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# Solace studies in therapeutic work with refugees and asylum-seekers

No. 1

Providing solace

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**Editor's note:** This is the first in a series of working papers reflecting on aspects of therapeutic work with refugees and asylum seekers undertaken by therapists and others working for SOLACE, a regional organisation based in Leeds (www.solace-uk.org.uk), and others associated with it. The views expressed here are those of the author. Anyone working in this area is welcome to submit drafts of short papers (3000-5000 words) to the series editor at Gary.Craig@galtres8.co.uk.

# Providing solace

## Abstract

*This paper demonstrates how Solace lives up to its name by delivering **emotional and bridging social capital** for refugees and asylum seekers (RAS) in Yorkshire in order to nurture their potential for growth, resilience and for moving on, in three ways;*

*(i) providing **emotional social capital for comfort and consolation** from a **'holding relationship**';*
*(ii) **alleviating distress and relief** by strengthening **internal resources** from specialist trauma-focused therapies; and*
*(iii) facilitating a process of building **external social resources** and **bridging social capital** to other social networks and organisations.*

*The main catalyst for this is through the psychotherapeutic alliance or the therapy **'holding relationship'** but also through fostering extensive relationships with other organisations or inter-agency work. The psychotherapeutic alliance provides social capital for **comfort and consolation**, enabling clients to gain some reflective awareness of themselves and to strengthen their inner resources and resilience. A strong therapeutic relationship facilitates the most traumatized to meet the challenges of communicating and building new social connections. Our therapists specialise in the management and promotion of methods for the **alleviation of physical and mental distress and relief**. They also promote **internal resources**, stability and individual growth through expert stress management and trauma-focused psychotherapeutic techniques for processing trauma. These skills facilitate for clients a stronger sense of the present and hopefully an emerging ability to move forward with their lives.*

*All RAS face the huge challenge of building new communities and nurturing new relationships when they can no longer take for granted pre-existing ones. Through interagency work, sign-posting and building clients' **external social resources**, we facilitate their **moving on**. We provide the resources they need to forge new and enhancing relationships that can provide stability during the transition period in a new country. These relationships will outlast their time with Solace.*

# Introduction

## Solace and Social Capital

In my experience working as a psychotherapist for Solace - it's hard to say why or how - but occasionally a client's story aligns with something inside you and connects you to them at a deep level. Vivid images can appear in your mind of a barren ground where a home and 30 year-old olive groves stood; or an empty heart due to the yearning for a family member left behind.

It is for people with stories such as these that we attempt to provide solace.
The dictionary definition of solace is comfort in sorrow or misfortune, alleviation of distress, consolation or relief. This paper outlines the ways in which *Solace* attempts to deliver this to many people with stories such as the above which leave them traumatised, disorientated and sometimes with PTSD (Post-traumatic Stress Disorder). Our work aims to provide a holding space to facilitate the moving on process.

The 'official directory' DSMV (2013) defines PTSD as including (a) exposure to actual or threatened death; and (b) serious injury or sexual violence in one or more of the following ways: directly experiencing it; witnessing it happen to others; learning about violent or accidental traumatic incidents involving close family or friends; or experiencing repeated exposure to traumatic events, for example as medics or first responders (US Department of Veteran Affairs). Generally, PTSD affects people's capacity for emotional regulation, resilience and their ability to sustain normal social engagement and functioning.
Global political violence and civil wars have led to the catastrophic internal and international displacement of unprecedented numbers of people and they may present the largest at-risk group of contracting PTSD according to Nickerson *et al*. (2011). By Nose *et al.'s* (2017) estimation, 100,000 people recently settled in Europe may have PTSD.

It is difficult to categorise with one description the myriad client base that we deal with. There are so many different experiences that people have been through. Asylum seekers are people applying for refugee status in the host country; refugees have gained legal status. Naturally many of the former are still living with not only trauma from the past but also deep anxiety and uncertainty about their future. The latter have stability but are facing massive adjustments to a new country, expanded on more in Section 3 below. Whilst nothing necessarily unites the diverse range of experiences, many of which breach basic human rights, western science is beginning to help us to understand the effects that these

experiences have on people. Many of our clients are struggling with physical symptoms that do not always seem to have medical explanations, which links to what is now being understood about how trauma can become somatic or stored in the body but may respond to trauma-processing techniques, examined a little more in Section 2. Psychotherapeutic training prepares us to be present with clients whilst unable to solve existential problems in what is called a ‘holding relationship’ explored more in Section 1.

I have found that a sound theoretical concept for what we do at Solace can be found from sociologists who discuss ‘social capital’, a resource available from our social groups, networks or figurations. Social capital has been linked to health benefits for people in communities: when networks are strong, health seems to correlate positively. Social capital can be perceived as a resource in the same way that we can think of a physical resource such as money. It is linked to the ideas of Bourdieu who noted how the privileged used their networks in order to succeed. The health benefits of social capital are reflected in the extent to which social networks provide cognitive and emotional help as a buffer against the stresses of life.  Relationships from other people can help us feel more resilient. It is within and from social networks that social capital can be obtained and used to promote mental health and well-being. Receiving help and support from those around us increases resilience, according to Heller et al. (1986).

*Providing solace in the different ways outlined in this paper is a form of social capital which links to the development of people’s internal and external resources via the therapeutic relationship, trauma-focused therapeutic techniques and links to other agencies in the community. During this period of global pandemic we have adapted our methods and have been delivering our services via Zoom and phone calls.*

# 1. Solace - Social Capital for Comfort and Consolation – the '*Holding Relationship*'

Generally, across all different modalities of psychotherapeutic practice, the therapy bond provides a human relationship with an attachment that can be therapeutic in itself. Indeed, evidence suggests that the quality of the relationship across modalities impacts by 30% on outcomes, according to Macaskie *et al.* (2013). Recent evidence "*strongly points to the conclusion that the strength of the real relationship is an important part of the success of psychotherapy across diverse orientations*". (Gelso et al. 2013: 1163) Clarkson (1995) writes that there is a need for human contact in the therapeutic relationship in the same way that this underpins all of our relationships and which is why social isolation and exclusion stirs amongst the worst human emotions.

Furthermore, it is a relationship that contains what psychoanalysts call *transferences* – ways of relating and patterns that have become embedded in our minds from our earliest relationships. Psychotherapists enable these patterns to become known and worked through. Part of a 'Relational Dynamic' way of working is to work and strengthen *positive* transferences and to use a technique called psychological contact or that feeling of human connection. This develops what is also known as a good therapeutic alliance or working relationship. Some commentators talk about deep caring and loving feelings for the therapist and whilst some may be grounded in transference they may also be "r*eality-based and genuine*" (Gelso *et al*. ibid.: 126).

The therapist may be seen as a real person offering a safe base; a trusted companion who aligns with a patient's inner being *(ibid.)*. This is encased in boundaries by time, ethics and space. There are regular beginnings and endings to individual sessions and to the therapy itself; the place where therapy takes place remains the same as do ethical practices such as confidentiality and standards of practice. In our work at Solace we also work with interpreters, which brings another facet or dynamic into the relationship.

There is ample neurological evidence now for the way in which therapy works, discussed a little more in section two. The dynamic part of the process enables change to emanate from the relationship which can help build new neural connections in the patient's brain (Renn, 2013). In other words, due to neuroplasticity, new positive, working models or schema for relationships can be structured. The therapist offers a safe base and a genuine, accepting, caring and empathic relationship, essential to the healing process (Gelso 2013). Psychotherapists attempt to connect with the client's feeling states through the firing of mirror neurons and intentional attunement. This is a physiological way of describing what we understand as empathy and links with my two examples at the start of the Introduction. Such techniques allow a vicarious experiencing and understanding of the clients' experiences. Employing this technique has been challenging during lockdown with remote therapies but not impossible. Emotions can be detected from tone of voice on the phone, or visual body cues via Zoom.

To draw this section to an end, the therapeutic relationship provides a resource for clients – something upon which to depend for a while: to learn and grow from. This is an aspect of social capital providing solace, that is comfort or consolation. It is a resource that can be used tangibly during time in therapy and then later through memory and change of internal relational neurological templates or memories of how relationships work. The significance of this relationship cannot be under-estimated as a support, potentially life-enhancing or life-saving channel for change.

## 2. Solace – Social Capital for the Alleviation of Distress and Relief – Building Internal Resources

**'[P]luck from the memory a rooted sorrow;**
**Raze out the written troubles of the brain**
**And with sweet oblivious antedote**
**Cleanse the stuff'd bosom of that perilous stuff**
**Which weighs upon the heart.'**

(SHAKESPEARE, MACBETH, ACT 5:SCENE 3)

Shakespeare clearly had a notion of events becoming ‘rooted’ but potentially nullified using certain techniques, as we would say. In the line “weighs upon the heart” you get a sense of memories having an impact somatically. Due to a freeze response activated by the endocrine system, traumatic memories are stored in the right brain and/or somatically in the body, and disconnected from explicit memory, due to hippocampus inactivation at the time of trauma. Indeed, eminent voices (Rothschild 2000, 2017; van der Kolk 2015; Cozolino 2016) in this area present evidence that traumatic memories take a different brain pathway compared with non-traumatic ones and can become cognitively inaccessible. In some cases they can become imprinted in other bodily areas, for example as “crushing sensations in your chest that you may label as anxiety or depression” (van der Kolk *ibid*.: 203).

Our therapists at Solace are working in different ways to attempt some kind of alleviation of distress and relief, not only from the therapeutic alliance described in Section1 above, but through the use of evidence-based techniques, protocols and procedures. There have been attempts to research and measure which methods or trauma-focused therapies would be effective with RAS. My MA dissertation was an attempt to examine this evidence base in 2018 discussed below.

One of the most tested therapies with RAS which is also in the NICE (National Institute for Clinical Excellence 2018) guidelines for the treatment of PTSD was Narrative Exposure Therapy (NET). Applying the principles of ‘testimony therapy’ developed during the Pinochet dictatorship, in this context NET was partly political and meant to document human rights violations. It is a brief psychotherapy for those who have been exposed to torture, organised violence or war-related trauma (Mundt *et al*. 2011). There is an emphasis on processing singular traumatic events at one time. The client receives an official written testimony documenting their experiences at the end. It also involves psycho-education about the effects of trauma on the body and a narrative about their life and is meant to be short-term, with as few as 3–6 sessions. There is some encouraging evidence from random controlled trials for the efficacy of NET with RAS, although critics have said it has not incorporated a phase of stability or internal resource building for clients, which always risks re-traumatization.

Some of our therapists practice EMDR (Eye-Movement Desensitization and Reprocessing Therapy) which has incorporated elements of safe trauma practice and internal stability. For example, clients are encouraged to have access to internal resources or anchors such as thoughts of a person who generate a feeling of strength and protection. There is a technique of assisting clients to physically “tap” into these associated feelings before trauma processing begins. This is done with the use of gentle tapping on arms or legs – a form of bilateral stimulation. EMDR also proceeds and develops bilateral stimulation that reproduces rapid eye movement or deep sleep neurological brain activity by either watching the therapist’s finger move from side to side or from the use of electronic tactile stimulators. This links now to a growing consensus for psychotherapy to adhere to what is known as a stabilization period, sometimes called *Stage one*, the stabilization phase, dedicated to the development of treatment alliance, affect regulation, psycho-education and internal and external resource building. *Stage two* confrontation with the traumatic memories themselves can then proceed safely with minimal risk of re-traumatization.

*Stage three* of therapy then targets life consolidation, restructuring and moving on.
I have identified evidence that Trauma-Focused Psychotherapy and NET have greater efficacy than Supportive Counselling or Psycho-education for RAS. There is also good evidence for adopting a Flexible Trauma Focused Approach drawing on different trauma-focused methods. This means having a selection of techniques in your toolbox and adapting to individual client needs, aligning with a traditional person-centered approach which is at the heart of many therapies.

We also have at Solace a Pain and Trauma Therapist specializing in Cranial Sacral Therapy using Acupressure points and EMDR. We have specialists in Hypnotherapy, CBT, sleep disorders and Rewind Trauma Processing (From The Human Givens Approach). We are in the process of being trained in and of trialing EFT (Emotional Freedom Technique) which involves the use of kinaesthetic tapping techniques with finger tips on meridian points of the body which work on keeping emotional energy moving. As trauma is encoded neurologically, as described above, EFT is a way of decoding emotions from neurological pathways. This is done by activating the initial response to the trauma by identifying the thought, feeling or bodily sensation. The tapping on meridian points then decodes the response mechanism through a process known as de-potentiation. It is widely understood that trauma becomes stuck or trapped in the body and this is linked to flashbacks (feelings of being back at the time of trauma). The tapping or freeing process is then crucial for unlocking and processing whatever is stuck.

Overall, our aim is to build clients' internal resources or resilience as trauma is respectfully unpacked. The work of building anchors or positive visual imagery - for example of a calming peaceful place or positive memory building - are crucial for stabilization. We encourage resilience and a belief in the self to heal. Mindfulness grounding using the five senses is a standard way by which we encourage a greater sense of the present contrasted with the past event that is not happening now. The therapeutic approaches above comprise a form of social capital used to strengthen internal mechanisms of coping and to begin to alleviate distress and bring relief.

## 3. Solace –Bridging Social Capital - External Resources and Moving On

When people arrive in a new country there is inevitably a transition period. Sociologists such as Bruce (2002) note that in this period, people often turn to their religion to help with the transition into a new community. Pryce (1979) showed how Pentecostalism helped Afro-Caribbean people adapt to British society. Holy places of worship provide meeting places where people can link up with others and enter into new networks.

Solace provides social capital in this way as RAS begin to put down roots in a community. Putnam (2000) argues that social capital provides a resource for people in communities. Vertical social capital comprises networks that link people of all groups in a community or local grass roots organisations. We also promote bridging or linking social capital through promoting or referring clients to community activities geared to their particular needs, other agencies for help with legal or financial assistance. Psychotherapy reports can help with clients' legal cases for asylum claims. An example of the section of Solace doing this is described below by the Clinical Director, Anne Burghgraef.

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**“The Child and Family Wellbeing project was set up specifically for the refugee children and families who have come to live in the UK through UNHCR Resettlement programme. These families are mainly Syrians who have been living in refugee camps in Jordan, Lebanon and Turkey, because they were particularly vulnerable or had a specific need, often medical.**

**While resettled refugee families are supported to access housing, medical care, education and other practical issues, they are without support to address such complex psycho-social issues as forced migration from their homes, witnessing the atrocities of war, the loss of loved ones and adapting to an alien culture. Migration Yorkshire [the regional migration coordinating body] became aware of many of the difficulties children were having in settling into their new life in the UK, so they approached the Home Office for funding to set up a project to address these issues in Yorkshire."**

Schools, GPs or caseworkers may refer families who are overwhelmed by the pressures of adjustment or the impact of trauma while children or young people may be struggling in schools to cope with the new demands placed upon them. The CFWP works from a systemic perspective to understand the challenges and resources families have and to intervene strategically. They may work with schools to understand the needs of refugee children to help them feel safer and more secure so they are available for learning, or they may work with children and young people individually or in groups to express themselves, share experiences and nurture relationships or they may work with parents to support their children at home and school more effectively. Sometimes therapists may work with the whole family to enable them to share their experience, enhance communication and develop effective solutions and ways to support one another.

A young boy was referred to Solace because of his behaviour in school, which was described as aggressive and non-compliant. He was said to have 'melt downs' for no reason, running around, damaging school property, screaming, crying, pushing and poking people. The school were on the verge of excluding him. Our therapist spoke to the school about their concerns and to his mother to explain the project and get her permission to work. The therapist worked individually with him weekly in school using a Relational Approach and creative materials whilst I worked with her together to see them as a family. The boy's behaviour in school changed very rapidly as he felt safer and understood. As the father had been separated from the family for 4 years we worked with them to prepare them for this reunion and had a few sessions together after his arrival to help them adjust to their new context.

This highlights that the bailiwick of Solace goes beyond pure psychotherapeutic intervention, although this remains the backbone. Solace is one organization in a larger figuration of agencies. These include schools, GPs, Refugee Council, legal agencies, local authorities and so on working together for RAS. Solace is often at the heart of all this, providing bridging social capital, links and resources for settling and orientating in a new place.

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Registered Member 376208
MBACP (Accred)

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