

# Vulnerable Women's Project Good Practice Guide:

## Assisting Refugee and Asylum Seeking Women affected by Rape or Sexual Violence

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# Foreword

The Refugee Council's Vulnerable Women's Project (VWP) was set up at the end of 2006 with the support of Comic Relief to address the needs of refugee and asylum seeking women who had been subjected to sexual violence, including rape. The project grew out of the work of the Council's bi-cultural mental health team (now known as the Specialist Team) that was established in 2000 and is integrated into a One Stop Service that offers advice and support to more than 30,000 asylum seekers and refugees every year. Alongside individual casework, the project aims to raise awareness amongst UK and EU decision-makers of the needs and rights of refugee women who have survived rape and sexual exploitation.

The project's 'pragmatic holistic therapy' approach (now known as "Therapeutic Casework") developed by the Refugee Council Specialist Team, scored well in a report of an external evaluation by the European Centre for Migration and Social Care at the University of Kent (Watters 2008), using an internationally established template. The service was assessed on six specific aspects of good practice and in relation to seven accomplishments in the care of refugees:

1. Taking refugees seriously as competent interpreters of their own lives
2. A holistic approach which offers integrated programmes of social, emotional and psychological help
3. A receptivity towards culture
4. A recognition of the impact of ongoing events on refugees' lives
5. An orientation towards empowerment through ownership and participation
6. An engagement with family and meaningful others
7. An emphasis on enhancing refugees' own capabilities.

The evaluators found that some clients were in situations where they were exploited and were in

perpetual fear of sexual or other forms of physical abuse. A high proportion of clients said they may well have committed suicide if it were not for the intervention of the team.

In the 21 month period Between 1 December 2006 and 31 August 2008 the project supported 153 women. Of these women,

- 76% had been raped, either in their country of origin or the UK
- 15% had become pregnant as a result of being raped
- 5% had had a child as a result of being raped
- 35% had suffered some form of violence
- 22% had been sexually abused
- 9% had been threatened with rape or sexual abuse while in detention in their country of origin
- 27% had physical injuries
- 76% were experiencing trauma-related psychological distress
- 20% had gynaecological problems as a result of their experiences.

The average age of women presenting to the Refugee Council in connection with rape or sexual violence was 34. The largest group of women (48%) was aged between 25 and 34; 8% were under 18. Most were asylum seekers with outstanding claims. The largest groups of clients were from the following countries:

Sri Lanka (Tamils):	50%
Eritrea:	7%
DRC:	6%
Ivory Coast:	5%
Somalia:	5%

This Guide explains the Refugee Council approach to best practice in caring for women in this situation and should be read in conjunction with the literature review (Refugee Council 2009) which examines the extent and impact of sexual violence against refugee women around the world.

# Introduction

*There is a young woman in the waiting room who is very distressed. Her name is Leyla and she is an asylum seeker. She has nowhere to sleep tonight. Leyla has been refused asylum and was evicted from her Home Office accommodation two months ago. For the past few weeks she has been staying with different friends, sleeping on sofas and floors, but she no longer feels comfortable with this arrangement. After a long and sensitively-conducted interview, it emerges that her house was destroyed by soldiers and she was raped a few years ago in her country of origin. She never felt safe after that for a long time and losing her accommodation now has brought a lot of difficult feelings back. The young woman was raped again in detention in her country last year and is still in considerable physical discomfort. She does not just need accommodation, she needs to feel safe in her accommodation, and until such practical issues are resolved it will be difficult to help her in respect of the distress she feels about her terrible experiences.*

Rape is a devastating event which impacts not just on the individual's physical and psychological health, but also at the family and community levels. The lasting effects for a woman who has to leave her country and seek asylum abroad because of the rape, are even further reaching. However, for a variety of cultural and psychological reasons, it may be extremely difficult to talk about it. Staff in many different agencies need to understand that, behind such presenting problems as homelessness may lie deep-seated physical and mental health problems resulting from rape and sexual violence, and these need careful, sensitive, skilled and often quite long-term help.

This **guide** explains the Refugee Council approach to working with women in this situation. It shows how we place the client in the context of her social circumstances and experiences at the assessment stage and how we work with both the client's internal and external world at the **treatment** stage. We call this approach "**Therapeutic Casework**"

The **guide** is for:

- Staff in Refugee Community Organisations (RCOs), Refugee Agencies and other welfare/advice organisations providing services to refugee and asylum seeking women who have been raped or exposed to sexual violence.
- Staff in rape crisis centres or health service settings encountering refugee and asylum seeking women who have been raped or exposed to sexual violence.

The first part of this **guide** covers the Refugee Council approach to **Assessment** (client history; physical health; psychological health; rape, trauma & memory; pregnancy after rape; support networks and relationships; day time activities; financial, accommodation & legal issues and coping strategies).

Readers may already have extensive knowledge in some areas and less in others (you may be a nurse who knows all about the physical impact of rape, but less about an asylum seeker's entitlements to financial support for instance). Some readers will work in settings where they have the time to conduct casework themselves with clients, others will be looking to refer on.

**Part One** therefore covers:

- The impact of rape / sexual violence on the various aspects of a refugee woman's life
- Our approach to the assessment of the issue and,
- Sources of more specialist assistance.

**Part Two**, on **Casework** is for colleagues who are able to engage with clients over a longer period and explains **Therapeutic Casework**, a model of intervention which combines counselling skills with advocacy and practical advice to support clients with their practical and emotional needs. **Therapeutic Casework** has been developed by the Refugee Council Specialist Team in London.

# 1. Impact and Assessment

## 1.1 Impact

### 1.1.1 Physical Health

The nature of rape and sexual violence can cause physical harm to intimate areas of a woman's body, so discussion of this needs to be handled sensitively. A client with such problems may be anxious about talking about her health. Some of the most frequently-encountered impacts on physical health are shown in the box below.

#### Box 1 Impacts on Physical Health

- Scarring on genital areas caused by cutting or burning
- Damage to the vagina, rectum or pelvis caused by introduction of instruments
- Tearing of the perinaeum and damage to the bladder
- Acute vaginal bleeding
- Sexually transmitted infections (STI's, including HIV/AIDS). The risk of contracting an STI is increased where there is damage to the genitals (WHO 2000, p113)
- Long-term infertility
- Disrupted periods
- Changes to fertility and a woman's ability to breast-feed (Lunde and Ortman in Basoglu 1998 pp 313–14)
- Women who are pregnant (possibly as a result of rape) can miscarry if beaten on the uterus during torture
- Abdominal pain or pain in a woman's hips can also be a sign of rape.

Bruising to arms and chest, missing patches of hair from the back of the head, and bruising to the forehead can be signs of assault (WHO 2000 p. 113)

None of these symptoms is necessarily a sign of rape, but they may be significant indicators which the worker should look out for. Care needs to be taken

in exploring the origins of the symptoms and what the woman feels they relate to. A woman describing any of these symptoms should be advised to see a medical professional.

### 1.1.2 Psychological Health

In the immediate aftermath of a rape or sexual assault, a woman can be in shock; paralysed with the fear of injury or death and feel they have lost control over their life (WHO 2000, p 113)

In the long term, a wide variety of different reactions can be observed. Some of these are outlined in the box below.

#### Box 2 Psychological Symptoms of Rape or Sexual Assault

- Nervousness, headaches, depression, reduced self-esteem and guilt (Van de Veer, 1992 p232)
- Memories of the rape or violence can be triggered by everyday events: sexual intercourse, pictures, newspaper articles or films (Lunde & Ortman 1998. 314)
- Degrading or insulting comments during the rape can lead to the woman feeling disgust for her own body, anxiety about sexual involvement and undermine her sexual identity (Lunde & Ortman 1998, p 314)
- Sex can be physically and psychologically painful for the rape survivor which can affect actual intimate relationships and create anxiety about forming new relationships
- Some women report flashbacks, intrusive thoughts, nightmares, hyper-vigilance and other post-traumatic symptoms as a result of the rape.

The psychological impact of sexual violence can be compounded by a breakdown in usual support systems and "...the absence of a safe and supportive environment for healing" (WHO 2000, p 113)

Although in the minority, some clients do express symptoms of severe and enduring mental illness

and these need to be considered at assessment, while bearing in mind the context within which the symptoms are being expressed: a client may hear the voice of their dead mother as part of a normal grieving process and this is not necessarily a sign of psychotic disorder. The impact of the rape, together with feelings of hopelessness about the future can lead some women to think about suicide or self-harm and issues of risk also need to be thought about and assessed.

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### 1.1.3 Pregnancy after rape

Becoming pregnant as a result of rape can be very distressing for women, bringing up confusing, contradictory feelings. This issue needs to be handled especially sensitively.

Some women chose not to continue with the pregnancy, but this in itself can be a problematic decision, especially where women have deep rooted religious or cultural views on termination. The termination itself can be a source of further trauma, shame and loss.

One client who spent some months in prison and then had a long journey to get to the UK wished to have a termination, but presented too late and had to go through with the birth.

Women have told us of conflicting feelings of joy at being pregnant and horror at bearing the child of a rapist. Some women describe feeling that the baby they are carrying is all they have left and are determined to continue with the pregnancy.

Others will not talk about the pregnancy at all and seem to dissociate or split themselves off from it. This can be a sign that the woman is not coping well with being pregnant.

Once the child is born, there can be initial issues around bonding and there is a risk the mother may reject the child and / or develop post-natal depression. One mother reported bonding very well with her baby, a boy at first, but that problems began when he grew and began to look more like the man who had raped her. This can lead to longer-term relationship problems, including the potential for rejection or abuse.

## 1.2 Assessment

Assessment must be handled sensitively: it is often still difficult for a woman to discuss rape with a stranger even if they are sensitive and empathic. Disclosure will often not happen until a containing helping relationship has been established and until the woman's most immediate needs have been met. The assessment may need to take place over several sessions. Clients may not begin by disclosing rape, which may emerge when discussing another area of their life. According to the World Health Organisation (WHO) some women will present for help with symptoms, without disclosing they have been raped and will re-present over many years with psychosomatic complaints which do not respond to treatment (WHO 2000, p 127). Fear of reprisals in their country of origin and lack of knowledge of services may have discouraged the women from telling anyone before.

The WHO recommends health workers should only ask about rape when they have established a trusting relationship with their client. (2000, p 127). The safer the woman feels, the more likely she is to disclose, which underlines the importance of two essential elements in the assessment process:

- Creating a safe environment and a relationship of trust
- Adopting a non-judgemental, empathic attitude to the client.

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### 1.2.1 History:

Many refugee women will disclose histories of traumatic events in their countries of origin, which can include periods of detention involving torture and rape. However, rape and sexual violence can take place in many different contexts, including the client's own home. It is important to allow the client to tell her story at her own pace as it can bring up painful memories and emotions. Some clients can be re-traumatised by having to speak about their ordeal (WHO 2000, p 131). The worker needs to allow clients time and space to recover at the end of the interview.

When taking a history, the **WHO** (WHO 2000, pp 131 – 132) recommends:

- Speaking quietly and taking care to move slowly and gently
- Informing the client about what you are going to do and how long it is likely to take
- Asking questions so that they can be answered briefly: this is less embarrassing for women
- Begin with asking about general history first, and then move towards questions about the rape when the client is ready
- Allow the client to decide when to start the interview and when she needs a break.

Psychological responses to rape are affected by how rape is seen in the **culture** of the survivor and care should be taken to understand this: the woman may be seen as unsuitable for marriage or viewed as a “whore” and rejected by her family (Groenenberg in Van De Veer, 1992 p 232.)

Caseworkers should explore the client’s perceptions of how her culture would view the incident sensitively.

How the client is feeling about herself and her current situation can be discussed here: she may talk about nightmares, fear, flashbacks, intrusive thoughts, sadness, loss or worry. The client’s sleeping patterns, appetite and self-care should also be considered. It is also useful to note how the client appears to be: is she angry, confused, and tearful? Is there a difference between how she says she is and how she appears to be?

Where the worker is unsure or feels they lack the knowledge or experience to make such an assessment, a referral should be made for a formal psychiatric assessment through:

- The client’s GP
- Their local Community Mental Health Team (CMHT)
- Psychiatric Liaison staff at their local Accident & Emergency

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## 1.2.2 Rape, Trauma & Memory

When someone goes through a traumatic incident, it can be common for her to be unable to recall aspects of what happened, if at all, because of how the brain copes with traumatic memories (Morrow, 1998; Van De Kolk 1997).

There may be gaps or inconsistencies in the account your client gives of the rape: this does not mean she is making the event up. There are three important points to remember here:

- It is always very important to believe the client and accept what she is saying
- Repressed memories can return as nightmares, flashbacks and other distressing symptoms
- Not believing your client can further repress memories, leading to distressing symptoms.

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## 1.2.3 Families & Support Networks

Clients can sometimes report feeling unable to disclose the rape to their family or friends for fear of being blamed, ostracised, or in some extreme cases, assaulted or killed, such is the stigma attached to rape in some cultures. This can cause problems where a woman is showing obvious signs of distress (screaming at night for instance), but is unable to tell her family what the problem is.

Some women report having to leave their children behind in the country of origin when they left, because they thought it would be safer. This can add massive feelings of anxiety and guilt, especially if the woman has been away for some years, or has lost contact with the children.

If the client’s immediate family are with her (partner and children), the impact of the rape on the relationships within the family may be causing tensions. The children may have witnessed the rape, or be disturbed by the impact on their mother. Some women report that sexual intercourse with their partner can trigger memories of the rape which may also be causing problems.

Clients may also worry about family members still in their country of origin or who are travelling to the UK. They may have lost contact with their relatives and be concerned for their safety.

Where a client does have family in the UK, it is important to explore how well she gets on with them, whether she has been able to tell them what happened and how supportive they are. Family members should never be asked to interpret for the woman and women should always be offered the chance to be interviewed separately from any family members who may be present.



Having a strong support network can be a protective factor for women, but it is important to understand just how supportive the network is and whether the woman feels able to access that support. The family may play a vital, supportive role, but may also be adding to the problem – for example through blaming the woman for the rape or not believing her story.

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### 1.2.4 Daytime Activities

Exploring what clients are doing during the day can reveal more of how they are affected by their experiences. A woman who very rarely goes out and spends all day in bed may be feeling depressed and anxious about being attacked again: a woman who sleeps badly, yet is able to attend an English course every day may be coping better and showing signs of what Papadopoulos (2006) calls *resilience*, or the capacity of the personality to remain unaffected by a traumatic incident. (He further defines *Adversity-Activated Development*, as the individual's capacity to grow as a result of traumatic experiences).

Encouraging clients to be more active during the day and exploring what they would like to do (study, volunteer) can foster resilience and recovery by focusing on the well, coping part of the client, on those positive aspects of their personalities which have *survived* the rape and trauma (Papadopoulos, 2006). This also encourages women to think into the future, not back into the past and can help with recovery from the impact of the event itself. Re-establishing normal routines can, of itself, be therapeutic.

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### 1.2.5 Legal & Financial Issues

11% of the women assisted during the first two years of the Vulnerable Women's Project (VWP) were destitute at the first point of contact. As noted above, destitution puts women at risk of further victimisation.

Poor housing, or lack of housing, can affect someone's mental well-being so we explore the nature of the client's accommodation. Many clients will be in overcrowded accommodation, possibly staying on a friend's floor or in a hotel where they are unable to cook their own food. Clients will often not have accommodation they feel secure in, reinforcing

the importance of providing a safe space through this service.

It is common for asylum seekers with no recourse to public funds and no permanent accommodation, to stay with people they know in the community, or meet through being homeless, spending a few nights in each place. The practice is sometimes known as "sofa-surfing". It is important to explore this arrangement: clients have reported having to agree to have sex with strange men in return for somewhere to stay or have been assaulted / raped by men who offered them accommodation.

For many clients, there is a strong link between their psychological condition and the stage of the asylum process they have reached: a refusal can lead to despondency and anxiety for instance. Appeal hearings can cause enormous amounts of stress both because of the consequences of another refusal and also because the client might have to re-live traumatic experiences under cross-examination. A final refusal can lead to the withdrawal of all financial support and possible detention and removal.

#### **It is important to understand where the client is in the asylum application process.**

This can affect:

- What financial and accommodation support she is entitled to
- How anxious the client is feeling about the process: negative decisions can affect some clients very badly and others can get anxious and stressed about an upcoming appeal hearing.

Caseworkers should also always explore with the client whether she has access to any form of financial support or accommodation, and if not, whether they are entitled to receive any:

In brief, clients with an outstanding asylum claim can receive financial support and accommodation from the UK Borders Agency (UKBA) and some of those at the end of the process are entitled to support under Section 4 of the Asylum & Immigration Act 1999. Asylum seekers are not entitled to local authority housing or welfare benefits.

In some cases, where a client has support needs above and beyond destitution, (such as a disability or severe illness which impairs their ability to care

for themselves), it may be possible to apply to their local social services for accommodation and support under Section 21 of the National Assistance Act, 1948.

Some asylum seekers can apply for permission to work if they have been waiting more than 12 months for a decision on their application.

This is a complex area of law and where you are unsure, specialist advice should be sought from one of the agencies listed in the “**Sources of help**” section below.

**It is important to remember: Good welfare advice can safeguard clients against re-victimisation**

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### 1.2.6 Coping Strategies

Asylum seeking women who have been raped can appear very vulnerable, especially if they are destitute, but it is important to remember the person has survived the appalling events she describes and to do so requires considerable strength. It may be helpful to reinforce the strengths and skills demonstrated in coping and surviving rather than seeing the women as helpless victims.

- The assessment should always ask the client what she can do herself to, relax, feel better, feel more positive
- It can help to reflect back to the client the strength, or courage she has shown to get out of prison, get to the UK, keep going while sleeping rough
- This can help give the client back some of the control she may feel she lost through the rape

Hawkes, Marsh and Wilgosh (1998) describe “Solution-Focused Therapy” (SFT), a model which concentrates on the client’s capacity to make positive changes in the present and future, rather than on discussing the problems of the past. We sometimes employ SFT techniques to explore with the client what she is able to do to cope and to seek out and expand exceptions to the client’s view of themselves as (for instance) “helpless”.

Such techniques must however be used sensitively and appropriately taking the clients actual reality and lack of choices into account.

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### 1.2.7 Client’s Priorities

As well as forming a rounded, holistic picture of the client, it is vital to our principle of putting the client at the centre of the work and empowering her, that we consider what her priorities are and how we can help her achieve these.

## 1.3 Sources of Help

**If the client needs more specialised psychological help or support, the agencies listed in the box below may be able to accept a referral:**

#### Box 3 Specialist Agencies

- **The Haven Centres** ([www.thehavens.co.uk](http://www.thehavens.co.uk)) provide on-going support to survivors on the emotional and physical impacts of rape and also a sensitive medical examination service
- **The Anna Freud Centre** in London ([www.annafreudcentre.org](http://www.annafreudcentre.org)) run a mother-infant psychotherapy service and are a good source of training and advice on the issue of pregnancy and children resulting from rape
- **The Women’s Therapy Centre** ([www.womenstherapycentre.co.uk](http://www.womenstherapycentre.co.uk)) is a specialist provider of psychoanalytic psychotherapy to women, including refugee and asylum-seeking women.

Helping the client access competent legal advice can be a very helpful intervention, however, advice on immigration matters should only be given by a solicitor or suitably qualified immigration advisor (someone who is registered with the Office of the Immigration Service Commissioner, OISC: [www.oisc.gov.uk](http://www.oisc.gov.uk)). Possible sources of legal medico-legal advice include those shown in the box opposite:

#### Box 4 Legal Assistance

- **The Refugee Legal Centre** ([www.refugee-legal-centre](http://www.refugee-legal-centre)) provides free immigration advice and representation to asylum seekers
- **Asylum Aid** ([www.asylumaid.org.uk](http://www.asylumaid.org.uk)) provides specialist assistance and advice to women in the asylum process through the Refugee Women's Resource Project.

Clients may be assisted in their applications for asylum by having a detailed medico-legal report prepared, which documents any medical evidence of the traumas experienced by the client. Again, such reports should always be prepared by a competent medical professional:

- **The Medical Foundation for the Care of Victims of Torture** ([www.torturecare.org.uk](http://www.torturecare.org.uk)) offers a medico-legal report writing service and advice and training to other professionals in this area. They also offer therapeutic services to torture survivors and support to professionals from their offices in London, Manchester, Birmingham, Newcastle and Glasgow
- **The Red Cross International Tracing & Messaging Service** ([www.redcross.org.uk](http://www.redcross.org.uk)) can assist clients who have lost contact with relatives to try to locate and contact them, through the Red Cross' network of organisations around the world
- **The Refugee Council** website ([www.RefugeeCouncil.org.uk](http://www.RefugeeCouncil.org.uk)) contains information in a range of languages about rights and entitlements to support for asylum seekers and refugees at all stages of the process.

# 2. Therapeutic Casework

## 2.1 Introduction

The Refugee Council Specialist Team has been providing an assessment, casework and referral service for asylum seekers and refugees with mental health and mental well-being needs for the past seven years. This work, a blend of counselling skills, practical advice and advocacy which is culturally sensitive, has been evaluated by the Migration and Social Care Department (MASC) of the University of Kent and found to be “highly successful” as a method of psychosocial intervention with this client group (Watters, 2008). Keefe (2008, pp10-12) gives an in-depth description of the model with reflections on a case study using this method.

All Refugee Council Therapeutic Caseworkers are bi-lingual in English and a relevant refugee language. Some have more than three languages. Staff are also familiar with cultural attitudes to mental health, illness and treatment systems in the UK and a culture from where refugees come to this country. Most staff have a background in counselling and or advice / advocacy and / or develop these skills on the job.

## 2.2 Principles

### 2.2.1 Background

Abraham Maslow, a Humanistic Psychologist developed the concept of the Hierarchy of Human Needs, beginning with the Physiological (food, water, warmth, air etc.) then Safety (structure, protection, peace, comfort), Love (love, friendship, acceptance, understanding), Esteem (attention, self-respect, recognition) and Self-Actualisation (challenge, curiosity, growth).

It is not possible to engage with a client regarding their higher level needs, such as Esteem or Self-Actualisation (the process of becoming fully yourself and achieving your potential) until lower level needs (food, shelter, warmth for instance), have been met.

#### Box 5 Maslow's Hierarchy of Human Needs

**Self-Actualisation Needs** (*challenge, curiosity, growth*)

**Esteem Needs** (*attention, self-respect, recognition*)

**Love needs** (*friendship, acceptance, understanding*)

**Safety Needs** (*structure, protection, peace, comfort*)

**Physiological Needs** (*food, water, warmth, air, shelter*)

Many counsellors and psychotherapists are concerned with clients whose needs are for Love, Esteem and Self-Actualisation. Specialist Team clients have needs on the level of food, shelter, warmth and safety, and we have found that unless and until these needs are met, it is difficult to work on needs such as acceptance, understanding and self-respect or on the psychological consequences of rape and sexual violence. We assist clients to meet these basic needs before moving on to dealing with other problems in their lives. *Safety* in this sense includes a feeling of psychological safety, enhanced through addressing distressing symptoms, as well as physical safety.

The case study below illustrates the importance of responding to immediate needs before psychological needs can be addressed:

#### Box 6 The Case of Fatima

Fatima had been sleeping rough at the back of a church for a week when she first came to the project: it was winter and she was freezing when she came into the centre. She hadn't eaten for a couple of days and her spare clothes and other belongings had been stolen. Fatima was destitute because she had been refused asylum. A few weeks before, she had met a man in the street who had offered her to let her stay in his house. He later demanded sex in return for letting her stay and beat her up when she refused. Fatima left and had been sleeping rough ever since. She was too distressed to tell us this at first, but took a shower and had breakfast in our Day Centre – we gave her some dry clothes and she could then talk to us about what had happened and we were able to help her apply for accommodation.

In **external clinical supervision** we consider the emotional impact on us and whether what we are feeling can be considered as a form of unconscious communication from the client about their current and earlier experiences. We are influenced in this by Psychodynamic thinking (in brief, the idea that our early experiences of relationships impact on how we relate to each other as adults, including how a client might relate to a counsellor and that client and counsellor communicate unconsciously as well as verbally.)

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### 2.2.2 Reducing Distress:

Reducing distress requires interventions on three levels:

- Practical (advice and support)
- Emotional (hearing and containing unbearable feelings)
- Symbolic (understanding the deeper meaning of the issue for the client)

Using one approach without the others will not work as the needs of the client will not be fully understood or met. To fully resolve an issue brought by a client, therefore it must be addressed on each of these three levels.

If, for example, a client presents as distressed due to destitution, one must:

- Find them somewhere to live
- Help her express the anxiety, shame and other emotions related to this.

*And*

- Consider whether, for the client their homelessness resonates with a deeper issue (such as an insecurity about being deported, losing somewhere in that sense) or is being used to defend against anxiety about other concerns, such as the loss and disorientation of moving cultures (Papadopoulos 2002) or an earlier trauma *in addition* its practical reality. Putting this to the client and helping her talk about it will be a relief.

The Team's work is:

- **Client-centred:** it is focused on the clients' needs and engaging with what they present

- **Holistic:** it considers the whole person, including physical, emotional and mental health, history and social circumstances as well as the client's internal world
- **Bi-Cultural:** we act as a bridge between the client's culture and the host culture.

## 2.3 Casework techniques

Therapeutic Caseworkers use the following ten techniques in their work:

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### 2.3.1 Counselling Skills

Clients are provided with a safe space to explore their feelings. Caseworkers use active listening, empathy, exploring and other skills to build a helping relationship with the client and build up trust. Where possible, sessions take place at the same time each week to provide a sense of structure and safety for clients. We recognise however the need for flexibility and that the nature of clients' existence sometimes makes it difficult to stick too closely to appointments.

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### 2.3.2 Advocacy

We advocate on clients' behalf with statutory agencies such as NASS, Social Services, Homeless Persons Units, and voluntary agencies such as Housing Associations to gain entitlements to food, shelter and warmth. Where possible, we empower clients to gain access to their entitlements themselves. Advocacy can also be with mental health services, such as Community Mental Health Teams: it can be necessary to put the client's presenting concerns into their cultural context for the professionals concerned while explaining to the client the methods and procedures of the service. This matters where the professional may not have met an asylum seeker before and could, for instance, mistake the healthy wariness of a political activist with paranoia, or dismiss the importance of a distressing symptom due to worries about making a diagnosis with a client who is from a different culture:

### Box 7 Jodit's story

Jodit became actively suicidal and began to experience hallucinations in which dead people were pushing her into a grave and telling her to kill herself. She had been severely tortured and raped in her country of origin. She was reluctant to seek help from a mental health team because she thought they only saw “mad people” and that they would lock her up again. Her caseworker explained she did not think Jodit was mad but that she was under enormous stress and this was perhaps causing the way she was feeling and thinking. The caseworker persuaded her to have a mental health assessment. The doctor and social worker who saw her were initially reluctant to believe she was unwell as they thought the hallucinations were “normal” within Jodit’s religious belief system and that her distress was caused by her “social circumstances.” (Jodit had been refused asylum and had nowhere to live). The caseworker, who was familiar with Jodit’s culture and with how asylum seekers respond to their social conditions, and our interpreter who was from the same country, were able to explain that what Jodit was experiencing was out of the ordinary and Jodit herself was very frightened by what was happening. They assisted Jodit to tell the doctor that while she was stressed about waiting for a decision, she felt her life was not worth living, even if she got status and she would still want to kill herself. Jodit was admitted to a psychiatric ward for a while and, with a combination of CMHT support and Therapeutic Casework, around her practical difficulties in-put, she began to recover.

The resolving of practical issues by the caseworker helps to build the helping relationship with the client. The client starts to trust the caseworker more and will therefore begin to speak more about their personal issues.

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### 2.3.3 Crisis intervention

Clients often present in a state of crisis, perhaps due to a refusal of asylum, eviction, sudden bad news from home, or a racial assault in the UK. Clients can become highly distressed or even suicidal at such times. Staff will provide the client with a safe space to explore the various and often complex causes of the crisis and where possible develop a plan to move forward. Staff will also assess risk and refer clients to appropriate mental health services where necessary.

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### 2.3.4 Practical orientation

Practical advice about rights and entitlements, services, the system in the UK, where to go for help, how to contact the family, how to learn English etc, can improve the client’s standard of living and enhance feelings of safety and familiarity with the new culture. This can extend to explaining the transport system, how to find a GP or where to shop for food.

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### 2.3.5 De-freezing

Clients are often “frozen” psychologically by their experiences when they present. De-freezing is a process whereby the trust and empathy built up between client and caseworker gradually warms the client and melts the ice. The client is thereby assisted to access different layers of ice representing the painful memories, losses and feelings they were previously unable to discuss.

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### 2.3.6 Cultural readjustment

Staff assist clients to work through the feelings of loss and confusion concerned with moving from one culture to another and also provide information about the host culture. We understand and address the impact of changes in weather and climate, food, dress, language etc on the individual’s sense of safety and belonging and allow time and space to discuss these.

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### 2.3.7 Normalising

The combination of trauma, loss and confusion experienced by many asylum seekers can be very distressing. Clients complain of being worried they are “going mad” and that they will be unable to cope. We explain traumatic symptoms such as nightmares, intrusive thoughts and anxiety as adaptive, understandable responses to extraordinary events and focus on clients coping mechanisms, strength and resilience. Traumatic symptoms are viewed as the mind’s way of healing its wounds. As part of this, we avoid using terms such as “mental illness”, “psychiatry” or “psychotherapy” with clients, preferring to talk about their worries /

sadness or other emotions and asking whether it is helpful to have someone to talk to.

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### 2.3.8 Putting experience into perspective

As with normalising, we help clients overcome overwhelming feelings by concentrating on positive aspects of their experience. Solution Focused Therapy (SFT) techniques are sometimes used here such as scaling (asking the client, “on a scale of 0-10, how anxious are you feeling at the moment? What could you do to bring your anxiety down from 9 to 8?) and exception seeking (“I wonder if there are any nights of the week when you don’t have nightmares...what is different about those times?”, rather than asking the client to tell you what happens in the nightmares for instance.) (Hawkes et al. 1998).

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### 2.3.9 Addressing traumatic symptoms

In addition to the *Normalising* techniques discussed above, the team are currently learning about Narrative Exposure Therapy (NET), a brief intervention technique developed for use in Refugee Camps (Onyut et al, 2005; Neuner et al 2004). NET aims to reduce distressing post-traumatic symptoms by assisting clients to tell their stories of trauma within the narrative of their life story and produce a testimony which can be used to support their claim for asylum. Where symptoms persist or are acute however, we would refer on for specialist intervention, whilst resolving any practical issues which may be contributing to the client’s stress.

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### 2.3.10 Mourning of Losses

Space is given to clients to work through the multiple losses with which they can present. These may include losses of actual people, but could equally be of their culture, country, home, status in society or language and it is important that these are recognised.

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## 2.4 Overview of Process

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### 2.4.1 Referral to the Team

Clients are referred to the Team by other sections of the Refugee Council, or by external agencies. Access is via a drop-in clinic for an initial screening. Clients may be asked to return for an in-depth **assessment** if needed, or may be referred immediately to a more appropriate service if this is indicated. Time permitting; the full assessment may be carried out during the Drop-In clinic.

At this stage, the caseworker considers whether there are any immediate, practical steps, such as referral to a GP, or a solicitor for immigration advice, which can be taken, or whether the client is an immediate risk to themselves or others. If not, the assessment will be considered at a team Referral Meeting.

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### 2.4.2 The Referral Meeting

Team members meet weekly to discuss recent assessments and consider how best to meet the client’s need. If appropriate, the client may be referred out to a community mental health team or provider of more formal counselling or psychotherapy. If it is felt they might benefit from our support, they will be allocated to a caseworker or put on our waiting list.

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### 2.4.3 Supervision

On-going case-management issues such as the process, progress or endings are discussed with the Team Manager formally in line-management supervisions and informally on a more regular basis according to need. We have also found it helpful to attend external, systemic clinical supervision which addresses the dynamics between the client and caseworker and the broader systems such as the team and organisation within which the work takes place. The emotional impact of the work on the staff can also be considered and processed through clinical supervision. Supervision also considers the progress of the helping relationship

as it develops between client and caseworker and the impact on the relationship of the caseworker's practical interventions. We consider for instance, the symbolism of the issues the client is bringing, using the model described above and ask whether anything is being avoided or acted out by the bringing of practical issues. What does it mean for the client to be helped or not helped by the caseworker?

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#### 2.4.4 Gender sensitivity

We aim to ensure that half the team are female at any given time and to offer all female clients the option of seeing a female member of staff (with a female interpreter if needed). However, we recognise that due to resource issues, this may not always be possible. Equally, we recognise that gender is an issue for our male clients as well. We ensure gender sensitivity in the team therefore through having the issue as a standing item in our team meetings. There is therefore a regular opportunity to discuss issues of concern and possible solutions.

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#### 2.4.5 Interpreting

We work very closely with interpreting team colleagues. Interpreters are briefed as to the nature of the contact (e.g. assessment or on-going work) and are also briefed on the likely specialist vocabulary which may arise and the various techniques (e.g. reflecting) to avoid misunderstandings. Time is allocated at the end of a session to de-brief the interpreter, who is offered support if needed, as it is recognised that working with this client group can also be stressful for interpreters. In supervision, we will also consider the development of the relationship or alliance between client and interpreter and the impact on the dynamics between client and caseworker of the presence in the room of a third person. The interpreter's emotional responses and acting out (through perhaps cancelling sessions at short notice for instance) are also considered for what they might reveal of their emotional response to the client and the client's internal world. As required, formal three-way supervisions involving caseworker, interpreter and supervisor are arranged to discuss and understand the impact of the interpreter on the work. (Tribe & Patel, eds. 2003)



# 3 Conclusion

Leyla, the woman screaming in the waiting room mentioned in the introduction was helped to move on by the Vulnerable Women's Project: the project helped her find a solicitor who looked into her case and made a fresh claim for asylum. We helped her find a GP and get treatment for her physical pain and be tested for sexually transmitted infections (STIs). Leyla also came to see a Therapeutic Caseworker for several months to talk about her experiences. This helped her to build up a sense of safety and she was able finally to apply for Section 4 accommodation and then accept it once it was granted to her.

The Refugee Council believes that this approach can help other women in this position.

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# Useful Resources

The Refugee Council:  
[www.RefugeeCouncil.org.uk](http://www.RefugeeCouncil.org.uk)

The Haven Centres  
[www.thehavens.co.uk](http://www.thehavens.co.uk)

The Anna Freud Centre  
[www.annafreudcentre.org](http://www.annafreudcentre.org)

The Red Cross  
[www.redcross.org.uk](http://www.redcross.org.uk)

The Medical Foundation for the Care of Victims of Torture  
[www.torturecare.org](http://www.torturecare.org)

The Women's Therapy Centre:  
[www.womenstherapycentre.co.uk](http://www.womenstherapycentre.co.uk)

A list of all Rape Crisis Centres throughout the UK can be found at:  
[www.rapecrisis.org.uk](http://www.rapecrisis.org.uk)

For advice & support on legal matters:  
[www.refugee-legal-centre.org.uk](http://www.refugee-legal-centre.org.uk)  
[www.asylumaid.org.uk](http://www.asylumaid.org.uk)



The Refugee Council is the largest charity working with asylum seekers and refugees across the UK. We campaign for their rights and help them to rebuild their lives in safety.



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