15 Working with people seeking asylum

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I began working with people seeking asylum as an NHS community child psychiatrist. We developed a new service that gave each family the use of an allotment alongside individual, family and group therapy, a community approach that brought local families together with asylum-seeking ones and aided integration. I was excited by the work.

Although stories were disturbing, there was much to learn – about other cultures and conflicts, working with interpreters, human rights, racism, injustice, amazing acts of solidarity and what enables people to keep hope alive in the face of inhumanity. I made links with community services and schools that had not been possible in my work before and found that the conversations we had in the team, the wider service, the community, the Trust and my professional body were enriched to the benefit of all the families attending CAMHS. It was easier in this setting to 'not know', to learn together with the families what they needed and found helpful, something that was invaluable in my generic work too.

The hardest part was seeing the injustice and the apparently arbitrary decisions of the Home Office that at times destroyed people's lives. Our capacity to help families was very limited although also very much appreciated. This work changed me.

Julia

Working with people seeking asylum brings unfamiliar experiences, and its own challenges and dilemmas. It can be rewarding, stimulating, and sometimes inspiring. However, it is not so for everyone, and sometimes it can affect us in ways that prevent us being as effective and compassionate as we would like to be. It is useful to be aware of common pitfalls, and the steps that can help avoid these.

Experiences of clinical work

Unfamiliar experiences and responses

What has been the biggest surprise to me is how badly he's been affected by what's happened to him in the UK.[1]

In this field we hear stories that may be broadly familiar from news, films, and books, but which feel different when told by a person in front of you. We learn new things and are often

[1] All unattributed quotes in this chapter are illustrations constructed on the basis of our own experiences and conversations with colleagues over many years of practice.

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emotionally touched what we hear. People sometimes tell us about incidents of great heroism, self-sacrifice, or overcoming great odds; far more often it's about the ways that their lives are unspectacularly but chronically, and irreversibly, derailed and damaged. They talk about situations worldwide, of extremes of human cruelty, of the reality of lives dominated by callousness, injustice, hardship, and insecurity, and of how heroic, exceptional acts may be ignored or even be used to discredit people. It can be disturbing to realise that some of the commonplace narratives about people seeking asylum, around illegality, exploitation, duplicity, and the like, are so often told for political purposes, rather than representing how people actually are. It can also be disturbing to realise how much our own UK asylum system harms as well as helps.

Of course, as Rukyya Hassan notes in Chapter 1, if you work in mental health services you are no stranger to harrowing tales. It is not that working with people seeking asylum is harder, more that it involves issues and presentations that are uncommon in other mental health contexts.

Sometimes the work has a profound impact. It can leave us noticing responses in ourselves that are unfamiliar, both bodily and mental experiences. Here, as in any clinical situation, the reactions a person evokes in a clinician are triggered by often unnoticed cues. They may include 'mirroring', a largely unconscious process whereby our feelings, posture, gestures, and tone start to align in part with those of the client and we feel something of what they are experiencing. They may also include feelings and actions which complement those of the client rather than matching them. An example would be when we find ourselves with an urge to 'mother' someone in a vulnerable, dependent state of mind.

Resonances

> *She is finding it so hard hearing about the political situation at home getting worse, not knowing where her son is, not even if he is alive or dead. I can't help thinking about my own son, safe at home now, but he won't be here forever …*

In mental health work it is common for clients' experiences to resonate in different ways with professionals' own lives and situations. To the extent that some themes recur in the experiences of people in the asylum system, there are patterns of resonance that are also common.

One frequent pattern is for a clinician's own vulnerabilities and insecurities to be brought to the fore. It is worth noting that the feelings stirred up by clinical encounters can persist well beyond their end and can sometimes spring back into awareness much later, especially when the resonating situation recurs in daily life. For the clinician in the quote this might be, for example, when their son decides to go travelling or isn't back home when expected.

Pain and hopelessness

> *She has heard now that her children died in the camp. She had told me before that this was the one thing that she would not be able to bear, and I was dreading her getting this news. But now that it's happened, she says she is doing OK and it sounds as though she is managing well.*

It can be hard to be with someone who is in great pain or despair, whatever the reason for this. In these situations, mirroring can be a discomforting experience. We also meet many people in the asylum system who manage to remain hopeful, and we have many encounters where distress does not dominate at all. However, especially when we have come to know a client a little, witnessing their agony as they relate what happened to their family, or their fear and

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despair at a further refusal of their asylum claim, can be upsetting. The fact that there are so many terrible events in people's lives can make the work painful, especially when there is often little we can do to make a difference.

When someone tells a painful story without any sign of the expected distress and despair, as well as wondering what this means for that person, we notice varying responses in ourselves. It is well recognised that clinicians may sometimes experience feelings that the client is expected to have but is showing no signs of. For example, we have all had the experience of feeling horror at something described by a client in an emotionless, matter-of-fact way. It can be a useful clue that the client may be consciously or unconsciously avoiding feelings.

Sometimes it's not only the client who seems surprisingly emotionless but we ourselves too. Noticing this can be a step towards considering possible explanations. Perhaps it is our own avoidance that needs attention, rather than the client's. Or perhaps it is an indication of the client's efforts to protect others from their own pain.

Power and powerlessness

> *I invited her to use my name, but she chose to keep calling me 'doctor'. I found it really uncomfortable. And however much I explained why I wanted to hear what she thought, she just said that I would know best, that she wanted to do whatever I thought best.*

People seeking asylum often arrive in the United Kingdom having lost almost all control over their lives, and the asylum system perpetuates this loss of control. In mental health settings, clinician and client differ profoundly in terms of their control over the interaction. At the same time, as clinicians, we can ourselves feel powerless in the face of clients' predicaments perhaps as employees of organisations that uncomfortably limit our control over our practice, for example in matters such as follow-up or the types of help that may be offered.

Clients often want us to be powerful on their behalf. This may be so that we can actively assist them in their struggles, or so that they can have an internal sense of a powerful, sustaining attachment, or a combination of the two.

In therapy itself, power and powerlessness are common themes and can be played out in the dynamic between therapist and client. Conversations about these issues will sometimes be useful therapeutically.

Differences in privilege

> *I hated having to say I would be away for three weeks in August. He said 'I hope you have a nice holiday'. I was acutely aware that he had never a holiday. He doesn't get any breaks from his life, though he needs one much more than I do. I'm not sure he's even ever been in a situation you could describe as pleasant or relaxing …*

Working with people who have lost everything, while we ourselves have enough, and often more than enough, can leave us feeling guilty and wishing to avoid the uncomfortable issues raised about the privileged lives we lead and don't want to give up. The nature of asylum support, the restrictions of the asylum system, and the structural racism and discrimination against migrants in society and within clinical organisations all contribute to the disparities in privilege. Differences may be extreme and glaring, and for clinicians new to the work may be outside their previous experience.

When it seems that such differences are relevant to a client's experience or to the therapeutic relationship, it may be constructive to talk about rather than ignore them. However, it may be that for the client the difference is more a fact of life and less of an issue than it is for the clinician.

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Losing Illusions

He told me he knew I could help him if I wanted to, that I just don't want to because he's from [country]. He kept saying 'you're all the same you English people'. Really I'm glad that he's not eligible for the service, I wouldn't want to see him again.

This work can highlight the limits to our compassion and concern, as we discover that we are, after all, only willing to go the extra *half* mile. While we might feel uncomfortable with our privilege, most of us continue to accept it. Most of us respect professional boundaries or organisational requirements even when we feel they are not good for a client. We are also part of a society where people seeking safety are routinely treated unkindly.

With individual clients we sometimes find ourselves with negative feelings that we would prefer not to have. Perhaps a client comes half an hour late for an appointment when we have gone to great lengths to set aside an hour, or they are irritable and demanding and we feel we don't deserve this treatment; although we may know of many possible psychological reasons for such behaviour, somehow this doesn't always help us to be as non-judgemental and curious about it as we would like to be. Similarly, while we might aim for cultural humility, we may come across attitudes that from our own cultural positions feel unpalatable – attitudes towards women, for example. And although we want to respond to all our clients empathically, encountering people who have perhaps betrayed friends, or perpetrated cruel acts to survive, can sometimes mean that we struggle to do so.

Working with people who have experienced great cruelty and heartlessness, we may have hoped to show that things can be different, that the world can be a kinder place, more humane and generous. Yet we encounter not just suffering that deserves relief, but also the same old problems of human nature – theirs and ours. We may discover not only that we are not quite as unvaryingly compassionate and generous as we had imagined, but also that unvarying generosity may not always be the best approach.

Even More Time Pressures Than Usual

When time is so short it's hard waiting patiently while each thing is translated, you end up choosing to not say things because any tiny query or comment can swallow another big chunk of time. The appointment over-ran by half an hour but I still felt I'd not asked what I'd needed to and that the contact was a poor deal for her.

In overstretched services, with this client group it can be more difficult than ever to feel we have enough time for thoughtful and effective work. Much of this book might be read as saying 'do more', but this is not what has been intended. In reality, time is limited, and our efforts need to go into 'doing differently' and being clear what we can and cannot do. 'Doing differently' is about skilfully and wisely choosing how we use the limited time. It is about appreciating with each client which among their many problems matter most at the moment – perhaps what is going on in their asylum claim or how insecure their accommodation is. It is not necessarily about doing more, but about shifting focus and holding in mind that the issues that matter most may be specific to their situation of seeking asylum.

A need for new knowledge and skills

There was so much that he needed, it felt impossible to know where to begin.

Doing differently, rather than doing more, sometimes means we need new knowledge and skills if we are to work as effectively with this client group as with others. To work out what

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could be helpful at a specific moment in a person's life, and at any given moment in therapy, may need not just sensitivity and thought but also some specific knowledge.

However, sometimes that specific piece of extra knowledge may be simple to acquire – a link to a local community group, or an understanding of the pitfalls in record-keeping, for example. As long as we are aware of the need to learn, advice can often be sought when needed, perhaps when someone presents in a way that is hard to understand, or a solicitor requests a letter. Many of the most crucial skills for this work are not specific to people seeking asylum at all, but about being able to develop a meaningful therapeutic relationship.

Differences between colleagues

It felt as though my colleagues didn't really understand the whole situation. They just kept talking about how we don't have the resources to do more.

There are some areas of clinical work more likely than others to result in colleagues within a team or organisation having very different views on what is needed and finding it difficult to compromise. Working with people seeking asylum, these differences often centre around why people are asking for help, and how much should be offered to them. Uncomfortable tensions can arise between colleagues, teams, and services, and committed professionals can become isolated and alienated from each other. Where differences lead to different clients receiving very different responses from the same service, and clients become aware of this, it may be not just puzzling for them but also interpreted as favouritism or disregard for particular individuals.

Isolation

I used to know somebody who thought it was a great joke whenever he met me to ask 'are you still letting the asylum seekers in?'

Working with people seeking asylum can feel like entering a different world from generic clinical work. Conveying what it is like to clinicians, or others, who are not involved can feel difficult. When you are asked what kind of work you do, answering may elicit admiration and interest, or, alternatively, suspicion that you are credulous or 'virtue signalling'. Sometimes colleagues, friends, and family have different views on what should be offered to those seeking asylum, or are simply not interested. However, talking about this work from first-hand experience may also feel like a worthwhile bearing of witness. Weingarten (2000) describes different types of witnessing in depth.

Conversations with colleagues who have little or no understanding of the context are inevitably limited in their scope and in the support that they can offer. Those with peers who work in similar contexts come to feel very valuable.

Rewards

The sense of togetherness and the sharing of views with other practitioners and community workers were thought provoking, strengthening, and equalising.

… A conference about mothers seeking asylum enabled women to speak about their experiences to commissioners and began a process whereby the women could support each other and be supported by us as clinicians. This in turn helped us to feel more positive about our work and to learn from the women what they needed and what would make a difference to them.

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… I was always aware of the personal reasons around my passion for this work. I understood more about my parents' experience of survival as refugees from Nazi Germany and appreciated how they had been able to hold on to a belief in the goodness of people despite the brutality they had witnessed.

Julia

The work can also be enormously rewarding. We see people move forward with their lives and they tell us we have played a part. We meet people who are warmly appreciative of our listening carefully to their stories and making attempts to help. We meet people who enrich our lives, both clients and colleagues.

Many of us choose this area of work because it has some meaning for us, whether a connection to a family story, an aspiration to contribute to society, or an attempt at compensating for something that has affected our own lives. This is problematic if it leads us on to work in ways that are detrimental to our clients – for example, depending on them to be needy, grateful, and beholden to us (a 'victim–saviour' dynamic). But in itself it is not a bad thing to choose a type of work for personal reasons, especially if we are aware of what they are; clinicians for whom the job is a good fit may find it easier to enjoy and sustain their work.

Some possible effects on practitioners

The work can be energising, restorative and transformative, even when the stories people tell are difficult to hear. Seeing our role as 'bringers of hope', rather than 'diagnosers of illness' can influence us as clinicians too. We can, and do, learn from our clients. I learned how people survive when they have lost so much, how they can find hope again and how to create or value the relationships that make one feel the work is worthwhile rather than too hard or not worth doing. I found working with people seeking asylum helped me in the rest of my CAMHS work and gave me new energy for it. In CAMHS I tried to re-energise families ground down by years of feeling failed by authorities, looked with them for their 'acts of resistance' and what sustained them rather than what made them feel more hopeless. It made me more aware of what CAMHS needs to do to engage families and how a service that worked for people seeking asylum would also be the best service for local families.

Julia

Working in this field can leave us feeling changed in a positive way – the clinician counterpart of 'adversity-activated development' in clients (Chapter 14). However, it can also affect us in less desirable ways. Some responses can interfere with good clinical care or leave us depleted. These are not by any means the main effects of the work, but they are important ones and may undermine the positives. For this reason, this section considers them in some detail, focusing on patterns of response that are especially frequent.

Oversimplification, polarised responses, and related pitfalls

All of our experience of reality is shaped by our own minds, even though we may have the impression of directly experiencing an objective world. We make cognitive and emotional shortcuts, perhaps taking the unfamiliar for the familiar, perceiving parts rather than wholes, or excluding things from our conscious awareness altogether. These are essential ways of managing information and protecting ourselves from too much anxiety and uncertainty, and are an integral part of life. Sometimes, however, such conscious and unconscious strategies can cause problems that we need to be aware of.

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There are some problematic responses that are particularly common in work with people seeking asylum.

Oversimplification and polarisation: Renos Papadopolous has described how complex needs are often perceived and treated as simpler than they actually are (Chapter 14). Seeing a presentation as clear-cut and unidimensional can make our work feel more straightforward, but it will be correspondingly limited in its effects. For example, sometimes clinicians can see 'trauma therapy' as the crucial intervention, to the exclusion of other help they could offer.

All the responses to the work that we are discussing here can be understood as forms of simplification. Many are also 'polarised' positions, where the simplified response is at one or other extreme of a range of possibilities. This can readily contribute to disagreements between different practitioners. One clue that this is happening is when we find ourselves very certain about our point of view while others see things differently. This may even extend to seeing our own views as 'objective' and the opposing views as merely 'subjective'.

Over-commitment and under-commitment: Sometimes, work with people seeking asylum can become an all-consuming 'cause'. Practitioners may feel closely identified with clients. They may feel an emotional need to make reparation for what the person has suffered. Boundaries can become hard to stick to and people may work longer and longer hours and find it hard to switch off. To those not sharing this position, it can be seen as over-involvement.

Sometimes the relationship with the client may develop into a dynamic of 'saviour and victim', where both clinician and client see the client predominantly as the helpless victim of others, and the clinician as the one person who can rescue them. This may have psychological rewards for both clinician and client, but is likely also to draw the client into a dependant relationship from which it may be difficult for them to move back to more adult functioning.

In contrast, other professionals may feel more detached, disengaged, or indifferent, perhaps suspecting people of using services just to help with their asylum claim. To people who don't hold this position, it may seem that these practitioners are being inappropriately aloof and 'cold', and withholding help inappropriately.

Each of these extreme positions may protect us against the discomfort of being aware of great needs that we cannot address. However, both are likely to be less helpful to clients than a more nuanced and complex approach.

Idealising and denigrating: For some practitioners, work with people seeking asylum can feel especially worthwhile or praiseworthy. This belief can be useful as a motivator, but of course is not necessarily true, and such a belief can lead to denigration of those who don't feel the same and judgemental dismissal of opposing views. Issues of self-worth may come to the fore. People around the clinician can also either idealise or denigrate the work – seeing it as compassionate and humanitarian or, alternatively, as gullible pandering to people who want to 'exploit the system'.

Giving up or persisting pointlessly: When there is little that a clinician can do in the face of overwhelming needs, it is easy to feel disillusioned. Regarding all intervention as useless may save us from experiencing the painful discrepancy between need and provision, but at the cost of people being denied services that could benefit them. Conversely, it can sometimes be harder to stop something that is not helping – a medication or a therapy, for instance – than it is to persist and ignore the fact that it is not achieving anything. It can be more challenging to consider whether there are other ways to make a modest but real difference.

Abuse dynamics. Clinicians working with those people seeking asylum who have experienced torture or other abuse may find themselves also influenced by dynamics related to clients' expectations that others will be indifferent to their suffering, fail to protect them, or even

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want to hurt them. Consciously or unconsciously, a client may expect treatment similar to that which they have received from authorities in other countries, or from the Home Office or courts. Clinicians may feel at times that they are not only being experienced as abusive but are perhaps actually *being* abusive. This might happen, for example, in an assessment for a medico-legal report when pressing someone to give more detail of the torture they experienced. Wanting to avoid a situation where the roles feel like abuser and abused may lead to clinicians being subtly drawn into a saviour–victim relationship.

Exhaustion, burn out, vicarious traumatisation, and existential reactions

Working with people seeking asylum can be emotionally taxing as well as rewarding, and it can be intensely challenging to realise that UK agencies acting in our name can frequently frustrate meaningful work. Some of the responses described herein may come to dominate our approach to our work. Practitioners can feel more and more helpless or find it hard to leave behind the stories they have heard. They may feel powerless, frustrated, or angry, and may have difficulty sleeping or even flashbacks. They may start to question their previous views of life. They may come to a point where they are demoralised and unhappy, or feel unable to empathise as they used to.

Various terms have been used for such responses. 'Burn out' is sometimes used to describe a reaction to prolonged work stress, particularly in the helping professions, where practitioners feel emotionally and physically exhausted, become cynical, and find work demands unmanageable. 'Vicarious traumatisation' has been applied to a wide range of negative changes that a clinician may experience through working empathically with individuals who have experienced high levels of adversity – for example anger, sadness, bystander guilt, self-doubt, preoccupation with clients, difficulty maintaining boundaries, numbing, pessimism, and cynicism.

Individual clinicians feeling overwhelmed by work will respond in different ways. The common theme is that negative changes can profoundly interfere with a clinician's ability to work therapeutically.

Organisational dynamics

Clinician: My client has just heard that their asylum claim was refused. He's been absolutely devastated and we haven't been able to do the work that we'd planned for the last few sessions. It's absolutely wrong that there can't be the flexibility to give him long enough to complete the work he needs.

Manager: We've already allowed you more than double the usual number of sessions because of the interpreter. You're over-involved and not seeing things realistically. All you're doing is making him dependent.

The need to attend to organisational dynamics

People seeking asylum can put particular strains on the organisations that work with them. They may also become used as a vehicle for the expression of problems the organisation faces from other sources. Whatever an organisation's overall purpose, there are stresses from multiple directions – meeting targets, managing financial challenges, and rivalries and mistrust between departments or professions, for example.

Organisational dynamics can be understood as ways in which organisations manage such stresses and strains. They reflect the psychological responses of all the individuals that

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constitute them, but particularly those in positions of power. They also reflect the dynamics of wider society – for example, the widespread polarisation of views about people seeking asylum. As with individuals, arrangements that feel rational, objective, and inevitable are often also serving psychological needs, protecting people from experiencing greater anxiety. In the example above, the certainty and extremity of both speakers' views suggests that both may be swayed by something more complex than a rational appraisal of the situation.

If problematic organisational dynamics are unaddressed, they may lead to an inhumane, mechanical, and sometimes brutal climate even in an organisation whose aim is to be helpful. In any organisation, anxiety can undermine collaboration and good practice at every level, if there are no well-established means of recognising, processing, and containing it.

Some patterns of organisational dynamics

The dynamics we have outlined in individuals working with people seeking asylum may be observable at the organisational level too. A particular attitude may be shared across the organisation or by certain groups within it.

Organisations may fragment, with one side taking up one or the other side of a polarity. For example, faced with the same situation of overwhelming need among people seeking asylum and limited resources to address these, some staff may take a firm view that the 'right' answer is stricter access criteria, while others may put huge effort into identifying more resources.

In addition, organisations as a whole may overtly espouse certain views, but embody the opposite in the way they work – in Jungian terms, the 'shadow' emerges. Thus, a proudly humanitarian organisation may be harsh and demanding towards its own staff, perhaps inducing guilt in staff if they draw attention to their own needs rather than focus only on their clients.

Effects on people working in the organisation

An organisation's dynamics influence the individuals who work in it, and this can in turn lead to consequences for the clinical work.

Where an organisation habitually fails to treat its staff with fairness, concern, and kindness, dismissive or harsh attitudes may in turn creep into relationships between clinicians and their clients (Ballatt et al., 2020).

Tensions and conflicts between staff holding different views on people seeking asylum may resonate with other tensions between different groups within an organisation. Front-line staff, with direct contact with the emotional experience of unmet need, may see themselves as needing to defend clients' rights against hard-hearted managers. Managers needing to attend to organisational survival or commissioners' demands may see front-line staff as unable to face reality and needing to have firm boundaries imposed on them.

Where views have become polarised, opposing groups may each feel very clear that the other approach is wrong, as in the short exchange that begins this section. A more thoughtful appraisal of the situation might conclude that both 'sides' hold truths, that every choice is in some way a compromise, and that dialogue, not conflict, is required.

The members of an organisation may also simply fight among themselves because none of us are as nice as we would like to be and (with our unintegrated shadows) we need to let off steam.

Vigilance about, and attention to, such dynamics is essential at all levels of an organisation. Without this, the well-being of staff, clients, and the organisation itself will suffer.

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Some dilemmas

Boundary or barrier?

> *Families coming to our community clinic had to go to the main hospital cash office, two further bus journeys away, to reclaim their fares. They often struggled to find the initial funds to get to us and usually did not have the return fare anyway, let alone the extra to get to the main hospital. It seemed it would be easy enough to arrange for the community clinic itself to reimburse the fares. It was however impossible … We often gave the fares ourselves, saying they came from the hospital. In the end, a local charity made funding for travel easily available.*
>
> Julia

'Ordinary' professional boundaries for a clinician may become barriers to some clients receiving an effective service, or any service at all. With people seeking asylum, situations frequently arise wherein it is difficult to decide how firmly to hold to a usual boundary and where it is appropriate to make adjustments. However, it can be difficult to know if an inclination to shift a boundary is driven by rational clinical judgement or is actually more about organisational pressures, or the clinician's emotional needs rather than the client's.

Wanting to 'go the extra mile' when someone is in a desperate situation and has suffered great losses is a normal human reaction, but of course not necessarily always helpful in a clinical setting. As with any client, providing what is asked for may relieve everyone's anxiety in the short-term, but at the same time might eliminate the space critical to developing alternative perspectives and enabling change. It can also be the wrong thing to do on a practical level – an example would be providing unsolicited letters or reports. Going too many extra miles can have adverse consequences for the clinician, too.

On the other hand, if flexibility helps engagement, connection, and trust, then it can be an important aspect of intervention. Generally, maintaining rigid boundaries does not work well when working with this client group. The obstacles they experience in accessing care, trusting clinicians, and feeling hope are greater than for the general population and mean that greater flexibility is needed to overcome them. For someone to feel their particular situation has been recognised and understood may require the clinician to consider responses outside their normal range to demonstrate this. They might, for example, allow more time, offer a drink, or agree to explain an incomprehensible official letter that is causing concern.

Dilemmas over when to end contact may be the most challenging of all (Chapter 9). In managing all such dilemmas, it is important to try and differentiate between boundaries or rules which are bureaucratic or procedural, and ones which exist to protect clients from clinicians' own issues. It is important to recognise when someone's request is about practical assistance and does not need to be understood as a psychological issue, and when bureaucratic demands are simply beyond someone's capacity to cope with (as with the bus fare example). As in many situations, the clinician's approach, their calmness, thoughtfulness, and careful listening, will sometimes be more important than their actual decision.

Neutrality or some self-disclosure?

> *I said 'I am sorry these things are happening to you, it is not right that you should be treated like this'.*

When working with people whose rights have been grossly violated, the question of whether we are explicit about our own position on human rights or other matters is always relevant. Some clinicians are accustomed to stating their opinions explicitly, while others may see this as burdening clients with their own views and agendas.

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However, in the context of human rights abuses, acknowledging that you believe that what has happened to someone is a violation of their rights can be a powerful validation. It may be a necessary step for gaining their trust. It can also be a counterbalance to the stigmatisation and racism the person is likely to have experienced in the United Kingdom.

There are other situations where clinician disclosures can help a client feel able to engage with treatment, or where the client gains from being able to identify with the clinician. For example, for someone whose own sexuality has been the cause of ostracism and persecution, disclosure can have particular importance. In peer therapies, it may be the sharing of experiences and attitudes that is the key active ingredient.

However, mental health traditions of non-disclosure exist, among other reasons, to protect clients. Disclosure is not necessarily the best option in all situations.

Clinician only – or clinician plus human rights advocate?

I support Doctors of the World and Amnesty International, write to my MP from time to time, help at the local refugees' support service …

It is impossible to work with people seeking asylum without realising how much harm is done to their mental health through political decisions. Realising the extent of the impact of UK asylum processes can be particularly arresting. If we are serious about wanting people's health to be better, is it responsible to confine our activities to clinical work?

For some clinicians it feels important to do more. We can often be sustained in this work by turning our despair or powerlessness into some form of action, or 'justice doing' (Reynolds, 2011a). For some, this may mean becoming politically active. Within the clinical role, interventions might include acknowledging injustice (as discussed earlier), or encouraging the person to talk about how they want to respond to abuses they have sustained, or how they might work with others or have their voice heard. There is an argument too that the clinical space is inevitably always political – a politics of action rather than rhetoric. Outside the clinical role, the possibilities for campaigning or political action are obviously numerous.

However, being highly committed to the clinical work does not necessarily mean seeing it as about 'human rights', which after all can be regarded as a concept only belonging to certain legal and political cultures. And as clinicians, even if we all agree with treating our clients with humanity and kindness, we will not all have the same views about matters such as global responsibility or border control. Risks of politicising clinical space include excluding those whose views don't fit and stifling reflection.

A further risk is that if a clinician is explicitly linked with 'a cause', this might affect their perceived impartiality when providing evidence in an asylum claim. There have been cases where the clinician's known allegiances have been used as a reason for disputing their evidence. However, it is also clear that it is possible to be an overt campaigner for human rights and still an effective medico-legal report writer – here the affirmation that the professional is recognising their primary duty to the court is crucial.

Decisions about what is appropriate to do and say are not clear cut. Even among ourselves as a small group of editors, we have different points of view about this.

How far to go with gifts?

She had talked in therapy about how she longed to visit her only friend in the UK but couldn't because of the bus fare, even though this was only a few pounds. Then, when she was leaving, she brought me not just a beautiful card, but also a bottle of wine and chocolates.

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When a client brings a gift, this can be a moment where difference in privilege feels acute and it can feel hard to accept something that will have been very difficult for them to afford. However, it can also feel like a rejection to refuse, a denial of the person's wish to give as well as receive, and a powerful way of connecting if you accept.

As a clinician, giving gifts to a client is very much outside normal boundaries. But fetching a glass of water, or preparing a cup of tea and a biscuit, for a client can cement something important in the therapeutic relationship.

Gifts, whether from client or clinician, have a symbolic dimension. Gifts always need understanding in the context in which they are given, and exploring the meaning of a client's gift will often be valuable.

How much to encourage distressing disclosure?

Dilemmas can arise about whether to try to help someone to 'open up' about what happened to them and how they 'really' feel, or whether to respect their efforts to keep their feelings at bay. Being able to talk about what has happened will sometimes be very much in a client's interests, but in other instances it will make things worse. We may equally need to respect a personal or cultural predisposition to deal with even severe adversity concretely and practically. For some, preoccupation with internal emotional experience may not have the value and virtue that is often assumed in the affluent West.

It is important to make the call on this according to what might be in the client's best interest at the time, rather than having fixed preferences about getting people to 'express their feelings' or protecting them from distress. Often, there are no right or wrong answers, but the important thing with this, as with the other dilemmas discussed here, is to keep in mind that the decision is not necessarily straightforward, or as 'either-or' as it first seemed. Self-reflection is crucial.

How to deal with different perspectives in the same team or organisation?

Because it is common for clinicians working with people seeking asylum to have different views from colleagues about how to go about the work, dilemmas may be experienced about how to manage this. This is especially challenging when compromising feels 'wrong'.

For clinicians, it can be helpful to remind ourselves of the polarised responses and other pitfalls discussed in the previous two sections, and of the likelihood that there are elements of truth in everyone's view. It may still feel difficult to balance our responses to clients with organisational rules.

For those with management responsibilities, it will often be necessary to make policy decisions about controversial areas – for example, about how many sessions are allowed or what kinds of help can be offered. Clarity about what is expected can have benefits not only for the organisation, but also in offering consistency to clients and supporting clinicians. But the extent to which such decisions feel supportive to clinicians is likely to depend very much on how they are presented – whether they are claimed as immutable, the only 'right' decision, or are discussed as a 'best current effort', with advantages and disadvantages and the possibility of future revision.

What helps clinicians do well? Finding space for reflection

The value of reflection

What helps clinicians to think clearly, remain emotionally present, be as effective as possible in the circumstances we find ourselves, and thrive rather than be overwhelmed? How can we be realistic about our contributions rather than self-idealising, self-righteous, or disheartened?

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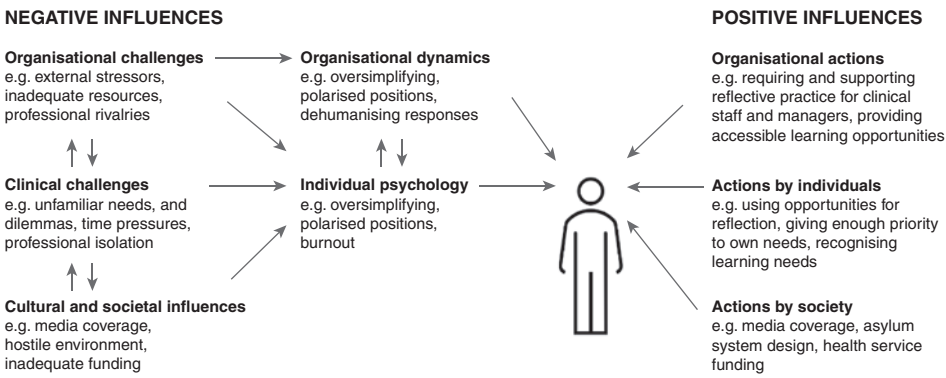

Figure 15.1 Influences on practitioners' capacity for being effective and compassionate

Finding space for reflection is important in any clinical work but the experiences, dilemmas, and pressures we have outlined make it all the more important in work with those seeking asylum. Figure 15.1 illustrates some of the factors that influence the clinician's capacity for being effective and compassionate. In both statutory and third-sector settings, allocating regular time for reflection is likely to ensure that the service is as effective and efficient as it can be. This is true for those managing the challenges of clinical work, and also for those managing the organisation(s) in which clinicians work and shaping their culture. The potential for clinicians (and organisations) to be unhelpful or unwittingly do harm makes it essential (Scanlon and Adlam, 2012).

The specific needs of those seeking asylum also call for some specific knowledge and skills, which might be acquired in different ways: through doing the job, training activities, supervision, or conversations with knowledgeable others. But these alone are not sufficient, and are not a substitute for the regular opportunity to step back and reflect with other people.

The chance of reflection with peers is particularly important for clinicians who work in settings with powerful cultures that are very different from the usual professional ones, and where they may be one of only a few people with a similar professional background. These may be institutions such as immigration removal centres or prisons or, alternatively, organisations with 'high-profile' political commitments or agendas.

This is also especially important for those who work alone, or who are professionally isolated because they do quite different work from their colleagues. One such group is the small pool of people who undertake expert witness work.

Issues needing attention

It was important to recognise the limits of what we could achieve in the roles and context we were in, and be careful not to go beyond these, however much we might have wanted to. Part of the supervision I got and gave was to help us all as a team manage the frustration and sadness of the work, not just trying to solve the problems but appreciating how important it was to witness and bear witness.

Julia

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This chapter has identified some ways in which working with people seeking asylum may sustain or challenge practitioners. All are areas that can benefit from attention in training, supervision, and other forms of dialogue and discussion.

Reflecting with others about the impact of factors such as culture, power, privilege, status, identity, gender, age, ability, education, religion, and politics can help with understanding the context and recognising how differences between clinician and client may manifest in clinical work. It can be particularly valuable to do this with others from different professional and cultural backgrounds, and from outside the organisations where we work. Thinking about these things explicitly with people with different perspectives offers the opportunity to become more aware of unconscious bias, and of how society's dominant discourses affect our language and unspoken formulations. Exposure to UK media coverage alone makes it difficult for anyone to have a default position of minimal bias, even if this is bias resulting from reaction to prevalent narratives, rather than agreement with them.

Discussing what the clinician has noticed about the *way* the client tells their story is important. This is particularly so with people who have become accustomed to not having a voice, as with so many of those seeking asylum.

Attending to our own feelings as clinicians can feel like a luxury, especially when we work with clients with many pressing needs, but it makes an important contribution to improving the quality of what we can offer. This is especially so in work where feelings may be strong and unfamiliar. Practitioners' responses to clients carry information about what is happening for the client, and this is true of bodily responses too, although these are often overlooked (Afuape, 2016). Supervision and other reflective spaces can help us as clinicians in the difficult task of distinguishing how far our responses relate to our clients rather than our own concerns and histories, and in noticing aspects of the interaction that we have overlooked or avoided. It can improve our awareness of the impact the work is having on us, and of similarities and differences to others' responses. In addition, support and containment – being able to express feelings openly, be heard, and not receive an untoward reaction – can be key to managing difficult responses without either denying or being overwhelmed by them.

Conversations about beliefs and values can help us to identify what attracted us to, and sustains us in, the work, and also to notice what it is that connects us to others. Such conversations may be especially useful when we feel tempted to change direction or give up. At times when giving up is a possibility, for clinicians as for clients, it can be useful to focus on what gives hope and what changes have already been noticed.

Where members of a single team hold conflicting views on important issues, it may be particularly helpful to have space to think together about how these have arisen, and about what each perspective can offer.

Lastly, we need opportunities for maintaining and acquiring specific knowledge and skills that may enable us to be more effective. Chapters 1–12 have set out the kind of information that may be helpful. Development of skills in considering different perspectives, and in dealing with complex situations, is a key piece of continuing professional development. This may be facilitated by access to a thoughtful and reliable reflective space.

Reflective spaces

The team worked well together. The discussions we had – and also the external supervision we bought in – enriched and enlivened our practice.

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Reflective space may be available in various formats, and under various names: clinical supervision, peer support, mentoring, team formulation meetings, reflective practice groups, staff support groups, Balint groups, or solidarity teams, amongst others. These may be with a leader of some type (a 'supervisor', 'facilitator' or 'mentor' perhaps); alternatively, they may be peer-led. What is important is to have a regular space where there can be thoughtful discussion, and a space that the clinician themselves perceives as helpful.

Taking time to reflect on one's own feelings individually can be helpful, but it is not a substitute for interchange with others. Sharing feelings and responses can enable us to see what we have not noticed or to realise where our thinking has been distorted by cultural assumptions, organisational culture, or our own anxieties. When things go well, external spaces for reflection will contribute to a process of opening up more space for reflection within our own minds.

The most fruitful spaces provide for clinicians to reflect regularly on their relationships with clients; on their own feelings, cognitive, and physical responses; and on unspoken communications. Some models (such as certain psychodynamic and narrative approaches) have a central focus on these issues and may be particularly helpful for supervision of work with people seeking asylum. This is different from the type of supervision that focuses on practical or management issues, decisions about what to do next, techniques, or managing caseloads.

Because of the risk of supervisors and other team members being caught in the same organisational dynamics, there can be particular value in arrangements that involve supervisors or peers from outside the organisation.

One approach to facilitated discussion (used, for example, in Balint groups) is for one person to present a clinical experience or dilemma to the group and for the others to listen and, in turn, reflect while the speaker listens, using their physical, cognitive, and emotional reactions. The listener then responds while the others listen again. Listening and being heard can be a useful exercise and brings forth a multitude of perspectives, as does a 'reflecting team' in systemic therapy.

Peer discussion, without a facilitator, can also be valuable. The 'solidarity team' is an idea from narrative practice (Reynolds, 2011b) whereby a clinician selects individuals who can offer a different perspective on a particular clinical dilemma or situation. They may be other clinicians, but could also be friends or people from another ethnic background or outlook, who are called on to discuss a dilemma or idea.

Geographical distance used to be a significant barrier to peer discussion and reflection. 'Remote' meeting through video conferencing now gives access to a wide pool of potential peers, and to facilitators with no travelling time needing to be taken out of busy schedules and commitments. The authors' own experience in a peer group that started meeting in 2015 has been that very real human connections form despite few of the members having ever met in person. It was in this group that the idea of this book emerged.

Forms of training which offer participants the chance to think with others about the work may be helpful. However, what is needed is not just initial training in preparation for a role but also something ongoing, and one-off training is no substitute for this.

Meeting people who are seeking asylum in non-clinical situations can be a valuable learning experience. Seeing people *only* in a clinical space can leave us with a one-sided view, particularly where that clinical space only attends to 'mental health' issues. More rounded encounters with people – for example, meeting in a community group, as work colleagues, or in social situations – can expand and deepen our understanding.

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Protecting reflective space

All of us thought the reflective practice group was a great idea, but in practice there was hardly ever more than a couple of people there, and usually just the same people every time. Everyone is just so busy!

Reflective space is easily obliterated. Time pressures, the pressing needs of clients, and practitioners' exhaustion can all result in this being the one aspect of work that is abandoned. Clinical supervision can turn into supervision that deals only with management issues, with a superficial appearance of efficiency. An opportunity to talk to colleagues can feel a luxury which must be foregone. Often it is when people feel that the reflective space can be sacrificed that it is most needed.

Opportunities to think about the work with colleagues need to be regular, consistent, and prioritised, and ideally encouraged by a reflective approach throughout the organisation. Organisational support is crucial so that it is an integral and expected part of the work, rather than something just for a few committed individuals (Chapter 13).

Clinicians also need to have their own mental space to use these opportunities. Something both obvious and regularly ignored is that none of us are at our best when we are exhausted and disillusioned. Especially when working with people whose needs are great, it is easy to feel we are burdening others if we take a break, even though this may prevent us reaching a stage of deteriorating effectiveness or not being able to do the work at all. Doing what is needed to remain effective requires us to respond to our own needs, and for organisations to recognise these too.

Clinicians are likely to be most able to maintain a reflective, helpful approach when working in organisations whose culture encourages this. Organisations themselves are more likely to avoid anxiety-driven and unhelpful practices if managers as well as clinicians are aware of the risks of these arising, and take steps to manage them, including through developing their own spaces for reflection. Thoughtful, reflective managers, with an understanding of how their own thinking and behaviour may become as irrational as anyone else's, can make all the difference in developing a healthy, well-functioning organisation.

Conclusion

The mental health needs of people seeking asylum, through their unfamiliarity, complexity, and sometimes their extremity, place particular demands on practitioners and organisations who want to provide fair, effective, and compassionate care. This is compounded by the fact that the environment in which we work is constantly changing, and fresh challenges emerge as old ones fade away.

Austerity policies and Covid-19 put healthcare providers under greater pressure than ever, while clients faced additional challenges in their daily lives, alongside diminishing sources of support. For years, practitioners in the United Kingdom have also worked in a political environment increasingly hostile to people seeking asylum. This has pressured organisations and individuals providing care to enact similar hostility.

Throughout this book, the chapter authors have indicated ways in which mental health practitioners can make a difference to clients, despite all these difficulties. When we do manage this in the face of greater challenges, the rewards can be greater too. One of the individuals who generously gave their time to comment on drafts of this book wrote of their own clinical work: '*This is the hardest work I have done, and also the most rewarding*'.

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A difficult working context makes it correspondingly more difficult for clinicians and organisations to work with consistent thoughtfulness and humanity. In such circumstances it is always difficult, but vital, to be vigilant about our own reactions, to sustain not just effectiveness but also compassion and kindness.

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Extract from a poem by Loraine Masiya Mponela

Please, can somebody break this glass bottle for me
Please somebody
Break this bottle for me
I need to breathe free air too
Like every other human being

(More extracts from this poem can be found on pages 1 and 274.)

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