to better address the mental health needs of refugees (Hoshmand, 2007; Miller & Rasco, 2004; Summerfield, 2001). By situating individuals within their social, cultural, religious and family contexts, these approaches make sense of the individual's traumatic symptomatology, rather than using the pathology of individuals as weak or deficient.

It has been argued that, in counselling training within refugee contexts, the available local, indigenous knowledge should not be undermined, nor devalued, by imposing Western counselling knowledge and frameworks (Pupavac, 2002; Summerfield, 2001). It should also be noted, for people in non-Western countries, *'talk therapy'* is an unfamiliar concept, and the word *'counselling'* is often used to refer to giving advice or instrumental solutions (Gilbert, 2009; van der Put & van der Veer, 2005).

'Empowerment' is *'the ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their lives and destinies'* (Staples, 1990). In fact, when guided by the principle of empowerment, Western interventions and theories may be transferable to work within indigenous groups (Rasco and Miller, 2004). It is possible within counselling training to selectively integrate Western ideas with local knowledge in order to build on participants' existing capacities, and their own healing traditions (Durland, 2008). van der Veer (2006) described a *'bottom up'* process of counselling

training, driven by the immediate concerns and needs of participants, a principle that guided the author in developing the counselling workshops in New Delhi and Aizawl.
Therefore, a counselling model appropriate to refugee contexts would: integrate Western knowledge with traditional approaches to healing; emphasise the context of an individual's distress; view trauma related symptoms as normal reactions to abnormal events; avoid the use of stigmatising labels; acknowledge individuals' strengths and resilience; and promote connection within families and communities.

Counselling workshops

The counselling workshops offered by the Centre were given over five days of training, organised into units or topics that were selected according to the requests of the participants. The training aimed to build on the participants' listening capacities, problem solving skills and abilities, in relation to providing practical or material assistance. In each unit, the teaching methods varied and included the following:

- Direct input with questions and discussion.
- Demonstration interviews by the trainer with one of the interns as the '*client*'.
- '*Fish-bowl*' role-play, where group members observe two people who are playing the roles of counsellor and client. The '*interview*' is stopped at various points to discuss '*where to next*'?
- Small group exercises, with reporting back.
- Small groups practice counselling skills, taking turns as counsellor, client and observer. When playing a client, selecting an issue that is minimally distressing.
- Participants presenting cases, or their own situations.
- Trainer providing counselling to a participant. In these situations, the group responds by sharing similar experiences and focuses on providing the person with ideas and constructive feedback.

Participants

Over the years of providing the counselling workshops, approximately 200 participants attended: all were women, and many had previously participated in the Centre's workshops on human rights, sexual and gender based violence, or advocacy. Participants' educational backgrounds varied: they were literate; most had attended some high school and approximately 5% had attended university, but not necessarily completed their degrees. Their skills and experience in counselling varied considerably. The more experienced were working in church communities, health clinics, Violence Against Women (VAW) teams and '*safe houses*' for women who had been physically and/or sexually abused. While none had previous professional counselling training, some had attended previous workshops conducted by the Centre. A few participants received a small stipend for their work as counsellors, but most worked on a volunteer basis, and received no income for their counselling work.
When providing training in Western countries, trainers can assume that, for the most part, trainee counsellors are living within a safe environment. In these workshops, however, participants and their families face(d) traumas and survival challenges very similar to their clients. In fact, some explicitly stated that they were attending in order to learn about supporting friends and family members.

The five-day programme

Counselling workshops was organised into 10 units, and conducted over five days with six and a half hours each day (Table 1).

Table 1.

Day 1	Day 2	Day 3	Day 4	Day 5
UNIT 1: Developing group safety	UNIT 3: Purpose limits and basic skills of counselling	UNIT 5: The 6 Steps of counselling	UNIT 7: Relationship conflict	UNIT 9: Alcohol abuse
UNIT 2: Situational analysis	UNIT 4: Exploring the main issues	UNIT 6: Domestic violence	UNIT 8: Trauma and loss	UNIT 10: Ending evaluation

Unit 1: Developing group safety

As in the formation of any group, participants needed to feel safe. This was particularly true when the workshop required them to practice skills in front of others, and to disclose stories of trauma and hardship. The aims of this unit were:

- For participants to become acquainted and begin to trust others in the training.
- To develop confidentiality agreements.
- To clarify expectations and develop goals for the counselling workshop.

The workshop started by developing a confidentiality agreement that had two components; one that referred to the trainer's obligations in relation to use of transcripts and photos, and the other that referred to both trainer and participants' responsibility to keep confidential any personal information and/or stories discussed within the group. This involved discussing participants' experiences of situations where confidentiality had been breached, and the harmful effect of such breaches. Following this, each group member introduced herself, naming the organisation she represented and her role, where she was from in Myanmar, and what she wanted to achieve by attending the counselling workshop.

Unit 2: Situational analysis

A *situational analysis* involves the group identifying problems and concerns, analysing them, and then developing possible solutions. The aim for this unit was for the group to undertake a situational analysis of the most pressing issues for the refugees living in their cities.

Groups most frequently identified the following problems: unsustainable or nonexistent livelihoods; problems with landlords and housing; lack of access to adequate medical care; discrimination against children at school; the cost of schooling; children left alone during the day, locked in a room or roaming the streets; local people intimidating, harassing and/or physically and sexually abusing refugees; lack of legal protection; domestic violence; problems with the distribution and quality of women's sanitary materials; and insufficient access to food and safe drinking water. Participants discussed how each of these issues impacted on different segments of the population, then analysed the effect of each problem and the results of current attempts to deal with the problem. This was followed by brainstorming solutions that could be implemented if there were sufficient resources and support. Having completed this analysis, the most relevant issues were selected to focus on in the counselling training. Usually, distress in relation to sexual and gender based violence, domestic violence, couple conflict, depression and addictions were high on the list.

The situational analysis had the effect of reducing ethnic, social and religious divisions, while at the same time increasing

group cohesion. It also enabled participants to contribute in a personal way as they described the daily struggles of their lives. Participants felt both heard and acknowledged, as the details of their problems were documented for later use in advocacy efforts. In addition, by beginning the workshop with the trainer in a position of learning and the participants in a position of teaching, enabled participants to be the experts.

Unit 3: The purpose, limits and basic skills of counselling, including personal reflections

This unit aims to review what counselling can and cannot achieve, to identify skills participants already use, and to develop skills in active listening, summarising content, identifying feelings and asking questions.

This unit began with the group indentifying various aspects of counselling, ranging from solving problems, giving advice and resolving conflict, to providing material, educational or emotional support. This discussion frequently led to participants saying that they felt ineffective, as they were unable to solve the environmental problems that were impacting their client's emotional wellbeing. For example, they had limited or no access to money from their organisation (or church) to help clients with medical expenses, rent, transport or food.

In a parallel process, I also felt helpless and powerless when hearing about these problems, and was also unable to find solutions. When this happened for the first time, I spontaneously expressed my feelings of inadequacy in relation to what I could offer them. In response, they assured me of the positive impact that was felt through my care and concern, and as a result, were able to see the importance of the consistent emotional support that they provided to their own clients.

In an exercise to identify basic counselling skills, and in order to demonstrate that participants already have many of these skills required, they reflected on a time in their lives when they felt distressed and turned to someone for help. From this exercise, a list of helpful and unhelpful responses was developed. Helpful responses often included: *'encouraging'*, *'listening'*, 'understanding', *'helping financially'*, *'praying for me'*, *'helping me escape'*, *'giving me advice'* and *'talking to my husband'*. Unhelpful responses included: *'moralising'*, *'criticising'*, *'judging'*, *'shaming'* and *'lecturing'*. The *'helpful'* responses were distilled down to the essential ingredients of listening, empathising and maintaining a nonjudgmental attitude. This exercise also served to emphasise the importance of being heard, validated and understood, even when *'solutions'* were unavailable.

In an experience that both energised the group and reinforced this learning, two role-play interviews were conducted. In the first, I took on the role of a counsellor with poor interpersonal skills. Participants enjoyed identifying my mistakes, easily discerning problems with my posture, my *'business like'* manner, judgmental attitude, avoidance of eye contact, absence of empathy and curiosity, and the too direct style. Sadly, this interview also reminded participants of interviews they had actually experienced in their dealing with officials in a range of contexts. We drew on these problems to craft the relationship building elements of a good counselling interview.

In the second interview, good interpersonal skills were demonstrated and participants identified the skills of summarising what the client was conveying, identifying and empathising with the client's feelings, asking open ended questions, and maintaining an

open body posture, warm tone of voice and eye contact.

Unit 4: Exploring the main issues
The aim of this unit is to undertake an assessment by obtaining information about:

- The issues present and current needs;
- How the problems developed; and
- Relevant aspects of the client's history.

People not trained in counselling often demonstrate a common error by taking the client's situation at face value, and then offering solutions prematurely. When participants were role-playing what should have been just the first part of an interview, some arrived at *'solutions'* within less than ten minutes.
This unit emphasised the importance of taking time to get to know a client, and of using a range of questions to explore and understand the complexity of the situation. An *'iceberg'* metaphor helped to convey the idea that the main issue, or problem, is often just the tip of the iceberg. This includes what the client says about when and where the main problem occurs, factors that impact severity, and the context in which it happens. Beneath the tip, i.e. under the surface, is the history of a problem, and all the other factors that have contributed to the current situation. As an example, we discussed a situation in which a woman had *'hocked'* (pawned) her refugee card in return for money to pay her hospital bills. Although the tip of the iceberg was her debt, beneath the tip were many other issues, such as conflict with her husband about his drinking and his inability to provide for the family. Participants hypothesised that he drank to dull his shame for failing to work and for leaving his parents in Myanmar.
In the next unit, participants learn how to obtain this information during the first interview, establishing a relationship and building trust.

Unit 5: The six steps of counselling
The aim of this unit is to provide a template for a first assessment interview: incorporating skills of questioning and active listening in order to build trust and elicit the client's story, as well as supporting the client to identify possible next actions or steps, and clearly conveying the kind of help the counsellor is able to provide. The template has six steps that are adjustable for most client contacts:
Step 1. Create rapport: introduce oneself, clarify your role and the client's expectations, and gather some general information about the client (where they are from, if they are working, special talents or other strengths). Discuss confidentiality while explaining the counsellor's role, and the nature of the organisation.
Step 2. Explore the clients main concerns, the *'tip'* of the iceberg.
Step 3. Explore beneath the *'tip'*; the background to the problem and other related aspects of the client's story.
Step 4. Assess the client's immediate safety concerns.
Step 5. Identify, with the client, immediate actions that need to occur, or give the client ideas or information.
Step 6. Develop a plan, with the client, about future counselling sessions, if appropriate.
Following a demonstration of these steps by the trainer, participants practice these steps in role-play interviews.

Unit 6: Domestic violence
The aim of this unit is for participants to understand domestic violence in relation to culture, gender and trauma, and to identify possible intervention strategies.

In most ethnic groups from Myanmar, men are expected to protect and provide for their wives and families, and women are expected to assume a subservient position. However, as a result of being uprooted, experiencing trauma and the negative impact on men's self-esteem resulting from being a refugee, many men were depressed and felt powerless to undertake their traditional responsibilities. Some of these men turned to abusing alcohol, and reacted with violence towards their wives, children and extended family members. Burmese women's organisations have '*violence against women*' (VAW) teams that demonstrate considerable skill in confronting men about their violence, helping women to leave relationships and find safe places to reside.

In the workshop, domestic violence is approached by discussing specific cases, identifying the issues in relation to gender roles, the refugee experience and current stressful, environmental circumstances. It was common for some of the participants to reveal that they had also experienced domestic violence. For each case discussed, the group brainstormed possible interventions including safety plans, practical assistance for family members, and the importance of ongoing support. This often led to a role-play of a counsellor talking to a man about his violence, or a woman about her decision to stay or leave the relationship.

Unit 7: Couple conflict

The aim of this unit is for participants to develop skills in conducting an interview with a couple.

In the refugee context, couples face numerous problems that cause them distress, including poverty, ill health, dangerous environments, lack of privacy and hopelessness about their own, and their children's, futures. One factor contributing to fights and domestic violence is the reluctance of women to have sex when their children and others could see or hear them, because they live in such close proximity to others. Often couples must share a room with their children or other people, so it is difficult for couples to find a space to have sex, or to discuss issues privately, and the resulting arguments have a serious impact on others. However, when neighbours or relatives try to intervene, they often do so in a way that escalates the conflict.

This unit focused on participants learning basic skills in conducting an interview with a couple. This included organising seating arrangements, balancing time with each partner and avoiding taking sides or prescribing a solution. They learned how to coach couples to use active listening (repeating back what their partner has said), and to brainstorm possible compromises.

Unit 8: Trauma and loss

The focus of this unit is about how traumatic events can impact an individual, and how a person's behaviour or symptoms may be related to having experienced trauma, loss and stress. The emphasis is placed on the importance of clients being able to talk about distressing events with a counsellor. This unit does not teach how to diagnose PTSD, nor how to conduct memory processing exposure methods, such as *Imaginal Exposure*[3].

Participants reported that they often avoided discussing traumatic memories with clients. They feared that talking about traumatic events would make clients feel worse, and would also have the consequence of triggering their own traumatic memories. However, through understanding the role of traumatic memories and grief in relation to depression, anxiety and addictions, and

how traumatic memories can be triggered by everyday events, participants were able to recognise the importance of asking about traumatic experiences and loss. A useful metaphor to get this idea across was that of a bottle being filled with soda, emphasizing that when feelings are not released, they are trapped in the bottle and will eventually explode. Participants learned the importance of being connected to others for healing to occur, and that a frequent consequence of trauma is loss of connection to others. They could help clients heal by encouraging them to talk about their losses and traumatic experiences while supporting them through their distressed feelings.

The group then identified traditional ways of dealing with stress, which included praying or singing together, head and shoulder massage, and/or using scents and oils. Participants also practiced progressive relaxation, meditation and the use of visualisation.

Unit 9: Alcohol abuse

This aim of this unit is for participants to understand the role of contextual factors in relation to alcohol abuse, and to develop skills in motivating the client to change.

Participants identified alcohol abuse as a problem in the Burmese refugee community. For many men, alcohol became a solution, a way of obliterating the reality of unemployment, a hopeless future, lack of connection to others, and of avoiding the distress of traumatic memories and depression. In a vicious cycle, alcohol abuse also became the cause of unemployment, hopelessness and depression, and a contributing factor in domestic violence. Counselling for alcohol abuse should address these contextual factors.

This unit drew from motivational interview techniques to teach participants how to explore, with the client, the benefits of the problem behaviour and the pros and cons of maintaining it.

Unit 10: Ending and evaluation

The aim of this unit is to consolidate participants' learning and to obtain feedback on the workshop.

In our last halfday together, participants reviewed what they had learned, asked any remaining questions and presented cases where the direction still felt unresolved. In discussing plans for self-care, participants agreed on ways to support each other more, formed peer support supervision groups and/or planned to seek support within their own organisations.

To review the training and elicit feedback, participants were organised into small groups to discuss what they had learned and to identify what could have improved the learning experience. The most commonly expressed negative feedback was disappointment that the training was not long enough, a sentiment the author shared.

Following the five days of training, participants from the counselling workshop joined with participants from the other workshops for a final session where they drew together the issues and key findings, decided what to include in reports and reached agreements on how reports would be circulated and approved. Representatives from each of the workshops presented either key issues or reported on what they had learned. The trainers from the Centre presented certificates of attendance and a small gift to all participants. It was a joyful, yet sad, occasion as we said farewell.

Reflections on the counselling training

This section identifies main issues and challenges that differentiate this type of training from similar training conducted by the

author in Australia. It also includes recommendations for counselling training that might be offered to other refugee or displaced populations.

'Whole of community' approach

The counselling training described here was supported by a *'whole of community'* engagement that focused more broadly on refugee rights within the local context. There were a number of advantages to this approach, but two stand out. First, the counselling training was not the only place where refugees could raise their concerns. They could also participate in consultations that addressed human rights issues, such as lack of safety, lack of sustainable livelihoods, inadequate and unsafe shelter, lack of access to adequate medical care and education for their children. This enabled the counselling training to focus on the psychological aspects of not having access to these human rights. Second, this *'whole of community'* approach enabled documentation of the issues and support for the community in their own advocacy efforts, something that the counselling training of itself could not have provided without diluting the counselling focus.

Complexity of the counsellor's role

In providing counselling training in refugee contexts, it was important to validate both the practical component of counselling and the value of emotional support, especially in relation to the many problems not easily solved, such as financial problems. In crisis situations, counsellors needed the skills of empathy and the ability to be emotionally attuned in order to assess clients' needs, as well as a range of practical interventions to ensure safety and access to medical care and refugee agencies. The aim was to help them integrate these two aspects of their roles.

Boundary issues

In training counsellors in Western nations it is assumed that counsellors do not formally counsel friends, relatives, colleagues or neighbours. In this particular context, some of the counsellors elected to participate in the workshop precisely because they wanted to be more effective in helping relatives, friends and acquaintances. It became a *'rule of thumb'* to ask about the counsellors' relationships to their clients. For example, a counsellor became tearful as she discussed a *'case'* where a father had seriously injured one of his children while he had been drinking. She had tried to counsel the mother to leave the father and felt powerless when the mother refused. When I asked her about her relationship to this family, she revealed that she was the child's aunt, the mother was her sister, and she had a significant investment in the outcome.

Using interpreters in counselling training

Working with interpreters (who sometimes have to interpret from English into two languages) challenged me as a trainer to be clear, to use simple language and to enact or demonstrate ideas whenever possible. The training was slower, but while waiting for the translation, I was able to think about what to say and how to express it succinctly. I remained alert to nonverbal responses that indicated people were confused, or did not understand, knowing that the *'message given'* was not necessarily the *'message received'*. Metaphors were often used effectively for conveying complex ideas.

The issues of space and privacy

The ideal Western standard of counselling is usually a face-to-face, private and confidential conversation that takes place in the counsellor's office. In this refugee context, crowded living conditions, lack of

office space and unsafe environments often impede the possibility of a private conversation, and exposed the counsellor and client to the risk of unwanted attention or abuse from neighbours or relatives. As a trainer, I learned that as a rule of thumb I should always enquire about the context of the counselling: where it was taking place, who was present and who might overhear the conversation. This point was brought home to me when I was visiting a young woman in her home (a small room), because she had recently been assaulted. At one point I glanced over my shoulder and was shocked to see that three family members and a friend had entered the room and were quietly crouching on the floor behind me.

Networks and supervision

Within a Western context, most counsellors have a wide network of services where they can refer clients for specialised services, or material assistance. They also have access to regular supervision and support. Refugee counsellors do not have such networks, supervision or sometimes even colleagues to discuss cases. Powerless to change oppressive environmental conditions, conditions in which they themselves also lived, counsellors often felt overwhelmed by clients' problems. Psychologically, counsellors were at risk from burnout when they were overexposed to negative stories, when they were unable to provide the help needed and when they did not feel supported. Physically, they were sometimes at risk of abuse from angry husbands, intrusive neighbours and people on the streets. Faced with no other resources, counsellors would sometimes offer their own homes to a woman fleeing domestic violence, putting themselves and their own families at risk of violence from the estranged husband.

In the last session of each workshop, participants formed support groups anticipating that they would be able to meet for peer support and case discussion. Each year, the few participants who had been present the previous year were asked whether or not they had been able to meet in these support groups. Those who worked together would often report that they had met frequently for peer supervision. Others had not been able to overcome a myriad of obstacles such as geographical distance, the danger and cost involved in travel, lack of time, and the fact some families had been resettled, while others had relocated to different areas. In view of these difficulties, the Centre is considering offering an advanced workshop that would include supervision knowledge and skills, with the hope that this may enable particular individuals to offer supervision more formally.

Concluding comments

This paper described an approach to teaching counselling to refugees working as counsellors within their own communities. The counselling training aimed to develop participants' abilities to respond effectively to people in distress, while recognising that the participants themselves were struggling with issues similar to that of their clients. Participants developed skills in active listening, asking questions and being empathically attuned, conducting the first assessment interview, responding to domestic violence, conducting a couple interview, motivational interviewing to help clients reduce alcohol abuse, and skills in responding to people suffering from trauma and loss. Counselling training needs to be holistic, recognising the interconnectedness of refugees' emotional wellbeing with their needs for safety, physical health and sustainable livelihoods.

This workshop was only five days long and was delivered to participants who worked as volunteer counsellors who did not receive wages for counselling work. A more adequate programme would be longer, and would offer an advanced level, perhaps opening doors for some participants to obtain paid work as counsellors. The breadth of the counselling role, combined with the fact that counsellors are refugees themselves, presents unique challenges that this counselling training aimed to address.

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[1] The Centre for Refugee Research (CRR) in the School of Social Sciences and International Studies, University of New South Wales (UNSW), Australia, advocates for refugee communities both within Australia and overseas. It conducts research and education, partnering with community based refugee organisations and provides training. Since 2002, the Centre has worked with Burmese refugees women's organisations in Bangladesh, Thailand and India. http://www.crr.unsw.edu.au/.

[2] Students who are enrolled in a Masters of Social Development at UNSW participate in these refugee training projects, presenting workshop sessions and documenting the process. On average, 12 students participate in each of the internships and their course fees cover the costs of providing the training, including refugee participants' costs. After each visit, interns and staff provide the refugee organisations with reports that document the issues that emerged during the training. If requested, reports include a DVD that shows the refugees living conditions and vulnerability to risks (Women's League of Burma, 2007).

[3] '*Imaginal Exposure*' is a method of memory processing which involves progressively increasing exposure to a traumatic memory through repeatedly recounting the details of the trauma event.

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