"I Feel Like I Am Finding Peace": Exploring the Use of a Combined Art Therapy and Adapted Seeking Safety Program with Refugee Support Groups

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Abstract: *This paper describes the creation and implementation of a trauma support group intervention which combined aspects of the Seeking Safety model with an art therapy technique in an effort to reduce trauma-related symptoms in a population of refugees. A preliminary assessment was carried out to evaluate the potential effectiveness of the combined approach with trauma-exposed refugees. Based on facilitator notes from 8 sessions of two women's refugee groups and one men's group, three themes were identified: mandala creation enhanced the Seeking Safety content, language barriers impacted the potential for implementation, and the trauma support group was a means of personal growth for participants. Reports from facilitators and participants also suggested a reduction in trauma-related symptoms and an increase in participant use of safe coping skills as a result of group participation. While additional research is needed, these exploratory results suggest that this combined approach holds promise for positively impacting trauma symptoms in trauma-exposed refugees.*

Keywords: *Seeking safety; mandala; art therapy; PTSD; trauma-exposed refugees; trauma symptoms*

By the end of 2014, 59.5 million individuals had been forcibly displaced around the world because of persecution, violence and conflict. Approximately 19.5 million of these people were refugees (United Nations High Commissioner for Refugees [UNHRC], 2015). It is estimated that, in the United States alone, there are 267,222 refugees/people in refugee-like situations, and an additional 224,508 asylum seekers (UNHCR, 2015). And, refugees are continually arriving. Given the increasing number of refugees coming to the United States, there is an increasing need for services and interventions to address their unique concerns—particularly around mental health.

The recommended treatments available for refugees who have been exposed to trauma include cognitive behavioral therapy (CBT), testimonial psychotherapy, eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (Ehntholt & Yule, 2006). However, these interventions are not appropriate for every client, and more research examining treatment options for trauma-exposed refugees is needed (Ehntholt &

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Yule, 2006). It is also possible that some combination of existing techniques could be appropriate for interventions with refugees, but few possibilities have been explored to date.

One intervention that has shown promise with trauma-exposed populations is *Seeking Safety*, which is a type of CBT that is present-focused and appropriate for those with post-traumatic stress disorder (PTSD) and other comorbid disorders (Najavits et al., 2013). This technique has shown promise in impacting PTSD and substance use symptoms in adolescents, veterans, and incarcerated populations, which are populations commonly exposed to trauma (Boden et al., 2012; Najavits, Gallop & Weiss, 2006; Zlotnick, Najavits, Rohsenow, & Johnson, 2003). The possibility of adapting this technique for use with trauma-exposed refugees warrants exploration.

Also of interest are mandalas, circular art forms that Carl Jung asserted in 1973 could have calming and centering effects on those who used them (Slegelis, 1987). As such, mandalas have been adapted into colored "feeling wheels" and employed as art psychotherapy techniques (Slegelis, 1987; Sorkes, 1991). The literature suggests that the use of mandalas may be promising in the reduction of anxiety, and there is evidence of their effectiveness as a part of art therapy with pediatric oncology patients (Curry & Kasser, 2005; Sorkes, 1991). Mandala art therapy is considered a promising art therapy technique for addressing a variety of symptoms in various age groups. The associated calming effects make it particularly appropriate for use with trauma-exposed clients (Slayton, D'Archer, & Kaplan, 2010).

Given the promise of both *Seeking Safety* and mandala creation in terms of intervening with trauma, anxiety and comorbid symptoms, it seems plausible that combining these techniques might be a natural fit for working with trauma-exposed refugees. Despite the potential promise of these techniques with trauma-exposed populations, to our knowledge, there is no documented information in the literature that explores the use of this technique with trauma-exposed refugees. Thus, the purpose of this paper is to describe the exploratory use of *Seeking Safety* adapted with mandala creation for the purpose of reducing trauma-related symptoms in groups of trauma-exposed refugees.

Review of the Literature

It is well established in the literature that refugees and asylum seekers are likely to have a trauma history. Many are exposed to extreme stress and multiple traumatic events such as forced migration, torture, rape, injury, starvation and/or the witnessing of the death of friends and family members (Lambert & Alhassoon, 2015; Palic & Elklit, 2011). Further, refugees are also likely to experience an array of new stressors during travel and upon their arrival in new countries, including separation from family and friends, exposure to disease, refugee camps, problems assimilating in new cultures, difficulty obtaining asylum status, housing problems and social isolation (Lambert & Alhassoon, 2015; Shannon, Wieling, McCleary, & Becher, 2015).

Exposure to various traumas compounded by psychosocial stressors has implications for the overall mental health of refugees and asylum seekers. The prevalence rate of PTSD in the refugee and asylum seeker populations varies in the literature depending on the

population of interest. However, research suggests that refugees are 10 times more likely than the general population to have PTSD and PTSD, depression and substance use have been found to be the most common mental health conditions in populations exposed to mass conflict and displacement (Delker & Freyd, 2014; Fazel, Wheeler, & Danesh, 2005; Steel, 2009). More specifically, researchers have reported various symptoms of PTSD and depression in trauma-exposed refugees, including separation anxiety, worrying, poor concentration, disorientation, flashbacks, nightmares, hypervigilance, violent outbursts, crying, anhedonia, suicide attempts and using substances for coping (Dupont, Kaplan, Verbraeck, Braam, & van de Wijngaart, 2005; Shannon et al., 2015; Tay, Rees, Kareth, & Silove, 2016).

Treatment and Challenges

Studies of therapeutic interventions specific to trauma-exposed refugee populations are limited (Nickerson, Bryant, Silove, & Steel, 2011) and include variations of CBT, EMDR and Narrative Exposure Therapy (NET, Lambert & Alhassoon, 2015). According to a systematic review done by Palic and Elklit (2011), refugee-adapted NET and culturally-sensitive CBT for Southeast Asians have the strongest evidence of effectiveness.

Despite existing evidence of potentially beneficial treatments, there are still challenges in treating PTSD in the refugee population. This population may not speak English well, or at all, and may have additional unique barriers, including: educational deficits, problems accessing services, cultural differences that impact treatment, stigma and fear associated with mental health issues and treatments, lack of confidence in treatment, fear of being perceived as unstable, a desire to hide mental health symptoms, and lingering effects from political oppression (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012; Shannon et al., 2015). Shannon and colleagues (2015) further assert that those who have experienced trauma from political strife and oppression may have difficulty talking about their experiences and symptoms, and they may require more time to trust and feel safe. Such findings have implications for traditional trauma-focused therapies that rely heavily on the client talking about and processing their experiences.

Additionally, concerns exist around exposure techniques, which are central to treatments like NET and CBT. Exposure may not be well tolerated by refugee populations and can be difficult to use because they are often aimed at only one traumatic experience when refugees often have complex, intersecting trauma histories (Hinton et al., 2012; Lester, Resick, Young-Xu, & Artz, 2010; Palic & Elklit, 2011). Further, Nickerson and colleagues (2011) argue using CBT to treat PTSD in the refugee population can also be challenging because it is based heavily on extinction learning, which assumes the treatment is occurring after the threat is over. Unfortunately, refugees often receive treatment while still facing real threats such as living in confinement, living in refugee camps, or living with the uncertainty of gaining legal status in their new country (Nickerson et al., 2011). As a result, there is a need for further research of novel, culturally-sensitive adaptations of empirically-supported treatment approaches to meet the needs of the refugee population (Hinton et al., 2012; Nickerson et al., 2011).

Seeking Safety

Given the need to expand treatment offerings for trauma-exposed refugee populations, treatment techniques that have not been previously used with this population need to be explored. One such option is *Seeking Safety*, which is a present-focused form of CBT treatment originally designed for individuals with comorbid PTSD and substance use disorder (Najavits et al., 2013). *Seeking Safety* helps individuals establish a greater sense of safety through psychoeducation and the use of effective coping skills (Najavits, 2002). Positive results in both individual and group formats have been demonstrated, with a wide variety of clients who have both diagnoses, one of the two diagnoses, as well as those that have symptoms not severe enough for either diagnosis (Brown et al, 2007; Lynch, Heath, Matthews, & Cepeda, 2012; Najavits, 2002, 2009).

Seeking Safety has 25 independent topics that can be flexibly applied in any order depending on the needs of the clients and the treatment timeframe allotted (for sample curriculum see Najavits, 2002). Although to our knowledge there is no existing literature documenting the use of *Seeking Safety* with refugees, various aspects of the model lend itself well to the unique treatment challenges of the trauma-exposed refugee population. Given that there is evidence that traditional exposure-based therapies might not be as effective for refugees with PTSD, as previously mentioned, a PTSD intervention that is present-focused and emphasizes the use of coping skills and psychoeducation was needed. Thus, *Seeking Safety* was adapted for this population, given that it has been shown to be flexible and adaptable for a variety of groups, which potentially lends itself to being adapted to the specific needs of the refugee population as well.

Art Therapy/Use of Mandalas

The use of art therapy as a treatment for different types of trauma allows space for individuals to explore various thoughts and feelings in a non-threatening way by removing focus on self (Naff, 2014; Skeffington & Browne, 2014). However, evidence suggests that art therapy seems to be most effective in combination with trauma-focused interventions (Naff, 2014; Schouten, de Niet, Knipscheer, Kleber, & Hutschemaekers, 2015). Not only is the combination more effective in comparison to art therapy as a standalone intervention, a review done by Schouten and colleagues (2014) found that trauma-focused psychotherapy in combination with art therapy was more effective in reducing trauma symptoms than a trauma-focused psychotherapy control group. Given the need for innovative and culturally sensitive ways to adapt treatment for refugees, combining evidence-based treatments for PTSD with art therapy may be useful in addressing trauma symptoms in the refugee population. Thus, adapting a trauma-focused therapy like *Seeking Safety* to include aspects of art therapy may help refugees begin to process feelings and thoughts around their trauma in a safe space until they are more comfortable or able to verbalize them.

The creation of mandalas is commonly used in art therapy (Stinley, Norris, & Hinds, 2015). Henderson, Rosen and Mascaro (2007) argue that the mandala is a task particularly suited to individuals with a trauma history, as it functions as a symbolic representation of difficult emotions while also providing personal meaning, order and integration. Mandalas

have also been found to decrease anxiety, distress and negative mood state (Babouchkina & Robbins, 2015; Stinley et al., 2015; Van der Vennet & Serice, 2012).

After considering the unique challenges of working with refugees who have PTSD, the need for innovative treatment approaches, and the strengths of both *Seeking Safety* and mandala creation, a trauma support group for refugees was created by adapting *Seeking Safety* and integrating it with mandala work. The purpose of this paper is to describe the trauma support group modality and the facilitators' experiences implementing the adapted *Seeking Safety*/mandala technique with three different groups of trauma-exposed refugees.

Description of the Intervention

Participants and Group Formation

Participants in the trauma support groups were adults currently residing at a nonprofit humanitarian organization in Western New York that provides food, shelter, clothing and legal assistance to refugees seeking protection in the United States or Canada. All participants volunteered to participate in the trauma support group. Participants were screened into the program by an LCSW, who used the Dissociative Experience Scale (DES; Carlson & Putnam, 1993), and the Post Traumatic Checklist (PCL; Blanchard, Jones-Alexander, Buckley & Forneris, 1996) as a guide for determining participant goodness of fit for the group. The LCSW considered factors such as motivation, country of origin, gender, and levels of PTSD symptoms. Individuals who experienced DSM-IV-TR, (the version of the DSM in use during the time that this intervention was conducted) symptoms of PTSD that they themselves believed were related to current and/or previous trauma were ruled in for inclusion. Individuals with dissociative symptoms were screened out.

Gender specific support groups were created and clients were referred to the groups based on several factors, including: similarity in countries of origin and availability of agency support services outside of the group. Groups were closed after the second session, in order to promote a sense of trust. One group of four women and another with three men was offered in 2014, with an additional group with 11 men was offered in 2014. Some participants missed a session due to illness or appointments. At least one group facilitator or group participant was skilled in translation in the participants' native language.

Intervention Techniques

Adapting *Seeking Safety*. With Najavits' (2002) (the original developer of the *Seeking Safety* curriculum) permission, treatment topics from *Seeking Safety* were modified into an eight-week trauma support group. The sessions mirrored *Seeking Safety* with regard to structure of content and time allotted for each session, activity and discussion, and session length. Also consistent with *Seeking Safety*, each session opened with a "check-in" to ask how participants were doing and what pressing needs participants wished to prioritize, and to allow participants to share brief examples of good coping they used since the previous session (Najavits, 2002). The facilitators then presented the *Seeking Safety* quotation for that week's treatment topic to stimulate the discussion, provided psychoeducation around that week's topic, discussed how the topic related to the participants' lives, and checked-

out at the end by having participants describe benefits of the session and then describe the new commitment for the following week (Najavits, 2002).

The facilitators chose eight of the original 25 *Seeking Safety* treatment topics based on the intended purpose of the group, which was to address trauma, encourage coping skills, help participants build their own tools for coping, help participants understand trauma and its impact, encourage self-reliance and provide a safe space for participating. The following topics were covered: *Taking Back Your Power; Detaching from Emotional Pain; Grounding; Compassion; Creating Meaning; Coping with Triggers; Healthy Relationships; and Self-Nurturing* (Najavits, 2002). For the full list of treatment topics, see Najavits (2002).

While several topics overlapped in the three separate groups, the topics chosen, the order they were presented in, and the number of sessions spent on each topic was based on the needs of the group. The *Safety* and *PTSD*: *Taking Back Your Power* topics were considered key to moving forward with subsequent topics, so these were covered first in all three groups. More than one session was allotted to these topics if the facilitators could not cover all the material in one session. The other treatment topics were chosen based on the number of remaining sessions and were tailored to the needs of the group. Group needs ranged from needing more information about PTSD to enhancing skills for functioning in day-to-day life. Treatment topic handouts from the *Seeking Safety* manual were modified to make the language easier to understand for those who had difficulty with English. Text-heavy handouts were condensed, pictures were added, and the language in more complex topics was purposely simplified.

Use of mandalas. The *Seeking Safety* treatment groups were further adapted by adding an art therapy component in the form of mandala creation to each session. The mandala was purposely chosen as the form of art-making so participants could create their own meaning for their experiences using creativity and self-expression through the use of words, pictures, symbols, and colors. Mandalas also lend themselves towards facilitating transfer of emotions into the art form, and result in a tangible product at the end of each session so participants can gauge their progress, even for those not participating in other forms of group sharing during the session. Ultimately, the mandala is intended to be uniquely meaningful for each participant. Unique meanings for each individual evolve through the creative process.

The Intervention Team

The team was supervised by one LCSW and two student facilitators. The team received six hours of mandala specific art therapy training from a certified art therapist. The training informed the facilitators how the mandalas were to be integrated into the adapted *Seeking Safety* material.

The Intervention Process

During the first session of the trauma support group, participants were given an overview of the mandala, and were encouraged not to comment on each other's work. Facilitators also emphasized to participants that the process of getting their feelings out

was more important than the product itself. In-between the discussion of content and the check-out of each session, group participants were given between 15 and 20 minutes to create a mandala based on the topic for that session. Participants were provided with pre-cut circles in different colors, magazines, markers, pencils, crayons, stencils, staples, tape, glue, fabric, and scissors in order to make their mandala in any way they chose. Soft background music accompanied the mandala creation time. Participants were then invited to share their mandala and its meaning with the group if they felt comfortable doing so.

In the first session of all three groups, participants were instructed to create a mandala that represented them or told a story about them. Depending on the topic used for subsequent sessions, participants created mandalas around themes of safety, reclaiming personal power, self-compassion, and self-nurturing. An additional mandala activity on the topic of grounding was offered and facilitators provided participants with a pre-made, blank mandala. Participants were instructed to choose a mandala, to select colors, shapes, images, sizes, and materials, and to notice the process of creating something beautiful while focusing their senses on the mandala. Participants could also add pictures or words if they chose to. The mandala activity for the final session had participants reflect on coming "full circle" by asking them to take out their mandala from the first session. They were asked to create a mandala that represented who they were that day and where they were on their healing journey overall. Each participant was provided with one wedge of a full circle in this session, so the facilitators could collect the wedges to make a group mandala. Figures 1 and 2 show examples of mandalas created in the women's group.

Figure 2- Example mandala

Figure 1 - Example mandala

Preliminary Observations

In order to assess whether the adaptation of *Seeking Safety* with the use of mandalas seemed to be helpful for participants, the three facilitators were asked to write up detailed progress notes after each session. Facilitators noted the goals for the session using the adapted model, the content covered, their affective experience and thoughts around what happened during the session, what went well and what could have gone better, and what the participants took away from each session. The progress notes also included quotes and descriptions of what group participants thought of each session and of the group overall.

After all sessions were completed, a member of the research team examined the progress notes from each facilitator and extracted common themes around the group members' and facilitators' thoughts, feelings and experiences about the group. Common themes were identified as those that were mentioned by at least two different facilitators. The progress notes were then re-examined in order to track how many times each of the common themes were mentioned throughout all of the progress notes. Common themes that were mentioned at least three times were grouped together into major themes. Table 1 below depicts the themes and subthemes.

Table 1. *Identified Themes and Subthemes of the Trauma Support Group*

1. Mandala creation enhanced the *Seeking Safety* material
• Mandalas were a symbol of personal reflection and meaning. (11) • Participants were actively engaged in mandala creation. (10) • Participants wished to create/created mandalas outside the group as a coping skill. (6) • Mandalas were a way to express difficult feelings and thoughts. (5)
2. Language barriers posed important considerations
• Extra time was required for translation. (9) • Needed to use more deliberate, simple and concise language. (6) • Concern that those who struggled with English benefitted less from the group. (6) • Tension between covering the material and ensuring concepts were clear. (5) • Facilitators found some topics difficult to explain. (3) • Group felt fragmented due to translation occurring while content was delivered. (3)
3. Trauma support group was a means of personal growth
• Participants reported personal growth as a result of the group. (9) • Participants talked about using what they learned to help others/wanting to help others. (4)

Note: Numbers in parentheses indicate the frequency of each sub-theme as noted by group facilitators.

Facilitators were also instructed to note any anecdotal reports from participants about the impact of the trauma support group. Participant quotes from the progress notes were grouped into two overarching categories: reduction of symptoms and use of safe coping skills. Examples of these quotes are presented in Table 2.

Limitations

This paper details the results of a case observation and is not a formal study. The adaptation of the model was created to offer additional techniques to help the trauma-impacted group to further process their trauma experiences. Participants were volunteers and the observed outcomes were practice observations and not conclusions from a study designed with formal research principles. Therefore, more research in this area is needed.

While the technique seems to have been promising for this one group, we cannot assume that the positive process that was observed will transfer to other groups, or that it will be maintained over time. We also did not conduct a formal follow-up to determine the

long-term impact of this intervention. Because this was an actual treatment group being observed, there was only one facilitator available to observe and record the reactions of the group. Future studies of this adapted technique should employ multiple raters to allow for inter-rater reliability when recording and categorizing the observations. Moreover, we recommend recording the therapy sessions to allow a supervisor to review sessions with facilitators and give them feedback, thus enhancing their training. Formal recording of sessions would also permit study personnel to measure fidelity to the intervention.

It is unknown if the positive effects observed were attributable to the intervention or attributable to some other form of therapy the client was receiving, and therefore future research studies should take this into account in their design. A pre-test/post-test research design where participants are randomly assigned to groups would allow the exploration of the impact of the specific intervention. If this is done, the research design should use clinicians who are blind to the subjects' trauma status.

Table 2. *Anecdotal Participant Reports as Reported by Observers*

Reduction of Symptoms	Use of Safe Coping Skills
• "I feel so happy…I feel like I am finding peace" (description of what was overheard) • Sleeping better, feeling better, focusing better and feeling happy • Slowly trying to let men back into her life again • Blood pressure has gone down • Feels free and "so good" • Helped her love and engage in life fully again • Comfortable with telling her story to others without crying	• Truly thinking about safe coping skills • Did some grounding techniques right before she attended her doctor's appointment • Learned that one can have power over one's emotions and safe coping skills • Using positive, safe coping (including going to the gym, surrounding self with positive people rather than being isolated, reaching out to supports) • Expressed she was able to deal with memories of her trauma by going out with friends, talking with people she trusted and doing positive self-talk

Discussion

Initial results of this exploratory evaluation suggest that there is potential for this adapted version of *Seeking Safety* with the inclusion of mandalas to reduce trauma symptoms in refugee populations. Given that *Seeking Safety* has improved symptoms in other trauma-exposed populations and that mandalas are considered a flexible means by which participants can safely express and explore their own experiences (Boden et al., 2012; Lynch et al., 2012; Parris, 2008), these outcomes are not surprising.

Our observations are consistent with Gerteisen (2008) who found that mandala art therapy was useful for impacting trauma symptoms in children, as it facilitated non-verbal expression at the child's own comfort level. Non-verbal expression was also a goal of the current intervention, which was one prominent reason for originally integrating mandalas with this *Seeking Safety* adaptation.

These preliminary results are also consistent with literature regarding the effectiveness of art therapy for treating trauma, which concluded that the use of trauma-focused mandala drawing in art therapy was associated with a reduction in trauma symptoms in adults (Schouten et al., 2015). Additionally, Allen (2011) found that mandalas were useful in impacting severity of PTSD symptoms, anxiety, and physical health issues in college students.

Directions for Future Research

Future research efforts should be directed towards examining the effectiveness of this adapted technique with various refugee populations over time. The development of fidelity measures such as a client self-report survey, semi-structured interviews and/or evaluation of the model through observations or video recording would further clarify and validate the dynamics, implementation, and effectiveness of the model. Further, a training manual and means of coaching practitioners using the validated fidelity measures is also needed. Future studies can be designed to assign some participants to the adapted *Seeking Safety* group and others to a standard treatment group to allow comparison of which groups facilitate the greatest reduction of trauma symptoms.

Conclusion

Trauma-exposed refugees are diverse in background and experience and may suffer from a wide variety of trauma symptoms. Currently established treatment protocols may be useful for some refugees, and not as beneficial for working with others. As such, innovative treatment modalities must be explored in greater detail, which was the purpose of the treatment adaptation presented in this paper. We recommend that social workers who practice with trauma-exposed refugee populations consider incorporating art therapy and the *Seeking Safety* content into group treatment sessions, given the potential for reducing trauma symptoms and the relative low cost of integrating this approach into existing programming.

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