

A group intervention for displaced survivors of persecution:

A reflective account through a psychosocial lens

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Abstract: Millions of displaced survivors of persecution are navigating the impacts of experiencing human rights violations and fleeing their homes, communities and nations in search of security. Their broad, pervasive, and complex psychosocial needs can develop into chronic and severe issues if they are not addressed. There is limited literature on clinical interventions and approaches that have a primary goal of promoting psychosocial health of displaced survivors of targeted persecution. The Orientation Group, developed by the Bellevue/NYU Program for Survivors of Torture in New York City, is one brief psychoeducational and skills-based group intervention aiming to support the psychosocial wellbeing of displaced survivors of torture, political oppression and other forms of persecution. Although not yet empirically studied, this group intervention has more than a decade of anecdotal support. This paper provides a reflective account of the Orientation Group and offers recommendations for enhancing the intervention, based on our years of facilitating and supervising the group, years of working with clients who participated in the group, and many conversations with developers of the intervention.

Keywords: groupwork; group intervention; psychosocial; displaced survivors; persecution; torture; refugees; asylees; manualized treatment; group work

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Introduction

Displaced survivors of persecution have fled from their homes and communities due to human rights violations and other forms of targeted oppression and abuse for who they are and what they believe in. They include refugees, asylum seekers, asylees, internally displaced persons and stateless people, and they make up the 70.8 million forcibly displaced people worldwide (United Nations High Commissioner for Refugees [UNHCR], 2019). Notwithstanding the continuous effort made by the United Nations and the international community, protection of and support for displaced populations remains demanding due to unceasing disruption of civil order in many regions, as well as a lack of adequate and sustainable solutions that would enable displaced people to ‘rebuild their lives and live in dignity and safety’ (UNHCR, 2018, p.27).

The United States (U.S.) has historically been one of the world’s top refugee resettlement countries, with a rising number of refugees and asylum seekers resettling in the country every year (Migration Policy Institute, 2017). However, between 2017 and 2018, the U.S. government implemented asylum and refugee policy and practice changes that severely restrict resettlement to the U.S. and that, many argue, are a threat to the safety and security of refugees around the world. Impacts of these changes have been acutely felt by individuals and families desperate to secure safety and by organizations supporting asylum seekers and facilitating refugee resettlement. The long-term effects of the policies are yet to be seen. As distress is exacerbated by restrictions, specialized support for displaced survivors of persecution is arguably more important than ever. Public and private organizations across the U.S. offer psychosocial support to survivors of persecution through resettlement services, health care, education, social services, and immigration support, but many service models, interventions, and clinical approaches remain unstudied and unshared. Additionally, more psychosocial interventions that consider the complex ecology of displaced survivors of persecution need to be developed and implemented with the unique circumstances of this particular population in mind (Salo & Bray, 2016).

Psychosocial emphasizes ‘the close connection between psychological aspects of experience and wider social aspects of experience, inclusive

of human capacity, social ecology, and culture and values' (Tol, Reis, Susanty, & de Jong, 2010, p.132). It is a perspective on human struggle in relation to the connection of individuals to their communities (Anonymous, 2014). Without best-practices to guide psychosocial services and approaches, organizations may develop systems of care and clinical interventions based on models for the general population or for survivors of other forms of interpersonal trauma, risking oversight of important considerations for this unique population of survivors who have been 'betrayed by their own society' (Gonsalves et al, 1993, p.362) and pushed to integrate into new societies.

A New York City-based organization that provides specialized care to displaced survivors of torture, political oppression and other forms of persecution has developed a manualized group intervention specifically for displaced survivors of persecution. Anecdotal feedback on this short-term intervention has been positive, and although the intervention has not yet been empirically studied, there is notable domestic and international interest in adapting it to other organizations and settings. The purpose of this paper is to expand the literature on specialized psychosocial support approaches for displaced survivors of persecution by sharing a reflective account of a short-term, psychoeducational and skills-based group intervention that has been implemented in dozens of cycles over a 15-year period at the Bellevue/New York University (NYU) Program for Survivors of Torture.

Indications for a multifaceted response

Humanitarian crises and human rights abuses are neither recent nor rare phenomena. In 2014, Amnesty International (2014) reported that 141 countries had tortured or otherwise ill-treated people within the prior five years. Torture as a tool of human rights violation that aims to overpower and to destroy an individual's sense of self and a community's sense of security, continues to flourish worldwide, as do other rampant forms of targeted persecution. The prevalence of trauma-related issues among displaced survivors of persecution is high (Slobodin & de Jong, 2015), and negative effects on mental health are well documented (Porter & Haslam, 2005; Siriwardhana, Ali, Roberts & Stewart, 2014; Slobodin & de Jong, 2015; Turrini et al, 2017).

While many vulnerable survivors remain in unstable and dangerous situations, unable to reach safe haven, even those who manage to escape the conflict and seek refuge in another country, are at risk for prolonged periods of psychological and social struggle as they endure insecurity, marginalization, disconnection, loss and other stressors (George, 2012). Pre-migration vulnerabilities and abuses, a perilous journey during migration, and difficulties in post-migration resettlement and acculturation become the three-phase narrative of so many displaced survivors of persecution (George, 2012; Hodges-Wu & Zajicek-Farber, 2017; National Capacity Building Project & Center for Victims of Torture, 2005; Siriwardhana et al, 2014; Slobodin & de Jong, 2015). Among the many potential struggles of displaced survivors of persecution is a universal experience – loss. Safety is shattered, social and economic support systems are splintered or decimated, homes and communities are left behind, linguistic and cultural familiarities are deprived, and a sense of control over internal states feels forgotten. As survivors navigate the multitude of stressors and their psychosocial effects, individual and community resilience and any available support systems serve as critically valuable resources in surviving, healing, and rebuilding in a new country.

To respond to the breadth and complexity of struggles faced by displaced survivors of persecution, there is a need for multi-sectoral support (Meyer, 2013) that considers the ecological systems in which survivors are embedded (Salo & Bray, 2016) and that recognizes strengths and resources alongside the great difficulties. In the U.S., refugee resettlement agencies aim to address social and environmental stressors through employment, education, public benefits, and language support (Office of Refugee Resettlement, n.d.); clinics and hospitals offer therapy and supportive counseling; medical settings provide care for physical and psychiatric needs; schools lead support efforts for children; community and cultural centers provide familiar support for their diaspora; and religious figures and traditional healers are sought as first lines of care or sometimes in conjunction with Western forms of treatment. While these contexts of support vary in innumerable ways, each offers a potential pathway to wellness and stability following intra- and inter-personal disruption. Recognizing the potential positive psychological and social impacts of each of these supports, there may be benefit to conceptualizing them within the

Mental Health and Psychosocial Support (MHPSS) construct used in the pre-resettlement humanitarian emergency field. The Inter-Agency Standing Committee (IASC), a well-known and respected body in the refugee and humanitarian emergency field, describes MHPSS as ‘any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder’ (IASC, 2007, p.1). Adopting this framework for post-resettlement support offers an integrative conceptualization for the range of supports that strengthen a person’s mental health and psychosocial health. This paper presents one group approach to promoting survivors’ mental health and psychosocial wellbeing.

The Orientation Group

The Bellevue/NYU Program for Survivors of Torture (PSOT), an internationally renowned organization, opened its doors in 1995 to support survivors of torture and other forms of persecution who were seeking services and support at New York City’s Bellevue Hospital, the oldest operating hospital in the United States (New York City Health and Hospitals Corporation, n.d.). Since its inception, PSOT has emphasized the importance of seeing clients as survivors whose health and wellbeing are multifaceted and whose current functioning must be considered within the complexities of their persecution and migration history as well as their current environment. Recognizing the significant impacts of conflict on social determinants of mental health and wellbeing and multiple components of a survivor’s ecology (Tol, Song & Jordans, 2013), PSOT’s service model aligns with the World Health Organization’s (WHO) conceptualization of health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO, 2014, p.1).

PSOT was founded as a multidisciplinary program that has evolved to provide interdisciplinary care to more than 4,000 clients from over 100 countries, and in 2017 alone, served over 800 clients (Bellevue/NYU Program for Survivors of Torture, 2017). Through an integrated approach to clinical care, the program aims to help individuals rebuild their bodies, minds, and spirits following human rights abuses and forced migration. In 2004, PSOT developed and launched a new clinical

service, a manualized group intervention called the Orientation Group (Porterfield, 2004), that was designed to facilitate clients' orientation to internal processes, connection to others, and navigation of the PSOT program.

Group development and rationale

At a time when the number of refugees entering the U.S. and needing support had mushroomed, from approximately 28,000 to 52,000 in a single year (Department of Homeland Security, 2006), the Orientation Group served as an adjunctive and triaging brief intervention that clinically supported a growing number of PSOT clients awaiting individual therapy and other services. Faced with the common challenge of increasing client needs and ongoing limited resources (Bunn, Goesel, Kinet & Ray, 2016), the Orientation Group, which is based primarily on supportive, psychosocial, and psychoeducational group frameworks (Porterfield, 2004), quickly became a highly valued intervention.

Since its inception, the Orientation Group has aimed to promote psychosocial health and to foster connection among clients recently accepted to the program. Most researched mental health interventions provided to displaced survivors of persecution target deficits and disorders, primarily posttraumatic stress disorder (PTSD), with outcome measures typically focused on reduction of symptom rather than promotion of psychosocial wellbeing (Slobodin & de Jong, 2015). In recent decades, trauma-focused individual treatments, including Narrative Exposure Therapy, Cognitive Behavioral Therapy, and Exposure Therapy, that target different symptoms of psychological disorders, have been studied with refugees and have shown positive results (Nickerson, Bryant, Silove & Steel, 2011; Paunovic & Öst, 2001; Slobodin & de Jong, 2015). Group treatments are also empirically supported for addressing mental health symptoms and other common sequelae of interpersonal trauma (Bunn et al, 2016; Foy et al, 2000; Levi et al, 2017), with one study of long-term group treatment outcomes for asylum seekers and refugees by Droždek, Kamperman, Tol, Knipscheer, and Kleber (2014) revealing a reduction of all the measured symptoms of PTSD, anxiety, and depression, to

sub-baseline levels seven years after receiving a trauma-informed, multi-component group treatment.

However, as Nickerson and colleagues (2011) and Siriwardhana and colleagues (2014) assert, the PTSD diagnosis and treatments targeting primarily PTSD symptoms insufficiently capture and address the psychosocial difficulties of displaced survivors of persecution. Significant portions of the population are left out and indicators of healing are missed when treatments and supports are disorder-based and outcomes are exclusively symptom-focused. Furthermore, there are limitations and clinical implications of using Euro-American assessment measures and diagnostic processes that do not consider indigenous constructs of illness, health, and resilience with populations displaced from other parts of the world (Lacroix & Sabbah, 2011; Lowy, Williams & Keleta, 2002).

Additionally, Kira and colleagues (2012) and others have argued that treatment of displaced survivors of persecution should be guided by notions beyond the focus of individual psychopathology and that community healing should be recognized as a critical component of the conceptualization of refugee wellness. Common impacts of torture and trauma are a communal climate of fear, disempowerment and mistrust, and challenges to 'not only the individuals' personal agency, but also their collective and social identity as political actors in their communities' (Kira et al, 2012, p.70). Inherent in the experience of forced displacement are 'loss of social belonging and identity, and interdependence between social destruction and individual distress' (Lacroix & Sabbah, 2011, p.44-45). Interpersonal trauma disrupts connections; group interventions aim to rebuild connections.

Furthermore, for displaced populations from collectivistic societies in which community is a natural forum for support, community and group-oriented interventions are a culturally-syntonic way to come together (Akinsulure-Smith, Ghiglione & Wollmershauser, 2009; Akinsulure-Smith & Smith, 2019; Bemak & Chung, 2017; Bunn et al, 2016; Kira et al, 2012) to counteract the isolation and alienation that commonly follow interpersonal trauma (Foy & Larson, 2006) and to enable survivors 'to connect with sources of resilience within themselves and others' (Mendelsohn, Zachary & Harney, 2007, p.228).

Group goals

While there has been some focus in the U.S. on providing multimodal treatments to address the mental health impacts of refugees' stressors and challenges (Nickerson et al, 2011), as well as on services that promote psychosocial wellness and that target post-migration stressors, these interventions are rarely discussed in the literature and seem to remain largely unshared. Even interventions for torture survivors in a recent systematic review that aimed to 'improve survivors' mental health, social functioning, or the health of the systems in which they are embedded,' (Salo & Bray, 2016, p.451) all targeted individual symptom reduction. Researchers and clinicians have recommended a broadening of targeted outcomes in order to lessen overreliance on PTSD symptoms as indicators of change and risk of 'medicalizing' the treatment of human rights abuse survivors (McFarlane & Kaplan, 2012, p.559). The Orientation Group provides a forum for clients with and without clinical diagnoses to build a community and ameliorate feelings of isolation resulting from displacement to a new country, as they learn sensorimotor, cognitive, and affective skills for stabilizing and improving their psychological and social functioning.

The stated goals of the Orientation Group are increasing members' knowledge about trauma and normal reactions to trauma; strengthening members' coping strategies; providing mutual support among group members; assessing treatment readiness for additional therapeutic support; and increasing knowledge about PSOT's interdisciplinary services and how to access them (Smith, Sullivan, Murakami, Porterfield, & O'Hara, 2017, p.3).

These goals are informed by Judith Herman's (1997) multi-stage trauma treatment approach. Many group interventions for refugees and survivors of persecution are modeled after this approach, often having an initial safety and stabilization component (Bunn et al, 2016; Droždek & Bolwerk, 2010; Robertson et al, 2013; Smith & Impalli, 2007). The Orientation Group draws heavily from Herman's (1997) initial stage, but it is also informed by the third stage of trauma recovery – reconnection and integration – which Orientation Group facilitators have found can begin to be promoted even in the early weeks of treatment.

Because persecution and displacement create disturbances across a survivor's ecology, the Orientation Group aims to promote both

trauma rehabilitation and social rehabilitation across the sessions. For example, both authors have felt the life-altering relief in clients as they described successful use of newly learned breathing relaxation techniques between group sessions and their first good night of sleep in months or years. We have also witnessed changes of engagement in the world in clients who had expressed terror about being in a room with people they did not know and then became the clients who attended every session and requested continuation in an ongoing support group.

Group membership

The target population of the Orientation Group is clients newly accepted to the torture treatment program. The intervention is designed for adult clients who endorse loss of community, isolation, disruptive trauma reactions, difficulty navigating NYC and its systems, and immigration stressors (Smith et al, 2017). The groups are homogeneous by language, presence of a history of persecution and forced migration, and endorsement of clinical conditions of trauma and stress – however, a psychiatric diagnosis has not been required.

The groups are heterogeneous by gender, nationality, ethnicity, and religion, offering therapeutic benefit to members' reentry process into their post-trauma world (Yalom & Leszcz, 2005), and adjustment to the diversity of American society (Kira et al, 2012). It should be noted, however, that the heterogeneity of the group can generate power dynamics that parallel those of the clients' larger community in the U.S. or home countries or even that relate specifically to the members' histories of persecution. For example, in Orientation Groups, political schisms may arise as members share different political views, expressions may be suppressed in a mixed gender group because of cultural beliefs about gender and gender roles, and racially-based oppression may manifest in the silencing of some members during discussions. Anticipating and monitoring these and other power dynamics in the group, and also in relation to the facilitators, become essential in order to develop a cohesive group and safe space.

Because blind spots during facilitation are inevitable, consulting with each potential member about the group composition and group topics in the screening process is critically important. To achieve this, Reading

and Rubin (2011) suggest that facilitators solicit potential members' commitment to creating a group environment 'in which the attitudes of discrimination and intolerance encountered in the larger social and cultural contexts outside of the group are not perpetuated' (p. 91) and that group facilitators should closely monitor the group's compliance with these rules and encourage conversation around such rules. Having members' input in rule-setting is of particular importance for displaced survivors of persecution, as a way to reflect and practice newly accessible power of individuals who have been violently disempowered.

Potential Orientation Group members are identified through a two-step programmatic intake process for new clients – an individual biopsychosocial assessment interview during which trauma history, stressors and strengths are captured; and an interdisciplinary team conference during which the intake assessment is presented and the team recommends an individualized treatment plan. Recognizing motivation as an important clinical criterion for treatment (Yalom & Leszcz, 2005), group facilitators conduct further screening of potential group members by inquiring explicitly about clients' interest, motivation, and expectation for the group. Clients who are highly motivated and see the benefit of participating may be more likely to contribute to interpersonal learning and the group's cohesion through consistent attendance. During these screenings, facilitators also elicit and normalize concerns about group participation and explore barriers to attending the initial session, recognizing that participation in a group may be distressing and knowing that clients' commonly developed isolative behaviors aimed at protecting themselves from further interpersonal harm, may be barriers to engagement.

The Orientation Group has a few exclusion criteria. Guided by language capacities of PSOT clientele, the Orientation Group is currently offered in English and French only, so clients not proficient in either language are screened out. The remaining exclusionary considerations relate to safety concerns associated with severe psychiatric distress and to group composition. Stressed throughout trauma literature, fostering safety is a fundamental element of care for individuals who have endured interpersonal abuse and violence (Fallot & Harris, 2008; Herman, 1997), so efforts are made to promote safety for both individuals and the group, such as inviting clients to share as little or as much about themselves during introductions as

they feel comfortable, co-creating the rules of the group, monitoring members' dysregulation during sessions, and facilitators being available to clients after the session for brief support if needed. Highly vulnerable clients experiencing acute or severe psychiatric symptoms, such as suicidality or psychotic symptoms, are typically referred for psychiatric stabilization prior to Orientation Group. Also, perpetrators of human rights violations are generally ineligible for all PSOT services and are excluded from Orientation Groups.

While there are no other firm exclusionary criteria, member composition is considered with each new group because power dynamics of the tribal, political and social conflicts that lead to clients' persecution and forced displacement can be unknowingly replicated through the group composition when members represent different identities or opposing factions. Some PSOT clients fear encountering another member whose nationality or social group identity is the same as their own, believing that the other person cannot be trusted. Others fear encountering a member whose political ideology, nationality, ethnicity, religion or social group identity is different than theirs because that member represents their oppressor. Recognizing these primarily adaptive fears of similarity and of difference that stem from persecution, facilitators talk to potential members about possible group composition, clients' choice around disclosure during sessions, and efforts made to promote safety and security in the group. When clinically indicated, alternative group assignments for members are considered.

Group structure and content

Originally a weekly, 8-session model, the Orientation Group was shortened to 6 sessions and then to its current structure of 4 sessions that run 90 to 120 minutes each. The rationale for reduction in sessions was multifactorial, with intervention content, staffing limitations, and clients' needs driving the modifications (H. Smith, 2018, personal communication, 3 August). Specifically, facilitators recognized that the content could be condensed; that referrals to the group were increasing; that the group had become a triage point for other mental health services so delayed participation impacted receipt of other care; and that participation conflicted with competing demands such as employment,

child care, and preparing for asylum hearings. Driven by both clinical and organizational constraints, the shortening of the orientation group had several important effects. More clients had access to the orientation group, the curriculum was paired down to what clinicians felt was essential, and there was improved bridging of clients to the treatment team after the group. Additionally, in our experience with the current 4-session model, clients recently accepted to the program have been easier to engage for the group, indicating an additional benefit of the shorter cycle that allows more members to be invited soon after program acceptance, when their engagement in services is typically greatest.

During an interview conducted on 3 August 2018, PSOT clinical director Dr. Hawthorne Smith recounted an experience that led to the removal of one specific content area of the group intervention – the guided visualization regulation skill. In a group session, the facilitator guided clients to envision a safe, calming place, like a gently flowing river, which the facilitator thought to be an innocuous visualization practice. For one client, however, this guided practice led to an activation of acute trauma symptoms when the client visualized dead bodies floating down the Congo River – a memory made more vivid by the practice. While there is some risk in all clinical interventions, the team decided that guided visual imagery was too risky to use in a group with clients not yet very well known to the clinical team.

To help establish safety, group sessions are held in PSOT facilities familiar to clients, in a location that affords privacy, and members are accompanied on the first day from the PSOT waiting area to the group room. The structured, closed-group format of the Orientation Group offers predictability and consistency, which are essential for promoting trust and safety within groups (Bunn et al, 2016; Yalom & Leszcz, 2005).

The content and order of the group topics were designed in accordance with principles of group development theory (Yalom & Leszcz, 2005), the aim for members to gain or reestablish agency and empowerment following their persecutory experiences, and Shapiro's (2012) sequence of four elements of stress reduction – Earth, Air, Water, Fire – which aims to address a person's accumulated external and internal stress triggers through body-oriented work that transitions from the feet, to the stomach or chest, to the mouth or throat, and eventually up through the head (Shapiro, 2009). Building upon survivors' resilience by

enhancing strategies to cope with the stressors of forced displacement (Dombo & Ahearn, 2017) promotes a sense of agency in healing. Coping strategies and use of homework are drawn from Cognitive Behavioral Therapy, which has empirical support with refugee and ethnic minority populations (Paunovic & Öst, 2001; Hinton, Pich, Hofmann & Otto, 2013). Also recognizing survivors' resilience and capacities to self-heal, facilitators have a responsibility to increase survivors' awareness of the roles of 'culture, traditional medicine, spiritual and religious practices, and other internal resources' in helping survivors cope with and recover from difficult experiences of the past (Dombo & Ahearn, 2017, p.109).

Although the Orientation Group is manualized, each group's unique client dynamic requires that facilitators are closely attuned to the needs of the group and flexible in utilization of the manual (Smith et al, 2017). However, aligned with trauma theory and trauma-informed practice, rituals and routine (Substance Abuse and Mental Health Services Administration, 2014) are fostered through the group's standardized session structure – introduction/check-in, review of any homework, interactive didactic component, learning and practicing a coping strategy, homework assignment and overcoming barriers to completing homework, and end-of-session check-in. Following are descriptions of the didactic components and coping strategies of each session (Smith et al, 2017).

Session one

This introductory session focuses on building therapeutic alliance and developing trust through welcoming, self-guided introductions, orientation to the treatment, and collaborative establishment of group rules, norms and expectations (Yalom & Leszcz, 2005). In this session, members learn the psychosocial concepts of Window of Tolerance (Siegel, 1999) and Subjective Unit of Distress Scale (SUDS; Wolpe as cited in Kim, Bae & Park, 2008) as ways to self-monitor and evaluate their arousal capacity and the degree of external and internal distress, respectively. Members learn and practice an *Earth: Grounding* exercise where their attention is directed outwards to safety in the present moment and an *Air: Breathing Regulation* strategy where members are invited to draw their attention to the breath and inwards to their center (Shapiro, 2012).

Session two

In this session, members learn about an interactional thoughts-emotions-behaviors-physical sensations paradigm (adapted from Padesky & Mooney, 1990), common emotional and interpersonal reactions to traumatic events, and PSOT's mental health and psychosocial support services. This discussion helps survivors better understand and reframe what they have been experiencing, it validates and normalizes their struggles, and it provides them with opportunity to support each other (Kira et al, 2012). A staff psychiatrist speaks about psychiatric care and psychopharmacology by exploring culturally-bound beliefs about mental illness and treatment and then discussing what typically occurs in an initial psychiatry appointment at PSOT. Members learn and practice a Thought and Emotion Tracking exercise that is based on the thoughts-emotions-behaviors-physical sensation paradigm. This exercise encourages members to recognize negative thoughts and the associated feelings, evaluate whether these thoughts are helpful, and synthesize what they have learned into an alternative, healthier perspective (McKay, Davis & Fanning, 2007). Additionally, members learn and engage in Pleasant Event Scheduling (PES; Lewinsohn & Libet, 1972), which is a behavioral intervention that has been empirically supported to be effective for treatment of depression (Jacobson et al, 1996; Cuijpers, van Straten & Warmerdam, 2007). In PES, members are instructed to take a proactive approach to distress by planning pleasant activities for themselves, however simple or small, and engaging in such activities with the goal to increase positive integration with their environment and consequently improve their mood (Cuijpers et al, 2007).

Session three

This session focuses on the asylum process in the U.S. and PSOT's immigration and legal services. The majority of PSOT clients apply for asylum (Wilkinson, 2007), so the PSOT Legal Services Manager presents on asylum processes and addresses general legal and immigration concerns. Immigration status impacts employment, health insurance eligibility, and access to resources, and has a significant impact on clients' emotional wellbeing (Wilkinson, 2007), so this group discussion often evokes worry and anxiety in members. Clients who have not yet

applied for asylum or who have pending asylum cases often endorse disempowerment, lack of agency, and overwhelming fear – all feelings that are also commonly reported in clients' persecution narratives.

Group facilitators guide a conversation about distressing reactions during or after the immigration presentation. Curative factors of universality, hope, and imparting of information (Yalom & Leszcz, 2005), are frequently observed during this discussion as members offer first-hand experiences and emotional support to others in earlier stages of the asylum process. Members learn and practice a *Water: Calm and Control* exercise by drinking water or chewing gum to increase the flow of saliva, in order to demonstrate reactivation of the parasympathetic nervous system that shuts off in response to a stress emergency, but can turn on the relaxation response in order to become calmer and more in control (Shapiro, 2012). In this session, members are also introduced to Progressive Muscle Relaxation (PMR; Jacobson as cited in Bernstein, Borkovec & Hazlett-Stevens, 2000), which is a technique for counteracting physiological responses to anxiety. In PMR, members are trained to voluntarily tense and release four major groups of muscles with the purpose of noticing the difference between tension and relaxation, and learning to gain greater control of their own bodily responses (Bernstein et al, 2000).

Session four

This final session focuses on integrating knowledge and skills, processing termination, and planning for further treatment. The group reviews coping techniques, reflects on experiences of the group, speaks about any psychosocial progress since starting treatment, and discusses the group's ending. Terminations can generate strong feelings of loss in individuals with limited support systems who have had unplanned and unwanted farewells (Akinsulure-Smith, 2009), so group members are encouraged to have an open dialogue about their reactions to the group coming to an end, and provide one another with support on saying goodbye.

Yalom and Leszcz (2005) argue that 'the drive to belong can create powerful feelings within groups' (p. 71), which is consistently demonstrated in this fourth session when members reflect on the value of having come together with new 'brothers and sisters' and no

longer feeling alone in their experience. Facilitators and guest speakers describe PSOT's ongoing individual and group services and how to access them. Members learn and demonstrate the final coping strategy through developing and sharing vision boards that portray their future lives, often with themes of family, hope, and justice. The vision board is based upon the *Fire element* strategy which entails lighting up the path of imagination to a safe space (Shapiro, 2012). At the closing of the group, each member receives a symbol of completing the Orientation Group – a silicon bracelet etched with the 4 elements of stress reduction coping strategies learned in the group.

Group facilitation

The Orientation Group is co-facilitated by two clinicians or clinicians-in-training, typically one in the field of social work and one in the field of psychology, and supervised by licensed clinical staff experienced in working with traumatized populations. Aligning with PSOT's interdisciplinary model of care, interdisciplinary collaboration (Petri, 2010) and interdisciplinary co-facilitation (Banach & Couse, 2012) have been found to be helpful for both clinicians and clients. Additionally, co-facilitation provides facilitator companionship that mitigates the intense reactions that facilitators may have to the group (Bunn et al, 2016).

Facilitators recognize the importance of practicing in trauma-informed and culturally-informed ways and of being compassionate, caring and open to addressing all group members' concerns (Smith et al, 2017), as members navigate a clinical intervention that is new to most. Facilitators actively work to safeguard the security, cohesion, and therapeutic value of the group by making efforts to follow up with clients who miss a session, documenting session notes in a medical record system accessible to all hospital treatment providers, utilizing clinical supervision, and attending to co-facilitator, group member, and member-facilitator relational dynamics.

When working with displaced survivors of persecution, it is especially critical to realize the power dynamic that is inherent in the therapeutic relationship as the survivors' feelings of disempowerment resulting from past trauma might be stimulated by the treatment experience in which

the group facilitators may be viewed as an imposing, powerful authority figure (Fabri, 2001). To this end, Fabri (2001) recommends that group facilitators perceive members as teachers and guides, and understand them not only in the context of their experience of torture or trauma but also in that of their cultural and social identities and traditions.

Recognizing the broad impacts of persecution and forced migration and the importance of addressing struggles across ecological systems, service providers from the disciplines of mental health, legal services, and social services join sessions of the Orientation Group as guest speakers in order to normalize struggles following persecution and displacement, to provide up-to-date information about policies and resources, and to begin bridging members to additional PSOT services and to the larger treatment team.

Implementation of the Orientation Group continues at PSOT, and an estimated 50 to 60 cycles of the intervention have been facilitated. The treatment manual is publicly accessible, and programs working with survivors of persecution and trauma are encouraged to adapt the treatment to their setting (see Smith et al, 2017). Professionals across the U.S. have been trained in the intervention through live trainings and webinars, and in 2017, a well-established international non-governmental organization in the humanitarian emergency field expressed interest in implementing the intervention in multiple sites around the world.

Discussion and recommendations

Informed by our years of facilitating and supervising the Orientation Group, we will discuss experiences in its implementation and propose intervention modifications that PSOT and organizations interested in adopting the intervention may want to consider for future cycles of the Orientation Group.

Since the Orientation Group began, resilience theories and research have expanded significantly, including within the refugee services field (Pulvirenti & Mason, 2011; Siriwardhana et al, 2014), but they are not yet incorporated into the Orientation Group manual. Cycles of Orientation Group clients have demonstrated capacity to survive and to heal and a commitment to recovery. For many, the initial

indication of this resilience is their walking into the first group session, despite personal histories of harm by others. Clients then proceed to demonstrate survivorhood by disclosing symptoms of trauma despite the silencing power of stigma and by speaking resolutely about hope for themselves and each other in the final session. More explicitly incorporating exploration and promotion of individual and community resilience into the Orientation Group would align with the group's aim to strengthen coping strategies, resource clients, foster mutual support, and be culturally-informed. Potential intervention modifications that integrate resilience theory include implementing resilience measures alongside clinical symptom measures, incorporating resilience- and strengths-based theory and language into the intervention manual, and selecting a coping strategy or homework assignment that strengthens community protective factors.

As in the general population, survivors of persecution have a range of abilities. Clients with limited literacy, visual impairments and mobility limitations, and clients who are deaf may need specialized support that is not discussed in the current version of the Orientation Group manual (Smith et al, 2017). The intervention relies heavily on both verbal and written communication, and handouts are text-heavy. Also, while many service organizations have interpretation services due to mandate or recognition of their critical importance, clients who are deaf may have unmet needs because American Sign Language (ASL) interpretation may be the only available form of sign language, and it does not meet the needs of all clients. Facilitators have addressed these gaps in creative, ad hoc ways over the years, such as audio recording the homework assignments and drawing images that represent the terminology in the handouts, but adjustments have been piecemeal and modifications are not reflected in the manual. A strategic review of the manual and consideration of additional resources and modifications for people with special needs is indicated.

The trauma and mental health didactic component of the Orientation Group manual covers western constructs of mental health with little discussion of other idioms of distress, beyond the psychiatrist's invitation to clients to share their cultural beliefs about mental health. It is important to orient clients to western mental health indicators because clients engage with U.S. healthcare systems, however, this portion of the treatment could incorporate additional constructs that may align well

with clients' beliefs and experiences and reflect recognition of cultural influences on mental health (Bemak & Chung, 2017). Experienced Orientation Group facilitators typically explore individual, family and community factors and perceptions of suffering following threatening experience, but manual modifications are needed to ensure that this is done consistently by all facilitators. Furthermore, because all members endorse psychosocial struggles, the trauma and mental health topic could be broadened to indicators of psychosocial stress and wellbeing. This session could also introduce available supportive services beyond psychopharmacology and therapy, such as community and cultural centers, religious and spiritual centers, exercise, and education.

Social supports have a valuable mediating role in strengthening survivors' capacity to cope with displacement and the associated stressors (Dombo & Ahearn, 2017). Most Orientation Group members report extremely limited support systems, and many identify PSOT as their only support. Ways to further strengthen the community-building component of Orientation Group need to be considered. Having an optional coffee/tea hour before or after each session would provide clients with additional time together, inviting members to exchange phone numbers or email addresses at the final session could foster ongoing connection, and offering a 'booster' session 2-3 months after the group ends could promote maintenance of the developed skills and relationships. We are always pleased to see clients who entered the group room alone and in silence, then exit sessions in conversation with fellow group members. Additional strategies can be recommended in the manual and also developed with each new group.

Lastly, research and evaluation are two important areas of discussion and recommendation for the Orientation Group. Evidence-based practice is establishing a stronghold in mental health and psychosocial fields, and there is need for more evidence-supported treatments in refugee care (Başoğlu, 2006). While there is anecdotal practice-based evidence from clients and facilitators that the Orientation Group has benefited participants and that participants seem better equipped to access and navigate other program services, we are unaware of any empirical study of the Orientation Group. The field is seeking more empirical support for interventions designed for displaced survivors of persecution (Alfadhli & Drury, 2016; McFarlane & Kaplan, 2012), and a study of this intervention in a leading torture treatment program or

a multi-site study of the intervention at additional agencies that have adopted the intervention, would be eagerly received by practitioners across the country.

Evaluation measures have not been utilized specifically for the Orientation Group. Depression and PTSD measures administered at the time of intake to the program and then again at clients' 6-month follow-up assessments consistently reveal improvements in symptoms for most clients, but these are not administered as pre- and post-measures for the Orientation Group. The narrative of the Orientation Group's development and continuance is a common one in the humanitarian field – an organization struggles to meet identified needs of its clientele, it develops a service that is informed by clinical expertise and is feasible with the currently available resources, then it has limited capacity to closely monitor and evaluate the effectiveness of the intervention, but it continues the intervention because of good anecdotal accounts from clients and clinicians. At PSOT, positive verbal feedback from members, facilitators, and supervisors about the group's value has been sufficient to maintain the intervention for 15 years. Its significant impact on clients is subjectively reflected in clinician reports of changes observed in clients and in client self-reports. For example, clients have described feeling relaxed for the first time since their persecution after practicing stress reduction exercises learned in the group. A client described her rekindled hope that her aspirations can still be achieved, while sharing her vision board in a final Orientation Group session. Clients have reported using emotion regulation skills learned in their Orientation Group when testifying in immigration court for asylum. Two clients in an ongoing therapy group at PSOT, reflected on the first time they met each other during an Orientation Group years prior and the pivotal role that the group had in sparking what had become an important, supportive friendship. Systematically capturing reactions to the group and experiences during and after the group through evaluation methods with the clients and facilitators is strongly recommended.

Conclusion

Impacts of persecution and forced displacement are broad, but the points of entry to care and the potential supportive responses are also vast. As we move away from pathologizing human reactions to inhumane events, more interventions that aim to promote psychosocial wellbeing are needed. The Orientation Group, developed and implemented at the Bellevue/NYU Program for Survivors of Torture in New York City, is one such intervention that aims to strengthen survivors' wellbeing through building connections, facilitating access to information, and enhancing distress management skills. This reflective account of the Orientation Group highlights important themes seen across services for displaced survivors of persecution – survivors exhibit both great need and remarkable strength, psychosocial approaches need to align with the complexities of the population, and evaluation strategies and empirical studies are needed to ensure that interventions promoting psychosocial wellbeing are effective. Survivors, practitioners, and agencies stand to benefit when successes in mental health and psychosocial services for survivors of persecution are widely shared. As clients and clinicians come together in the healing process, their insights will continue to inform us of the power of groupwork.

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