CULTURAL COMPETENCE IN THE TREATMENT OF POLITICAL REFUGEES BASED ON SYSTEM APPROACHES

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Abstract

This article analyses the integrative trauma focused systemic treatment, developed for refugee families with regard to current views on cultural competence. The contextualized and multifaceted conceptual framework and flexible settings that facilitate treatment of culturally diverse populations are described and illustrated with a case example. The potential pitfalls of cultural competence as a strategy in addressing cultural diversity are discussed. The importance of implementing different markers of diversity, including the political dimensions applied in the process of assessment, building therapeutic relationship and treatment is underlined.

Key words: trauma, cultural competence, families, refugees

Declaration of interest: none

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Introduction

War and political oppression claim numerous victims every day. Today the media show victims of civil war and revolution in Syria and Mali but it is well known that in a couple of months there could be other wars, other countries and more people involved. History of mankind shows that war is part of life and there have always been victims of war. Some of the victims flee to other countries. In the 20th century, after World War II, with increasing mobility and means of transport, political refugees travelled long distances to find a safer place to live. They are called asylum seekers when they are required to prove that their fear of violence is legitimate and their claim that they will be prosecuted upon re-entering their country of origin is genuine. Once permission has been granted to stay in the host country they are categorized as political refugees.

Some refugees are victims of violence, imprisonment, torture, rape and other human rights violations. Others fear they will become victims of these gruesome events or have to flee with their families. Children are victims as well, both when directly facing violent situations and as witnesses to violence perpetrated against other family members. The effects of war do not end when individuals are in a safer environment. Physical and psychological consequences of war can last a lifetime and sometimes even continue into the next generation (Kirmayer et al. 2011). Refugees can suffer from Post Traumatic Stress Disorder (PTSD), Depression and other mental disorders (Silove et al. 2010). They sometimes find treatment for these disturbances.

In some European countries, Australia, Canada and in the US, specific mental health services for political refugees have been developed. In understanding the health-related complaints of refugees there is a wide variety of services. Individual differences of professionals working with refugees are based on their discipline and theoretical concepts. In explaining mental health problems, some health care professionals include the present condition of refugees, often facing a lot of uncertainty, discrimination and racism in the host country. Understanding and treating political refugees can be seen as a complex phenomenon. Mental health providers are confronted with multidimensional problems (psychological, medical, social, political, cultural, existential) and need to decide whether to reduce them, make them manageable or expand the context to understand the problems in their complexity. There are different explanatory models and options to approach problems on an individual, family, or community level or to focus at the interplay among different system levels. In all cases, therapists need to be sensitive to the cultural background of their patients.

In this article we will discuss the cultural competences of therapists in the treatment of political refugees based on a system approach developed by the Youth and Family team at Foundation Centrum ’45, one of the specialised treatment clinics in the Netherlands for psychotrauma complaints resulting from persecution, war and violence. This approach includes different dimensions of the experience of political refugees and pays attention to both individual and collective needs.

We will start with a case example to illustrate the

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impact of major intrusive events in a family and the consequences thereof for treatment, followed by a description of current theoretical perspectives of cultural competence. These ideas about cultural competence are used as a framework to analyse the systemic approach and interventions that therapists use in their work with refugee families. After a detailed explanation of the concepts used to understand and treat refugees, including trauma, loss and uncertainty, the integrative family focused systemic treatment is introduced. Illustrations of therapeutic interventions with a family underline the complexity of therapy processes and connect them to rethinking cultural competence.

Case: family from the Caucasus

In response to the increased severity of symptoms in an eight-year old boy from a family from the Caucasus living in an asylum-seekers centre in The Netherlands, his family was referred for mental health care to Centrum '45. The family consisted of father, mother, the boy and his brother who is three years younger. In their home country, they enjoyed life in the outdoors, living close to the mountains and growing fresh vegetables and fruit. Their way of living was disturbed by the continuing threats creating an unsafe environment.

They are introduced at the institute with the following problems: The eight-year old boy has nightmares and he is hyper alert, expecting something bad will happen at any given moment. He has difficulties adapting in school. He shows aggressive behaviour, and is provocative towards his brother. Mother has severe symptoms of PTSD and depression and is inactive and withdrawn. During the initial encounters, she has no wish to continue living. Father is the strongest person in the family. He suffers from feelings of guilt and feels powerless to change the situation. He has been offered a voluntarily job at a farm nearby but has recently stopped his activities there. The youngest boy prefers to spend time outside the family mostly. He enjoys school and at times rejects interference by his family members. He attracts attention from others easily.

Prior to the referral to Centrum '45 the oldest son had been offered EMDR[1] *and other family members were offered support as well (the voluntary work offered to the father, pharmacotherapy to the mother). They were referred to the institute when these efforts proved insufficient.*

Cultural competence: current thoughts

Cultural competences describe the knowledge, skills and attitudes of therapists dealing with cultural differences – in this case ethnic, religious, political and social factors in the background of patients. Thinking about cultural competence has been developed since the term was popularised in the '90s (Kleinman and Benson 2006a).

Increased diversity in societies has led to processes of change in mental health organizations. Professionals became aware most of their theoretical models about psychological problems and mental health complaints were based on research and theory using white middle class families as the mean. Attempts to broaden conceptual frameworks of psychopathology, treatment and efforts to change organizations in order to make them more culturally sensitive have taken on many forms. One of these approaches is thinking about cultural competence.

The initial and perhaps dominant mode of cultural competence emphasizes specific attributes or characteristics of individual practitioners (Wendt and Gone 2011). Different models, descriptions and questionnaires exist to help therapists evaluate their knowledge, skills, and attitudes in the treatment of patients who are culturally different from themselves (Sue et al. 1982, Sue et al. 1992). One of the problems with the idea of cultural competency is that it suggests that a cultural sensitive approach can be reduced to a technical skill. Culture is in this perspective considered synonymous with ethnicity, nationality, and language, and therefore predominantly regarded homogeneous and static (Kleinman et al. 2006a). Rethinking cultural competencies implies the risk of stereotyping and enlarging cultural differences and underestimating institutional and political dimensions of intercultural care. The focus should be on both the organisation and the individual therapist instead of individual competences alone. With a model that focuses on individual knowledge, skills and attitudes of cultural differences, one can easily assume that if therapists have the necessary competencies, they can treat all patients equally. The organization, as a whole, is responsible for the training of their staff and for issues of accessibility. Despite the fact that cultural competency might draw the attention of professionals to certain ethnic groups, these professionals face the risk of perceiving all members of a specific ethnic group as similar and minimize the influence of other aspects of diversity like gender, age, education and social class (Kleinman and Benson 2006b, Mirkin 1998).

Another issue in rethinking cultural competence is the intergroup and intragroup difference. Falicov (1995) writes about cultural niches to stress the fact that cultural identification is multifaceted and dynamic. Creating a stereotype of the 'cultural other' can actually do more harm to individual patients than treating them all the same. For therapists working with refugees, this second line of critique on cultural competencies deals not only with the overestimating of ethnic diversity but deals especially with the overestimating of the differences between refugees suffering from PTSD (or other disorders) and 'regular' patients suffering from (other) traumatic experiences.

A third aspect of rethinking cultural competency is associated with the different meaning of diversity markers. Ethnicity, gender, religion, education, sexual orientation and political position can lead to very different values and burden the concept of cultural meaning people give to life and their experiences. Much attention has been given to the mix of variables like ethnicity and gender (Boedjarath 2002, Wekker 2009), and less to religion though that seems to get more attention recently (Pargament et al. 1998). However, the influence of political ideas about the meaning of experiences is still undefined and often not included in thinking about cultural competencies. People living in societies where conflicts between different ideological groups might lead to danger, are well aware of this kind of thinking. A context of mistrust and a taboo or restrictiveness in disclosure about one's own thinking, can have serious effects on psychological processes and mental health issues.

Another and last critical argument on cultural competency is that it underestimates institutional biases, socio-political influences and power dynamics (Wendt and Gone 2011). The argument is that psychotherapy and other psychological interventions are culturally

[1] Eye Movement Desensitization and Reprocessing

European from origin and can be ineffective or even harmful to people with a different cultural background than the therapists. Mainstream psychotherapy is based on a western cultural concept of the self as individualistic, rationalistic, monological, univocal, and egocentric (Cushman 1995, Kirmayer 2007, Taylor 1992). To participate in psychotherapy one embraces the 'talking cure' in service to personal transformation. The awareness of the political position of service providers has lead critical psychologists to question the dominance of the medical model (Ingleby 2005) and evidence based practices where the evidence comes from homogenous patient populations (Knipscheer et al. 2012). An alternative has been provided by Wendt and Gone who think that cultural commensurability between available forms of psychological intervention and the treatment needs of culturally diverse populations can lead to alternative frames of treatment programs.

Models about cultural competencies have been redefined in different ways, changed and polished in order to take into account the complexity and diversity of the therapeutic interactions. A phenomenological study of clients' experiences of cross-racial therapy (Chang and Berk 2009) shows that clients perceive most cultural competencies of their therapists as 'just' good qualities and they evaluate these competencies as professional without referring to cultural differences. "Cultural awareness, knowledge, and skills are clearly valued in cross-racial contexts but clients are particularly sensitive to acts of cultural incompetence. Such acts to be avoided include applying either 'generic' or 'textbook' interventions that do not take clients' lived experiences into account, addressing only particular facets of clients' complex cultural selves, and invalidating the social realities of being a racial or cultural minority" (Chang and Berk 2009 p. 530). In order to avoid cultural incompetence, therapists need a broad base knowledge and appropriate attitudes and skills to deal with different cultural sensitivities in building a relationship with the client, assessment of psychological problems and treatment.

The context of refugee experience: traumatisation, loss and uncertainty

Refugee families are confronted with cumulative stress and multiple disruptions in their life. Organized violence, forced migration and several losses are often intertwined with multiple stressors in post resettlement period due to long-lasting asylum procedures with uncertain outcomes. Therapists need a basic knowledge of the commonalities of the refugee experience. This entails an understanding of the pre-, peri- and post-migration factors.

Pre-migration

Refugees have felt forced to flee. At one point in time they decided that the best alternative would be to seek shelter elsewhere. This decision was prompted by experiences such as risking one's life because of repeated captivity and torture, on-going instability due to bombardments and shelling, the loss of all property or being threatened and discriminated.

The experience of violence and loss (more than just poverty) as a reason to migrate has been found crucial for understanding refugees' mental well-being. In light of understanding the consequences of the accumulation of stressful experiences, the refugee experience has become a synonym for the occurrence of Posttraumatic Stress Disorder (PTSD). And indeed, the prevalence of PTSD in refugee populations has been significant (Fazel, et al. 2005, Fazel et al, 2012, Reed et al. 2012). However, the majority of refugees do not suffer from PTSD nor from co-morbid disorders.

Peri-migration

Once they have made the decision to leave their country, many refugees are often the targets of human traffickers to whom they offer their life savings. The flight itself is often stressful and at times, dangerous and hazardous. It is time consuming and many people are unaware of their travelling itinerary. They are handed from person to person and are not always treated well. They sometimes end up in different countries or are separated from family members.

Post-migration and acculturation

After arrival in a Western (European) country such as the Netherlands, asylum seekers are granted a very basic level of residence (bed, bread and bath) during which time they await the outcome of the legal procedure. Children are allowed to go to school; adults however are not allowed to work or start activities that would facilitate integration in Dutch society. Living in an asylum-seekers centre means living in a communal centre with people who are stressed by long lasting uncertainty. There is limited privacy, different languages and other asylum seekers who are primarily focused on themselves. Some of these asylum seekers have serious mental health difficulties. The staff turnover of these centres is at times problematic and in some centres there have been serious escalations of aggression.

Asylum-seekers are regularly confronted with judicial hearings by the authorities and many must report daily to get a stamp. Upon referral to a mental health service, some are reluctant to give information during the intake procedure because they experience this as the next interrogation they have to go through and are not easily convinced it's for their benefit.

For many refugees a new challenging period starts once they have been granted legal refugee status. They need to restart their disrupted life and prove to the relatives left behind that the migration has been worthwhile. Often they have waited for this moment for years. At the same time, it is often difficult to adapt to this new situation and suddenly invest in their environment. Many refugees find it difficult to build up a new social network in which they feel understood, acknowledged and respected. At the same time, they miss - worry about - and feel responsible to help - their relatives in the country of origin who are maybe still in danger and have been supportive in them leaving the country.

Acculturation refers to the process of adapting to more than one cultural group. It means being able to live in at least more than one cultural context. This includes learning another language, trying to find work and additional education but also potential challenges for values and norms that are believed in; the customs and festivities that are maintained and the extension of social contacts. These choices are usually made implicitly and gradually in time; generations within one family often differ in the speed and domains of acculturation.

Reconnecting: building up a trusting relationship

A premise for all therapies is a basic trust between client and therapist. In the case of refugees, as in other trauma survivors, this basic trust is often severely damaged. Creating a comfortable, safe and trusting relationship might include addressing four elements of the 'refugee experience'.

a. The importance of hope and acknowledgement of resilience;
b. The continuous re-identifying experience;
c. The significance of justice and (dis)trust in authorities;
d. The gap between refugee and civil experience (social disruption).

a. The importance of hope and acknowledgement of resilience

Refugees have been strong enough to make the decision to seek safety, shelter and/or freedom elsewhere. It is very important to support their resilience. Most often they have been through worse times excluding their stressful stay at an asylum seekers centre. In the course of counselling or therapy it may be helpful to seek and strengthen these islands of coping and remaining resources by rebuilding a sense of hope. As a result of isolated living (surrounded by different languages) combined with high anxiety level, many clients are not accustomed to speaking out or discussing problems to find solutions.

b. The re-identifying experience

It's rare for refugees to encounter people that are genuinely interested in their past. The life they lived, the ambitions they had, their aspirations for a certain future have vanished the moment they left. Upon arrival in a host country, they are registered as asylum-seeker and their opportunities to socially connect with the host society are limited. During asylum-procedure and at times even later they live amidst fellow anxious and stressed refugees. Many of them choose an isolated and withdrawn life. Some consider talking about their past risky in the face of legal authorities that judge their narrative for inconsistencies and missing information. When granted legal status, re-starting their disrupted lives requires the capacity to socially connect and trust in a new social and cultural environment.

c. The significance of justice and (dis)trust in authorities

In need of acknowledgement of the severity of the events that led to the escape to a safe country, refugees' feeling of safety is often dependent upon the local safeguards that serve justice. Refugees feel vulnerable in their sense of being protected, especially if they have been confronted with brutal violations of human rights without perpetrators being caught or held responsible. As one male Kurdish refugee from northern Iraq proclaimed, when, after seven years of waiting he had received his passport: "Now I am free, safe and no longer alone".

d. The gap between refugee and civil experience (social disruption)

Asylum-seekers live in communal shelters in large-scale buildings usually in the outerskirts of towns and sometimes hidden in the forest. In the Netherlands, a separate insurance arranges health care provision. Asylum seekers live on a social island and are generally excluded from integration. Few local citizens get in touch with these newcomers. They feel looked upon as strangers, and are sometimes discriminated. For many refugees and their families these circumstances may last several years. After being granted a legal permit, it is a major challenge to change this semi-dependent life-style into a pro-active, self-realizing way that lives up to Western society's expectations.

Integrative trauma focused systemic treatment

An analysis of the complex mental health needs of refugees includes cultural sensitive assessments and interventions. A broad contextual framework is necessary to understand the complex problems and the cultural diversity of the family consequences of cumulative stress (Bala and Kramer 2010). The integrative approach to treatment of refugee children and families, developed within Youth and Family team in Foundation Centrum' 45 (Van Essen and Bala, 2007, Van Essen et al. 2007) is based on systemic and developmental perspectives and on theories of family stress and coping. The assessment and treatment focuses on the interplay between internal (biological, psychological) and external (familiar, cultural, social, political) influences that hinder or facilitate the development of children and families (Cicchetti and Cohen 1995).

Assessment

The assessment of the problems starts with exploring how the organized violence, forced migration, and ongoing stressors influence family life, how family members make sense of it, try to cope with it and adapt to it.

Premigration period – antecedent events: what was the family structure, organization, socio-economic status before the period of violence, past stressors

Period of organised violence**:** the impact of political economic changes, violence witnessed of experienced by family members, separations and losses and its consequences on family members and to the family as a whole, how family members try to cope with it

Flight and migration**:** reasons and circumstances of flight, planned or abrupt, permanent or temporary, who stayed behind, worries about family members, how family members deal with separations and losses

Post migration period: asylum seeker status, changes in socio-economic position, family structure and organisation, influence of socio-political context toward refugees in country of arrival, coping with uncertainty

Acculturation process**:** impact of migration on family life, differences in acculturation tempo, experiences of discrimination or racism and how the family deals with it.

As part of the assessment, we try to understand how family members perceive and define their problems, what matters most to them and what are their expectations. The co- creation of shared meaning of problems and goals of treatment is a gradual process that requires a certain degree of intercultural flexibility and openness for mutual adaptation between the therapist and clients. Besides the problems we explore the coping capacities and resources of the family, looking for what they perceive as being helpful and at what kind of support they have or expect.

Political violence leads to changes in multiple dimensions of family life and also to strategies for managing those changes (Weine et al. 2004). Living in cumulative stressful circumstances impacts not only the individual but the family as a whole as well. Responses that are part of mental health disturbances caused by traumatic experiences (e.g., PTSD, depression) can interfere with individual development and the family as a whole. The disruptive processes of traumatisation, uprooting and marginalisation affect children and families differently, according to the developmental stage and the stage of the family life cycle (Bala 2005).

The interplay of cumulative trauma with recent stress such as post-resettlement, acculturation and perceived discrimination are associated with greater PTSD symptoms (Ellis et al. 2008, Steel et al. 2002). Trauma related symptoms are often undermining parental functioning and parent-child interactions (Appleyard and Ostrovsky 2003, Kiser and Black 2005, Price et al. 2010) lack of empathy, hostility, diminished emotional availability and negative perception of the child's behavior (Van Ee et al. 2012).

Beside the family consequences, during assessment we explore the *post-traumatic family processes* that are influencing functional or dysfunctional adaptation, based on research findings, clinical observations and reflections of prolonged clinical work (Bala and Kramer 2010, Van Essen et al. 2007). We explore how family members make sense of experiences, in which way they communicate about traumatic and other stressful events, in which way they respond to painful experiences, and how their relations and roles in the family have been changed.

The family from the Caucasus had fled their country after the youngest child had died as a result of violence directed at the family by a paramilitary group. The two older children were present during the assault. For a long time it remained unclear to what extent they had witnessed what had happened. Mother had fainted at the time, father had been absent as he had been captured at that time.

After the death of the child, the family had buried the child at a local graveyard and decided to leave the country. Father and mother are still searching for a way to make sense of the events. They believe that after all what happened they would never ever be happy. Life would never take a good turn. The assumption that the events would not have happened if father had been at home increases father's feelings of guilt. The long lasting uncertainty related to the asylum procedure reaffirms the assumptions of family members that there is no place for them to stay and leads to an aggravation of the anxiety. Parents feel powerless to reduce the anxieties of children because they themselves feel unsafe.

Mother is overwhelmed with sadness and stays in bed most of the time. All family members struggle with nightmares and reoccurring memories. There are strong bonds between family members but they don't know how to approach or support each other. Parents find it too painful to talk about the past; children do not dare to ask questions. Without understanding what really happened, the children believe that family members can die any moment. Mother can hardly take care of children beyond their basic needs. Father is taking over parental responsibilities, but neither he nor mother succeeds to set limits. They feel powerless in stopping the fights between the children. Faith and connectedness help family members to cope with problems, but parents believe their resources to cope are depleted.

In their adaptation to high stress levels, refugee families make use of both old and new ways of coping. We explore the family coping and resources, what family members find helpful, in which way they support each other, pleasurable activities they share together, problem solving skills and utilisation of external resources.

Integrating cultural competent mental health approach in therapy

The program of Youth and Family team at Centrum '45 is family centered; strength based, focused on trauma, the impact of grief and on ongoing stressful events. The work is multi-disciplinary, combining methods and settings, and a contextual and inter-cultural approach is being used to adjust the programs to the problems and needs of refugee families. Individual, family and multifamily therapy are integrated, using trauma focused treatment in individual setting with reducing the relational consequences of traumatic experiences and ongoing stress within family settings, working when necessary with subsystems. Interventions are directed at reducing the stressors, overcoming the psychosocial burdens of refugees' experiences, altering dysfunctional family adaptations and strengthening coping capacities, family and community resources. In family and multifamily group settings the aim is to enhance the management of emotions and memories of family members, open communication when acceptable, the co-construction of family meaning and strengthening mutual support. Improving the marital and child relations, with specific focus on restoring competent parenting undermined by consequences of long lasting cumulative stress is one of the essential goals in this work.

Refugee families supporting each other is one of the most fruitful way of facilitating family adaptation and change in the face of adversity for refugee families (Weine et al. 2004). A mentalisation-based form of multifamily therapy has been adopted from the Marlborough Family Service in London (Asen and Scholz 2010) and adapted to the work with traumatised refugee families. Multifamily therapy is a combination of group therapy with family therapy. The therapist's role is to facilitate and maximize interaction and create settings for change. Preferably, interactions are elicited that represent real-life behaviour that is at times problematic in the home environment. In a highly structured whole day treatment, a context for change is being created through variation of flexible settings (intra-family, inter-family, parents-children apart) and activities. These activities intensify the interactions, offer possibilities for studying problematic interactions that occur in daily life and give room to new experiences. Systemic interventions and video feedback are used to punctuate current problems. Other families present are encouraged and invited to reflect on critical interactions, communication and give feedback.

Reflection and generation of multiple perspectives facilitate the process of mentalization (often reduced by posttraumatic stress symptoms and/or comorbidity and stress) that allows family members to understand their own and other's thoughts, feelings and needs better. Encouraging experimentation and engagement through playful problem solving or family activities, foster-parenting, role playing help family members to practice new behaviour in a safe surrounding.

The therapy has four ingredients:
1. Family members interact with and support each other
2. Norms and values and perspectives are (re-)defined within the group
3. Playful activities generate interest in and curiosity for fellow participants
4. Sharing information evokes acknowledgement and respect which positively influences sharing narratives and social connection.

As we work with multifamily groups from various socio-cultural background supported by several translators, a specific intercultural exchange develops. The cultural competency is achieved by consciously working with both commonalities and diversities within the group. Evoking these generates multiple perceptions and new learning experiences among the members.

During multifamily therapy, family members get more insight in the consequences of traumatic experiences and ongoing stress on their daily life. They get a better understanding of each others reactions, become more supportive, engage in minor pleasurable activities and break their isolation through contacts with other families. Supported by other families parents become gradually more emotional available to their children. Parallel with individual trauma focused therapy for the oldest boy followed by multifamily therapy, the processes that were blocking the communication about the past were discussed with parents to create space for the exchange of family narratives. Realizing the impact of her own posttraumatic reaction on her children, the mother opened up and could start trauma-focused therapy.

Cultural competences in working with political refugees

Based on the rethinking of cultural competences in general, we can elaborate on cultural competence in working with political refugees. Those include individual cultural competences of therapists and cultural competences of the organisation.

Some basic knowledge about war, oppression and violent conflicts in the countries refugees fled from is required but a therapist is not a Human Rights watcher by training. It's certainly helpful when the organisation facilitates the gathering and exchange between workers of the 'basic knowledge' about countries and ethnic, political, religious, gender, class and other differences that are relevant for treatment.

The development of the Integrated trauma focused systemic treatment for refugees in Foundation Centrum '45 shows that time and experience is required to integrate many aspects of the experiences of refugees and the psychological reactions to trauma, coping and adaptation processes in families. For assessment and interventions, a multifaceted framework, flexible therapeutic settings are helpful and combining different disciplines seems very fruitful.

Working with survivors of trauma, especially when caused by other people, includes paying attention to the shattered basic trust. The recognition of factors that make political refugees cautious to relate to other persons – in this case the therapists - and discussing the effects of distrust, helps refugees to establish the needed base of trust to explore the impact of traumatic experiences both in their individual lives as well as in their family relations.

The family consequences of cumulative stress need to be understood in the context of pre- and post post-migration context. A culturally sensitive assessment requires openness to different perspectives and interpretations, related to how problems are perceived, understood and responded to (Measham and Rousseau 2010). Creating space, where mutual understanding and negotiation of various meanings become possible, is a precondition for an effective cultural exchange. Besides being open to how the family defines what constitutes the problem, the therapist must be prepared to examine, adapt, or even discard the usual assumptions, methods and goals of the therapy (Di Nicola 1997).

Engaging in clinical reflection on what way oppressive ideologies and practices might be influencing family members is, according to Dallos (1997) a valid component of the therapy. Placing the origins of the events to the socio-political domain where they belong, helps differentiating the personal and political aspects of the problems and understanding their interplay (Bala 2005).

Approaching the family with respect and curiosity and a 'not knowing attitude' are important ingredients for a successful assessment process. Therapists working with political refugees need to be attentive not just to what is told, but sometimes even more to what is not told. Developing tolerance for "not knowing" by being ready to deal with ambiguities, uncertainties and inabilities or cultural inhibitions to talk about various aspects of experiences is essential when working with political refugees. The untold, as a consequence of distrust, fear of avoidance of pain or consequences of what has been told, is used often as a protective measure. Realizing that protection is needed before one can disclose painful experiences or want to protect other family members from it, helps therapists to avoid being cultural incompetent.

Integrating individual and family therapy introduces more options and flexibility in treatment. The multi family therapy includes various settings that facilitates a cultural sensitive approach and enhances the therapist competences to adequately meet the need of refugee families. The setting and interaction with other families, helps refugees realize how each family and individual family members react to and manage traumatic experiences and ongoing stress. What seems very logical, but unhelpful to one family, could be seen in another perspective by other families and regarded an alternative to dysfunctional adaptation. Coping strategies can be restricted, fixed or have become inflexible, can be loosened up in a context of trust, sharing of experiences and learning new ways to manage past and present stressors from each other. Cultural, gender, political or religious differences can became an enriching experience for families sharing common problems.

Political dimensions of cultural competence are in essence not different from other markers of diversity. Therapists need to remain open minded to meanings people give to their experiences that can be very different from their own interpretation. Political aspects of the experiences of refugees can be connected to their past, the impact of violence against specific groups or the tensions in family relations as a consequence

of such. But political dimensions of problems in the present situation have major influence on daily life and mental health problems of the refugees as well, needs to be dealt with, because for almost all refugees it takes a long time to get certainty about their stay in the Netherlands and feel safe.

For therapists it's important to use an idiographic perspective, conceptualizing the client as a whole person with multiple and intersecting cultural identities that are changeable through time. Interactions with the clients and interventions shouldn't stereotype the client based on normative assumptions about their cultural group (Ridley 2005). Therapists should try to avoid being cultural incompetent by understanding and dealing with multiple markers of diversity and facilitate discussion about the impact of experiences both on individuals as on family members.

Conclusion

The acknowledgment of diversity in patients seeking mental health has led to the development of models of cultural competences. Rethinking, redefining and shaping these models underline pitfalls in focusing on the cultural background of both patients and therapists. We argued that patients probably take cultural competence for granted. They are much more sensitive to signals of cultural incompetence of therapists. It is important that therapist pay attention to different markers of diversity, including the political dimensions and their consequences for the perception of problems of refugees to avoid stereotyping certain ethnic and cultural groups.

The contextualized and multifaceted conceptual frames and flexible settings offer multiple opportunities to include diversity in the treatment of refugee clients. Facilitating an open dialogue with the clients within family therapy and promoting exchange of experiences in the multiple family therapy with clients of diverse cultural background increases awareness of own interpretation of the problems and opens up different perspectives. It creates an environment in which individuals and families regain more adapted ways to integrate life- and trust shattering experiences. The method described in this contribution is being applied to a wide variety of families with regard to cultural and societal backgrounds. We see no reason that it's usefulness is restricted to industrialized countries. Rather, working with families in both a systemic, group and trauma-focused way may work well worldwide and contribute to the cohesion in communities. Evidence-based trauma therapies can be included as long as they are reconsidered with regard to the impact of specific cultural components of the background of refugees. The emphasis on increasing curiosity for alternatives and differences facilitates inter- and intra-cultural growth and development.

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