Working with asylum seekers in a clinical setting




Melinda Rees, Pennie Blackburn, Damon Lab *and* **Jane Herlihy** *offer some advice.*

TO many mental health professionals, working with asylum seekers may appear to be a specialist area that requires particular expertise. However, our experience tells us that generic psychological skills are most useful in facilitating the well-being of this client group. In this article we hope to illustrate the various ways psychologists can work with asylum seekers.

When faced with an acutely distressed client experiencing a bewildering array of difficulties, ranging from complete social isolation and fears of deportation, to disturbing nightmares and suicidal ideation, clinicians (and clients) can feel overwhelmed (Burnett & Peel, 2001). It is therefore helpful to see a first stage of intervention as being focused on creating some sort of stability and safety. This first focus allows the initial therapeutic stage to feel clearer and more manageable for both the client and clinician. Arguably, it is the most useful element of intervention.

This first focus often involves addressing the client's context. This may include their housing, asylum status, employment/vocation, social isolation, language, experiences of racism and discrimination. But don't feel that you have to sort out your client's problems alone. There are statutory and voluntary agencies that offer advice and support in, for example, housing matters. In more pressing cases, solicitors are often able to help clients secure appropriate accommodation. You may help by writing a supporting letter to the housing department. However, try to strike a balance between taking on a crucial but demanding advocacy role and becoming involved to the point that clients are disempowered (and the clinician overwhelmed).

As with all clients, facilitating and offering basic symptom management techniques can also be helpful at this stage. Often only after the client/clinician relationship feels more established and stable can more complex psychotherapeutic work can be carried out: to think about, for example, the long-term effects of traumatic events, multiple losses and challenges presented to living in the current environment.

'Don't feel that you have to sort out your client's problems alone'

Clearly this work should be carried out in the context of a trusting and respectful therapeutic relationship, which may take time to develop. The reparative and significant nature of this attachment should not be underestimated, bearing in mind the inhumane experiences (for instance torture) clients may have been subjected to in the past (Gorman 2001). A secure relationship, within which client and therapist feel able to constructively address power differentials, ambivalences and 'failings', is a place from which to embark on further therapeutic conversation.

The following fictitious case example will illustrate in more detail a typical intervention. It is important to note that there is no absolute prescribed path to follow and that various processes must be pursued in collaboration and may occur simultaneously.

A case

Mrs X was quiet and withdrawn – 'People tell me I've changed,' she said. She, her husband and son were living in one small room in a block of flats. The previous week a woman had been assaulted in the waste ground around the flats. Mrs X said she felt she was not caring for her son, who was being 'very clingy' and she was concerned about him. She said that she could not sleep and frequently suffered from extremely distressing nightmares. She also had memories during the day, in which she re-experienced her rape and the death of her father, who was killed at the same time. 'I don't know what to do with myself in those moments,' she said, and explained that once she had taken an overdose of antidepressant medication. She reported feeling very ashamed of her experiences and said she could not tolerate being around other people. She reported that her problem had got worse since her asylum application had been refused. She cried and said: 'It's impossible for me to go back, I'd rather be dead than go back.'

An assessment (including assessing domestic violence, child protection and suicide risk) should be embarked upon, as a transparent and collaborative process. This may well take several sessions. A therapeutic contract can then be described between client and clinician. Language support and advocacy may be supportive resources; alternatively, clients may prefer to communicate in a second language despite limited shared vocabulary.

Alongside the process of facilitating access to appropriate agencies to address impacting contextual needs, it might be appropriate to offer interventions with the intention of containing symptoms that can often seem uncontrollable to clients. In the first instance, this may involve a better understanding of Mrs X's main difficulties and offering normalising reactions and symptoms, given experiences and contexts. It may also be helpful to work towards developing a shared perspective of Mrs X's proven resourcefulness and coping strategies – most refugees have had to draw on reserves of resilience and strength to escape and surmount enormous difficulties.

Eventually, client and clinician might negotiate to work together using anxiety management strategies, such as guided imagery and relaxation exercises, employing techniques for coping with intrusive experiences and minimising dissociation (Kolk *et al*., 1996) and focus upon techniques to improve sleep, self care and enlist practical and emotional support (Basoglu, 1992).

It is clear, given the number of therapeutic tasks described above, that clinical services would be required to hold flexible expectations regarding the amount of time assessment and intervention might take. The first steps are vital: initial tasks also serve to facilitate a trusting relationship between client and therapist, which then paves the way for further therapeutic endeavour.

Going deeper

A couple of short descriptions of specific therapeutic approaches using more complex psychotherapeutic techniques follow as a way of suggesting a theoretical framework for therapeutic conversation.

If we take, for instance, Mrs X's experience of shame, the narrative therapy approach might enable the client and clinician to locate the experience of shame within the cultural and familial discourse in which Mrs X feels embedded (Freedman & Combs, 1996). Through naming and deconstructing political agendas, criminal acts, gender and power discourses Mrs X may then feel able to reposition herself in relation to her experience of rape and allow an alternative narrative to be revealed about rape (White & Epston, 1990). This approach could be sufficiently liberating to enable a movement away from entrapping feelings of shame and towards new territory (Cienfuegos & Moneli, 1983).

SUPPORTING CLAIMS

You may be approached by the solicitor for a report to support the claim for refugee status, or for permission to stay on the grounds of the Human Rights Act. Here are a few pointers:

- Do not write a report without a detailed Letter of Instruction from the solicitor. This should ask specific questions – which should be addressed systematically and thoroughly.
- You are usually being asked to give a professional opinion regarding the psychological functioning of your client. If you use diagnostic categorisation, reference your diagnoses using DSM-IV or ICD-10.
- Do not go beyond your expertise, e.g. it is not your job to make judgements regarding eligibility for refugee status – this is a legal decision. Similarly, 'I cannot comment on the state of health services in Kosovo, not being a country expert.'
- You can however, comment on psychological difficulties which may lead legal decision makers to doubt the client's credibility – such as dissociation, concentration or memory problems.
- Refer to relevant papers, e.g. on memory functioning, discrepancies in repeated accounts, shame and disclosure, suicide risk in PTSD and depression.
- If there is a risk of suicide, state your reasons for believing it likely (from risk assessment) and quote the client if possible.
- You may be required to present your opinion in court, so be sure that you can justify your opinions, whether by professional experience or by reference to research literature.

Alternatively, the therapeutic contract might facilitate further conversational examination of Mrs X's concerns about her parenting and a cognitive behaviour therapy (CBT) approach that incorporates the consequences of experiencing (multiple) trauma and loss (Ehlers & Clark, 2000) could be employed. For instance, the CBT hypotheses might suggest that Mrs X's experiences have resulted in unhelpful cognitive representations, distorted self-instruction, disturbances in information processing and changes in world view (van der Veer, 1998). That Mrs X felt that she was not caring well for her son might be discussed as a resultant distorted self-instruction, rather than a reality. Conversational and behavioural techniques and observations could be employed to help client and clinician explore this.

Empowering clinicians

The perceived complexity of the contexts and stories involved with asylum seekers and refugees might serve to render the clinician themselves feeling disempowered and hopeless. However, we hope to have offered a window into a kind of therapeutic process and alliance that is possible, given that clinicians already possess a rich repertoire of skills for supporting clients who are people seeking asylum.

■ *Dr Melinda Rees is Lead Clinical Psychologist for 'Transitional Populations' at Newham PCT, London. E-mail: melindarees@yahoo.co.uk.*

■ *Dr Pennie Blackburn is a clinical psychologist at the Traumatic Stress Clinic, London. E-mail: pennie.blackburn@candi.nhs.uk.*

■ *Dr Damon Lab is a clinical psychologist and Service Manager in the Traumatic Stress Service at Maudsley Hospital, London. E-mail: damon.lab@slam.nhs.uk.*

■ *Dr Jane Herlihy is a clinical and research psychologist at the Trauma Clinic, London, and at the Bristol Doctoral Programme in Clinical Psychology. E-mail: j.herlihy@traumaclinic.org.uk.*

References

Basoglu, M. (1992). *Torture and its consequences: Current treatment approaches*. Cambridge: Cambridge University Press.

Burnett, A. & Peel, M. (2001). Health needs of asylum seekers and refugees. *British Medical Journal, 322*, 544–547.

Cienfuegos, A.J. & Moneli, C. (1983). The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry, 53*, 43–51.

Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.

Freedman, J. & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York & London: Norton.

Gorman, W. (2001). Refugee survivors of torture: Trauma and treatment. *Professional Psychology: Research and Practice, 32*, 443–451.

van der Kolk, B., van der Hart, O. & Marmar, C.R. (1996). Dissociation and information processing in posttraumatic stress disorder. In B. van der Kolk, A.C. MacFarlane & L. Weisaeth (Eds.) *Traumatic stress: The effects of overwhelming experiences on mind, body and society*. New York: Guilford Press.

van der Veer, G. (1998). *Counselling and therapy with refugees and victims of trauma*. Chichester: Wiley.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: Norton.