9. Contextualising Therapist Self-Care in Therapeutic Work with Refugees

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The authors are two Gestalt therapists working in Berlin with refugees in different settings: 1) providing free individual therapy in private practice for undocumented refugees and 2) providing individual and group therapy for refugees at a devoted centre. Our focus, in this article, is therapist self-care in a complex field. Doing such work as we describe, exposes therapists not only to clients' responses to past severely traumatising experiences elsewhere, but also to their reactions to adverse policies on refugees in Europe. This can make us feel we merely "pick up the bits", rather than help people to process past stressful experiences and "start a new life". If we identify with our clients' dead-end current situations and succumb to feelings of powerlessness in ourselves, we risk burning out. In this article we present a perspective that is based on the "field theory", which is a component of Gestalt therapy, draw on our recent book contributions and share ways of addressing this challenge to initiate a comprehensive discussion.

1. Introduction

Somewhere along the way to becoming therapists we realize that we must learn how to cope with the fact that in our work we will constantly be confronted with human suffering and hardships. We are taught or look for strategies that protect us from being too strongly affected by our clients' struggles, at least enough to remain helpful to them and to avoid allowing our own health to suffer. After beginning our practice, we develop our own personal ways of recuperating and of gaining satisfaction from what we do.

Generally, our clients feel supported by us, they "make progress", they improve their situations and/or their sense of well-being.

But how is it when we work with people who have fallen victim to serious human rights violations and consequently to forced migration? These are people who have often experienced not just one but multiple traumatic situations and are still subject to severe restrictions on their freedom to live

a life of dignity in peace and prosperity – and above all, in safety. They come to us for help in dealing with their symptoms and with coming to terms with often devastating losses and experiences, and yet cannot concentrate on doing that because their daily lives remain unsafe and fraught with frustrations, restrictions and continuing injustices. Added to these they have to deal with feelings of estrangement, displacement and disorientation, with missing of and being worried about loved ones they had to leave behind. These are not merely neurotic problems!

As a result our clients struggle with strong feelings of hopelessness and powerlessness. Our job as therapists is to support them in the monumental task of managing their symptoms and negative emotions, of finding their own ways of facing these many challenges and of coming to terms with their experiences "in a foreign culture". As trauma therapists we know that the very first task of therapy is to ensure that the client is safe before we can begin with "therapy proper". As Gestalt therapists we are challenged with "staying in contact" with our clients and ourselves, with "being present" and making our clients present (Buber, 1999), of practising "inclusion" (Jacobs, 1989) and "commitment" (Perls, 1989; ed. or., 1986) etc., in short, with using our skills to facilitate the development of an authentic and trusting relationship with our clients. We do not want to allow technique to get in the way of this relationship. Repairing the capacity for true dialogue is also a central task of trauma therapy.

But how do we do this without ourselves being overcome by feelings of powerlessness, as we see our clients burdened by the often many years of uncertain waiting for the final results of their asylum procedures, and who are frequently challenged, often "bowled over", by one setback after another? While this has always been a difficult process for refugees, over the last few years in Europe it has been made more and more difficult, even seemingly impossible, by increasingly repressive legislation. Whereas 15 or even 7 or 8 years ago traumatized refugees had a relatively good chance of gaining some kind of long-term residence permit in many European countries, today this is becoming increasingly uncertain. Push-back and dawn raids by the police attempting to catch people for deportation before they leave their homes for the day, families being separated by deportation, are becoming almost every-day occurrences.

Both of us, as Gestalt therapists working with refugees in the same city but in different contexts, became aware of the dangers of the increasing pressure as we exchanged experiences and did peer supervision together. It became clear to us that the traditional therapist self-care and protection strategies no longer suffice, and we began to look for other ways that lead us out of isolation (with our clients) and spread the responsibility for sup-

porting them and ourselves in our therapist role over a broader field. We presented the results in summary form as a table at the workshop we co-facilitated at the EAGT Human Rights Conference in Berlin in October 2018 (see below). This article presents a more detailed view, illustrated by some brief case examples, showing some ways we have personally found of supporting ourselves in dealing with some of the issues we listed in our table (see table 1, pp. 145-148).

The kind of self-support that psychotherapists give themselves usually includes techniques that separate their own lives from those of their clients.

After feeling close and connected during the therapeutic contact, it is important to make a clear break and step back into one's own life. Mental hygiene also includes various dimensions of exchange with colleagues and supervision in order to be able to shift from resonating with the client to a more distanced view.

On comparing notes with each other, we found that the techniques we had developed over the years do not suffice to help us cope with the challenges we encounter in our work with refugees, partly because of the severity and sheer number of the problems, that our refugee clients bring into our consulting rooms, but also, and especially, because they differ substantially in nature from those that we are used to dealing with. In the course of our discussion we identified some specific stress-factors that we face as therapists working with refugee clients and found that it helped us to group them under seven headings (cf. also Stahlmann, 2018b). These are:

1) Urgency – pressure to act fast;
2) Complexity – multi-problem areas, many of which are interdependent;
3) Confrontation with trauma, extreme suffering and existential emergencies;
4) Cultural differences;
5) Challenges to therapist role – as complexity of refugee's needs are undermining therapist's professional confidence;
6) Therapy with refugees is often poorly paid, or not at all;
7) Confrontation with treatment of refugees that is aversive and often even inhumane.

In our experience these seven challenges can lead to various emotional, physical and/or behavioural responses in therapists, who are not adequately protected by our usual self-care strategies. We realized that this has much to do with the contexts in which our refugee clients move and that we had adapted and expanded our coping strategies to tap other resources that are available in these contexts.

At the conference in Berlin we presented our list of challenges as a basis for exchanging views and discussing them with colleagues. We do not therefore consider it exhaustive, but merely as a starting point for a collegial discussion. We feel that this discussion is becoming increasingly necessary as the conditions in the contexts of therapy with refugees continue to become more and more complex and difficult – mainly for the refugees themselves, but also for us as therapists (Stahlmann, 2018a; Winter, 2018).

We therefore invite readers to compare our observations and suggestions with their own experience and to continue the discussion both in their own work contexts and in the broader field. In what follows we have picked out some of the challenging areas on our list and present some brief examples from our own work to illustrate what we mean in greater depth.

2. Case Examples: Katharina (Working in an Individual Setting – Private Practice)

I begin with the stress factor "Urgency – pressure to act fast" (see table below, stress factor no 1). From my experience I find that I respond to this sense of urgency and pressure to act by becoming breathless, hyperalert, worrying, becoming irritable and tense, working overtime and needing to protect myself from burning out.

I had already been working with a client from Angola and a Portuguese/German interpreter for some sessions. The client had experienced severe incidents of sexual violence in her home country and felt a strong need to overcome the symptoms of traumatisation. However, the therapy was rudely interrupted when the client was transferred to another region in Germany where all Angolans have to apply for asylum. I was unable to say goodbye to her, which was difficult for me to process. Some time later, on a Friday afternoon, on December 21st I received an email from a social worker who was currently supporting my former client, informing me that her interview with the German Federal Agency for Migration and Refugees (BAMF) was scheduled for January 7th and that on January 4th she would prepare the client for that important interview, which would determine whether she would be accepted as a refugee or not. The social worker asked for a report from me as a psychotherapist concerning the credibility of the client's statements and how her symptoms are typical sequelae of what she experienced.

My Christmas holidays lasted from December 22nd to January 4th, so I had to decide whether I would refuse the request for a report, knowing that this could prejudice my client's chances of being awarded asylum, or

whether I would quickly change my programme for my holidays in order to find the time to write a report. The need to make an urgent decision and the impact that my decision would have placed a high demand on me as a psychotherapist. After all, my therapeutic commitment to this client finished when she was transferred from Berlin to western Germany.

So how did I react? The first reaction on receiving the email was to be angry: No, that's not possible! What an imposition: 2 hours before leaving for my Christmas holidays! I felt worried and unfairly treated by being exposed to such an inner conflict.

My first step was to split off my feelings from the situation: nobody had deliberately done anything to harm me. Nobody can influence the timetable for the interviews except the Federal Agency – and I could not really expect the Federal Agency to take my Christmas holidays into consideration.

The next day I read the email again and decided first to reply to the social worker asking for more information: what do they exactly need and am I the right person to write the report? As reports for the Federal Agency fall into different categories, it is important to be precise, in order to be able to follow the right guidelines and to avoid having to do unnecessary work. This helped me not simply to accept what I was told to do, but also to think about different possibilities.

Perhaps I could share the responsibility for writing the report with a colleague at the client's new location? Then I would not have to do all the work on my own and would also not have to bear the responsibility alone.

I also made up my mind that my responsibility as a psychotherapist was over. Whatever was asked of me now I would do for political and humanitarian reasons. The client had told me she had been brutally raped by several members of the secret police and that the Angolan police stopped the investigations after they found out that the perpetrators where members of the security forces.

Psychotherapy must include respect for the individual and his/her human rights. It must be a vital concern of psychotherapists to support a political system that respects human dignity and rights. And because of that concern I decided to write a report that included what I had learned about the client's experience, adding that I see her descriptions as reliable and that she really needs asylum or at least humanitarian protection in Germany to protect her from re-traumatisation in Angola.

Having done this I felt satisfied that I had done all that I could while at the same time taking care to protect both my capacity to process and my energy.

3. Cultural Differences as Stress Factor (Heading 4 in the table below)

Refugees come from a culture that is different from our own, have somewhat different expectations of how to organize life in Europe together and have difficulty in understanding our language and culture, and in adapting to life in our society. They usually have little idea of what psychotherapy involves. As a therapist I also feel uncertain whether I understand my client, both linguistically and in terms of personal meaning, and also as to whether the client may feel I am being intrusive, impolite or discriminating. I am also not sure whether my client understands what psychotherapy is about, what impact my interventions may have, or how I might help in a different way.

Cultural differences may play a role in many different ways. This was very evident in therapy working with a client from India. He was not a refugee, but working with him I came to realise clearly, how cultural differences can play an important role, not only in the therapeutic relationship, but also in my work with refugees. He came to Germany to continue his studies and did well, but after two years he became very depressed, only thinking about his problems with his friends and a girl he had fallen in love with. He was too shy to confess his love to her and was angry with his friends but did not find a way to tell them. He simply withdrew from contact and did not feel peace with himself nor with them.

His friends were also Indian, young people studying abroad.

As a German, I have some ideas about appropriate ways to express anger and love in my culture. When a German client tells me about his way of expressing himself, I can somehow imagine how his friends would feel about that and help the client to expand his repertoire of appropriate social interactions. But I have absolutely no idea what kinds of social interactions are appropriate among people in India. I also know nothing about how young Indian men who leave their country to study, communicate among themselves. Which parts of German culture do they adopt, and which not?

I felt disoriented and I was uncertain whether I could help the client because his problem was so closely connected with a culture with which I am not familiar. As the client decided that he wanted to continue with therapy in spite of the gaps in my knowledge, I asked him to tell me about the Indian way of expressing feelings, which is more indirect.

He shared with me that he was afraid that nobody would like him anymore if he expressed his disagreement with something and so he held it back.

When I noticed something in his descriptions, I shared my point of view with him and asked him how this interaction would be interpreted in India.

He is the expert on his culture. He knows about the rules of caste interactions and about expressing feeling. I tried to help him recover his knowledge about his culture and to find out what had led him to lose his capacity to act. Gradually he realized how much his depressive withdrawal had been linked to an inner conflict that he had about his own cultural rules. For example, he rejected the caste system and the influence that families exercise on their children's marriage choices, but he also realized that the fact that he had fallen in love with that particular girl was also influenced by her belonging to the same caste and region, because it meant that there would be no problem with their families. When he became aware of this, he felt ashamed because he realized that it was in contradiction to his personal values. Becoming conscious of this helped him to find a new way of acting that was more in line with both his values and also more in contact with the other person.

4. Confrontation with the Aversive and in Many Cases Inhuman Political Refugee-System/Treatment Implemented by Germany and Europe

Refugees have been forced into a situation where they are almost wholly dependent in an existential way on governments, aid organisations, immigration authorities/police and other people in societies and systems that are by definition totally unfamiliar to them. Unfortunately, this dependency exposes them to varying degrees of painful and degrading behaviours on the part of their "hosts", ranging from being inconsiderate, harassment and demeaning actions – to outright abuse and even renewed violence in a place where they had hoped to find safety and have their dignity restored.

As refugee clients gain trust in us, therapists, they not infrequently share such experiences with us. We may respond to these reports with various emotions, including anger, shock, shame (as representatives of our society) and ambivalence. Other reactions besides anger, shock and shame are: need to apologise (i.e. guilt), to split loyalty, allow the ambivalence, physical and mental tension and uncertainty about how to proceed.

Some weeks ago, a client told me (Katharina) about the rules and the behaviour of the security personnel in the hostel where he has to live: visitors must leave by 9.30 p.m. at the latest. The security guard knocks on his door at 9.30 on the dot and waits while his visitors put on their shoes and leave.

My client is about 30 years old – not 12 – and has been in Germany for three years. He asked me: «Why do they treat us like that? I've done nothing wrong, I'm not a child or a criminal».

For refugees with a residence permit that is valid for less than one year, it is almost impossible to find a flat to rent. Prospective landlords simply send them away. My client was forced to stay in the hostel and submit to the degrading and isolating rules and behaviour of the security staff.

While such degrading behaviours are not in themselves threatening in an existential way, my client experiences them as part and parcel of the other restrictive measures and legal hurdles to which he is subject and which for him are a clear sign that he is not welcome and that he does not have the same rights to personal freedom as German and other European subjects.

I feel ashamed that my country – a wealthy, democratic country that is proud of its Constitution and its commitment to the European Convention of Human Rights and Fundamental Freedoms – acts like that.

What can I say to my client? How should I behave? What should I show him of my feelings? And how can I intervene therapeutically to help him overcome the experiences of violence and powerlessness he faced before he fled to Germany, when he is still constantly being made to feel powerless?

I felt very angry and helpless, but I knew that I had to find a way out of this trap if I did not want to become cynical. I reminded myself that my client was not only a victim of circumstances and that he has many great abilities that he can use to cope even with difficult conditions. I also reminded myself that I was not responsible for the degrading rules of the hostel and that I could share this with my colleagues and we could see whether there was anything we could do about it: is there perhaps an ombudsman for such cases? Can we raise public awareness?

It was harder to face up to how privileged I am –politically and economically – despite the fact that I have done nothing to deserve it, apart from being born in this country. My privileged status separates me from my client. I have the right of freedom of movement, he does not have. I have permission to work; my diploma is accepted – most of his qualifications are not. What did he think about this unfair state of affairs? Was he jealous or angry, did he split off those feelings? How does our privileged status influence our therapeutic contact?

I felt grateful that I have groups of both fellow therapists and political activists with whom I can share all these questions and feelings. Together we can try to find a way either to deal with them or to fight against them.

5. Case Examples – Deirdre (Working at a Centre)

At the other end of the spectrum we, therapists are currently witness to the escalation of forced deportations to home countries that are clearly not safe. Incomprehensibly harsh legal decisions understandably throw our clients into deep despair and doubt as to any justice in life at all. And it is not only the feared consequences of the deportations that are the trouble, but the way in which they are not infrequently carried out.

Working as a therapist in a centre for traumatised refugees, over the years I have heard many stories and been witness to numerous dangerous situations, and have noted a steady increase in pressure on refugees. The Dublin regulation of the EU, for example, has had devastating consequences for some families. It does not respect people's need to live with or close to members of their own nuclear or extended family, even when they are sick. Where, through force of circumstances or lack of funds, some family members have had to flee before others and via a different route, a family can be split up across different EU countries. The German authorities have not always respected the need for parents to stay together with their children or for sick members to live in one area. Recently even pregnancy has not deterred them from deporting a father and some small children, leaving the pregnant mother here to follow them after delivery.

This kind of apparently arbitrary decision and practice leaves refugees in fear of deportation literally at any moment. Since the police have taken to arresting people for deportation at the immigration authority as they try to extend their residence permits, and to arriving before dawn to catch people at home, many refugees no longer feel able to go out or to sleep, particularly when they have direct experience of other refugees being taken away.

Periodically over the years, instances have occurred where the police have felt it necessary to use a high degree of force when arresting people for deportation. This is a highly distressing experience for refugees who have been maltreated or tortured by police in their home countries. In recent cases police have come in large numbers to arrest one family member, subjecting the remaining members to violent interventions (being thrown to the ground, having a knee forced into their back) and/or clapping handcuffs on them. In some cases this has even been done to people who are sick or pregnant and thus cannot be considered to represent a threat.

As I listen to such reports my main feelings are of frustration at not having the means to help in my therapeutic role and anger at such treatment of people. Although clients do feel some relief at being able to share their distress with a trusted person, their suffering and fear is realistic, not some-

thing that can be removed through therapy. In such situations I am grateful that I work in such a centre where clients can obtain social support from a social worker and the centre has relations with a large network of lawyers and supporting organizations. In the situations described above we can contact lawyers and doctors who can intervene and write reports. As a therapist I can also write a brief certificate to the effect that my client has been diagnosed with post-traumatic stress disorder and/or some other mental disorder and must therefore be protected from stressful treatment. Clients feel safer knowing that they have this to show to the police if necessary. We can also notify the Refugee Council, which collects reports of irregular and unnecessarily distressing or discriminating procedures.
This can help to counteract our own feeling of powerlessness so that our ability to maintain the therapeutic stance is not compromised.

Table 1 – Some brief case examples, showing some ways we have personally found of supporting ourselves in dealing with some of the issues.

Stress Factor	Description	Therapist Responses Emotional/Body/Behaviour	Self-Oriented/Individual. Self-Care Strategy, e.g.	Contextualised Self-Care Strategy
1. Urgency – pressure to act fast	**Clients present** - With problems that need urgent intervention Outside of therapy ; - Or Inside of therapy in crisis, e.g. acute risk of deportation.	**Feels** - Breathless; - Hyperalert; - Worried; - Irritable; - Tense; -Works overtime. **Worst-case scenario?** - Burn-out.	**General:** - Be aware of bodily reactions. **In situation:** - Breathe/relax; - Stimulate vagus nerve; - Ensure (long) enough breaks. **Long-term:** - Consult / delegate; - Ensure good use of free time.	**Define level of intervention:** - Therapeutic; - Legal; - Social work; - Political.
2. Complexity – too many different problem areas, many inter-dependent	**Clients** - Come with traumatic reactions due to past violence, persecution and extreme stress while fleeing/ migration; - Are in acute or semi-acute fear of deportation; - Experience prolonged and/or unresolved grief, missing lost loved ones, families left behind and home surroundings; - Cannot speak the language of their host country; - Currently live in cramped, atrocious accommodation; - May also be physically quite seriously ill; - Need help with legal and social problems.	**Feels** - Confused; - Disoriented; - Dizzy; - Sleepy; - Weary; - Blocked; - Overwhelmed. And - Has no clear figure; - Has difficulty making decisions; - Withdraws emotionally in defence.	- Keep reminding yourself you are not alone.	**Reflect on bigger picture** - What are the forces contributing to this situation? - Who is responsible for these forces? - Where can I/we best intervene? - Spread burden – other professionals can help networking; - Get advice/supervision for yourself - Direct/refer/client to: - Advice centre; - Social worker; - Lawyer; - Refugee council; - Doctor.

Stress Factor	Description	Therapist Responses Emotional/Body/Behaviour	Self-Oriented/Individual. Self-Care Strategy, e.g.	Contextualised Self-Care Strategy
3. Confrontation with trauma, extreme suffering and existential emergencies	**Clients** - Describe or relive experiences of extreme cruelty / massive violence and/or powerlessness; - Have experienced many different traumatic events in different "sequences" (e.g. childhood trauma, adult political trauma/war, highly stressful and/or prolonged escape from violence in homeland); - New trauma(s) experienced in host country (e.g. victim of racial attack, additional severe physical illness).	**Feels** - Shocked; - Strong fear; - Anger; - Grief; - Helpless/Powerless; - Guilty; - Very strong reactions in and out of therapy; - Anomie/Alienation. **Has** - "Shattered assumptions"; - Secondary traumatization. **Is** - Over-protective of client - Worried about triggering client/deepening emotion as client in unstable state.	**In general:** - Use general strategies for protection against secondary traumatization. **In situation**: - Be aware of own reactions: - Bodily; - Emotional; - Cognitive; - Do grounding exercises; - Try to avoid emotional confluence; - Remind yourself you are safer than client (unless you are also subject to same persecution).	**Step back, take a field perspective and** - Decide when to look at the man-made disasters and when to look at the rescuing activities. Both are part of the whole: both are true. It makes a difference inside myself where I look. Life includes both at the same time. - Consider the Buddhist approach of letting/observing things happen and not-acting (wu-wei). - Get informed about collective/community strategies for processing trauma.
4. Cultural differences	**Client** - Comes from a different culture. **And has** - Different expectations; - Difficulty understanding language and culture and of; - Finding a way to live comfortably in host country; - Little idea of what psychotherapy is. **S/he** - May feel s/he is going crazy; has different ways of communicating emotional needs and conflicts. - May have culture-bound symptoms. **Women and minorities** - May be subject to different restrictions and/or persecution in country of origin, restrictions may also apply in host country. **Therapist** - Lacks detailed knowledge of what client's ground may be – the figure remains ambiguous.	**Feels uncertain** - Whether client understands; - Whether client may feel you are intrusive/impolite/discriminating; - What impact his/her interventions may have; - Whether client understands what therapy is about; - How to help differently.	- Phenomenological approach; be aware of not knowing and dealing with it openly. - Get informed about situation in host country. - Ask client what s/he finds different /strange/misses - Be sure not to get stuck in anxiety and focusing on problems.	**Consult** - Interpreter (if available) or; - Colleague or; - NGO or; - Other individuals from client's culture or about cultural differences. **Re-formulate goal as both client and therapist** - Gaining awareness of the whole situation together and; - Developing creative adjustments for addressing the field conditions together.

Stress Factor	Description	Therapist Responses Emotional/Body/Behaviour	Self-Oriented/Individual. Self-Care Strategy, e.g.	Contextualised Self-Care Strategy
	- Does not know exactly how to be trustworthy for the client.			
5. Challenge to therapist's role – Traditional therapeutic goal – supporting (client's individual) awareness – not enough	**Client** - Is (not just feels) in fact helpless to manage many aspects of daily living; - Does not know the language, culture or social/administrative system. **Therapist** - Provides information; - Advises; - Makes phone calls; - Writes reports. Meeting basic concrete needs is figure, reflection takes second place.	**Feels** - Unable to get to "therapy proper" because client has pressing "other": concrete problems - That all her/his training has not prepared her/him for this.	- Case supervision; - Consultation; - Read literature to help understand; - Protect self-esteem by telling oneself this is all due to cultural differences etc.	- Remain aware that while it may be right in the short term to provide concrete help or discuss how to get it elsewhere, there is another level: - Ask yourself whether you think it is political will that clients do not get this kind of help from other services before they come to you; - If so, why is that so? - Do you think some change in the system could be made? - If so, do you want to support that and how?
- Identity/therapeutic frame – leading to destabilisation / insecurity **- Mutual dependency of therapist and client**	**Client** - Needs concrete, basic survival support with activities of daily living (ADL[1]). **Therapist** - Feels pulled to intervene at the level of concrete daily living in order to establish basis for therapy.	**Feels** - Challenged in his/her therapeutic identity; - Uncertain how much to intervene actively and/or how much simply to be in contact/relationship and/or help clarify needs. **Questions** - Point of therapy content of traditional therapy. **Is tempted to** - Do things for client; - Be present in clients' lives outside of therapy – e.g. provide help find accommodation, clothes, etc.; - Make decisions for clients about choices. **Boundary between therapeutic role and friendship is challenged, risks** - Becoming blurred; - Close to dual relationship; - Disempowerment .	- Allow yourself to overcome the traditional role of psychotherapist in order to be able to adapt to the need and the situation.	

[1] "Activities of Daily Living" is a term from the field of healthcare and psychiatry. See https://en.wikipedia.org/wiki/Activities_of_daily_living.

Stress Factor	Description	Therapist Responses Emotional/Body/Behaviour	Self-Oriented/Individual. Self-Care Strategy, e.g.	Contextualised Self-Care Strategy
6. Working for nothing or very low pay	**Therapist** - Feels honour-/duty-/emotionally bound to help; - May not have sufficient income; - Full-time work with refugees funding is uncertain; - Little or no public or charitable funds available for therapy. **Client** - Has no money but is in desperate need. **Therapist** - Responds to need; - Must be careful not to neglect own financial and energy needs too much.	**Experiences internal conflict:** - Wants to do more versus certain needs-level must be fulfilled to work properly; - Own relatives also have needs; - May ignore own emotional and physical needs; - Has existential worries due to low income; - Feels angry when clients miss appointments without canceling or at last moment; - Finds it more difficult to honour boundary between therapy and friendship.	- Remember that you need to take care of your own needs in order to be able to help efficiently. - If you neglect your needs, you may make errors that harm the client. - Traumatised clients are particularly vulnerable.	- Find out where you – personally as an individual therapist – can get funds to do this work – including: - Local authorities; - Charities; - Human Rights Organizations; - Crowd-funding; - Etc.
7. Confrontation with the aversive and in many cases inhuman political refugee-system/treatment by Germany / Europe, which produces deliberate, additional unnecessary problems for the clients.	In many countries, refugees are treated badly, discriminated against and even subjected to hardship and/or renewed violence	**Feels** - Ambivalent about being part of an-aversive host-country. **Sometimes feels the need to:** - Explain; - Apologize; - Share loyalty; - Favor one side of the ambivalence. And feels - Tension; - Uncertainty; - Anger; - Shame.		**Field perspective:** - Reflect on latent guilt feelings due to being implicated in the structures of exploitation and unearned privileges; - Clarify own responsibility and its limits; - Be aware of these inner conflicts and develop a stance in order to be able to be in full contact with clients; - Write a medico-legal assessment to support your client's asylum procedure; - Do an interview on the subject with the press/radio/TV; - Join a group (therapists, lawyers, doctors etc.) that does active human rights work/lobbying in your area.

References

Buber, M. (1999). *Elements of the Interhuman.* In: Judith Buber Agassi, Martin Buber on Psychology and Psychotherapy. Essays, Letters, and Dialogue. Syracuse (USA): Syracuse University Press, pp. 72-88.

Jacobs, L. (1989). Dialogue in Gestalt Theory and Therapy. *Gestalt Journal*, 12, 1: 25-67.

Perls, L. (1986). Opening address given at the 8th Annual Conference on the Theory and Practice of Gestalt Therapy on May 17, 1985. *Gestalt Journal*, 9, 1: 12-15. (German version: Commitment. In: Sreckovic, M. (Ed.), *Leben an der Grenze. Essays und Anmerkungen zur Gestalttherapie*. Köln, Germany: Edition Humanistische Psychologie, 1989),.

Stahlmann, K. (2018a). Das Gesellschaftliche am individuellen Leiden das Politische an der Psychotherapie. In: Stahlmann, K. (Ed.), *Begegnungen mit Geflüchteten. Möglichkeiten der Gestalttherapie. Reflexionen zu Therapie, Beratung, Politik*. Gevelsberg, Germany: Edition Humanistische Psychologie, 13-38.

Stahlmann, K. (2018b). Therapie Ohne Gesicherten Aufenthaltsstatus. In: Stahlmann, K. (Ed.), *Begegnungen mit Geflüchteten. Möglichkeiten der Gestalttherapie. Reflexionen zu Therapie, Beratung, Politik*. Gevelsberg, Germany: Edition Humanistische Psychologie, 194-216.

Winter, D., (2018). Ein Feldtheoretischer Blick auf die Psychotherapeutische Behandlung Traumatisierter Flüchtlinge in Deutschland. In: Stahlmann, K. (Ed.), *Begegnungen mit Geflüchteten. Möglichkeiten der Gestalttherapie. Reflexionen zu Therapie, Beratung, Politik*. Gevelsberg, Germany: Edition Humanistische Psychologie, 165-194.