2018

When There Are No Therapists: A Psychoeducational Group for People Who Have Experienced Social Disasters

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Brief Biography

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Introduction

When a disaster strikes, there are often distressing and destabilizing consequences for people, including symptoms of trauma. Although most people who have experienced a disaster will not develop post-traumatic stress disorder (PTSD), many will have trauma-like symptoms (Miller, 2012). These include emotional flooding, repetitive thinking about the traumatic event, avoidance of trauma-inducing stimuli, hypervigilance, a pervasive sense of dread and hopelessness and triggers which activate the traumatic symptoms. But when a natural disaster strikes, such as an earthquake or tsunami, or a technological disaster such as a collapsed dam or a wildfire, there is often a beginning and an end to the disaster.

A disaster usually refers to an event marked by destruction, death, physical injury, and human suffering that causes permanent change to human societies, ecosystem, and the environments (Braga, Fiks, Mari & Mello, 2008). The classic typology of disasters is typically three-fold: natural disaster, technological disaster, and intentional disaster or complex disaster (Halpern & Tramontin, 2007; Miller, 2012; Rosenfeld, 2010). Natural disasters include floods, hurricanes, earthquakes and tsunamis, etc. Technological disasters refer to human negligence that leads to collapsed buildings or mines, toxic chemical spills or nuclear plant meltdowns. Complex or intentional disasters signify acts of terrorism, armed conflict, ethnic cleansing, and genocide. Complex disasters have some unique features: someone is intentionally trying to hurt someone else through the threat of further conflicts, war, or terrorist attack, which makes it more difficult and

complicated for innocent survivors to heal and recover. In reality, there are not always clear distinctions between types of disasters; when a hurricane or earthquake strikes, the impact is magnified by poorly constructed schools, dams that collapse or levees that break.

Social Disaster: An additional conceptual category

We propose a fourth type of disaster - social disasters, which receive less attention in disaster practice and theory and yet have similar consequences to complex disasters. The objectives of this paper are to describe the unique characteristics of social disasters, and to describe a psychoeducational group model, field tested by the authors and to be used when there is an absence of professional social workers and therapists, to help targets of social disasters to recover. We define social disasters as politically and socially precipitated catastrophes, such as the Cultural Revolution in China or the internment of Japanese Americans in the United States during the Second World War; when people are targeted due to some aspect of their social identities and suffer oppression, and persecution, either at the hands of the state or through institutionalized social practices, such as racism. Like complex disasters, victims are aware that there is a threat and often experience a lack of safety, anxiety, and hyper-alertness. While natural disasters tend to expose large populations to threats, that are not limited to certain social groups (Braga et al, 2008), social disasters very much affect members of targeted social groups. And unlike other types of disasters, the injurious effects linger because the threats are recurring.

Carter (2007) has explored the notion of "race-based traumatic stress injury", which stems from facing ongoing threats and a sense of not being in control, while facing

discrimination, harassment or chronic disempowerment. Symptoms include intrusion, arousal and avoidance, often accompanied by self-blame. McCrea, Guthrie, & Bulanda (2015) have described the trauma-like symptoms for youth living in poor, socially isolated neighborhoods, where risk is high and social support and validation are low. Extrapolating from social norm theory, social disasters have differential impact because they appear normative to those who have power and privilege but are devaluing and denigrating to those who are the targets of oppression (Pratto & Stewart, 2012). And social dominance theory describes how groups in power strive to retain their privileged position in society through laws, resource hoarding and social practices, at the expense of groups lacking privilege (Pratto & Stewart, 2012). Terrorism or armed conflict increases the threat of being shot or stabbed, social disasters, while also carrying such threats and raising the specter of social submission through thousands of psychic paper cuts, institutional and interpersonal, such as through microaggressions, ongoing, "normalized" interpersonal assaults on targeted people (Miller & Garran, 2008; Solorzano & Yosso, 1999; Sue, 2010).

While there are many dimensions to social disasters, we would like to highlight three factors: 1). the devaluation of identity, for example, for being Queer or a person of color; 2). being the target of bullying, violence, and often state-sanctioned surveillance and punishment; and 3). ongoing threats. Social identity theory describes how people have intersecting aspects of their identity – e.g. race, ethnicity, gender, sexual orientation – and that each of these identities carry either privilege or may be socially targeted (Miller & Garran, 2008). Different aspects of social identity interact in a process referred to as 'intersectionality', sometimes leading to internal struggles and contradictions as a

person constructs their sense of self.

Social identity is a concept that includes one's internal view of oneself, say as a woman, and how this view is socially performed, perceived, and valued, as well as how one experiences the perceptions and behaviors of others. Identities are unstable and fluid, socially constructed and sensitive to context. For example, a Han Chinese immigrant to the US from China may have an internalized sense of being a member of a dominant ethnic group with social power and privilege in China, but in the US becomes the target of racism as a Chinese immigrant, socially constructed as a person of color. This experience can cause pain, confusion, and even traumatic symptoms, depending on the level of hostility and devaluing experienced when assuming the new social identity.

Targeted social identities mean that people are vulnerable to assaults or attacks and state violence (such as the murders of young black men by white US police officers or the arrest of the human rights defenders in a range of countries). Identity-based oppression includes experiencing a pervasive lack of social mirroring and validation, which lowers self-esteem and resilience and heightens the level of perceived social threat.

Often, people who are the targets of social disasters push back and advocate for their human and social rights. But this can lead to additional state punishment, such as surveillance and imprisonment, which can be a further cause of trauma. For example, advocating for LGBT rights in certain countries entails risks of retaliation from state and non-state actors. The pressures from facing such threats can cause tension and dissension within groups and also foment acts of betrayal by group members and their allies, so that trust further erodes and a sense of vulnerability and lack of safety escalates.

The threats from social disasters do not go away easily. Hyper-vigilance is not

only an understandable response to social disasters but a rational one as well. If one lives in a place where members of one's ethnic group are attacked, the threat of further attacks is ever-present; if advocating for the human rights, civil rights, labor rights, or women's rights this can lead to state surveillance and imprisonment.

Lastly, many people who suffer from social disasters do not have access to formal counseling and therapy. This can be because there are few clinical resources available to them or therapy is culturally or socially not a normative response for people who are suffering. There can also be risks for people targeted by social disasters when they seek counseling help: this can be used against them to discredit them and there is often a compromised sense of safety for both the client and the clinician.

In summary, we argue that social disasters can lead to symptoms, similar to other disasters, but that unlike most other types of disasters the threats that caused the trauma and the conditions which undermine trust and foment betrayal, continue to exist. Though natural disasters also have long-term social impact, which can further marginalize certain groups (such as African Americans after Hurricane Katrina), it usually will not happen again, at least for a certain amount of time. Given the social devaluing in social disasters intrinsic to symptoms of stress and trauma, a deficit oriented approach can further undermine the confidence, self-esteem and hope of those who have been targeted. A strengths-based approach is therefore important, one that fosters resilience, a sense of self-determination and efficacy, and increases confidence and optimism (McCrea, et al, 2015).

Thus we have been working on developing a model of a psychoeducational group as a way of helping people who are the targets of social disasters as an intervention that

offers social support, alleviates and manages stress and trauma symptoms and draws on the sources of strength and resilience of group members as they gird themselves for further violations of their human rights and dignity. As we will describe the model and its use as a pilot project with people who have experienced social disasters, we also will be vague about specific details, which will be disguised, including the nature and location of the social disaster as the threats to the well-being of group members continue to be present.

A Group Model to Respond to Social Disasters

As we have argued, given the dynamics of a social disaster, it is important to utilize an approach that cultivates client resilience and strengthens social support. Strengthening client resilience is important for any method that helps people to recover from disasters (Miller, 2012) and social connections and networks are particularly salient because social disasters target categories of people; thus strengthening social solidarity and cohesion is an important way of mitigating the divisive effects of the social disaster. Also, trauma and other negative consequences that accrue from being the targets of a social disaster are in some ways a response to a breakdown in social relationships and trust; groups are a helpful way to rebuild trust and repair ruptures in relationships (Smith, Bernal, Christman, Whitt, Christman, Donnelly, Wheatley, Guillaume, Nicolas, Kish, & Kobetz, 2012; Kukihara, Yamawaki, Uchiyama , Arai , & Horikawa, 2014). Positive social networks foster better health and well-being increase levels of hope, optimism, self-esteem and self-care practices (Christakis & Fowler, 2009). It is normal for people who have survived extreme violence to feel alone, isolated, mistrustful and alienated from other people (Bragin, 2007). Being in a group where others have experienced the

same social threats offers greater social support and attachment.

A psychoeducational group offers the potential to teach participants about the social, psychological and neurobiological components of stress and trauma while also facilitating sharing, learning from other group members and offering social support inside and outside of the group. This fosters a sense of safety and security, which is an important foundation for healing from trauma. Participants can learn about ways of responding to trauma that are explicitly linked to their lived experiences and explore their own reactions, including successful and unsuccessful self-attempts at managing their symptoms. And by de-emphasizing the need for a therapist and emphasizing the strengths among group members, such groups can foster peer leadership, whereby group members can learn skills which they in turn can use to facilitate other groups for people suffering from similar social disasters. Adopting a strength perspective, this group both normalizes typical reactions to social disasters while offering group members a sense of autonomy, efficacy and empowerment. Of course any risks from using such an approach (such as emotional contagion or flooding) need to be thoughtfully considered and the maxim of "do no harm" should be front and center.

We recommend that such groups be held with people who either already know one another or have a lot in common so that trust is easily established and the focus of the group can be on experiences common to all of the members. This also makes it easier for insights and learning gleaned from the group to be reinforced and practiced outside of the group. While it is important for the group facilitators to have ideas about content and a structure, flexibility is essential. Ideally, there is interaction and negotiation between group members and facilitators about the way the group will be conducted and what it

will cover; this is an empowerment model, which views participants as co-constructors of the group. Since self-disclosure and discussion about individual strategies to respond to social disaster-induced trauma are important parts of the group process, an ideal number of group members is 6-12, with two facilitators; enough participants to form a critical mass but small enough to have intimate, focused, trusting discussions. Having two facilitators makes it possible for one facilitator to be available to leave the room for a one-on-one discussion with a group member if they are emotionally triggered and temporarily struggling with remaining in the group. It is also important that the membership of the group is closed so that intimacy and trust can evolve. Usual norms for such groups, such as confidentiality, voluntary participation and respect for all group members should be developed and agreed upon by group members. We recommend that the minimum number of sessions for the group is three while having an indefinite number of further sessions is fine should group members want this. Sessions should be scheduled for about 2-3 hours to allow sufficient time for emotional expression, sharing stories, and teaching concepts and techniques and self-care strategies.

With these recommendations in mind, we will now describe the structure and content of three sessions, using examples from an actual group intervention. The example is of a group of native LGBT activists who were experiencing the effects of a social disaster in an East African country where it is illegal to be LGBT. There were a total of 7 LGBT activists in the group: two were gay, four were lesbians, and one was a transgendered man. They had all known each other before joining the group and many of them had been suffered from constant harassment from the police. Two of them had been detained by the government more than a month because of their activism and this

detention having strongly impacted on all group members. The group was facilitated by two social workers, and a total of three sessions, held at bi-weekly intervals, were conducted over one and a half months. The group was defined as a psychoeducational group with the goal of helping the group members discuss and process reactions to stressful events, learn what can cause these reactions, receive feedback and validation from group members, and develop effective self-care strategies that drew on the collective group wisdom. The group was also framed as a 'training of trainers' model, so that group members could teach friends and colleagues who suffered from similar predicaments the skills learned in the group.

Session One: Talking about Stress and Trauma Reactions Openly

In this session, the goals are to introduce group members to one another, establish the purpose of the group and to begin to share knowledge about social disasters and trauma, while beginning to have group members share their experiences and possible symptoms (see Figure One).

The first exercise can be about social identity and to have group members do a "social identity pie" (Miller & Garran, 2008) in order to situate themselves and to discuss their identities in pairs and then share their discussions with the larger group. This is important because the social disaster hinges on their targeted social identities. It also affords the opportunity to explore intersectionality of different aspects of identity and for group members to share with one another which parts of their identity are most salient.

After completing this exercise there can be a discussion about power, privilege, social exclusion and socio-political targeting. While facilitators can present conceptual material in this area, it is helpful to have the group members discuss their own

experiences of social privilege and targeting based on the construction of their identities. Additional concepts that can be introduced into this discussion are social mirroring (or lack of) and the historical, social, cultural, institutional, interpersonal, and internalized aspects of oppression.

This can be followed by considering how social disasters can cause trauma and other psychological and emotional reactions. In general, it is helpful to discuss how exposure to overwhelming events is a factor with all forms of trauma. However, there are some particularly salient points to make about social trauma that should be emphasized. One is loss of control. For people experiencing social disasters, there is often a profound loss of control and loss of autonomy as they face harassment, surveillance, or even attacks or arrests. Related to this is an intense fear of harm, loss of liberty, and even death. The losses that come with facing such threats – such as a sense of safety, security, autonomy, self-efficacy and self-validation are important to discuss, as well as feelings of being socially devalued, and a lack of safety in public and social spaces. It is important to ensure that these concepts are introduced into the discussion while also facilitating reactions and the sharing of stories from group members. This is a good place to consider the historical narratives and memories of participants regarding the targeting of their social identities socially and politically. For example, if the group is being run for queer participants, a focus on assuming various social identities, coming out, reactions from parents and friends, and the experiences in society at large would be relevant.

Next is a consideration of the psychological and emotional symptoms accrued from experiencing social trauma. As was mentioned in our introduction, we have observed that these include avoidance of areas, people and other stimuli associated with

the trauma, repetitive and obsessive anxious thinking about what happened or might happen, emotional activation and numbing, uncontrollable emotional expression, flashbacks, triggering, and loss of hope and confidence. This is an ideal time to have participants share some of their negative reactions, followed by a question such as "what has been the hardest part for you" or "what do you find most troubling?" It is important to take time for this part of the meeting as there may be a lot of emotional expression, including accompanying feelings of guilt, anger, alienation and hopelessness. A simple mindfulness exercise, such as focusing on breathing, can be helpful, although if someone is highly activated they may find closing their eyes too frightening. In such situations, they should be encouraged to keep their eyes open or to not participate in the exercise if it causes further distress.

It is important that the first session not immediately end after people have described their distress and trauma. Two areas that are helpful to cover: one is post-traumatic growth (Bannink, 2014), which refers to 'positive psychological change experienced as a result of the struggle with highly challenging life circumstances' (Tedeshi & Calhoun, 2014, p.1); the other is addressing strategies for symptom management. Questions that can be used are: 1). How have you survived other challenging times in your life? 2). In what ways have you grown or become a more resilient person when as you have faced adversity? There can be discussion about how our deepest growth, recovery, resilience, and life enrichment often comes from surviving overwhelming and challenging experiences (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). Examples such as re-evaluation of meaning and spirituality, commitment to improved interpersonal relationships, and re-assessment of what is

important in one's life are examples of post-traumatic growth. It also discusses how people have been managing their symptoms and ideas about helpful strategies that can be shared among group members.

Case Example

The first session covered the areas described above. Referencing the existing literature on trauma caused by natural disaster, a brief introduction was given about "what causes trauma"[2] and "the symptoms of trauma"[3]. Participants listened intently, some crying and sharing their feelings, pessimism, and their resonance with the description of trauma symptoms. One participant was so emotionally triggered that she left the group for a few minutes. When she returned she shared the following story:

> When the police finally broke into my apartment, they made a lot of mess, and took my friend. I pretended I was at peace, but I was scared to death. Afterwards I was filled with all kinds of anxiety. I realized that I was not as strong as I expected …..I wanted to erase the memory. I lost my sexual desire…..

Another participant, whose partner was arrested, described the following:

> I was forced to come out to my parents- before this they did not know that I am a lesbian. Homosexual couples are illegal and cannot get married here, so I had no legal right to visit and even deliver some food and clothes to her. I was desperate and anxious and worried all the time about what would happen to her in prison.

Other participants described similar reactions, especially triggering and flooding when passing places where they had been accosted by the police. They also shared other symptoms - sleeping problems, uncontrollable, flashbacks, emotional activation and uncontrolled expression, and emotional numbing, etc. Group members stated that by

[2] Exposure to overwhelming events; loss of control of one's life; fear of harm or death; experiencing assault or bodily harm; experiencing profound losses; constantly feeling harassed, misunderstood, and devalued.

[3] Avoidance, repetitive thinking, emotional activation or emotional numbing, difficulty concentrating, uncontrollable emotions, flashbacks, triggering, loss of hope.

sharing their symptoms they felt connected to other group members and no longer alone in their suffering. The facilitators emphasized that these were normal reactions to abnormal stressful situations, and that their bodies were trying their best to protect them.

Before ending, participants were taught how to do a "safe-space" meditation. One participant became anxious when her eyes were closed but could do the exercise when they were open. At the end of the session, the participants expressed their eagerness to know more about trauma and how to manage traumatic symptoms.

Session Two: Adapting Trauma Management Strategies (see Figure 2)

We believe that the second session should be held 1-2 weeks after the first session. If too much time elapses it is difficult to pick up some of the threads from the first session and yet convening meetings can be challenging due to busy schedules (or unsafe due to surveillance or other threats). The second session can begin with a review of how people have been doing since session one. This can focus on their daily lives, symptoms, and any changes, both positive and negative, since the first group. Were there any remaining questions or points that seemed particularly salient from the first session? It is then helpful to review some of the major "take-aways" from the first session before beginning the group.

An ensuing exercise can be to ask participants to discuss in pairs which reaction is troubling them most. What have they tried in response to their reaction? What have been the hardest or most debilitating aspects of their reactions? What do they most want to change? Sufficient time should be allocated for this discussion, which is likely to bring up strong feelings, including pessimism, hopelessness, and helplessness. Typical symptoms shared by participants include sleeping problems, nightmares and fear and

startle responses to knocks on the door or the ringing of telephones. We believe that every group session should eventually move to teaching, goal setting and empowering exercises so that participants are not left feeling helpless and despondent. A basic neurobiological presentation to follow this discussion is helpful and also sets the stage for the four major strategies for coping with trauma that will be shared next. Describing neurobiological responses to threats and the dynamics of trauma can be a useful way to normalize reactions and also provides a rationale for why certain interventions and activities can stimulate different brain regions and help with distraction, offering a sense of well-being and integration and alleviation of traumatic symptoms. We draw from four major strategies for managing trauma that all have been shown to have validity and efficacy but that are particularly suited to a non-therapy situation; control-focused behavioral treatment; EMDR techniques, self-calming and mindfulness strategies, and self-care, drawn from positive psychology approaches. While they may not "cure" a person of their trauma symptoms, at the very least they can help with managing them, helping participants to regain a sense of control, self-efficacy, security, and experience positive emotions.

Control Focused Behavioral Treatment

Basoglu & Salcioglu (2011) have developed a model of treatment for earthquake, war and torture survivors that does not require the ongoing presence of a therapist. Their method involves trying to help survivors decrease their reactivity to stimuli associated with the disaster, which they are trying to avoid. It involves encountering the aversive stimuli in small steps and doses, while attempting to build up the person's tolerance. Examples of things people avoid are specific locations, activities, taking public

transportation, or visiting a doctor. For example, if someone is afraid of a building that they were in or near that collapsed during an earthquake, they might visit the street where the house is located the first time without trying to pass the house. The next time may involve walking closer to the house, and over time increasing their control and tolerance of emotional reactions as they gain closer proximity to the aversive stimulus and can handle longer time periods of exposure. This helps the survivor to feel as if they are regaining a sense of control over their lives through managing their activation and avoidance.

In their model, Basoglu & Salcioglu (2011) describe how this can be supported by a group, where members of the group can report back about their progress and can support fellow group members by accompanying them while they try and desensitize themselves. The rationale for controlled exposure and desensitization can be explained to group members and encouragement given for doing things in small doses and not giving up when there are setbacks.

We initially wondered if this approach would be viable for people experiencing social disasters because unlike an earthquake, the disaster is still happening. However, what we found is that there is a distinction between having a reaction to a police officer passing on the street and not being able to go near a bus stop where a person was arrested. The first example is a realistic threat in a situation where one is being watched or harassed by the police and it may well be better to not try and become acclimated to this stimulus. The bus stop, however, happened to be the location where the arrest took place and carried a negative association that may be very disruptive to a person's life for (e.g. to not being able to use the bus), and yet and the likelihood of the bus stop being a

dangerous place for the individual is probably not higher than any other public place.

Therefore, we recommend that survivors do not learn to lower their guard when facing ongoing threats but that they do learn how to control and minimize their reactions to stimuli associated with the threat, but which are in themselves not actual threats. This is a delicate balance and group facilitators have to rely on group members and the group process to ascertain and sort between realistic ongoing threats and more benign associations.

EMDR

EMDR (Eye Movement Desensitization Reprocessing) is an evidenced based method of working with people with trauma symptoms (Gelbach, 2008, Shapiro, 2014). It has been used in international settings and one of its advantages is that it involves physical activity – bi-lateral stimulation while the survivor visualizes their traumatic fears. Usually this is done by a trained practitioner moving their finger in front of the survivor's eyes from side to side while the survivor imagines the traumatic experience. EMDR relies on a therapist trained in this method; the basic training lasts for two days. This is a disadvantage for a psychoeducational group in areas where there are no therapists. However, there are aspects of EMDR that can be extracted and taught to group participants, which do not require the ongoing presence of a therapist. One is the idea of imagining a safe space; visualizing a person or place where a person feels a sense of safety or security. This is a prerequisite before asking survivors to imagine what they fear. Imagining a safe space does not involve much risk and is very useful for people experiencing social disasters, whose ongoing safety is compromised. The act of imagining a safe space is empowering because this is something that external forces of

oppression are unable to control. It becomes not only a safe space, but a zone of imaginative autonomy. Group members or the group itself can be visualized as the safe space and this often helps people to feel more connected with one another. The group itself becomes a refuge from the social disaster which can be conjured up in any member's imagination, akin to Winnicott's notion of a "transitional object" (Eagle, 1989).

The other technique that can be extracted from EMDR is the "butterfly hug" (Jarero, Artigas, Uribe, & García, 2016), which a person can do on their own. With a butterfly hug - a person crosses their arms and alternately taps each shoulder in a sustained, rhythmic way. Not only does this function as intended by EMDR to aid in the bi-lateral neurobiological reprocessing of trauma, but like the safe space becomes a technique that an individual can use on their own to give themselves a sense of control and autonomy. It can be used, for example, while a person is being questioned or interrogated by a hostile questioner. We have experimented with ways that people can utilize hidden bilateral stimulation – such as resting one's hands on one's thighs and tapping with one's fingers – which works well if sitting behind a table or desk – and we have also taught people to tap their toes in their shoes, which is one of the least visible methods of bi-lateral stimulation. What we heard from participants is that they found this to be empowering because they felt that by doing this while under threat, they were potentially mitigating some of the traumatic effects of the present and immediate threatening experience and they were also exercising a form of autonomy and self-control that felt like an act of resistance.

Self-Calming Techniques

The ability to self-calm is one of the most helpful tools for survivors of disasters (Hobfoll, Watson, Bell, Bryant, Brymer, Friedman, Friedman, Gersons, de Jong, Layne, Maguen, Neria, Norwood, Pynoos, Reisman, Ruzek, Shalev, Solomon, Steinberg, & Ursano, 2007). The importance of self-calming transcends cultural differences although how to self-calm and how a person evaluates their emotional state is very much influenced by culture. Self-calming is an end in itself but as with the safe space and butterfly hugs, the ability to do this also gives a person a sense of mastery and control in the face of uncontrollable oppression. We will share some self-calming techniques that we have used but there are many more that facilitators can utilize.

One of the most straightforward self-calming techniques is to teach people to sit and focus on their breath. The act of concentrating on one's breath focuses attention, which is helpful for people who are feeling physically and emotionally aroused, and often by concentrating on breathing, the rate of breathing eventually slows down, which leads to a greater sense of serenity and centering. For some people "belly breathing," where one hand is placed over the stomach to feel the breath entering and leaving can be helpful.

Another self-calming technique is to do a body scan (Kabat-Zinn & Hanh, 1990). Although ideally this works best when a person is lying down and can take their time (e.g. up to an hour), this is often not feasible in a group setting. However, participants can be taught how to do a body scan, which involves systematically focusing on different parts of the body, and breathing into any areas where tension is being held, while sitting up in a group.

Visualization is another self-calming technique, beginning with the safe space

exercise mentioned above. Participants can visualize people who they love and trust and breathe in their positive energy and breathe back their gratitude (Miller, 2012). Participants can also be taught the basics of loving-kindness meditation (Salzberg, 1995), which can help with feelings of self-criticism, low self-esteem and doubt, which are common reactions for people experiencing social disasters. Lastly, for people who are targeted and oppressed, it can be useful to shift one's focus to what one is grateful for – such as other group members, or other people who are part of one's support network. So teaching people to do a gratitude journal (Seligman, 2012), such as writing down three things at the end of the day that you are grateful for, can be an entry point into feeling greater positive emotions, which can facilitate feeling calm.

Self-Care

Self-care can be a casualty of social disasters and helping people to re-establish routines is an important part of recovering from social disasters' negative effects. Self-care is a component of most models of interventions for people with severe stress and trauma (Miller, 2012; Miller, 2016) and self-care strategies can be generated by group members and shared with one another. Group facilitators can suggest self-care strategies, such as fostering greater social connections (Christakis & Fowler, 2009), engaging in creative activities such as writing or playing music (Niederhoffer & Pennebaker, 2009), and connecting to nature and what is beautiful in the world (Coleman, 2006), which counter the sense of pessimism engendered by the social disaster. Another self-care strategy is performing altruistic acts and helping others, which helps people to focus on the needs of other people and also generates improved self-confidence, self-efficacy and self-esteem (Miller, 2012; Otake, Shimai, Tanka-Matsumi, Otsuie & Fredrickson, 2006).

Lastly, helping people to establish or re-establish an exercise program is essential; doing physical activities that are engaging, elevate heart-rate and flush out toxins that have accrued from the social disaster stressors may be the single most helpful self-care strategy to use (Miller, 2016). When one's body is feeling better, it lowers stress and tension and elevates self-esteem and a feeling of well-being.

Case Example

The second session began with a check-in and reviewing key points from the first session, particularly the dynamics of hyper-vigilance, sleep disturbance, fear of public places and carrying a sense of dread. We looked at what situations troubled people the most. One participant stated:

> Every time I got near the bus station, I felt scared and intimidated. I am afraid to take a bus, which causes a lot of inconvenience to my life.

Another participant described the following:

> I am so afraid when somebody knocks on the door; every time I get scared and feel as if policemen are coming again, although I *know* that only an ordinary person is knocking at the door.

We asked about specific behavioral responses and some members also made links with their current stress reactions and earlier experiences in their lives. As hyper-vigilance was the most common reaction for all participants we focused on this and discussed "triggers" and how people can gradually increase their tolerance of their triggers, distinguishing between realistic threats and benign reminders of their traumatic experiences. The four techniques described above were introduced and practiced. The butterfly hug seemed to gain the most traction as participants found that it not only helped them to feel better in the moment, but gave them a sense of empowerment as they

anticipated future stressful and frightening encounters with authorities. They felt that secretive bi-lateral stimulation, like patting their thighs or tapping their toes, gave them a sense of control of their bodies at a time when they were losing control in their lives.

The session closed with self-care strategies, which were practiced, and planning for how to utilize the techniques in their daily lives, either on their own or in collaboration with one another.

Session Three – Reiteration, Practice and Moving Forward

This session helps participants to review and reinforce what they have learned, to encourage and validate the progress that they have made, to identify any barriers inhibiting progress, and to make future plans for their own recovery as well as teaching others who were not part of the group.

Case Example

Participants were excited and enthusiastic about their progress. One participant reported how she had been able to work on her fear of a bus stop:

> I asked one of my friends to go to the bus station with me. We bought some snacks and hung out in the station for quite a while. We chatted. I asked my friend to take my picture, and I chose the nicest one and put it on my Facebook page with the title "A nice day hanging out with my friend at the bus station," and many friends gave me positive feedback, though they may not know why I hung out at this particular bus station. Their feedback brought me a lot of positive energy and reduced my anxious feelings. The next time I needed to go to the other side of town to attend a meeting. I asked my colleague to take the bus with me. I took a selfie with him and posted it on my Facebook again, with the title "First bus ride in three months."

Butterfly hugs were also used by one participant creatively:

> I have trouble sleeping at night. Whenever I lie down, there are so many thoughts going on in my mind, and sometimes it takes hours. One night I could not sleep, so I sat up and did the butterfly hug for…maybe 10 minutes…I felt much calmer at heart and fell asleep afterwards.

And….

> When I heard unexpected knocking, I learned to pat my legs. It would be odd if I did a butterfly hug at office, but patting on my legs is usually unnoticed. I found that it did help me to rationalize the sound of knocking and help me to center myself.

From the participants' feedback, it appeared that they felt that discussing the symptoms of trauma, control focused exposure, and butterfly hug were the three strategies most useful for them. We ended this session with a discussion on a positive note: "How can people grow despite having experienced trauma?" Participants had different answers: by having more autonomy, by becoming more determined to succeed at what one is doing, by realizing that the struggle for LGBT rights in their country will take a long time, and by feeling closer and more connected with their peer activists. When considering future planning, many participants asked for the materials summarizing what had been discussed in the group and planned to share them with their peers who had not had the chance to participate in the group. Lastly, some participants planned to form a buddy system, where they and their partner would text one another each day to check up on their self-care strategies.

Conclusions

This article describes a model of a time-limited psychosocial educational group for adults suffering from the oppression of a social disaster. We found that people exposed to social disasters shared many similar traumatic symptoms with people who experience natural disaster, however what is different and most challenging for recovery are the ongoing threats from the social oppression. All of this was taking place with

people with little or no access to trained therapists.

Although the group described in this article lasted for only three sessions, there is no limit on how many times a group can meet, although for socially targeted people there are often realistic constraints. The emphasis was on psychosocial education, sharing traumatic experiences and reactions, the connections between group members and sharing simple strategies that can be used in their ordinary lives and even in the presence of ongoing threats. Framing the group as "training of trainers" model empowered the participants and fostered a sense of resilience and strength. We know that two participants took the lead with organizing a similar workshop afterwards for their peers suffering from the same social disaster.

Specifically, the adapted versions of Control Focused Behavioral Treatment and EMDR were found very useful for the participants. Participants quickly learn to creatively adapt "prolonged exposure" and "butterfly hugs" to manage and control their symptoms and to give themselves a sense of control and autonomy in dealing with their fears and in facing future threats. The descriptions of the symptoms of the trauma was also very useful because this helped participants to name and identify their own reactions, which helped to normalize their experiences while also helping them to share their own symptoms with others, which also generated universality among group members and developed group problem-solving strategies.

Every session started and ended with a mindfulness technique, which participants found helpful to create a peaceful atmosphere while discussing stressful topics as well as teaching them techniques that could be used outside of the group. The facilitators introduced different types of mindfulness, including focused breathing, "safe space",

"body scans", and "loving kindness," and gratitude exercises. Although many of the elements of the group have been empirically tested, they have not been evaluated in this configuration. We believe that this is important to do in the future although each social disaster differs and occurs in a social and cultural context which calls for adaptations. We also feel strongly that any evaluation process should be co-constructed with participants in a way consistent with participatory research (Kang, 2015). Despite the limitations of conclusions based on the positive feedback of group participants, we believe that this model offers hope and a sense of efficacy and can be adapted by different groups in a range of cultures and societies, who are facing social threats and disasters.

The model described in this paper is rudimentary and preliminary. It is an attempt to co-construct and co-evaluate a model of intervention that can be successfully used by people experiencing social disasters in the absence of trained professionals and under challenging and at times threatening political circumstances. We hope that other practitioners and scholars will adapt this model to different political and cultural contexts (including its utility in developing and developed countries); with people from different age groups (e.g. children, adolescents and older adults); refine the concept of social disasters; and that eventually a manual for the use of psychoeducational groups in response to social disasters will be developed. Social disasters are occurring throughout the world, leaving millions of people with their psychosocial, social and emotional residues. Developing models to help people in such circumstances to recover will require courage, creativity, cultural humility and collaboration.

References

Bannink, F. (2014). *Post-traumatic success: Positive psychology and solution-focused strategies to help clients survive and thrive.* NY: W.W. Norton and Co.

Basoglu, M. & Salcioglu, E. (2011). *A mental health care model for mass trauma survivors: Control-focused behavioral treatment of earthquake, war and torture trauma*. NY: Cambridge University Press.

Braga, L.L., Fiks, J. P., Mari, J. J., Mello, M. F. (2008) The importance of the concepts of disaster, catastrophe, violence, trauma and barbarism in defining posttraumatic stress disorder in clinical practice, *BMC Psychiatry,* 8, 68.

Bragin, M. (2007). Knowing terrible things: Engaging survivors of extreme violence in treatment. *Clinical Social Work Journal, 35*(4), 229-236.

Carter, R.T. (2007), Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The counseling psychologist, 35*(13), 13-105.

Christakis, N.A. & Fowler, J.H. (2011). *Connected: The surprising power of our social networks and how they shape our lives.* NY: Little, Brown.

Coleman, M. (2006). *Awake in the wild: Mindfulness in nature as a path to self-discovery.* HW: Inner Ocean Publishing.

Eagle, M. (1989). *Recent developments in psychoanalysis.* Cambridge, MA: Harvard University Press.

Gelbach, R. A. 2008 Trauma, research, and EMDR: A disaster responder's wish list, Jou*rnal of EMDR Practice and Research*, 2*(2)*, 146-155.

Halpern, J. & Tramontin, M. (2007). *Disaster mental health: Theory and Practice.* Belmont, CA: Thompson Learning.

Hobfoll, S.E., Watson, P, Bell, C.C. , Bryant, R.A., Brymer, M.J., Friedman, M.J., Friedman, M., Gersons, B.P.R., de Jong, J.T.V.M., Layne, C.M., Maguen, S., Neria, Y., Norwood, A.E., Pynoos, R.S., Reisman, D., Ruzek, J.I., Shalev, A.Y., Solomon, Z., Steinberg, A.M., & Ursano, R.J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry 70(4)*.283-315.

Jarero, I. , Artigas, L.,Uribe, S., García, L. E.(2016). The EMDR integrative group treatment protocol for patients with cancer. *Journal of EMDR Practice & Research*. 10*(3)*, 199-207.

Kabat-Zinn, J., & Hanh, T. N. (1990). Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness. New York: Delta Trade Paperback.

Kang, H. (2015). "We're who we've been waiting for: Intergenerational community organizing for a healthy community. *Journal of Community Practice, 23*, 126-140.

Kukihara, H., Yamawaki, N., Uchiyama, K, Arai, S., & Horikawa, E. (2014) Trauma, depression, and resilience of earthquake/tsunami/nuclear disaster survivors of Hirono, Fukushima, Japan. *Psychiatry and Clinical Neuroscience*, 68: 524-533.

McCrea, K.T., Guthrie, D., & Bulanda, J.J. (2015). When traumatic stressors are not past but now: Psychosocial treatment to develop resilience with children and youth enduring concurrent, complex trauma. *Journal of Child and Adolescent Trauma,* Published online November 24, 2015.

Miller, J. (2016). Seven self-care strategies. *Reflections, 21*(1), 51-58

Miller, J. (2012). *Psychosocial capacity building in response to disasters.* New York: Columbia University Press.

Miller J. & Garran, A.M. (2008). *Racism in the United States: Implications for the helping professions*. New York: Routledge.

Miller, J. & Schamess, G. (2000). The discourse of denigration the creation of other. *Journal of Sociology and Social Welfare, 27*(3), 39-62.

Otake, K., Shimai, S., Tanka-Matsumi, J., Otsui, K., & Fredrickson, B.L. (2006). Happy people become happier through kindness: A counting kindness intervention. *Journal of Happiness Studies, 7(3)*, 361-375.

Pratto, F., & Stewart, A. L. (2012). Group dominance and the half-blindness of privilege. *Journal of Social Issues*, 68(1), 28-45.

Rosenfeld, L. B. (2010). *When their world falls apart: helping families and children manage the effects of disasters*. Silver Springs, MD: NASW Press.

Salzberg, S. (1995). *Loving kindness: The revolutionary art of happiness.* Boston: Shambhala.

Seligman, M. (2012). *Flourish: A visionary new understanding of happiness and well-being.* New York: The Free Press.

Southwick, S.M., Bonanno, G.A., Masten, A.S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: Interdisciplinary perspectives. *European Journal of Psychotraumatology, 5,* Accessed at http://dx.doi.org/10.3402/ejpt.v5.25338.

Shapiro, F. (2014). The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experiences. *The Permanente Journal, 18*(1), 71-75.

Smith, L. E., Bernal, D. R. Christman, S. T. ,Whitt, C.L. , Christman, S.T., Donnelly, S.,

Wheatley, A. , Guillaume, C., Nicolas, G, Kish, J. & Kobetz, E. (2012). Coping with vicarious trauma in the aftermath of a natural disaster, Journal of Multicultural Counseling and Development, 42(1), 2–12.

Solorzano, D., & Yosso, T. (1999). Critical race theory, racial microaggressions, and campus racial climate: The experiences of African American college students. *Journal of Negro Education, 69(1),* 60–73.

Sue, D.W. (2010). *Microaggressions in everyday life: Race, gender and sexual orientation.* New York: Wiley.

Tedeshi, R.G., & Calhoun, L.G. (2004). Posttraumatic Growth: Conceptual Foundation and Empirical Evidence. *Psychological Inquiry,15(1)*, 1-18.