‘Helpers’ Learn to Connect, Not Control

Although we all know that suffering is a universal human experience, the modern world still does not know how to speak about and understand the terrible experiences that human beings inflict on each other every day.
— Richard Mollica, MD, *Healing Invisible Wounds*

RYAN LIPSCOMB, LPC

At the Saint Alphonsus Center for Global Health and Healing in Boise, Idaho, we serve a large number of families and individuals who have come to the United States through the Department of Health and Human Services’ refugee resettlement program. Many have been subjected to significant trauma in their home countries — according to the National Consortium of Torture Treatment Programs, 44 percent of individuals who have come to this country through U.S. refugee resettlement have been tortured or have close family members who have been tortured.

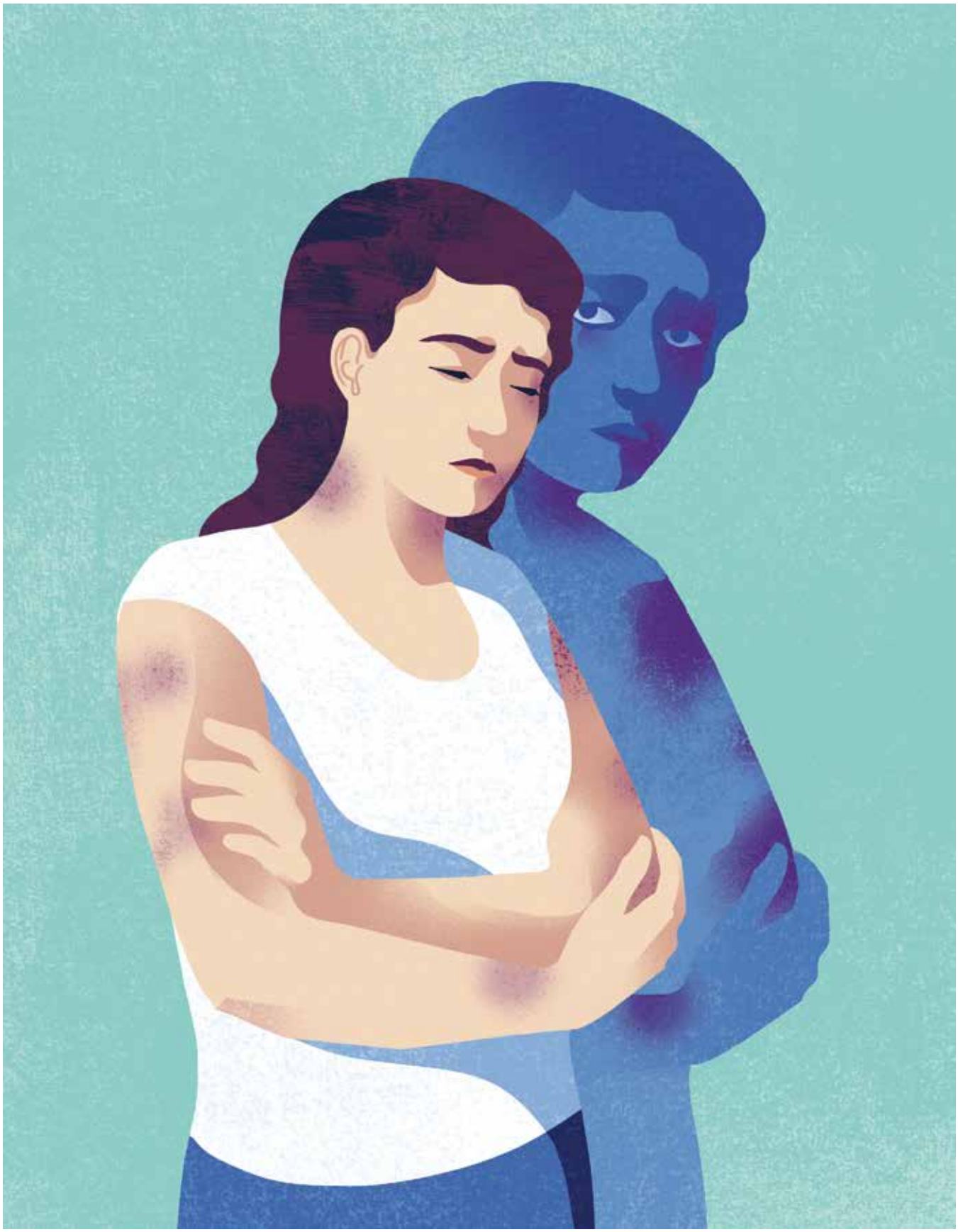
For many resettled individuals, the path of healing can be lifelong. For the helpers who give them care at Saint Alphonsus, burnout and compassion fatigue are ever-present concerns.

Idaho has been a refugee resettlement site since the early 1980s, and the Saint Alphonsus Center for Global Health and Healing was developed to serve the needs of the families coming into the community in this way. In FY2016-2017, Idaho resettled individuals and families from 18 different countries, including Burma, Bhutan, Iraq, Somalia and Afghanistan.

Many of the individuals have experienced significant trauma during conflict in their country of origin that forced them to flee. Often the result is a complex range of symptoms including body pain, headaches, sleep disturbance, hypertension, anxiety and depression that can be deeply intertwined with feelings of shame and humiliation. Providing holistic support can offer the individual a framework for developing trusting relationships and creating a space for healing.

The Center for Global Health and Healing provides an integrative model of family medicine and OB-GYN services that focus on trauma-informed, culturally responsive and linguistically appropriate care. The center’s multidisciplinary team is made up of physicians, nurse practitioners, certified nurse midwives, community health workers, interpreters and social workers. As part of its integrative model, the center receives federal funding for its program for survivors of torture that offers rehabilitative services addressing patients’ physical, psychological, social and legal needs.

The Saint Alphonsus center is one of 33 member centers that make up the National Consortium of Torture Treatment Programs within the United States and is the first program of its kind in Idaho. Additionally, the center has developed the community health adviser program, a community health worker model that partners with individuals from within the respective linguistic and/or cultural communities to help patients navigate the health care system through case management,



language access and cultural brokering between the patient and the health care team. In addition, the center works closely with community partners such as mental health agencies, medical providers, resettlement agencies, lawyers and schools to provide wraparound care.

COMPLEXITY OF SUFFERING

Universally, the experience of suffering can draw one human towards another. However, the opposite also can be true — depending on the proximity, intensity and duration of an individual's suffering, he or she might withdraw and avoid interactions.

It is important to acknowledge that grieving practices and expression of suffering can look different across cultures. For example, from within the cultural context in which I was raised, we might struggle to keep space for our own suffering and grief because we sense that others feel we should be fine by now, that it is time to "move on."

I bring this up because as helpers, it is critical for us to be aware of and understand our own response to suffering. Often there is a parallel process that takes place between the helper and the families coming through resettlement. From my experience, it is through relationship and "entering in" that we can participate in another's healing journey. More often than not, our own healing is connected.

However, helpers can find themselves becoming uncomfortable when there is no quick fix for a situation. The initial empathy for the resettled individual and the desire to help can be replaced with feelings of burnout and compassion fatigue. When working with traumatized individuals, the helpers also are susceptible to experiencing vicarious trauma and may notice an increase of trauma-related symptoms within themselves.

STAGES OF RESETTLEMENT STRESS

During the initial months after their arrival, individuals coming through resettlement sometimes have a romanticized outlook, referred to as the honeymoon stage. They experience a high level of hopefulness that they and their families finally have reached a welcoming place filled with opportunity.

Then comes the reality: demands on them to become self-sufficient, find full-time employment while trying to attend English-language classes, pay rent, go to doctors' appointments and care for their family. The stress can be overwhelming and trigger or exacerbate trauma.

Such ongoing stress tends to lead to disillusionment, a stage in which individuals become more aware of the systemic barriers they are facing. There tends to be a correlation between the disillusionment stage and an increase in physiological symptoms such as chronic headaches, body pain and chest pain. For some, that stage can last for many years. They may feel stuck and require support that provides continuity and holistic care to effectively address comorbid symptoms caused by past trauma plus current challenges.

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Some people are able to move into the third stage, acceptance. This stage does not mean individuals have moved past their suffering, but it may indicate that they are moving through it. Individuals may recognize the challenges and barriers they continue to experience, but they are able to maintain a sense of hope and meaning.

Austrian-born neurologist and psychiatrist Viktor E. Frankl, in his book *Man's Search for Meaning*, stated that "life is never made unbearable by circumstances, but only by lack of meaning and purpose." Frankl, a survivor of Nazi concentration camps, focused his writings on the idea that meaning not only plays a pivotal role in one's ability to endure suffering, but also is an essential element for the healing journey.

STAGES FOR HELPERS, TOO

For helpers, the parallel of these stages can be quite striking. Most of us enter into a helping role in response to either a perceived or real need. When working with survivors of trauma and torture, we sometimes can feel emotionally drawn to them and moved by the suffering they have

endured. Others may idealize or romanticize the idea of working with survivors of such suffering — for example, when someone asks me or my colleagues about the work we do, it is not uncommon for us to hear, "Wow, that must be really rewarding."

In fact, that's how most of us feel when we begin as helpers — we anticipate being able to do such rewarding work easing the suffering of traumatized victims and assisting their adjustment to a new life.

Left unrecognized and unchecked, this perception can lead to a subconscious need to rescue, not help. In its most unhealthy form, we put ourselves in the emotional center of our engagement with the survivor, fueling our feelings of being important and needed. One hallmark of a helper in this unfortunate state of mind is an inappropriate use of the phrase "my refugees." That phrase indicates ownership, and it indirectly reflects that the helper has placed himself or herself in the emotional center of the work, where the survivor should be. A helper in this stage also tends to assume the role of teacher, even engaging in infantilization with adults who have come through resettlement.

The truth about this work is that a helper can become overwhelmed by the survivor's circumstances. As we enter more fully into the individual's life and realize the magnitude of his or her needs and the barriers he or she is facing, we can feel like we are ducking under one wave of need and coming out on the other side only to be met by another wave barreling down. The helper can not only feel discouraged but start to enter into the same place of despair as the survivor.

Feelings of burnout and compassion fatigue often are the signs that helpers have reached a stage of disillusionment. Key identifiers: Their attitude shifts towards a negative view of the survivor, they unwittingly start putting blame on him or her for the difficult situation.

Within our medical community, one tip-off to placing blame is labeling patients as "noncompliant" when they do not follow our orders. Not only is the term pejorative, using it often indicates lack of insight into what might be happening for the patient culturally, religiously or from a trauma perspective. The helper has become stuck in viewing the survivor from an ethnocentric viewpoint. More tip-offs: a helper whose language displays separateness — referring to patients as "them" or "those people" — or who seems to feel that the patient is not grateful enough for help and services being provided.

Helpers who find themselves in the disillusionment stage usually come to a professional fork in the road. For some, burnout and compassion fatigue become so great that they walk away from helping a particular individual, or sometimes from the work as a whole. For others, they stay stuck in their current helping role despite their own burnout and compassion fatigue. Often they do more damage than repair with the survivor.

Fr. Henri Nouwen, a Dutch Catholic priest and theologian, describes this tension best in his book *The Way of the Heart*: "Compassion is hard because it requires the inner disposition to go with others to a place where they are weak, vulnerable, lonely, and broken. But this is not our spontaneous response to suffering. What we desire most is to do away with suffering by fleeing from it or finding a quick cure for it."

REALIZATION AND ACCEPTANCE

Nouwen's words lead us to a third group of helpers, those who tend to turn inward and reflect on what is happening, either with the support of a team or through other support, and recognize they are bringing their own issues into the situation. These helpers have an increased self-awareness that allows them to hold both the individual's suffering and resilience within the relationship. They come to a place of realization — it is not solely dependent on them, as a helper, to "fix" the survivor, and they acknowledge that in many cases, they have no power to change what has happened to him or her.

Stripping away self-imposed responsibility for rescuing the individual leaves the helper with the most valuable offering of all: the gift of just being in another's suffering. Nouwen suggests that we are able to drink deeply from the cup of life only when we realize that it is made up of both the cup of sorrow and the cup of joy. That illustration beautifully describes an arrival into the stage of acceptance.

NO ENCOUNTER IS NEUTRAL

It's important for us to understand as helpers that for trauma and torture survivors, there are no neutral encounters, and every encounter has the potential to be a healing encounter. One of

the ways that the Center for Global Health and Healing team has been guided in its work has been through the "Healing Encounters" training curriculum and framework, developed by Marla Lipscomb, MSW, LCSW, and Traci Harrod, founder and director of Refuge, a nonprofit organization based in Boise. "Healing Encounters" focuses on the importance of providing trauma-informed, culturally responsive and linguistically appropriate care, which they call the Equitable Triad. Harrod and Lipscomb state that if any of the triad's three components are left out of an interaction with a patient, then we no longer are providing equitable care, and that ultimately leads to patient suffering.

One of the framework's tangible applications highlights the importance of being able to pause. When working with trauma and torture survivors, there is a high probability that the individual will experience a trauma trigger during an appointment and struggle to stay calm.

Sometimes we, the helpers, are caught off guard. Sometimes it seems like the individual is directing feelings and emotions at us, and we take the interaction personally.

In a moment like that, one of the most valuable responses for helping a survivor regulate emotions is the process "Pause, Validate and Collaborate." Pausing helps us to respond, rather than react to the situation, by taking a step back and looking at the interaction from a trauma-informed perspective. This affords us the opportunity to become conscious of our own emotions and/or feelings that are coming to the surface, and to remain within the brain's prefrontal cortex — the calm, relaxed and wise operating center.

The next step is to acknowledge what the individual is experiencing and to validate the experience without trying to correct his or her perception. Validating helps both the survivor and the helper to access the limbic system, which allows for connecting and empathy.

Harrod and Lipscomb refer to this process as "choosing connection, not control." It supports individuals as they re-regulate their response and helps them move from the amygdala (survival brain) to the prefrontal cortex.

When someone experiences torture and/or trauma, they are stripped of dignity, choice and trust. These are the three things that helpers can offer in a healing encounter. Providing dignity can be as simple as putting ourselves in the learner position and out of the center. This creates a space for the survivor to become the teacher and guide the helper through a phenomenological perspective of how they view their health and themselves within their contextual setting.

Choice sometimes can be one of the hardest aspects of restoration for helpers, especially within a medical environment. Often we struggle with seeing what could be the long-term impact of a certain choice when the individual makes a decision that can seem counter to the outcome the medical team is trying to achieve. However, it is important that we recognize the right to self-determination. By removing it for survivors, we are taking away a right we would expect to have in that situation.

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"Healing Encounters" offers a different approach in these difficult situations by encouraging the helper to discuss with the individual all of the possible choices available and explore each possible outcome. This is what Harrod and Lipscomb describe as "being informational, not instructional."

EQUITABLE CARE

It is most important for us, the helpers, to be aware of our own biases and need to control the outcome. Helpers can have good intentions, but the impact often is one of perpetuating systematic oppression. Providing equitable care relies on our ability to trust the individual and provide a space where he or she feels empowered and where we continue to offer support.

Equitability is more than just equal access. We achieve quality of care and support through

adapting services to meet the patient's needs — not the medical team's or the helper's. Harrod and Lipscomb coined the term "ethnomutuality," which describes a culturally inclusive look at how to "make the circle big enough" for all. They contend that it is impossible for individuals to provide healing encounters when we are stuck in ethnocentrism.

Ethnomutuality emphasizes the need to move away from getting individuals and families to "become like us" and, instead, to focus our energy on "becoming us" as a community. A first step in ethnomutuality often begins with conscious use of people-first language. We remove the label of "refugee" as the primary descriptor of individuals and families who are now part of our communities and one of us.

Similar to Nouwen's illustration of drinking from both cups, this approach requires us to learn the art of holding both the suffering and challenges with the beauty and resiliency of the survivor. It is through intentional and mutual relationship that we are able to move from seeing ourselves as a "helper" to seeing ourselves as a friend.

Reducing suffering for the survivor begins with the restoration of dignity, choice and trust through this relationship. In their book *Compassion: A Reflection on the Christian Life*, Nouwen and co-authors Donald P. McNeill and Douglas A. Morrison, connect us to what true compassion is:

> It is not reaching out from on high to those who are less fortunate below; it is not a gesture of sympathy or pity for those who fail to make it in the upward pull. On the contrary, compassion means going directly to those people and places where suffering is most acute and building a home there.

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QUESTIONS FOR DISCUSSION

- Ryan Lipscomb is a clinical counselor at the Saint Alphonsus Center for Global Health and Healing in Boise, Idaho. Since the early 1980s, Idaho has been a refugee resettlement site, welcoming a significant number of refugees who have suffered torture and other trauma. What facilities, services or levels of cultural competency does your ministry offer to patients with foreign origins and traumatic histories?

- One of the dynamics Lipscomb explores is the difference between a healthy, helpful relationship between the survivor of trauma and the helper, and one in which the helper begins to act as rescuer, which can be harmful for both helper and survivor. Describe some of the attitudes and behaviors that might indicate the relationship between survivor and helper is becoming unhealthy.

- Lipscomb points out that there are no neutral interactions in the process of healing for trauma and torture survivors. Every interaction has a potential for healing as well as a potential for harm. How does your ministry train its associates to communicate with people who have suffered trauma? What are the specific skills needed to help them access and navigate services in the ED, in labor and delivery, in securing family care and at the end of life?

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