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Merlin (Terry) Baker [a]
[a] Australian Counselling Association

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An Integral approach to counselling refugees

Merlin (Terry) Baker*

Australian Counselling Association

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Refugees seeking to settle in a country other than their own are a fact of life in our global society today. A counsellor faced with supporting a client who is a refugee may be more effective by approaching this work from a point of view that is as inclusive and holistic as possible. This paper presents an approach to counselling refugee clients based on the Integral Theory and Psychology of Ken Wilber and associates, focusing on at least four basic dimensions of human experience. The four dimensions are the subjective and the objective of the individual and the collective, or the 'I', 'It', 'We' and 'Its' realms of reality, as they arise in the client's life. The counsellor is charged with assisting the refugee client to attain healthier functioning in every one of these four dimensions, while giving equal value to each and not privileging any one of them without good reason. It should be noted that, while Integral Theory is in itself not a new *therapy*, it allows the counsellor to situate anything that arises in the therapeutic context on the multidimensional Integral 'map' so one can then make informed decisions to guide assessment, intervention and evaluation. This approach then can be characterised as both multiperspectival and practical, and is thus a comprehensive answer to the complexities and challenges presented by the refugee client.

Keywords: counselling; integral; refugees

Refugee situation

According to the United Nations High Commission on Refugees (UNHCR), a refugee is a person who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country'(United Nations High Commission for Refugees, 1951). Having fled their country, many times without a chance for preparation or planning, they may then be detained for long periods of time, often several years, in refugee camps, enduring harsh conditions that result in serious mental and physical pathologies before settling in a host country (Refugee Council of Australia, 2010). They are survivors, people who have often experienced horrific human rights abuses and lived. The UNHCR's 2008 statistics indicate that there were 42 million people forcibly uprooted by conflict and persecution worldwide, including 16 million refugees (4.7 million in Palestine) and asylum seekers (United Nations High Commission for Refugees, 2009).

*Email: merlin_11@mac.com

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Following an extensive review of the literature, Schweitzer, Buckley, and Rossi (2002) found that, 'In almost all instances, refugees report forced separation from family, traumatic experiences within their homeland, commonly associated with war trauma and loss of family members ... (including) deprivation of food or water, lack of shelter, being in a combat situation, murder, kidnapping and forced isolation' (p. 2). The impact of such trauma on an individual, as noted by Duignan (2010), can include physical symptoms, such as chronic pain, fractures which have not healed correctly, severe injuries and brain damage, as well as psychological symptoms, including depression, severe anxiety, sleep interruption, survivor's guilt, lack of trust (particularly those seen as authority figures), severe memory problems, intrusive thoughts and family conflict. Thus the counsellor intending to assist refugee clients may find complex issues presenting, as reported by Shakespeare-Finch and Wickham (2010):

> Coupled with past traumatic experiences and the stress of involuntary migration, refugees ... are also faced with the challenges of acculturation . . . (including) the need to adapt to differences in language, customs and norms for social interaction, rules and laws, and general lifestyle . . . The enduring stress of acculturation may reduce an individual's chance of successfully adapting to a new culture due to factors such as social isolation, unemployment, discrimination, poverty, and intergenerational conflict resulting from children adapting to the new culture more quickly than their parents. (p. 2)

To deal effectively with such complexity, it will be important for the counsellor to operate from a framework that is as inclusive and as holistic as possible, to address psychological, social, cultural and physical issues, while also remaining flexible enough to focus on a single dimension, in order to offer interventions that meet the actual needs of a refugee client. A truly integrated framework, such as that described in this paper and based on Integral Theory as described by Ken Wilber (2000a, b), offers an all-inclusive guide, or map, from which the counsellor can operate. As integral psychotherapist Forman (2010) points out, it may not be realistic for a therapist to use or master all therapies in all these dimensions; however, it is possible, for an individual therapist to honour and carry out an inclusive approach to treatment:

> An Integral therapist helps facilitate an exploration of the client's thoughts and emotions; supports appropriate behavior modification and lifestyle changes, including medication referrals, if necessary; aids in contemplation of issues of ethics, familial and cultural values, and ethnic and cultural identity; and encourages socioeconomic advancement and empowerment, *without the assumption that any one of these approaches must define therapy for a given client*. (Emphasis in original, p. 41)

Integral theory

The four basic perspectives

Integral Theory attempts to provide a map of reality that is as comprehensive and all inclusive as possible, drawing on as many perspectives as possible, and their resultant methodologies, to address the complexities that face us in the twenty-first century. Wilber's (2000a, b) Integral Theory, which he has been developing for over 30 years and includes over two dozen books, describes a framework of reality that includes comprehensive theoretical formulations of states of consciousness, such as waking, dreaming, sleeping, and various induced states such as meditative and drug-induced. It also addresses types, such as masculine/feminine, or introvert/extrovert and other personality formulations. Furthermore, it incorporates developmental theory, or stages or structures of

consciousness, and notes that development through these stages occurs both in individuals and societies or groups, and in lines or streams, such as cognitive, moral, self-identity, world-views, values and more.

Moreover, Zeitler (2007) notes that Integral Theory focuses on 'four ... basic and irreducible perspectives available to sentient beings, each of which has significant and important truths to offer' (p. 60). Forman (2010) states that this four-dimensional 'approach to psychotherapy, (focuses on) how to blend psychological, behavioral–biological, cultural, and socio-economic perspectives in psychotherapy', and this 'is the central foundation on which the other aspects of Integral Psychotherapy rest' (p. 5). Integral Theory then, as referred to in this paper, is to be distinguished from being 'integral', in that Integral Theory makes 'holistic' the starting point of the theory and its application, not the end product (Zeitler, 2007, p. 60). Although it is beyond the scope of this paper to thoroughly describe the Integral framework, I will limit our discussion of Integral Theory to these four key dimensions of any phenomenon – personal/individual, cultural, social/systemic and physiological/behavioural. Figure 1 illustrates the four quadrants.

To focus more clearly, the person and any part of their life will present both individual and collective perspectives, and these perspectives have both interior and exterior dimensions, each with different distinct characteristics that cannot be reduced to each other. The individual interior, or 'I' dimension, consists of those experiences that can be talked about and discussed, such as joy or fear, but cannot be located empirically or physically – they are subjective experiences. In terms of refugee experience, an example of the 'I' dimension is found in the story of Peter, as recorded in the Companion House (2008b) newsletter:

INDIVIDUAL

I **SUBJECTIVE (INTERIOR)** Thoughts, emotions, memories, states of mind, immediate sensations, intentions	**IT** **OBJECTIVE (EXTERIOR)** Physical body (including brain), and anything you can see or observe scientifically
WE **INTERSUBJECTIVE (INTERIOR)** Shared values, meanings, language, relationships, and cultural background	**ITS** **INTEROBJECTIVE (EXTERIOR)** Systems, networks, technology, governments, financial institutions, and the natural environment

COLLECTIVE

Figure 1. The four quadrants

> Peter had strong Post Traumatic Stress Disorder symptoms in the first three months after his release from detention. Two years after release from detention he still had profound depression and anxiety. Peter's self-confidence is greatly eroded and he continues to have a deep fear of authority. (p. 4)

On the other hand, there will be brain and body events which may correspond to the interior subjective feelings and intentions. These *can* be physically observed and located and thus they belong to the individual exterior, or 'It' dimension. Thus, the 'I' dimension refers to feelings, intentions, moods, affect, images, dreams and so on, while the 'It' dimension refers to physiological events such as brain activity, blood pressure, sweating, behaviours and issues of physical health. By way of example, again from Companion House (2008a), 'An older woman arrived in Australia as a refugee after 15 years in a refugee camp ... She ... suffered from a physical disability which limited her mobility and independence' (p. 5).

The two remaining dimensions are the interior and exterior of the collective. The social systemic, or 'Its' dimension, refers to such things as legal formulations, educational institutions, social service organisations, housing, transportation and political systems. From the perspective of a refugee, this could include one refugee's experience of the 'Its' dimension: '*because the refugees are put together with the Australians, like, to access the childcare, the payments and all these things, yes and for us it's really hard, because when we come here we have nothing completely . . . '* (emphasis in original, Shakespeare-Finch & Wickham, 2010, pp. 6–7).

The interior/subjective of the collective, or the 'We' dimension, refers to the meanings, values and understandings that groups of all sizes and configurations, including families and whole cultures share with regard to their experience – what it *means* to be 'one of us', and this dimension should not be ignored or underestimated by either the counsellor or the agency supporting the refugee client. According to Wilber (2000), there are 'substantial amounts of modern and postmodern research showing that cultural backgrounds ... profoundly mold perceptions in all domains' (p. 237, *n* 4). The refugee, as anyone else, sees the world through the lens of the shared meanings and understandings of their previous experience, or their shared understandings of their home country and its culture. The refugee then arrives in the new country and confronts new conditions but still 'sees' through the old lens – the values and shared meanings come with them even if the country, the conflict, the danger, does not. Thus they may not *understand* how these new conditions operate, and 'refugees may feel distrustful towards government agencies because of traumatic pre-migration experiences' (Colic-Peisker, 2002, Importance of ethnic community section, para. 5). For example, they may be afraid of police officers, or representatives from governmental agencies if in their country of origin they had to pay bribes to get things done. As another example, a refugee family arriving in a new country may notice family tensions arise as the children grow up in the new culture, taking on its values and meanings, and the parents remain entrenched in the ways of the old culture (Hodes, 1998, p.1).

Looking at this dimension positively, a refugee person makes sense of their situation and their values, including subsequent ways of thinking and making decisions, when these subjective dimensions are shared with others, including other refugees and perhaps members of the dominant culture, such as an understanding counsellor. For example, in Shakespeare-Finch and Wickham's (2010) study, 'Participants reported receiving friendship and emotional support from family members: " *. . . you can share something in common . . . they'll advise you, give you some company . . . Makes life a bit easier"* and,

from other Africans: " . . . *so many different people came from Africa . . . we become brothers, so everything we just cooperate together . . .* "' (emphasis in original, p. 8).

Our task here is to point out that often the counsellor's task is to assist the client 'to move fluidly between formerly achieved and presently achieved capacities as situations and roles dictate' (Forman, 2010, p. 63), thereby increasing effectiveness and growth and achieving a better quality of life. In other words, as a refugee grapples with challenges presented by significant changes in their life conditions, and seeks counselling for assistance, how can the counsellor best help them meet challenges in all four dimensions, integrate them and find greater problem-solving capacities within themselves, in an entirely new, and perhaps more complex bio-psycho-social-cultural context?

Key areas for counselling refugees from an Integral perspective

Counsellors should address the four basic perspectives

An Integral approach, by providing a comprehensive map to human experience, frees the counsellor to provide services in all the dimensions (interior, exterior, individual, collective) without privileging any of them (unless there is good reason) (Wilber, 2000b, p. 74). In other words, 'an integral therapy would therefore attempt to address as many facets of the quadrants (dimensions) as is pragmatically feasible in any given case' (Wilber, 2000b, p. 113).

Although it cannot be assumed that all refugees will be suffering from mental health pathologies *or* that conventional Western individual psychotherapy will be the most effective method for mitigating symptoms, counselling should take into account the 'I' dimension of personal subjectivity. According to the Forum of Australian Services for Survivors of Torture and Trauma, 'A high percentage of torture and trauma survivors suffer from extreme levels of depression and anxiety which manifest in ... sleep disorders, recurring and intrusive memories, poor self-esteem, difficulty in concentrating, sadness, fear, anger, guilt' (2006, p. vi). Individual psychotherapy is appropriate here, and Wilber states that '..individual therapy tends to involve strengthening boundaries ... contacting and befriending shadow feelings ... and cognitive rescripting ... but that bringing awareness to the facets of experience that were previously distorted or repressed in itself can be curative' (as cited in Araujo, 2008, p. 140). An example of interventions in the 'I' dimension could also include psycho-educational interventions such as 'providing information about the trauma reaction so that the symptoms themselves do not evoke excessive anxiety is invaluable . . . as this tends to allay fears' and can normalise their experience (Victorian Foundation for Survivors of Torture, 1996, p. 38).

In addition to the 'I' dimension, Integral counselling also takes into account the 'It' dimension of physical health, physiology and behaviour. Although the 'It' dimension is distinct from the other dimensions, as is indeed true of the others, interventions in any dimension can positively affect other dimensions as well, as is often the case with psychopharmacology. However, psychopharmacology may not be the only approach to healing in the 'It' dimension. For instance, Araujo (2008), discussing Integral Therapy for soldiers with symptoms of PTSD, reports that yoga, bodywork and massage can produce changes to brain and other body structures and bring relief from their symptoms, not only physiologically, but also in the 'I' and 'We' dimensions:

> Results have shown that soldiers are able to sleep better, with less insomnia, and feel less anxiety, depression, and fear. Participants ... also reported improved interpersonal relations and an increased sense of control of their lives, being paradoxically more comfortable with situations they could not control. (p. 147)

The counsellor, in concert with medical and other services, can take these issues into account and provide practical guidance, including health promotion with focus on nutrition, hydration, exercise and medications, and addressing substance abuse.

Counsellors should also take into account the 'Its' dimension and help the client negotiate the difficulties and challenges accessing services related to housing, finances, welfare support, transport, education, and so on. Ott, a psychologist who counsels refugee clients, states that 'most refugees come to counselling first to get practical help, especially in negotiating government bureaucratic form letters and procedures and rules' (personal communication, 13 June 2010). The counsellor's task therefore can include offering practical help in negotiating the bureaucratic complexities of modern Western society, so that the problem is resolved. It should be noted that not every refugee who seeks counselling will require individual therapy for psycho-emotional issues, and counsellors should not assume simply because of a traumatic background, intense loss and other aspects of refugee experience that a refugee is necessarily psychologically impaired. For example, the Victorian Foundation for Survivors of Torture (1996) notes that, 'Often workers believe therapeutic intervention only derives from a counselling process, however, resolution of practical issues generates substantial therapeutic benefits' (p. 35).

Integrally informed counsellors also take into account the 'We' dimension, or the cultural inheritance of the client, their relationships and the cultural and community attitudes of the host country. Thus, the Integrally informed counsellor will recognise the validity of issues arising from the challenges of aculturation and attempt to assist the client in accord with their own culturally appropriate needs and ways of healing. Timimi (1998) puts it this way: limiting oneself to a Western approach to healing 'often undermines the families and their culture's own methods and beliefs about healing and help ... More respect and understanding need to be shown to refugees' own cultural background ... Refugees find intrusive the attempt to professionalise and pathologise their experience'. Colic-Peisker (2002) describes this cultural tension: 'Western capitalist culture, especially its Anglo variety, places great emphasis on, and accords high status to individualism, efficiency, professionalism, competition, paid work, independence and privacy, leaving little room for communitarian, extended family models that value mutual support and interdependence' (Importance of ethnic community and extended family section, para. 8).

The relationship of the counsellor with the client, it should be noted, is itself an aspect of the 'We' dimension and remains foundational to the counselling process. Forman (2010) notes that 'empathic ability ... and multicultural awareness ... have been shown to positively correlate with identity development' (p. 21), positively impacting the therapeutic alliance, and thus the problem-solving capacity of the client. He points out in some detail that emotional and relational problems, especially when the client has experienced deep trauma, respond positively to the counsellor offering simple expressions of concern and care, verbally and nonverbally, and that these 'support the central task of defining self-boundaries at the most basic physical, emotional and verbal levels. As a consequence of this work, a sense of trust and safety can be built, upon which further development might take place' (p. 171). Araujo (2008) puts it this way, when speaking of the therapeutic relationship:

> This is summarised by clinicians and clients forging a shared experience of 'we' in the therapeutic setting, and using the therapeutic relationship to address relational difficulties, especially those to do with trust, communication, boundaries, and identity. Support, especially in a nurturing environment such as therapy, increases resiliency to the effects of trauma. (p. 142)

Government and NGO agencies, as well as counsellors, serving refugee clients need to be aware that a solution in one dimension, such as finding the client adequate housing or

a job, may or may not be adequately helpful unless the needs arising in all the dimensions are also addressed. If they are not, then there may be a fundamental mismatch between the client's personal/individual capacities, and the social/systemic and cultural context, and the counsellor's role becomes one of assisting both the agency and the client to bridge the resultant gap. For example, a male refugee client sought counselling support when he was offered culturally inappropriate work in a kitchen, which he saw as 'women's work' (Ott, personal communication, 13 June 2010). An Integrally informed counsellor will be able to effectively serve refugee clients by holding a four-dimensional model so that, whatever the client presents to the therapist, it can be located somewhere in the model. This will help the counsellor avoid the reductionist tendency, or the 'conceptual perspective ... to focus on clinical treatment of trauma rather than social, political and economic (and cultural) factors, which may also play a role in the health of the refugee' (Schweitzer, et al., 2002, p. 7). Summerfield (1999) states more emphatically 'interventions that ignore this (complexity) are in danger of being experienced as irrelevant or imposed and will fail' (p. 6).

In my own counselling experience, a client who had suffered significant abuse and trauma as a child and had developed into a creative and reasonably well-functioning young adult told me that what had helped him the most was certain people who 'took him in' and 'looked after him', and who gave him support of various kinds – in his words, 'someone who cares'. Together, we identified this caring support as the following: interior strengths such as creativity, resilience and ambition ('I' dimension), social support from agencies, financial support from government ('Its' dimension), relatively good behaviour and health ('It' dimension) and personal and professional relationships, such as counselling, that could be counted on ('We' dimension). Certainly, he had had many dark moments or episodes in his life *after* his abusive experiences had finished, but from his perspective, none of it mattered as much as someone with a generous spirit, an attitude of caring and compassion, who could spare him some of their time, their resources, their encouragement, their skills and their own self.

As a map or guide to human experience, Integral Theory offers a comprehensive view of how life is experienced, and as such it can be very useful to the counsellor in at least three ways. First, Integral Theory can be used in assessment to help the counsellor understand the clients' needs – where does what the client presents fit on the map? Which dimension is being brought forward here? Which is being ignored or minimised? Second, Integral Theory can guide the interventions the counsellor chooses to provide, focus on or recommend, depending on whether the issues presented are more or less individual, collective, interior or exterior, or an inter-related complex of issues from multiple dimensions. Third, both during and after the counselling process has concluded, the counsellor can use Integral Theory to evaluate the outputs and the outcomes, or the procedures and the results, of the process as it unfolds. What dimensions are the most important for the client? What actually happened that made a difference for the client – was it more or less cultural, social/systemic, physiologically oriented or based on insight or reduction of fear? Furthermore, Integral Theory can also be used effectively to guide future research by applying methods that are appropriate to the particular dimension(s) being studied.

Conclusion

We have discussed the counselling of refugees from an Integral Theory perspective, with particular focus on the four dimensions of reality, and have noted that all these dimensions are equally important and deserve full consideration, while also noting that one or more dimension(s) may have particular relevance to the client at a particular time.

When assisting the refugee client, the therapeutic goal could be seen as helping the client attain better cultural connectedness ('We'), more social competence in the new living conditions confronting them (Its), a reduction of inordinate levels of fear, anxiety, and inner conflict ('I') and healthy physical functioning and behaviours ('It'). In other words, the counsellor, while holding an Integral perspective which views all four quadrants simultaneously, is charged with helping the client develop a greater capacity to attain a balance of stability and effictiveness in the new conditions as they arise in the four dimensions.

Integral Theory invites the counsellor to view the client not so much as a refugee, but as a being, a subject-self *having* a refugee experience. These experiences arise in all four dimensions simultaneously, and presents us with opportunities to assess, intervene and evaluate our interventions with a truly holistic and comprehensive map as our guide. In this way, we may be able to effectively assist the refugee client to heal the wounds of trauma, and increase capacities for awareness, connection and healthy functioning in the context(s) in which they find themselves.

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Some additional resources on Integral Theory

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http://www.integrallife.com
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