The Routledge Handbook of Religion, Spirituality and Social Work

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Publication details
https://www.routledgehandbooks.com/doi/10.4324/9781315679853.ch34
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Published online on: 27 Mar 2017

https://www.routledgehandbooks.com/doi/10.4324/9781315679853.ch34

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Spiritually informed social work within conflict-induced displacement

Malabika Das

Introduction

Globally, more than 60 million people have been forcibly displaced by conflict from places such as Syria, Afghanistan, Myanmar (Burma), Iraq, Sudan, Somalia, Eritrea and many others (UNHCR 2015). Conflict-induced displacement is a type of forced migration where people flee their homes from armed conflict, civil war, generalised violence or persecution on the grounds of nationality, race, religion, political opinion or social group, and where the state authorities are unable or unwilling to protect them (FMO 2012). Within these cruel, human-made disasters, displaced persons (hereafter, survivors) must leave everything they know for safety. Survivors are at risk of high degrees of traumatisation from often harrowing conditions encountered during displacement, including torture.

Spirituality and religion are frequently accessed for relief when normality becomes devastated (Worland and Vaddhanaphuti 2013). As one faith-based service provider from my research in Hong Kong has commented:

The spiritual aspect is crucial because if you take away that you’ve got little hope. The hope factor is reinforced with faith. Faith, hope and trust, they are the key areas, but love is crucial to the whole of that.

This chapter emphasises spirituality and its expansive dimensions inclusive of faith and religion. It seeks to highlight the intersection of spirituality within conflict-induced displacement and how social workers can play a more spiritually informed role in the healing journey of survivors. Here, spirituality is conceptualised as a core human aspect, broadly encompassing meaning, purpose, wellbeing and morality in relations with self, other beings, the universe and engagement with sacred or transpersonal transcendence (Canda and Furman 2010). Religion refers to an organised set of beliefs and practices, and faith refers to the transcendent and interpretive elements of religious experience (Tuskan 2009); both embody spiritual dimensions.
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Trauma and displacement

Survivors face a myriad of traumatising factors during the displacement journey. An event becomes traumatic when coping skills and normal stress reactions are overwhelmed and where physiological and mental functioning cannot normalise afterwards (Murakami 2015). Trauma can result from single, continuous or accrued events in life (Clervil et al. 2013). The stages of migration and commonly identified features generally include: Pre Flight (violence and persecution), Flight (loss of loved ones, trafficking and smuggling risks), Displacement (tents, urban areas or within country borders) and Resettlement (third country or voluntary repatriation) (Farmer 2015).

Trauma and holistic health impact

Trauma impacts psychological, physical, behavioural, social, emotional and spiritual health domains. Torture, for instance, produces physical pain, social degradation, humiliation and spiritual distress (Tuskan 2009). Fortunately, many people will recover from trauma; some, however, experience severe and devastating health and mental health consequences (Clervil et al. 2013). They are often not equipped to deal with the emergence of overwhelming emotions and can be consumed by negative feelings (Mollica 2006).

Post-traumatic stress, somatisation, substance misuse, headaches and chronic pain are just a few common issues. Untreated mental health problems can advance into physical health issues such as diabetes, cardiovascular disease, hypertension and cancer (Jeon et al. 2001). The accumulation of interacting mental, physical and behavioural health conditions can rapidly increase overall disability. The range of bio-psychosocial-spiritual health sequelae can vary; however, common features include:

1. **Bio**: body, head and joint pains, infectious disease, torture and violence injuries
2. **Psychosocial**: loss, grief, sadness, betrayal, hopelessness, weakness, anger, shame, guilt, humiliation, economic insecurity and loss of livelihood
3. **Spiritual**: doubting faith, questioning divine and life

Health and wellbeing research

Research and practice confirms how health deterioration associated with negative life experiences can be mediated by spiritual practices (Mollica 2006). While religious and spiritual beliefs are recognised strengths during adversity, they are under-investigated (Ai et al. 2003; Gozdziak 2002). Historically, the trauma model, focusing on pathology, dominated refugee research. It was valuable in creating reliable trauma outcome measures and documenting human rights abuses (Jeon et al. 2001). Later, displacement stressors, such as unemployment and family separation, also revealed mental health deterioration (Schweitzer et al. 2006).

Research eventually turned towards psychosocial growth (De Haene et al. 2010), offering a balanced understanding of trauma and positive aspects of human experience (Park and Ai 2006). Nevertheless, individual and collective psychological resources and coping strategies are often missed and underutilised by researchers, practitioners and policymakers (Puvimanasinghe et al. 2014). However, excitingly, the limited but emerging evidence largely supports spirituality’s important role in survivors’ wellbeing, including the intersection of worldviews and health, the concept of health as holistic and examples of spirituality dimensions from my research.
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Convergence of cultural and spiritual worldviews for coping, health and wellbeing

Survivors exemplify diverse worldviews comprised of cultural factors, belief systems, healing traditions and help seeking behaviours and norms. This abundant diversity informs understanding of spirituality, coping, resilience, health and wellbeing (Canda and Furman 2010). Several studies illustrate these aspects. In Australia, Sudanese refugees’ belief in God enabled emotional support, control and life meaning and prayer offered solace for sadness and loneliness (Schweitzer et al. 2007). In the US, Liberian refugee women’s gratitude aided the appreciation of helpful people and new things, supported positivity and generated goodwill towards new friends (Clarke and Borders 2014). Similarly, Burundian and Sierra Leonean refugees in Australia expressed how being helped and helping others assisted in surviving displacement, adapting to Australia, helping others back home and religious-inclined meaning making (Puvimanasinghe et al. 2014). These facets of altruism related to their empathy and gratitude. For some Sierra Leoneans, beliefs of destiny and God’s will supported meaning making from suffering and coping with distress.

Some Bosnian refugee women in the US viewed religion as an organised institution and spirituality as a belief in higher power (Sossou et al. 2008). A study of cognitive and spiritual resources for Bosnian and Kosovo refugees in the US revealed how optimism associated with positive religious coping and higher education and hope associated with education but negatively associated with negative religious coping (Ai et al. 2003).

In the UK, Somali refugee women accessed spiritual and religious support largely through familial and personal resources (Whittaker et al. 2005). Somali and Islamic beliefs informed spirit possession views. Zar possession was punishment for lacking religion, but prayer and Qur’an reading/narration offered spirit protection. In the US, Somali refugees’ religious beliefs impacted health behaviours; the Qur’an was accessed prior to formal medical care and illness and wellbeing were determined by God’s will (Clarkson-Freeman et al. 2013).

Spiritual coping factors for Tibetan refugees in India involved strong faith for protective spiritual leaders, including the belief that His Holiness Dalai Lama was the manifestation of the Bodhisattva (enlightened being) of Compassion, reborn to serve humanity (Hussain and Bhushan 2011). Faith in karma and reincarnation enabled acceptance of suffering and building of resilience. Interestingly, the Dalai Lama himself fled to India from Tibet after China annexed Tibet in 1959; afterwards, thousands of refugees followed.

Interconnection of health domains

Survivors’ worldviews often embrace a holistic health perspective where health domains interconnect within the whole person. Karen refugees in the US identified health as not merely the absence of disease, but a balance between spiritual, physical and mental health, impacted by lifestyle, food and environment (Oleson et al. 2012). Similarly, participants of testimonial and spiritual healing ceremonies in India, Sri Lanka, Cambodia and Philippines regarded body and mind as one; conceptualised as ‘embodied spirituality’ (Agger et al. 2012: 571). This included elements of prayers, rituals, dances and symbolic pilgrimages.

Within healthcare, the interconnection of spirituality facets is emerging. Reiki, combined in a multi-disciplinary approach, accelerated torture rehabilitation (Vargas et al. 2004). Qigong and Tai Chi with refugees decreased psychosomatic complaints, increased body attunement, psychotherapy introspection and overall holistic wellbeing (Grodin et al. 2008).

Whole traditional medical systems, such as Traditional Chinese Medicine (TCM), dominated a systematic review of complementary and alternative modalities (CAM) with refugees...
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(MacDuff et al. 2011). TCM views the body, mind and spirit as a connective and interactive system (Leung et al. 2009). Vital energy (qi) flows freely when health is balanced but can be blocked due to physical, emotional and/or spiritual distress.

**Hong Kong case illustration**

Spirituality dimensions were integral for coping and wellbeing in my research regarding ecological forces impacting mental health and psychosocial wellbeing of survivors in Hong Kong (Das 2015). Research participants noted a variety of pre-flight trauma: cruel and inhuman treatment, persecution, kidnapping, violent death of loved ones and massacres. One faith-based provider shared:

There are people who suffered significant traumas; some who have been tortured and threatened with death; some experiencing periods of imprisonment by secret police. The trauma is almost indescribable over time. How they survived and remained reasonably intact is a miracle in itself.

Case study participants experienced a cycle of holistic health deterioration linked to systemic empathic failure of humanitarian, livelihood, protection and healthcare services. Fears of refoulement (forcible return to a country where they may be subjected to persecution and violence) and living in traumatic uncertainty (uncertain lengthy protection processing time without livelihood options) increased health deterioration. Unaddressed mental health issues worsened. Eventually, physical and behavioural health issues also manifested, including hypertension, diabetes, chronic body pain, family violence and substance dependency.

Coping strategies revealed how participants accessed a variety of spirituality dimensions. For instance, altruism, helping others without expectations, was integral to a participant’s wellbeing when he helped at an organisation; he shared: ‘When I am helping, I am too much happy.’ Also, gratitude emerged as a healing catalyst and daily coping strategy for another participant living in limbo for more than 11 years. His gratitude attitude comprised both spiritual and cognitive aspects; he shared:

In life is to be grateful everyday. So at Chungking Mansion for example, I see people sleeping on the stairs or old ladies pushing the trollies just to get one or two dollars. I say “God, thank you for everything”. I feel like my situation is not the worst, I am so thankful.

Features of strong faith and having a belief system was helpful for one participant’s inner strength and daily stressors:

My faith really helped me a lot. What I decided is God has a plan for me, no matter what. Because if you have two sides of your expectations, that’s not really faith. You suffer because God is planning something better for you. That means, he’s teaching you, bringing you to get that wisdom, which will lead you in a better and joyful situation.

**Bio-psychosocial-spiritual approach**

Research and practice has demonstrated spirituality’s integral role in wellbeing. ‘When the traumatized inner self is thrown into chaos by violence, spirituality can prevent a total disintegration of the person’ (Mollica 2006: 176). When violence occurs, the bio-psychosocial-spiritual
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self-healing force is activated (Mollica 2013). However, if not appropriately supported, trauma reactions can cause holistic health deterioration.

For multi-dimensional issues such as conflict-induced displacement, integrative assessment and treatment approaches incorporating physical, cognitive, emotional, social and spiritual experiences are needed (Leung et al. 2009). A bio-psychosocial-spiritual approach should be used for traumatised refugees (Mollica 2008). It can aid holistic exploration inclusive of torture, stress, isolation, losses and social support (Das and Chan 2013).

Social work has long encompassed the strengths perspective as a fundamental pillar; this emphasises people’s inherent healing and resilience capacities, as opposed to reductionism (Canda and Furman 2010). Drawing from this ideal, the bio-psychosocial-spiritual approach represents interconnected health aspects of the whole person that should be accounted for: bio (physical), psycho (mental/emotional/psychological), social (cultural/political/economic) and spiritual (life meaning) (NASW 2005). This view resonates with social work’s person in environment commitment (Canda and Furman 2010).

However, professionals have not been prepared to work with cultural aspects of mental health, such as spirit possession beliefs (Whittaker et al. 2005). Spirituality issues have often been passed to spiritual providers (Piwowarczyk 2005). While no professional consensus around spiritual practice exists (Crisp 2010), practitioners can become more attentive to spiritually informed features, which can aid strengths, healing and transformation support for survivors.

Table 34.1 summarises three primary features and corresponding components, each of which will be discussed in turn.

| Table 34.1 Spiritually informed features |
|-----------------------------------------|----------------------------------|----------------------------------|
| Practitioner attributes | Bio-psychosocial-spiritual assessment | Healing and transformation support |
| Spiritual self-awareness | Ecological system | Advocacy |
| Trauma informed | Holistic trauma and health impact | Strengths-based therapeutic approaches |
| Empathic learner | Worldviews and belief systems | Multi-disciplinary holistic healthcare support |
| Self-care | Spiritual protective and risk factors | Spiritual and faith-based resources |

**Practitioner attributes**

Practitioners can build and strengthen certain attributes to heighten their awareness of spiritual matters. These include ensuring their own spiritual awareness, using a trauma informed practice approach, being an empathic learner and engaging in self-care strategies.

**Spiritual self-awareness**

Social workers should explore their own spirituality to effectively help in the spiritual and religious matters of others (Crisp 2010). Self-evaluating faith and belief systems, transpersonal connections, and life meaning and purpose can enhance broad self-awareness and understanding of personal and professional boundaries and limiting judgments. Bias may impede clients’ posttraumatic growth potential (Piwowarczyk 2005); hence, accepting others is reliant on self-acceptance (George and Ellison 2015). Spiritual self-awareness serves as a strong foundation during trauma work enhancing grounding, meaning making and self-care.
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**Trauma informed**

Trauma’s impact can be lost amid the variety of multi-dimensional issues faced by survivors throughout displacement. Incorporating a trauma informed practice approach is recommended particularly because it emphasises safety and the intersection of culture and trauma. A trauma informed approach recognises trauma’s broad impact and considers cultural factors, sharing power, supporting control and autonomy, and preventing retraumatisation (Clervil *et al.* 2013). It entails awareness of a survivor’s resilience and the need for empowerment and safety (Murakami 2015).

**Empathic learner**

*Empathy* broadly entails understanding others’ perspectives that can guide our own action. Empathy is both active and passive, entailing affective response (feeling and mirroring), cognitive processing (self-awareness and perspective taking) and conscious decision-making (empathic action and altruism) (Gerdes and Segal 2009). Spiritual practices, supervision and therapy can help build empathy (George and Ellison 2015).

Being an empathic learner or listener can help restore control and agency, which is often stripped away during displacement. It can allow spiritually important information for healing and treatment (McKinney 2011). The empathic learner may view mental images of trauma story as art, which enables a detached but ‘deeper, more meaningful understanding of the survivor’s world’ (Mollica 2006: 116). Healing and survival can be learned from the trauma story (Mollica 2008).

**Self-care**

Often, practitioners may not be emotionally or therapeutically prepared for the high levels of distressing trauma stories heard (Farmer 2015). Experiencing overt or subtle vicarious or secondary trauma is not uncommon in trauma work. Supervision, peer groups, counselling and relevant stress reduction practices can increase strengths and decrease isolation, burden and burn out. Spiritual practices can assist when experiencing upsetting feelings and thoughts (Agger *et al.* 2012). Self-reflection and awareness of extreme human capability can increase ability to be an empathic vessel for the survivor (Piwowarczyk 2005).

**Bio-psychosocial-spiritual assessment**

A bio-psychosocial-spiritual assessment involves a holistic exploration of people in their environments. This includes accounting for ecological factors, trauma’s holistic health impact and diverse worldviews and belief systems.

**Ecological system**

Ecological displacement stressors can cause immediate distress and compound prior traumatisation, which intensifies health disability (Das 2015). Starting by addressing basic needs such as food and shelter can help to build a level of trust (Piwowarczyk 2005). Then, identifying employment, livelihood, acculturation and basic social welfare needs is valuable to ongoing support needs. It is also critical to consider how systems (micro to macro) impact health empowerment or deterioration. The acronym HEALTH: Healing partnerships, Empathy, Advocacy, Livelihood, Trauma-informed care and Human rights may be helpful in remembering the
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various ecological components that can positively impact body–mind–spirit wellbeing and inform the bio-psychosocial-spiritual assessment (Das in press).

Holistic trauma and health impact

The holistic health impact of violence, torture and cruel treatment is vast, hence, identifying health needs is crucial to overall wellbeing. Conducting or facilitating referrals for forensic, medical and psychological evaluations and trauma assessments is usually necessary. The Istanbul Protocol is an internationally recognised holistic torture assessment tool (PHR 1999) and can assist in protection cases and care continuum.

Trauma-informed toolkits and holistic guidelines can help providers with assessment (Mollica 2008). The Harvard Trauma Questionnaire (HPRT 2011) is the most well-known comprehensive trauma assessment, traditionally used in refugee research and is valuable for identifying mental health disorders. Short non-diagnostic tools such as the Refugee Health Screener 15 can quickly identify distress for further care and referral (Hollifield et al. 2013).

Worldviews and belief systems

Every survivor embodies unique life experiences and worldviews that inform strengths, spirituality dimensions and health aspects. ‘Proper understanding of traumatic experiences and its outcomes requires knowledge of the cultural factors that affects one’s worldview’ (Hussain and Bhushan 2011: 575). Knowledge of cultural, indigenous and traditional healing practices and societal norms can inform human development, trauma manifestation, help-seeking behaviour and barriers and appropriate referrals. A belief system (faith, political, or otherwise) can serve as a coping mechanism and can be a clinically relevant tool (Brunea et al. 2002).

Spiritual protective and risk factors

Once a trusting healing partnership is established, it is necessary to explore all protective and risk factors with survivors, especially those having spiritual features. For many survivors, faith has sustained them through challenges and is critical in recovery (Farmer 2015). Previous and current spirituality and other coping facets accessed can enhance awareness of strengths. It reminds survivors of their inherent strengths and capacities through past life challenges (Lee et al. 2009). Questions that could be asked include: ‘What thoughts, rituals or mantras were used in the past or currently during stressful times?’ ‘Who do they rely on for strength?’ ‘What gives them hope?’

While understanding how spiritual dimensions supported them in the past, practitioners can sensitively assess whether these dimensions were connected to their persecution, violence and/or torture. Traumatic events such as torture can lead to a loss of faith or changes in belief systems (Piwowarczyk 2005). Therefore assessing faith belief changes is necessary (Brunea et al. 2002), including the previous and current meanings for them. There are also specific spirituality assessments addressing torture and trauma available, which offer guidance and further resources (GCJFCS 2012; Piwowarczyk 2005; Tuskan 2009).

Healing and transformation support

Practitioners can promote healing and transformation from victim to survivor. Some overarching components of this feature include offering advocacy, strengths-based therapeutic approaches and access to multi-disciplinary holistic healthcare support and spiritual resources.
Advocacy

Survivors are often immersed within complex ecological contexts. Adopting an advocacy perspective can aid holistic and comprehensive support, since advocacy can bridge micro and macro practice (Das et al. 2013). Advocacy for this community can be broad reaching and individually tailored. Practitioners can become educated about their setting’s policy and legal infrastructure as well as historical events and public sentiment around conflict-induced displacement. This can elucidate a broader and more comprehensive lens about the situational context including how resources and services are impacted. Also, understanding the survivor’s protection status and legal case needs can reveal areas where practitioners can provide or refer for psychosocial support.

Survivors often face discrimination or oppression in their displacement setting. Practitioners can become advocates for change, dignity and human rights since focusing on displacement stressors may be a greater priority to the survivor than trauma from conflict or persecution. This may include advocating for dignified basic services, the right to legal employment, or a fair and just legal and protection process. Additionally, seeking mental health help can be a foreign or stigmatised concept for many since traditional counselling practice is not normative in many cultures. Therefore, becoming survivors’ advocate can build trust and a bridge towards further healing and transformation support.

Strengths-based therapeutic approaches

Approaching therapeutic work from a strengths-based perspective is critical in healing and transformation. For instance, providing psychoeducation around the holistic impact of trauma and bio-psychosocial-spiritual health interconnections can heighten empowerment and awareness of health status and trauma reactions. Holistic stress reduction tools such as diaphragm breathing, body scanning and mindfulness techniques can increase relaxation and mental and physical awareness of pain and stress and decrease rumination (Agger et al. 2012: 572). Stress reduction techniques can be introduced early on to prevent retraumatisation and enhance wellbeing, since survivors often face a myriad of stressors. More about these techniques can be found in Chapters 10, 11, 25 and 30.

Narrative therapeutic approaches can elucidate lived experience. Through a trusting healing partnership, a survivor may share their life history and past traumatic life events. ‘Facilitating the entry of the full trauma story, one of the most exciting dimensions of self-healing, into the social dialogue, is another essential goal of recovery’ (Mollica 2006: 237). The survivor can share at their own pace to prevent retraumatisation. The empathic learner can emotionally support and validate the survivor’s experience to combat shame and isolation (Mollica 2006).

Moreover, practitioners can help to reframe perceived deficits into a strengths outlook, validating resilience and facilitating empowerment and cognitive changes. Crisis and loss can create life imbalance but also present opportunities to discover new strengths (Leung et al. 2009). Meaning making can help to restore life meaning after trauma (Park and Ai 2006). This can generate new ideas for hope and resilience. The trauma story can become one of survival and strength.

Providing opportunities for altruism can be an extremely healing component. Altruism can facilitate coping while also strengthening communities and networks (Puvimanasinghe et al. 2014). Altruism can help restore purpose and meaning for many survivors who may be unable to legally work, or wait in traumatic uncertainty while their case is processed.
Multi-disciplinary holistic healthcare support

Survivors often have commonality within forced displacement experiences. However, trauma and healing are individualised occurrences and most people require varying levels of assistance. Practitioners can facilitate access to targeted multi-disciplinary holistic healthcare support. This can be valuable for conducting health and mental health assessments and providing specialised care for trauma and torture. Integrative services inclusive of health, mental health, bodywork, mind–body practitioners and spiritual providers can be effective to address complex healthcare needs. For some, traditional healing practices are beneficial; therefore, seeking appropriate and available indigenous healers may be necessary.

Spiritual and faith-based resources

Connecting service users to spiritual resources enhances a diverse collective care network. Appropriate assessment and consent can enable referral to a ‘spiritually-relevant resource that expands the fabric of care for the person’ (McKinney 2011: 65). Faith-based resources have traditionally supported survivors’ psychosocial–spiritual services, and while many provide genuine support, it needs to be recognised that some religious institutions hold beliefs towards women, shame and sexual abuse that may be harmful to some survivors (Mollica 2006). Further information about faith-based care and good practices with survivors include information from UNHCR (2014) and Vine (2014).

Conclusion

As conflict-induced displacement continues to accelerate globally, millions of people affected by this crisis will look to spirituality for strength and survival. Spirituality can be a catalyst for the innate self-healing abilities of survivors. Spirituality can manifest through a variety of dimensions and features and is informed by diverse worldviews, cultural factors, religion and faith.

Spiritually informed social workers and other practitioners can enhance care and healing for survivors by strengthening practitioner attributes, incorporating a bio-psychosocial-spiritual assessment and supporting their healing and transformation. By embracing spirituality’s connection to overall health and humanity, the human potential for self-healing can be utilised.

References


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