Community Mental Health Journal
https://doi.org/10.1007/s10597-020-00743-z

ORIGINAL PAPER

Inspiring Life in Frozen Communities Supporting Migrant Women in Brussels to Regain Control over their Lives

Bibiane van Mierlo[1] · **Nicole Nagel**[2] · **Willem van de Put**[3]

Received: 30 November 2019 / Accepted: 3 November 2020

Abstract
In Brussels, many migrant women without legal status have no or limited access to health care and other basic services. Their access to descent care is mainly hampered by a lack of information, limited financial resources and poor experiences in the past. Three non-governmental organisations joint efforts to help migrant women without legal status to come out of their isolation. Action research during the implementation process was conducted in order to know which elements contributed to increased feelings of trust and reinforced autonomy among the target group and more willingness to support migrants among a larger population. Our major conclusion is that mental health and well-being is largely defined by (the quality of) social relations and interactions – an aspect that is too often forgotten as a result of the medicalization of mental health related problems.

Keywords Migrant women · Mental health · Well-being · Social relations

Introduction

In Brussels, many migrant women without legal status (undocumented migrants or UDMs) live in precarious situations while having no or limited access to health care and other basic services. These women face a multitude of problems; and most of the time they lack confidence and are afraid to go out to seek help or participate in society (WHO 2018). Increased focus on the mental health needs of UDMs has been recommended in several studies over many years (Trummer 2010, Teunissen 2014, Henkelman 2020). Mental health ranks highest among the health challenges for UDMs in Belgium (Roberfroid 2015) and mental and social problems account for a significant morbidity burden for UDMs. (Pavli 2017, Aldrige 2018), and overall, there are significant socio-cultural barriers in Belgium in linking social and mental health services to immigrants from other cultures (Lafleur and Marfouk 2017; Cordero 2020).

A non-governmental organization (NGO), Medecins du Monde, based in Belgium conducts migrant assistance programmes in Belgium and internationally. The goal of their projects in Belgium is not only to encourage migrant women to stay connected to the health system, but above all to give women the opportunity to re-gain control over their health, which includes their mental health and psychosocial well-being. In March 2019 this NGO asked the support of two other NGOs to help them with an initiative to get migrant women without legal status out of their isolation; one NGO with expertise in the development of theatre productions, Theatre & Reconciliation (T&R) that aims to reinforce the social cohesion of vulnerable people with a different culture, background and age; the other NGO, Culture 4 Change (C4C) with expertise in conducting (action) research for and together with fragile populations.

The NGO T&R with expertise in the development of theatre productions with fragile populations, including mental health patients, always works from improvisations, based on daily experiences of the actors, which are the building blocks of the final productions. The underlying principle of theatre as defined by this NGO is the development of a common ground

✉ Bibiane van Mierlo
bibiane.vanmierlo@culture4change.com

Nicole Nagel
nn@rolfing-stimme.de

Willem van de Put
wvandeput@itg.be

[1] Breedstraat 36, 3512 TX Utrecht, The Netherlands

[2] Dagobertstraße 59, 50668 Köln, Germany

[3] International Health Policy Department, Institute of Tropical Medicine, Vlasmarkt 27, 2000 Antwerp, Belgium

Published online: 09 November 2020

where people feel safe enough to share and discuss sensitive issues and give words to feelings and experiences that are usually surrounded by rumours and suspicions. Collaboration in this initiative was the result of observations during one of their theatre productions in Rwanda in 2018 when working with community members in order to reinforce autonomy and psychological well-being. People started to come out of their isolation and got involved in discussions and a playful collaboration. Feeling of shyness and reluctancy made place for boldness and the courage to speak out and address sensitive issues, all necessities for a psychological recovery/healing of a community. The dynamics were achieved with minimal means and the involvement of a large number of people, who have all benefited directly and indirectly from these theatre productions in the open air. The methodology deserves more attention, and here we report on a small study we organised alongside an intervention in Brussels.

The participating organization with expertise in conducting participatory action research, C4C, formulated two major questions:

(1) Whether the project indeed results in feelings of more trust and reinforced autonomy among the target group that participated directly in the theatre production (migrant women in Brussels without legal status);
(2) Whether there would be a willingness to support migrants among a population that lives in the near surroundings of the target group.

This article is a summary of the overall process and major results of the action research conducted.

One of the major challenges of the project was to mobilize migrant women to participate in this specific project – even to get in touch with this isolated group of women was not easy. It took time to win their trust, and only a few women volunteered to 'play along' with the theatre group. During a first phase we were able to identify eight women who were interested to participate in the project. At the time of the rehearsals, five women showed up and participated in a final theatre production that was developed together with some 40 other women and men, of which three were semi-professional actors and the rest a mix of immigrants without legal status (3), students of the 'Université Libre de Bruxelles' (20) and drug addicts in treatment and their caregivers (14). The group of (5) participants who should benefit from the intervention described here shall be referred to as 'target group' throughout this text.

Methods

Action Research

We conduct participatory action research to include all participants, including actors, spectators and other stakeholders in every step of the process. This approach helps to create trust, gain understanding and build capacity to undertake action at the same time (Green et al. 1995). Given the rich variety of ethnic identities and personal histories the action research method was chosen to increase: the relevance of the program to the daily realities of the participants; work on community empowerment; and create an immediate connection between research-generated knowledge and practice (Macaulay et al. 1999; Jagosh et al. 2011). This method has been specifically developed to explore social relationships and group behaviours, called social processes and avoids the pre-conceptualization of the problem (Glaser and Strauss 1967). It permits to understand the situation from a specific context at a given time and to construct a theory based on data systematically collected and analysed. This means that we do not focus on the evaluation of a specific intervention but that the whole process is taken into account, from the definition of the problem to the long-term effects.

Tools Used

We applied a mixed approach for the data collection:

- Literature and references.
- Interviews with key informants (actors, theatre directors, target group, immigration experts).
- Group discussions with actors and spectators.
- Recorded testimonies and observations.
- Evaluation sheets among actors and spectators.

Collection of Data on Different Levels

Phase 1

In line with the principles of the participatory action research data collection was done in several phases and at several levels.

The first level of data collection has been that of the initiator. Medecins du Monde, based in Brussels, Belgium, acts on its mandate, mission and vision, hence their decision to work on the mental health and well-being of a group of migrants. We have been collecting data at those places where the target group lives and is used to come

together while taking into account the method of operating and long-term objectives of the initiator.

The second level of data collection consisted of a description of how T&R is processing when developing a theatre production. The objective of the specific production as part of this project was to create democratic and peaceful spaces for dialogue among the population of the Brussels region, with the aim to enhance social cohesion between men and women of different ages, cultural and social backgrounds.

The third level of data collection has been a description of the target group (migrant women without legal personality status) and an exploration of their problems as formulated by themselves. In collaboration with the initiator, we conducted key informant interviews and focus group discussions about the perceived quality of life, level of participation in social life, fears and their hopes for the future.

Phase 2

On the basis of these baseline data the next step consisted of actual participation of the researchers in the rehearsals where the play was developed. The information from this direct experience was deepened by conducting individual and group interviews with both actors and people in charge of the theatre production, during rehearsals and the periods in between rehearsals of the theatre production.

We disseminated simple evaluation sheets among all participants that took part in the rehearsals while inviting them to indicate any change in mood before and after a rehearsal. The evaluation sheet has been developed based on the information collected during phase 1 and in line with what the target group reported when we asked for their major complaints. We could distinguish three main categories: lack of social contact /isolation, (high) level of stress, hopelessness/ lack of energy. The results of these discussions and evaluation sheets together with testimonies and observations during that same period permitted to collect the necessary information about experiences and perceived changes in feelings of well-being among the target group that participated in the final theatre productions. We focussed on several main categories when collecting information during this period:

- What were the problems and topics selected by the target group to start their improvisations?
- Did the target group focus on the experiences of the present or did they tend to evoke the past when selecting their topics?
- What were the most important moments for the target group during rehearsals?
- What were the effects of the improvisations and different exercises during rehearsals on their feelings of well-being?
- Did their relationships among themselves and with other members of the groups change during the overall process?

The Underlying Theories

Discussing the development of the project and the required data helped us to identify key theories to apply to the specific context of the target group, their perceived problems and potential solutions:

(1) People's mental health and well-being depend on many social, political and economic factors that are closely related: the social determinants of health (Centres for disease control and prevention 2018).
(2) We aim to respond to calls made by Wahlbeck and Heinz et.al., who stress the need for "using interdisciplinary perspectives in order to better understand the complexity of mental health" and "qualitative studies [that] can generate new lines of research and explore what a given situation really means for patients and their relatives as well as the general population. Indeed, neuroscience has turned social." (Heinz et al. 2015; Whalbeck 2015).
(3) The importance of interventions in the social domain is slowly accepted in the MHPSS field. Increased recognition of the social determinants of mental health supports the importance of social interventions that stay far from medicalization of individual problems. Promoting social participation is a more promising approach (Burgess et al. 2019; Ajduković 2013).
(4) We are led by the five intervention principles that have empirical support to guide intervention practices and programs as identified by Hobfoll: promoting a sense of safety, calming, a sense of self–and community efficacy, connectedness, and hope (Hobfoll et al. 2007).
(5) We believe that the wellbeing and the mental health of individuals and communities need interventions that "embed mental health awareness within the wider processes of empowerment, allowing communities to develop the skills, strategies, and recourses to respond collectively to wider structural challenges that place their mental health at risk" (Burgess et al. 2019). Therefore, the intervention needs to focus on self–and community efficacy, connectedness, and hope, and we use the concept 'cognitive social capital' to understand social cohesion.
(6) Social capital is viewed as a collective feature characterizing whole communities (Putnam 2000) and the more specific cognitive social capital refers to norms of trust, solidarity, and reciprocity. The importance of cognitive social capital is that it refers to what people feel with regard to social relations, rather than to

what they actually do (Harpham et al. 2002). This allows to make a distinction between the actual social ties between people and the process of activating social ties to achieve desired outcomes (Portes 1998). Cognitive social capital creates the right ambiance to engage in collective action, or in other words, strengthening cognitive social capital helps people regain agency over their own potential to change their situation (Wind and Komproe 2012; Eriksson 2011).

These perspectives from the social sciences is underpinned by developments within the domain of neurobiology, explaining that trauma resides in the nervous system and not in the event itself (Heller and Heller 2004). A dominant neurological reaction to a stressor involves orienting, fight, flight, or freeze reactions that will be repeated at subsequent exposure to similar events (Ledoux 1996). The "Polyvagal Theory" of Stephen Porges explains how an impaired social engagement system may result in fight, flight, or freeze reactions (Porges 2009; Porges and Dana 2018). Drawing on the "Theory of Dissolution" as developed by the British neurology pioneer John Hughlings Jackson in 1910 (York and Steinberg 2002), Porges explains how under stress, we involuntarily try our newest, most sophisticated and efficient equipment first. If that doesn't work, older strategies are attempted, and if they don't work, the oldest resources are employed. Therefore, under stress, humans first use social/relational tactics, then fight/flight, then immobility, as survival strategies. This hierarchical scheme is undermined by traumatic experiences. If social engagement did not work in the past, we are less likely to try it again in the present. Instead, we go to straight to the older strategy, the fight/flight modus. And if even this did not work earlier in life, we may skip the 'sympathetic stage' and simply go to the last level, the parasympathetic stress responses (freeze, immobilize, dissociate).

These principles and theories permit to look at human behaviour from a different angle. Dysfunctional or impaired behaviour can now be explained by a deregulation of the appreciation of internal or external stimuli. Instead of treating trauma though the interpretation of an individual narrative and/or the discharge of emotions and/or the rewriting of behaviour, today we have new information that underlines the importance to look at the (quality of the) relation between people that permits or hinders the recalibration of the autonomous nervous system (ANS). This information also gives us a more coherent image of the psychological and psychosomatic complaints as expressed by the target group (lack of social contact/isolation, (high) level of stress, lack of energy, hopelessness. And finally, this way of looking at symptoms and behaviour can orient us when looking for potential solutions.

Final Phases of Data Collection

The last phase of data collection focused on the appreciation of the public that came to see the performances. We wanted to have at least an impression of the effect of the intervention in terms of increased understanding and empathy, and willingness to actively engage with the target group on a longer term.

Appreciation of the Public

Simple questionnaires were distributed among the public that came to see the two final performances of the theatre production in a theatre that has place for some 250. The questions were mainly about their willingness to help illegal immigrants finding their way in Belgium and to act as a buddy or friend when these people are facing difficult times. On the first evening of the show 59 people completed the questionnaire; on the second evening 53 people participated in this exercise.

Longer Term Effects among the Target Group

We were able to meet the five members of target group members three times after the final performances. The first meeting was organized two weeks after the shows in the presence of four members of the target group; the second meeting 3 weeks after the shows in the presence of three women. The last meeting took place 6 weeks after the show during a meeting in a theatre in Brussels where four women from the target group participated in a new theatre production.

Results

We have been able to distinguish the following categories that characterize the change in perceived feelings of well-being among target group members and the audience through this project:

•Expressing Emotions in a Secure Context

Feelings of distress often occur when emotion is deregulated, and the affect is repressed or inaudible. Expressing what is felt inside is a key strategy in any mental intervention. And it is often from here that healing can begin (Herman 2016).

The target group has been invited to express themselves freely, to go beyond shyness and to speak directly to people, while giving them also a clear structure that allowed them to stay in control. The discipline and concentration as required by the theatre directors throughout the process, emphasizing that the actors are always "on stage" and must remain

present, avoided feelings of mental dissociation among the participants.

•Arriving in the "Here and Now"

The point of departure for each improvisation was what people live or feel in the present in relation to what they have experienced in the past or in their present life. No need to be an actor or to have special gifts. Members of the target group were invited to translate their own narrative into movements and new words. The discomfort and hesitations of the beginning were followed by repeated attempts and eventually resulted in stories somewhat transformed and completed by other improvisations. This process created a distance between the lived experience and the scenes on the set which allowed them to take a first step towards autonomy. This was audible and visible through voices that changed in intensity, gestures that became more subtle or wider, bodies that took more and more space.

•Getting out of the Frozen State and Re-Regulation/ Re-Articulation of the Autonomic Nervous System

Moving the body in an open space together with others invited the target group members to come out of their frozen state. By moving together in the space, participants met others and they began to exchange looks and to express themselves in ways that go beyond words.

Creating dynamics at different levels while using different modalities and resources (rhythm, voice, music, emotion, themes) helped to awaken more vitality and to re-regulate the ANS of the participants. We could see how tensions of participants at the beginning of the process transformed in lively and touching expressions during rehearsals and performances. We have also been able to observe the members of our target group during informal moments and in relation with the other actors; they became more and more active and were able to engage with others during the process.

•Focusing on Form and Rhythm Instead of only Content; Giving a New Meaning to a Lived Experience

Group members were asked to reconstruct their story and to rebuild themselves. Present and past experiences have not been denied but have been re-processed and observed from different angles which has broadened the horizon of both actors and spectators. It was in this free space that the women of our target group were able to disidentify from their problems and had a chance to reconstruct their story. We were able to see how the meaning of a past experience emerged through the form and that it was the aesthetic aspect, more than the narrative, that gave meaning.

In this same (educational) space the spectator has been invited to reflect on his/her role, behaviour, points of view and future actions. Involving the public during the final performances has made the experience more interesting for spectators who do not have the same experiences, which has increased their interest for the stories of the actors as confirmed by the results of the evaluation among the spectators.

•Regaining Confidence and Self-Esteem

Members of our target group were invited to address topics they experience or have experienced. Others listened and watched them play until it was their turn. Participants laughed about stories and sometimes about mistakes made during the rehearsals, but there was always respect for actors and their stories. While listening and paying attention to each other, cultural exchange took place, trust could be established, and relationships were built. The pride of having played a scene with success and their participation in the project has had a direct impact on their self-esteem and self-confidence; the women of our target group talked about this at several occasions.

•Restoring Social Relations and Regaining Autonomy

Members of our target group mentioned several times that the project motivated them to leave their homes and to come out of their isolation. Their timidity and reluctance made place for courage and pride to participate in the project and their wish to take part in social life. The results of the evaluation among the actors during the rehearsals reinforced this observation. During the project they felt supported by the other actors and theatre directors who did not stop to believe in them. These positive effects were still present during the two meetings that were organized 2 to 3 weeks after the final shows. During a meeting some 6 weeks after the shows, we saw them surrounded by a new group of actors as if they were part of this new group for years.

This observation is in line with the theory that a reinforcement of social capital and cohesion helps individuals to regain their autonomy, and to make use of their potential to change their situation (Wind and Komproe 2012; Eriksson 2011). Unfortunately, the scope of this project did not permit to measure the effects on a longer term.

Discussion

Our sense of agency, how much we feel in control, is defined by our relationship with our bodies and its rhythms.

> In order to find our voice, we have to be in our bodies – able to breath fully and able to access our inner sensations. Acting is an experience of using your body to take your place in life.
> Bessel van der Kolk.

Applying theatre or theatrical techniques in therapeutic contexts or other precarious situations is no new phenomenon. There is a lot of literature on how to deal with trauma as a result of violence, war or other negative events while making use of theatre related techniques (Barnes and Coetzee 2014; Corcoran 2018; Moran and Alon 2011; Spandler et al. 2007). It's generally acknowledged that collective movement and music can create a broader context that enables people to give meaning to life which goes beyond individual destiny. We only have to refer to the many existing rituals and ceremonies worldwide (Morris 2015; Agger 2012).

According to Bessel van der Kolk, psychiatrist, trauma expert and renowned author, the existing initiatives in this field all have a common denominator: the confrontation with the, often painful, reality of life and the symbolic transformation through joint action. Very often people that went through distressful event close themselves from what they feel inside. Our target group learned to go against this trend. And they learned to transmit these feelings to the public; they wanted their public to understand what happens inside of them and they invited the public to open up to these same feelings. In "The body Keeps the Score" van der Kolk expresses similarities between what happens in theatre and therapy (van der Kolk 2014):

> Traumatized people are afraid to feel emotions because this might lead to a loss of control. Theatre invites people to embody emotions, to give a voice to feelings, to become rhythmically linked to others, to assume different roles and to embody them. Theatre is the collective confrontation with the reality of humanity,
> Traumatized people are afraid of and avoid conflict. They withdraw from conflict and remain in a frozen state. Conflicts are an essential part of theatre. A theatre set is the place to process internal, inter-personal, family conflicts or social conflicts, in all its dimensions and with all its consequences.
> Traumatized people want to forget, hide how frightened and powerless they are. Theatre provides an opportunity to tell the truth and share what has happened with a public. To achieve this, actors have to break down their own barriers, discover their own truth and express this truth through their own voice and body.

It's important to note here that T&R does not claim to conduct or apply theatre therapy. Their goal is to organize theatre performances to enhance social cohesion and resilience, while working with marginalized or vulnerable populations within their respective communities; the therapeutic aspect would, and indeed appears to be, an added value.

We tried to answer two questions: whether the method of T&R indeed results in feelings of more trust and reinforced autonomy among the target group, and whether there would be a willingness to support migrants among the population in the near surroundings of that target group. More specifically, we wanted to know which elements of a collective approach that has the potential to reach large numbers of people and that doesn't focus on the therapeutic aspect to begin with, might contribute to increased feelings of trust and reinforced autonomy, important indicators of psychosocial well-being, among our target group and the willingness to support migrants among a population that lives in the near surroundings of the target group.

We can answer the first question in the affirmative. Indeed, the methodology of T&R has a positive effect on the mental health and psychosocial well-being among the target group who participated directly in the project as an actor. We would like to emphasize here our target group was no self-selected group before taking part in this initiative and they were very reluctant and sceptical when we first approached them. It took us a considerable effort to get them on board of this experience. Their attitude started to change during the rehearsals. We could see that the simple fact of bringing people together in a space where they are invited to express what they experience, inside of themselves and in contact with their environment while using different modalities of expression, permits to get people out of their isolation and improve their sense of well-being without the interference of therapists or doctors.

The answer to the second question is positive as well. The spectators' answers and remarks on the evaluation sheets that were distributed to them immediately after the show demonstrate a willingness to be actively involved in helping people that participated in this project to come out of their isolation and to participate in daily life; 94% of the spectators indicated that they would be willing to act as a buddy or friend of illegal immigrants who are facing difficult times. A justified objection to the reliability of this kind of assessment is that the people who were ready to come to see the show, are necessarily interested in the subject (otherwise they would not have come) and have therefore necessarily responded positively to the different questions without necessarily translating their words in deeds. Being aware of the fact that the show "preaches for his parish", we have added the question on the sharing of coordinates in case they respond positively to the question if they would be willing to help vulnerable people concretely; 47% shared their name, email address and often a phone number. Of this group, 19% were close relatives or friends and 81% was not related to

any of the actors. This means that half of all respondents indicated they not only would like to help, but they were also ready to be identified and contacted to make this happen.

During the overall process we focussed on the specific elements that contributed to these positive results. Within the context of this project, theatre was used to help migrant women to come out of their isolation and to reduce their levels of stress, hopelessness and lack of energy. Major challenge has been to convince the target group before starting of possible beneficial effects on their health by participating in the project. But once convinced, we could clearly see how the mood of the participants in this project was influenced by playing together which allowed the reestablishment of social relations and a revitalization through the expression of feelings and the creation of a (dramatic) tension on the set using different modalities and resources; expressing emotions in a secure context, being able to relate to the here and now, moving the body, using voice, music, form and rhythm, were all elements that permitted our target group to regain confidence, self-esteem and autonomy and to restore relations. Working rhythmically with the voice and the body created more belonging to the group and a common pulse that was described by the participants as relaxing and beneficial. Also humour and free laughing could be released. These elements had a positive influence on feelings of well-being of our target people and can be obtained by relatively simple techniques without the interference of medical or therapeutic specialists. We were also surprised by the large number of people that came to see our target group and expressed their willingness to be actively involved in efforts to support our target group in daily life.

Our major conclusion is that mental health can indeed be improved by social action, based upon the creation of a space for stories to be transformed. We believe this finding may help in formulating answers to problems that are often unnecessarily medicalized.

Compliance with Ethical Standards

Ethical Approval Given the (illegal) status of our target group and the sensitivity of the subject, all information that has been obtained through interviews and other methods of data collections was strictly confidential and has been anonymized. We have informed all stakeholders of the purpose of this research and they all agreed to participate on the condition that confidentiality and anonymity could be ensured. All respondents, including the audience that came to see the final performances in the theatre participated on a voluntarily base. Those who gave their contact details to act as a potential buddy of friend of the target group did so out of free will. The use of this research for study purposes has been discussed with both the participating organisations and people interviewed and observed, including our target group, and all stakeholders gave their approval. The reading of the results by two experts was free and voluntary. We agreed on a non-disclosure agreement regarding the use of the results by a party, other than the research organisation in charge of the documentation of the results.

References

Agger, I., Igreja, V., Kiehle, R., & Polatin, P. (2012). Testimony ceremonies in Asia: Integrating spirituality in testimonial therapy for torture survivors in India, Sri Lanka, Cambodia, and the Philippines. *Transcultural Psychiatry, 49*(3–4), 568–589.

Ajduković, D. (2013). Introducing the notion of social context of collective trauma to ESTSS. *European Journal of Psychotraumatology, 4*(1), 21258.

Aldridge, R., et al. (2018). Global patterns of mortality in international migrants: A systematic review and meta-analysis. *The Lancet, 392*(10164), 2553–2566.

Barnes, H., & Coetzee, M.-H. (Eds.). (2014). *Applied drama/theatre as social intervention in conflict and post-conflict contexts. Newcastle on Tyne: Cambridge Scholars Publishing. Lan, D., 1990. Desire and other plays*. London: Faber and Faber.

Burgess, R. A., Sumeet, J., Inge, P., Crick, L. (2019). Social interventions: A new era for global mental health? *The Lancet Psychiatry*, *7*(2), 119–121.

Centres for Disease Control and Prevention. (2018). Social Determinants of Health: Know What Affects Health.

Corcoran, S. (2018). In the theatre of the self: Reflections on the use of drama in treating traumatic stress. *Neurophysiology and Rehabilitation, 1,* 29–31.

Cordero, S. (2020). Socio-cultural determinants and barriers to providing effective mental health services to the Filipino community in Belgium. Faculté de santé publique, Université catholique de Louvain. Prom: Filion, Nataly. https://hdl.handle.net/2078.1/thesis:23889.

Eriksson, M. (2011). Social capital and health – implications for health promotion. *Global Health Action*. https://doi.org/10.3402/gha.v4i0.5611

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Green L, George MA, Daniel M, Frankish CJ, Herbert CP, Bowie WR, O'Neill M. (1995). Review and Recommendations for the Development of Participatory Research in Health Promotion in Canada Ottawa: The Royal Society of Canada

Harpham, T., Grant, E., & Thomas, E. (2002). Measuring social capital within health surveys: Key issues. *Health Policy Plan, 17,* 106–111.

Heinz, A., Charlet, K., & Michael, A. (2015). Public mental health: A call to action. *World Psychiatry, 14*(1), 49–50.

Heller, D. P., & Heller, L. (2004). Somatic experiencing in the treatment of automobile accident trauma. *U.S. Association for Body Psycho-Therapy Journal, 3*(2), 42–52.

Henkelmann, J., De Best, S., Deckers, C., Jensen, K., Shahab, M., Elzinga, B., & Molendijk, M. (2020). Anxiety, depression and post-traumatic stress disorder in refugees resettling in high-income countries: Systematic review and meta-analysis. *BJPsych Open, 6*(4), E68. https://doi.org/10.1192/bjo.2020.54

Herman, J. (2016). Trauma and Herstel. Paperback Nederlands.

Hobfoll, S. E., et al. (2007). Five essential elements of immediate and mid–term mass trauma intervention: Empirical evidence. *Psychiatry: Interpersonal and Biological Processes, 70*(4), 283–315.

Jagosh, J., Pluye, P., Macaulay, A. C., et al. (2011). Assessing the outcomes of participatory research: Protocol for identifying, selecting, appraising and synthesizing the literature for realist review. *Implementation Science, 6*, 24. https://doi.org/10.1186/1748-5908-6-24.

Kolk, B. van der (2014) The Body keeps the Score - Brain, Mind and Body in the Healing of Trauma. Penguin Books Ltd.

Lafleur, M., & Marfouk, A. (2017). Pourquoi l'immigration ? 21 questions que se posent les Belges sur les migrations internationales au XXIe siècle. Collection: Carrefours. Broché.

Ledoux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Touchstone Books.

Macaulay, A. C., Commanda, L. E., Freeman, W. L., Gibson, N., McCabe, M. L., Robbins, C. M., & Twohig, P. L. (1999). Participatory research maximises community and lay involvement. *British Medical Journal, 1999*(319), 774–778.

Moran, G. S., & Alon, U. (2011). Playback theatre and recovery in mental health: Preliminary evidence. *The Arts in Psychotherapy, 38*(5), 318–324.

Morris, G. (2015). Special issue on applied theatre healing and trauma. *South African Theatre Journal, 28*(1), 1–3. https://doi.org/10.1080/10137548.2015.1011860

Pavli, A., & Maltezou, H. (2017). Health problems of newly arrived migrants and refugees in Europe. *Journal of Travel Medicine*. https://doi.org/10.1093/jtm/tax016

Porges, S. W. (2009). The polyvagal theory: New insights into adaptive reactions of the autonomic nervous system. *Cleveland Clinic Journal of Medicine, 76*(Suppl 2), S86–S90.

Porges, S. W., & Dana, D. (2018) Clinical Applications of The Polyvagal Theory. The emergence of Polyvagal-Informed Therapies. Norton Professional Books.

Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology, 24*(1), 1–24.

Putnam, R. D. (2000). *Bowling alone: The collapse and revival of American community*. NY: Simon & Schuster.

Roberfroid, D., et. al. (2015). What health care for undocumented migrants in Belgium? KCE REPORT 25. https://kce.fgov.be/sites/default/files/atoms/files/KCE_257_Health_care_Migrants_Scientific%20Report.pdf.

Spandler, et al. (2007). Catching life: The contribution of arts initiatives to recovery approaches in mental health. *Journal of Psychiatric and Mental Health Nursing, 14,* 791–799.

Teunissen, E., Sherally, J., van den Muijsenbergh, M., et al. (2014). Mental health problems of undocumented migrants (UMs) in the Netherlands: A qualitative exploration of help-seeking behaviour and experiences with primary care. *British Medical Journal Open, 4,* e005738. https://doi.org/10.1136/bmjopen-2014-005738

Trummer, U., Novak-Zezula, S., Metzler, B (2010) Access to health care for undocumented migrants in the EU: A first landscape of NowHereland.

Wahlbeck, K. (2015). Public mental health: The time is ripe for translation of evidence into practice. *World Psychiatry, 14,* 36–42.

Wind, T. R., & Komproe, I. H. (2012). Mechanisms that associate community social capital with post-disaster mental health: A multilevel model. *Social Science and Medicine, 75*(9), 1715–1720.

World Health Organization (2018). Health promotion for improved refugee and migrant health. Technical guidance.

York, G. K., & Steinberg, D. A. (2002). The philosophy of hughlings jackson. *Journal of the Royal Society of Medicine, 95*(6), 314–318. https://doi.org/10.1258/jrsm.95.6.314