Sharing Circles: learning from a community based psychosocial intervention model implemented with vulnerable populations in Myanmar

Maria Vukovich & Gwen Vogel Mitchell

The last several decades of ongoing conflict and oppression in Myanmar (as it is now officially known) has had an extensive psychological and emotional impact on its people. Unfortunately, there has been a distinct lack of psychosocial programming provided through culturally appropriate methods in Myanmar. This study investigated an eight session psychotherapy group called Sharing Circles. Trained local staff implemented a group intervention in Yangon, Myanmar with 57 Burmese participants from Yangon identified as belonging to one of three vulnerable groups. Preliminary findings suggest the Sharing Circles may be an effective psychosocial technique for improving psychological symptoms and providing psychosocial support. Limitations included: lack of a comparison group, relatively small sample size, convenience sample, and simple pre and posttest design. Further, well designed, studies of group interventions with identified vulnerable groups are needed to confirm and clarify initial findings as well as to evaluate its potential application in other conflict affected regions.

Keywords: bisexual, former political prisoners, gay, lesbian, Myanmar, people living with HIV/AIDS, people questioning their sexual identity, psychosocial intervention, *Sharing Circles*, transgender, vulnerable populations

Key implications for practice

- *Sharing Circles* is used as a mental health intervention for vulnerable groups.
- Participants of this intervention reported decreased depression and anxiety symptoms.
- *Sharing Circles* is a feasible and measurable psychosocial intervention that can be replicated in other conflict affected settings.

Introduction

Political context

Myanmar freed itself from colonial rule in 1948 only to be ruled by the totalitarian regime of General Ne Win (and its various guises) from 1962 until 2010 (Topich & Leitich, 2013). Harsh conditions under this military rule included: the imprisonment of political prisoners; attacks on ethnic minority groups; forced labour; and widespread forced displacement.

After years of stagnation, change has come to Myanmar at a rapid pace, although still on military terms. Starting in 2011, the Burmese government began to release several hundred prisoners, although a small number remains behind bars, and roughly two hundred currently still face criminal charges (Human Rights Watch, 2014). While some laws have been amended, repressive laws remain. The army has targeted civilians in an armed conflict with the Kachin minority group. Further, a string of violence erupted between Arakanese Buddhists and the long persecuted Rohingya Muslims, with state security forces taking part in abuses against the Rohingya.

Mental health

Myanmar has a population of 53 million, with a present ratio of 44 psychiatrists per 10,000 people (World Health Organization (WHO), 2012). While Buddhism, the dominant religion within Myanmar, has had an enormous impact on the way of life in general, individual perceptions of mental illness are much influenced by pre existing Burmese supernatural beliefs related to the worship of *Nats* (supernatural spirits), astrology and the practice of alchemy (Tint Way, 1996). This means that the treatment of disordered persons by traditional healers usually involves a process of overcoming malevolent spirits and other intervening forces.

Further impacting the treatment of mental health, years of authoritarian economic management have left the majority of the country's people in dire poverty (Amnesty International, 2012). As well as a lack of mental health expertise, identifying the mental health needs of the population of Myanmar and providing appropriate treatment requires exploration and incorporation of culturally significant signs and symptoms of distress, within the context of widely varying social experiences (Kirmayer, 2005).

A severe lack of community based mental health and psychosocial support services was noted in the latest WHO Assessment Instrument for Mental Health Systems report (WHO-AIMS, 2006). Further, no current research on mental health inside Myanmar was identified in the intensive evaluation. The WHO-AIMS team planned to unveil a five year plan to develop mental health and psychosocial support services (MHPSS) inside Myanmar, however, progress in this area remains to be seen (WHO, 2006).

Cultural idioms of distress

In their examination of traumatic experiences and mental health outcomes in Karenni refugees living on the Thai border, found that a high prevalence of reported depression and anxiety outcomes were physically expressed through psychosomatic symptoms (e.g. chronic body aches, stomach discomfort, heart pain, etc.) These are often called idioms of distress. Nichter (1981) further defines idioms of distress as *'an adaptive response or attempt to resolve a pathological situation in a culturally meaningful way.'* These idioms can include somatic complaints, possession, and other culturally significant experiences. The help seeking behaviour of an individual inside Burma, as in other parts of Asia, may be influenced by a number of culturally determined factors, such as difficulty in complaining to a doctor about close relationships, the social constructs of illness (which is often determined by various indigenous beliefs) and expectations of the doctor or healer.

Terheggen, Stroebe & Kleber (2001), and Lim, Stock, Shwe Oo & Jutte (2013), have noted similar findings in which people from non western countries of origin, including Myanmar, India and Tibet, often use somatic symptoms to communicate their feelings of depression, anxiety and stress. In addition, because of a collective experience of political oppression and paranoia, many individuals are reluctant to share their mental health concerns. Individuals often describe these conditions as hurt and sadness being *'stuck in the mind'* or *'buried in the heart.'* Additionally, pressures and stress of living in poverty and having a poorly established legal standing often leads to an increase of alcohol/drug abuse, domestic violence, child abuse, depression, anxiety and, potentially, suicide.

The organisational actors

SalusWorld, a global nongovernmental organisation (NGO), was founded in 2006 with the mission to heal emotional and psychological scars of human rights violations across the globe. The overarching vision of *SalusWorld* is to generate and support the local development of comprehensive, culturally

appropriate solutions, rather than launch emergency measures, driven by outside actors, as a means to assist people to live beyond the level of mere survival. Through capacity building and training, *SalusWorld* has worked alongside local NGOs, in conflict affected areas, in order to establish sustainable partnerships. *SalusWorld Myanmar* is funded by the Open Society Foundation (OSF).[1]

Developmental evaluation within complex settings

Aside from a few published studies (Draminsky et al., 2000; Allden et al., 1996; Lopez-Cardozo et al., 2004), few attempts have been made to examine mental health issues inside Myanmar. Conflict affected settings, such as Myanmar, pose a myriad of challenges and barriers that often obstruct the ability to evaluate projects. Developmental evaluation (Patton, 2011), however, is responsive to contextual complexities by providing a utilisation focused method to gather and interpret data, frame issues and test programme developments centred on the values and commitment of the actors to social transformation. In turn, organisations are then enabled to make changes in response to emerging conditions, or increased learning. Developmental evaluation is particularly appropriate for contexts where there is not a comprehensive enough knowledge base to know what to do, or how to implement effective interventions or programmes (Patton, 2011). This approach to evaluation, therefore, was a natural fit for exploring the initial effectiveness and value of the *Sharing Circles* intervention inside Myanmar.

The present project was developed in direct response to the identified gap in available mental health services inside Myanmar, and to the distinctive psychosocial needs of a few identified vulnerable groups, including: people living with HIV/AIDS (PLWHA), former political prisoners (PPs), and individuals identified with the collective lesbian, gay, bisexual, transgendered and queer (and/or those questioning their sexual or gender orientations) (LGBTQ) community. The following two research questions guided the evaluation: 1) does the *Sharing Circle* intervention have an impact on the psychological symptoms and psychosocial stressors in the people of Burma/Myanmar; and 2) how can the *Sharing Circles* model inform future mental health programming inside Myanmar?

Theoretical framework

In response to the systematic and ongoing human rights violations in Myanmar, *SalusWorld* integrated several psychological theories (e.g., intersubjective relational theory, narrative theory and trauma informed, psycho education theory[2]) in the development and implementation of the *Sharing Circles* intervention. In specific, relationally focused, trauma informed, and strengths based interventions were utilised in order to foster connection, meaning making, storytelling and collective therapeutic support strategies. These strategies offered participants the unique opportunity to express needs, concerns and fears in a supportive environment, while building reparative relationships with others who have experienced similar issues. This shared space allowed participants to learn how to help themselves and one another, rather than strictly relying on the guidance of therapeutic facilitators (Brough, Schweitzer, Shakespeare-Finch, Vromans, & King, 2012). Further, this framework assisted participants in developing a repertoire of coping skills, which enabled them to manage stressful situations effectively and work through difficult events and memories from their pasts. Potential opportunities for reparative work (based on an understanding of Transitional Justice Theory and Systems Theory[3]), within and between family systems and intimate partner and peer relations, were also explored

in the facilitation of these group sessions (Robins, 2012; Walsh, 2003). Through the utilisation of trauma informed interventions that focus on empowerment and resiliency, participants obtained material and internal resources, knowledge of how to rebuild individual lives, and the development of a community wherein the sustained process of collective healing can reside (Lee, 2001; Brough et al., 2012).

Activities facilitated within *Sharing Circles* were aimed at exploring the participants identified hopes and dreams, and what they wanted to change in their lives (i.e., connecting to others, "*coming out*", making amends, coping with grief and loss, finding a new path, etc.). The local facilitators first worked hard to solidify a therapeutic alliance with, and between, group members. Mobilising hope in the therapeutic process was aimed at helping participants see him/herself as having the agency to affect change and the ability to identify pathways for change (Griffith & D'Souza, 2012; Snyder et al., 2002). Contextual factors outside the therapy sessions, including the amount of social support and availability of employment, were also examined and explored within group sessions. The development of a deep understanding of cultural differences in appraisal of authority, models for self-disclosure and the shared language between therapist and client all influenced the therapeutic relationships, and were essential elements of establishing and maintaining Sharing *Circles* (Jordans et al., 2007; Tol et al., 2005).

Methods

Sample

Sharing Circle participants were recruited through contact with service providers at a local clinic, and in collaboration with staff at three local NGOs in Yangon whose work is aimed at empowerment, with a focus on human rights. Participants consisted of PLWHA outpatients, who travelled from their village communities to receive Highly Active Antiretroviral Treatment (HAART) treatments (a special mix of HIV/AIDS medicines), and members of local, former political prisoner and LGBTQ groups. No exclusion criteria was included in the study, however, participants were placed in *Sharing Circles* intervention groups based on their identified membership to one of three, specific, vulnerable categories (PLWHA, LGBTQ and former political prisoners (PP)). The PLWHA and LGBTQ *Sharing Circles* groups were mixed gender, however, the former PP group were all male. Participants ranged in age from 24 to 50 years old. A total of 57 participants were retained in the sample, including 38 female, 17 male and 1 self disclosed as other.

Overall, participants identified with a variety of ethnic and religious backgrounds. Due to the political climate and timing of the intervention, specific identifying information was kept anonymous in order to protect the security of participants in the study. Each participant gave informed consent prior to participating in the intervention, and was reminded that enrolment was completely voluntary and could be discontinued at any time.

Sharing Circles intervention

Six therapeutic facilitators, two of whom had received a certification in Applied Psychology from the University of Yangon, Department of Psychology, were hired to lead each of the *Sharing Circles* psychosocial groups. Two of the facilitators were also members of local minority groups, and all were fluent in both Burmese and English. Intervention integrity was addressed by providing 30 hours of implementation training, and regular group and individual supervision provided by visiting expert consultants and the director of international services.

Sharing Circles was a time limited, pilot intervention of eight group sessions over eight months, with a few groups running bi-monthly based on time availability demands

Table 1. Structure and topics of Sharing Circles

Session	Activities	Purpose
Session 1: Joining, engagement and establishing safety	Consent form; ice breaker, introduction and ground rules for group; Pre test (*Brief PHQ*); explorations of hopes and fears for group, close with re-cap and reflection of how first group was experienced	Structure established around respect, non-judgment and confidentiality; initial exploration of identity and facilitation of group cohesion
Session 2: Life narrative exploration & sharing	Open with energiser and team building exercises; check-in; lifeline activity; share in small groups; close with re-cap and reflection session about group	Encourage development of membership to group; check-in with thoughts and feelings of the group in last month/week/2 weeks; provide method to share and map out life experiences
Session 3: Discovering our identity – memories, moments and meaningful relationships	Open with energiser and team building exercises; check-in; use of a number of different stories to create a context and frame a clinical discussion about identity (who we are, where we come from, what we want for ourselves and our loved ones); stories utilising highlights of how, when things happen to us, we don't always know if it was a good thing or bad thing	Participants deconstruct their identity story, early experiences and meaningful relationships; examine how we have and can grow through adversity and traumatic experiences
Session 4: Communicating with available (& unavailable) support systems	Open with energiser and team building exercises; check-in; story activity to explore good and bad experiences; empty chair activity (focus of activity depended on specific group issues); process experience with activity; relaxation and visualisation activity; close with re-cap and reflection session	Encourage connection among participants in the group; ongoing process of life experiences and how these experiences impact overall functioning; exploration of dynamics with significant people in their lives and how they relate/communicate; emphasis on shared experiences

Session	Activities	Purpose
Session 5: River of life activity: exploring the hard places and great celebrations	Open with energiser and team building exercises; check-in; river of life activity; close with re-cap and reflection session	Activity targets resilience, recovery and coping strategies; psycho-education over good stress and bad stress, and other psychological concerns
Session 6: Our dignity, our value	Open with energiser and team building exercises; check-in; exploratory activity around finding our dignity and value, close with re-cap and reflection session	Participants will identify their value in the world and reflect on the dignity of all human beings. participants start to explore ways they can help their communities, space for connections to be made
Session 7: Future dreams: setting goals and examining potential roadblocks	Open with energiser and team building exercises, check-in; revisit river of life activity and look to the future; predict and prepare for what may lay ahead	Participants evaluate their hopes and dreams for the future and how they might get there; process any roadblocks they have experienced
Session 8: Closing activity and certificate ceremony	Farewell activity; compliment cards, certificates and good-bye messages; eat & celebrate; post test (*Brief PHQ*)	Participants participate in and experience what it is like to take part in a healthy goodbye; leave time for the group to discuss ways they might stay connected after the group, if they are interested

PHQ = Patient's Health Questionnaire.

of the participants. A total of six *Sharing Circles* intervention groups were led over the duration of year, which were balanced among the three identified vulnerable populations. The *Sharing Circles* were developed to provide a safe space for clients to receive support for symptoms of psychological distress, empowerment, and social support. Each of the *Sharing Circle* groups was implemented through a therapeutic manual, in which topical discussions, activities and practices were adapted to the distinctive clinical and psychosocial needs of the specific vulnerable population (See Table 1).

Each meeting began with an establishment of the ground rules and then facilitators introduced a topic, either via a didactic talk or an experiential activity. Intervention activities consisted of interactive and narrative tasks, body mapping, role playing, gestalt psychotherapeutic activities (see Table 1), lifeline and memory book, as well as engagement in meditation and other self care activities. Discussion of depression, anxiety and trauma symptomology, good stress and bad stress, substance abuse, identity, support systems, and grief and loss were also core components of the support groups.

Each intervention activity was followed by a 30 minute reflection session aimed at exploring thoughts and feelings experienced during the activity. The issues of identity, stress and mental health problems (e.g., post-traumatic stress disorder (PTSD), depression, grief and loss) were also addressed over several sessions.

Specific group topics and focus were adjusted for each vulnerable group, according to identified needs. For example, the issue of identity and disclosure of sexual identity to friends and family was explored in the LGBT group, whereas issues of loss and regret were explored with the PPs due to the fact they reported struggling with not knowing their children who grew up while they were imprisoned. The PLWHA groups focused more on disclosure of HIV status and the grief and loss tied to the death of loved ones or infection of children. These adjustments were made both in the facilitation of discussions as well as in how gestalt exercises were utilised and applied.

Instrument: The Brief Patient's Health Questionnaire

The *Brief Patient's Health Questionnaire* (*Brief PHQ*) (Kroenke & Spitzer, 2002) was selected because it offers a more concise and user friendly measure than the majority of mental health instruments with equivalent specificity (72%), sensitivity (84%), and a positive likelihood ratio of 2.9 (Martin, Reif, Klaiberg, & Braehler, 2006). As a result, the questionnaire has been frequently used in practice and research settings worldwide (Spitzer & Kroenke, 2005). *Sharing Circles*, however, has provided the first known administration of *Brief PHQ* among marginalised populations in Myanmar.

The *Brief PHQ* included six domains to assess depression and anxiety symptoms, as well as psychosocial stressors in participants. Nine items were included in the *Depression* domain, in which participants were asked how much they were bothered by emotions, sleep, fatigue, appetite, negative thinking, concentration, speech and self harm over a period of the previous two weeks. This was based on a four point rating response scale from '*not at all*' to '*nearly every day*.' In the *Anxiety* domain, participants were asked to respond to five items on sudden, or reoccurring, anxiety, panic attacks and physiological symptoms (e.g. heart racing, shortness of breath, sweating, dizziness or fainting, numbness and upset stomach) over the last four weeks, using a dichotomous response scale of '*yes*' or '*no*.'

Participants were then asked to rank how difficult problems with depression or anxiety had made their work, home life or relationships on a four point response scale from '*not difficult at all*' to '*extremely difficult*' in the third domain. Next, the *Psychosocial stressors* domain consisted of 10 items, which consisted of inquiries over: health concerns, weight or physical appearance, desire for or enjoyment of sexual relations, difficulties with partners, taking care of children or family members, finances, and tragic events or flashbacks of terrible experiences in the past. Participants were also asked to rate how much these stressors had bothered them on a three point response scale of '*not bothered*' to '*bothered a lot*.'

In the next domain, participants were asked whether they had been physically hurt (e.g. hit, slapped or kicked) by someone, or forced to perform an unwanted sexual act in the last year. Participants responded to the *Abuse* domain using a dichotomous response scale of '*yes*' or '*no*.' The final domain inquired whether participants were, or were not, taking medication for depression, anxiety or stress.

Prior to administration, the *Brief PHQ* was translated into Burmese by the Metta Moe Myanmar & Heal the World NGO[4] staff, and back translated into English by a bilingual consultant. The language and concepts in the *Brief PHQ* were then reviewed by a local Burmese psychiatrist in Yangon, and deemed appropriate to local culture and

understanding of mental health. All participants were administered the *Brief PHQ* prior to beginning the *Sharing Circles* as a pre test. After participating in eight *Sharing Circles* sessions, group members were administered the *Brief PHQ* again, as a post test. Heal the World NGO staff entered the data on spreadsheets, after data collection following pre tests, and after post tests were completed. Any personally identifying information was removed from the data, and stored on a password protected office computer to maintain confidentiality.

Analyses

Paired sample *t*-tests were conducted in the statistical programme SPSS 24.0 (IBM, 2013) to examine any potential significant differences in reported responses to the *Brief PHQ*, prior to and following participation in the *Sharing Circles* intervention. In addition, a Rasch Model analysis was performed in Winsteps 3.80.1 (Linacre, 2014) on pre and post intervention responses to depression symptoms and psychosocial stressors included in the *Brief PHQ*. The Rasch model is a mathematical framework, based on Item Response Theory (IRT), in which fit indices are used to measure whether the scoring and summing of items are justified within a data set (Bond & Fox, 2007). Item fit is expressed in logits, where a value of 0 is set as the mean of item difficulty estimates (Bond & Fox, 2007). The Rasch Model was utilised to identify whether specified items were more highly endorsed by participants prior to, and following, participation in the *Sharing Circles* intervention.

Results

The paired samples *t*-tests revealed a statistically significant difference in reported psychosocial stressors (including concerns about health, future relationships, social support, sex, family and finances) post intervention, $t(46) = 2.68$, $p = 0.010$. The mean of reported psychosocial stressors post intervention ($M = 12.74$, $SD = 3.61$) was found to be lower than reported psychosocial stressors pre intervention ($M = 14.46$, $SD = 4.91$). Further, findings indicated a statistically significant difference in reported depression symptoms (including difficulty with energy levels, sleeping, concentration, restlessness and speaking) post intervention, $t(53) = 2.16$, $p = 0.035$. The mean of reported depression symptoms post intervention ($M = 14.26$, $SD = 3.15$) was also found to be lower than reported depression symptoms pre intervention ($M = 15.79$, $SD = 4.06$) (Table 2).

The infit indices for nine items on the depression domain and 10 items on the psychosocial stressors domain, pre and post intervention, were reported within the range of productive measurement (Linacre, 2005) (See Table 3). Thus, findings suggested an overall appropriate fit of items to persons in the *Brief PHQ*. Additionally, findings indicated a strong fit of items within the underlying construct of depression in the *Brief PHQ*, and provided evidence of construct validity in the measure (Bond & Fox, 2007).

In addition, item position logit was examined to determine the stability of reported symptoms and stressors over different phases of the test administration. Thus, correlations of item logit position for Time 1 (pre test) to Time 2 (post test) were performed for the *Depression* domain and the *Psychosocial stressors* domain in the *Brief PHQ*. The correlation of item logit positions for depression symptoms, pre and post test, was found to be statistically significant, $r = 0.67$, $p = 0.035$. This result suggested the item positions changed in the post test administration. That is, participants reported less difficulty in responses to depression symptoms after receiving the intervention. Responses to *Depression* domain sub items 1b (i.e. feeling down, depressed or hopeless), 1 f (i.e. feeling bad or a failure about yourself), and 1h (i.e. moving or speaking noticeably slower, or being so restless that you move more than normal) were

Table 2. Test of mean differences in reported psychological symptoms in Sharing Circle participants, pre and post intervention

Paired differences	Mean	SD	95% Confidence interval	df	*t*
Depression symptoms	1.72	5.85	[0.13−3.32]	53	2.16*
Psychosocial stressors	1.51	3.86	[0.38−2.64]	46	2.68**

** $p < 0.01$.
* $p < 0.05$.

reduced to less reported severity following participation in *Sharing Circles*.

In contrast, the item logit positions for items under the psychosocial stressors domain reported no significant differences, before and after implementation of *Sharing Circles*, $r = 0.52$, $p = 0.147$. Despite no significant changes in the item difficulty across pre and post test, there were psychosocial stressors that showed slight increases in severity of responses to psychosocial stressors, post intervention. In particular, participants reported slight, nonsignificant increases in psychosocial stressors at work outside of the home, financial problems, having no one to turn to with problems and/or that something bad happened recently.

Lastly, an analysis of frequencies was performed on participant responses to anxiety and panic attack symptoms, physical abuse, women's health and psychosocial stressors at pre and post intervention. Reported instances of anxiety and panic attacks were reduced from 33.3% to 22.8%. Of the participants who reported panic attacks post intervention, fewer reported panic attack occurrences without warning, concern about future panic attacks and physical symptoms during panic attacks.

Before participating in the *Sharing Circles* intervention, 64.91% of participants reported that mental and physical health symptoms made work, home and relationships as somewhat to very difficult; whereas, only 51.8% reported any difficulty after the intervention. There were also fewer reported instances of physical and sexual abuse, post intervention. Finally, fewer participants reported taking medication for anxiety, depression or stress after participating in *Sharing Circles,* with a reduction of 28.07%.

Discussion

The initial *Sharing Circles* provided an opportunity for members of vulnerable populations, including PLWHA, LGBTQ and former PPs, to receive psychosocial support and mental health care. As a whole, the intervention demonstrated several promising

Table 3. Infit and item difficulty of depression domain and psychosocial stressors domain items

Domain	Pre		Post	
Depression	Infit (MNSQ)	Difficulty	Infit (MNSQ)	Difficulty
	84 to 1.12	−0.48 to 0.56	0.76 to 1.44	−0.35 to 0.17
Psychosocial stressors	0.82 to 1.27	−1.70 to 0.75	0.73 to 1.28	−1.17 to 0.69

Note: Infit and difficulty measured in logit.

outcomes that provided preliminary support for the efficacy and value of the *Sharing Circles* intervention with these sub groups in Yangon. Specifically, participants reported decreased depression and anxiety symptoms, as well as lesser concern about future symptoms. Fewer PLWHA reported using medication for depression, anxiety and stress symptoms after participating in *Sharing Circles*. Initial findings also indicated decreased physical and psychological symptoms related to work, home and relational stress. Moreover, there was a reduction in reported instances of physical and sexual abuse.

Results of the Rasch model, however, also revealed slight increases in reported psychosocial stressors, post intervention. Although unexpected, this finding may be related to the emphasis placed on normalising psychological symptoms and stressors within the groups. Creating a safe, shared space for PLWHA clients to express their concerns openly, and feel supported by others, may have promoted greater awareness and increased reporting of mental health symptoms and psychosocial stressors. The increase in reported severity of psychosocial stressors may also be related to cultural norms, or local idioms of distress, present in Myanmar. Considerable emphasis was placed on identifying sources of stress within *Sharing Circles*, and may have contributed to a greater awareness of psychosocial stressors in participants. Further, participants may have also experienced additional traumas or challenges in their lives during the course of the group that may have impacted their psychosocial stress levels. Overall, the design, small sample size and power of the present study curtailed our ability to make sense of the slight increases in reported psychosocial stressors post intervention. Therefore, further exploration of the management of psychosocial stress is warranted in future mental health and psychosocial support studies inside Myanmar.

Burmese idioms of distress and local ethnopsychology models about psychological issues also have yet to be studied in any sort of comprehensive or systematic way. One of the most startling observations made after reviewing the literature on trauma related and mental health disorders concerned the relative absence of studies of the most affected populations in their original locations, or countries of origin (Nickerson, et al., 2011, Kohrt & Hruschka, 2010). According to a recent meta analysis on the epidemiology of PTSD, only eight (6%) of 135 studies meeting the inclusion criteria were conducted in developing countries (Pedersen, 2002). Although there were some studies focused on newly arrived Burmese refugees to western countries, little knowledge exists on the psychological functioning of Burmese or ethnic minority groups inside the country of Myanmar (Schweitzer, et al., 2011; Fazel et al., 2005; Norredam et al., 2009). No studies were found among victims of terrorism, torture, political violence or wars inside any populations in their countries of origin (De Girolamo & McFarlane, 1996). Compared to the number of epidemiological studies of PTSD and depression, there is a dearth of studies of these local conceptual frameworks influencing diagnosis and treatment of psychological disorders in non western settings (Lemelson, Kirmayer & Barad, 2007).

Based on anecdotal evidence gathered inside Myanmar since 2008, psychological trauma and emotional deregulation have been shown to be multi-faceted concepts.

A number of participants from *Salus World's* capacity building trainings focused on mental health from 2009–2012, articulated different categories of psychological dysfunction in relation to impact on heart, mind, body, spirit and social status, with differences in perceived types of traumatic events, symptom sets, emotion clusters and vulnerability. Local counsellors, working with Buddhist clients, indicated that clients feel blamed for experiencing negative events, which were seen as karma transmitting past life sins, or family member sins, into personal

loss. They also believed a substantial need for awareness raising and stigma reduction remains in Myanmar before locals will seek care for psychological trauma, out of fear of the stigma of bad karma. Additional research focused on cultural idioms would help to build culturally competent systems of mental health and psychosocial support care in Myanmar. Observing the current push by UNHCR to widen the application of mental health and psychosocial support (MHPSS), this intervention represents a feasible and measurable psychosocial intervention that can be replicated in other conflict affected settings.

Limitations

Although promising, this pilot study also had multiple limitations. A number of these limitations were apparent to investigators prior to beginning the study, including: limited resources, the unavailability of a control group and a small sample size. Despite using appropriate cross-cultural methods, there are also always potential translation difficulties in adapting instruments, constructs and language from one culture and language to another (Rogler, 1989; Egisdottir, Gerstein, & Cinarbas, 2008; Terheggen et al., 2001). Given the challenging context, participants were recruited through convenience sampling through local NGO networks. Consequently, the results demonstrated in the study are limited to the PLWHA, LGBTQ, and former PP participants included in the initial *Sharing Circles* groups. Further, limited funding restricted the breadth of this study. Nonetheless, the reduction of psychological distress and improved psychosocial support are hopeful preliminary findings to build on in future studies. In addition, the response rating scales on the *Brief PHQ* ranged from dichotomous yes/no to 4-point, therefore the depth and complexity of the analyses were restricted. Consequently, a new psychological inventory has been developed to facilitate a more comprehensive evaluation of the project across a larger sample, and enhance the rigor and power of the quantitative analyses. Finally, waitlist/control groups have been identified using local NGOs through random assignment and are now implemented in current *Sharing Circles* groups.

Future implications

Initial findings suggested *Sharing Circles* were an effective psychosocial tool in collectively treating depression, anxiety and stress and creating a feeling of membership in three identified vulnerable groups in Yangon, Myanmar. The preliminary quantitative results indicated that the *Sharing Circles* intervention was a valuable method of mental health and psychosocial programming among the present sample of former PPs, LGBTQ and PLWHA in Yangon, Myanmar. Therapeutic activities utilised in the groups, such as lifeline and Gestalt empty chair, left a lasting impact on the ways in which participants cognitively and emotionally related to family and friends. Consequently, the preliminary findings implied the shared giving and receiving of social support served as a useful therapeutic tool within the group process.

The *Sharing Circles* intervention model must be replicated with additional vulnerable populations, in other post disaster and conflict affected settings, in order to validate the utility and versatility of the psychosocial intervention. Future research will also serve to augment the understanding of contextual complexities in providing MHPSS to people inside Myanmar. In turn, this will allow for further improvements to the *Sharing Circles* intervention, as well as promoting greater advocacy and stigma reduction for issues related to mental health, trauma and psychosocial stress in Myanmar.

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[1] Open Society Foundations, formerly the Open Society Institute, is a grant making network founded by George Soros, aimed to shape public policy to promote democratic governance, human rights, and economic, legal, and social reform.

[2] Intersubjective relational theory is used in philosophy, psychology and anthropology to conceptualize the psychological relation between people; Narrative therapy is a form of psychotherapy using personal stories and narratives; trauma informed psychoeducation and interventions are techniques that specifically educate about and relieve the symptoms associated with post-traumatic symptoms.

[3] Transitional justice principles consists of judicial and non-judicial measures implemented in order to redress legacies of human rights abuses and Systems theory is the interdisciplinary study of systems in general, with the goal of elucidating overlapping systems such as family, societal, ethnic, religious, governmental, etc., systems that directly impact individual and group functioning.

[4] Metta Moe Myanmar and Heal the World local NGOs established inside Myanmar under the auspices of *SalusWorld* with the end goal of becoming independent and self-sufficient.

Maria Vukovich has a Masters degree in International Disaster Psychology, and is a Ph.D. candidate in Research Methods & Statistics at the University of Denver in Denver, Colorado. Additionally, she is a research & evaluation advisor at SalusWorld.
Dr Gwen Vogel Mitchell, Psy.D., specialises in trauma recovery and international disaster psychology. She is the Director of Clinical & International Services for SalusWorld, and is an Associate Professor at the University of Denver's International Disaster Psychology (IDP) Masters Program in Denver, Colorado.
email: gwenatu@gmail.com