An Exploration into Trauma and Healing:

Using a Focusing-Orientated Art Therapy Approach

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Abstract

How can using one art therapy activity which integrates all three stages of trauma therapy as outlined by Judith Herman (1992b), help survivors of trauma and abuse heal? What precautions need to be made to assure safety and stabilization are established and felt throughout?

This thesis is an exploration and discussion on the integration and benefits of Focusing-Orientated Art therapy (FOAT), mindfulness and the 3 stages of trauma therapy (Herman, 1992b) into an activity which functions to increase safety and stabilization and healing from trauma and abuse. This activity was an emergent adaptation of one created by Laury Rappaport (1998). With a here-and-now focus on the adaptation and responsive approach this art directive took during session, we will look at the process used by a group of women who were working on healing years of abuse and Complex Post-traumatic Stress (C-PTSD) symptoms.

A key component of this discussion is the relating of pertinent theory to the process of art therapy in a group setting working with survivors. The need for staying in the here-and-now becomes evident as we explore the way the directive unfolded in session. Establishing safety was paramount and imperative when working with this population. I will highlight the benefits and effectiveness of the directive in the final discussion by connecting the art making process to relevant theory.

This art directive has also been explored within the context of relevant theory of attachment (Bowlby, 1969, 1988), feminist (Brown, 2004, 2010), trauma informed (Herman, 1992b; Malchiodi, 2015; Van Der Kolk, 2014) and Focusing-Orientated (FOT) (Gendlin, 1978) therapies. The integration of creating a resource image and connecting to a ‘felt sense’ with the

use of mindfulness and connecting to a higher power became a significant part of this directive in response to client needs. A focus on therapeutic interventions and the various obstacles and challenges that may come up when working in this area will also be investigated.

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"The first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery." (Herman, 1992b, p. 133)

How can using one art activity which integrates all three stages of trauma therapy (Herman, 1992b; Rappaport, 1998) help survivors of trauma and abuse heal? What precautions need to be made to assure safety and stabilization is felt throughout? In looking at the three stages of trauma therapy outlined by Judith Herman (1992b), my research explores a directive that I have modified and adapted and called "*Let me be free: in 1, 2, 3*" used with female survivors of trauma and abuse.

My approach used in executing this directive was initially inspired by the directive described in Laury Rappaport's article *Focusing and Art Therapy: Tools for Working Through Post-traumatic Stress Disorder* (1998). Rappaport is a Focusing-Orientated art therapist and developed an art activity using Judith Herman's (1992b) three stages of trauma therapy. With further personal reflection and advice from my supervisor Millie Cumming in supervision, I adapted the directive spontaneously in response to the clients' needs during the session; altering the directive throughout to facilitate the therapeutic experience the women were having.

I have taken a theoretical and practical exploration of Laury Rappaport's (1998, pp.1-6)

Focusing-Orientated Art activity utilizing and integrating mindfulness, attachment and art therapy to address the three stages of trauma therapy when working with survivors of trauma and abuse. A Focusing-Orientated Psychotherapeutic model designed by Eugene Gendlin (1978) underlines the bulk of my exploration into trauma therapy and the art directive used. My approach in this study uses a feminist model of understanding, focusing in particular on traumas that have typically been ascribed to women and children. Using a strength based model (Saleebey, 2005), art and mindfulness were integrated to 'safely' explore the memories of trauma. With an emphasis on staying open and responsive to the needs of the clients in the here-and-now, the art directive evolved.

The question of how to work with women who have experienced trauma and not to re-traumatize by having to go directly into the trauma again or having to witness other's trauma was ongoingly evaluated throughout the process. It was also a request by the members of the group to not dive into the details of their trauma, mentioning that they had experienced this in past therapies and did not find it helpful.

Paramount in my exploration was the importance of empowering these women. They were encouraged to honour their internal feelings at all times and given space to take care of what their needs were as they arose. The positive effects of this activity were intended to stimulate growth, self-awareness and internal strength within the client.

It was my intention for this art directive to facilitate internal shifts psychologically to assist these survivors to move through the second and into the third stage of trauma therapy: Acceptance and Reintegration into Ordinary Life (Herman, 1992b, p. 196). This was done in a manner that felt safe to the clients and allowed them to take the lead in their own process. Using a feminist perspective and checking in with the clients throughout the process allowed for the

continued assessment on how to support them to feel their internal desire and power to take care of themselves. The intent of the therapy was to assist in building this capacity within so that the survivors were moved to overcome the repeated and continued effects of trauma and symptoms related to Post-traumatic Stress Disorder (PTSD).

This discussion will include ways to decrease the effects of Post-traumatic Stress Disorder (PTSD) by revisiting the trauma in a manner that is resourced and supported so that memories don't 'fragment' or destabilize the client emotionally.

A look into the history of trauma will set the frame for the necessity of precautions when working with trauma survivors. Beginning with an understanding of how trauma has been worked with in the past as well as the political underpinnings that have shaped societies understanding of trauma will be explored.

Using a body focused and mindfulness approach follows the research of leading therapists, theories and manuals (Alexander & Rand, 2009; Carey, 2006; Gendlin, 1978; Herman, 1992b; Levine & Frederick, 1997; Malchiodi, 2008, 2011; Rappaport, 1998; Rosenberg, Rand, & Asay, 1985; Rubin Wainrib, 2006; Van Der Kolk, 2014) which I have referenced throughout my exploration of trauma and transcending the effects of Complex PTSD.

So why do we need to work and pay attention as therapists to not re-traumatize our clients? How does this happen when the goal is to help? Pathologizing symptoms and treating these instead of the underlining issues can result in misunderstandings about what trauma survivors need (Van Der Kolk, 2014). Following the important steps initiated by Judith Herman (1992b) outlined in this discussion, the clients were guided on a path of healing that honoured the uniqueness of their own personal experience.

Above all, my approach in researching the material and in my writing was to acknowledge the *impact* trauma has rather than the *illness* or *disorder*. Through this exploration, I hope to move the conversation from "*What is wrong with you?*" to "*What has happened to you?*" Through the making of art and deep reflection that reached underneath the scars to move and shift awareness and behaviours, support was given to assist these women in transcending and healing the effects trauma had on their lives.

Based on personal experience and research on this topic, it is my belief that mind/ body focused modalities of therapy are most effective and empowering to the survivor in alleviating symptoms of trauma. For this reason, it was important that the directive first focused on connecting the women to their *felt sense* (Gendlin, 1978) through a brief meditation exercise. It was through connecting with this felt sense within the body that they were encouraged to acknowledge and remember the strength they had in overcoming traumas previously faced in life.

When I was first inspired to use this activity, I remembered my own experiences that took place while working with thick black paper as a background and frame to a large white mandala circle. Because the materials felt grounding for me, I chose to include them in the activity for the women. I also reflected on the materials mirroring attachment in the therapeutic session (Carpendale, 2009; Rubin, 2001). The materials were intentionally chosen to be securely attached to one another and others not. Using the materials symbolically, I invited an opportunity for deep reflection in what feelings and experiences felt attached to self and where they may have originated. The process worked on both conscious and unconscious levels.

A sense of control and empowerment was evoked through reflecting on what feelings, symbolized by the materials, could be moved. This process also encouraged and supported an

affirmation around establishing healthy boundaries (Cumming, 2013; Schaverien, 1999). John Bowlby (1969) a pioneer in the field of attachment theory speaks of the potential for early attachment disruptions to be symbolically repaired within the therapy sessions. With new insights into Object Relations Theory, “The therapeutic situation is now seen as an interpersonal, inter-subjective matrix within which at least some developmental deficits can be repaired” (Irwin, 2001, p. 80 as cited in Rubin, 2001).

Throughout this thesis, I explore the effects trauma has and the ways in which art therapy, Focusing-Orientated therapy (FOT), and Judith Herman’s 3 stages of trauma and therapy work collaboratively in an art directive experienced by a group of women moving to end a life time of debilitating PTSD symptoms.

Chapter 1:

A Theoretical Framework: Feminism and Trauma Informed Therapy

How can using one art activity which integrates all three stages of trauma therapy help survivors of trauma and abuse heal? What precautions need to be made to assure safety and stabilization is established and felt throughout? In this chapter I will explore feminist theory and the ways in which it developed as well as the cultural and social conditions that were happening during it's development. An in depth exploration into how therapy and diagnoses for female survivors of trauma have changed over a hundred year span will also be a focus in this chapter. Also included is a clear description of Judith Herman's three-stage trauma therapy model, the symptomology of PTSD and C-PTSD, and how the two diagnoses differ. Finally, we will look into the impact trauma has on people in both positive and negative ways focusing on symptoms, healing, post-traumatic growth, vicarious trauma and early attachment disruptions.

Feminist Theory

Throughout my inquiry into using this art directive, I have taken a feminist approach using current, relevant feminist theory (Brown, 2004, 2010; Mahaney, 2007; Marecek, 2001a). My intention is to show what the historic and present treatments are for women dealing with trauma. For this reason I wish to expand on what feminist theory is, how it arose in our culture, and the relevance of taking this approach when working with this population. Laura Brown (2004), a feminist psychotherapist, leading researcher and author of several books and publications on this subject defines feminist therapy as:

> The practice of therapy informed by feminist political philosophy and analysis, grounded in multicultural feminist scholarship on the psychology of women

> and gender, which leads both therapist and client toward strategies and solutions advancing feminist resistance, transformation, and social change in daily personal life, and in relationships with the social, emotional, and political environment. (2004, p. 22)

Development. During the late 1960's within the United States, an atmosphere that triggered change in human rights was in full force. Included in this revolution was the second wave of feminism (Marecek, 2001a). Women lobbied government and gathered together creating conscious raising groups. The intention of these was to discuss and transform the ways in which women were treated. By investigating the traditional roles women were conditioned to fulfill, these groups highlighted the reality of how traditional roles restrained and isolated women from each other.

The feminist movement activities that formed during this time helped women come together to share their interests and discuss major factors that had a significant influence on their lives (Israeli & Santor, 2000). Having the support of other women with similar viewpoints empowered women and brought up issues that needed addressing in a larger social context.

During this time, several organizations began programs specifically designed to help women, such as domestic violence shelters and women's health centers. Within the mental health profession, these areas had previously been for the most part, neglected (Brown, 2010). These organizations raised awareness and social consciousness about women's rights, which impacted many women of the time, therapists among them. These therapists formed the first feminist therapy groups, which were founded on the principles of equality, mutual respect, and empowerment (Johnson & Worell, 1997).

The Association for Women in Psychology (AWP) established in 1973 (Tiefer, 1991), further fueled the feminist therapy movement with more research being done on gender biases. Feminist psychologists rose awareness on how women's mental health issues had historically been neglected. This was very important in the 1970's since the top recognized publications had still not included any chapters related to therapy with women (Johnson & Worell, 2001). Feminist therapy evolved to remedy the biases against women that were created by society, as well as earlier psychotherapeutic theories, which were based around negative connotations towards feminine characteristics and roles (Brown, 2004; Johnson & Worell, 1997).

Theory. By the 1980s, several feminist theories emerged to test traditional theoretical frameworks (Marecek, 2001b). In time, research began to shift as professional women began to lobby for the implementation of research to further understand more knowledge concerning women in therapy. Gerald Corey (2008) stated that "they took the stance that therapy needed to move away from an intra-psychic, psychopathology perspective to a focus on understanding the social, political, and pathological forces in society that damage and constrain girls and woman, as well as males" (p.342).

As a therapeutic model, feminist therapy is influenced by a number of philosophies: Rogerian, Adlerian, and Gestalt therapies (Marecek, 2001b), as well as several kinds of feminism. It is a person-centered, politically informed model that understands treatment within a cultural context. A major goal in feminist therapy is to empower the person in treatment. This is done through a number of areas; one being to establish a more egalitarian relationship between client and therapist and a collaborated effort to working on treatment goals (McEvoy & Ziegler, 2006).

Therapists are encouraged to offer a non-hierarchal relationship by emphasizing mutuality and equality. According to Corey (2008), feminist therapists understand that it is when the therapist gives the client a sense of control that they are best able to understand their situation. This egalitarian approach also helps distribute the power of the client and the therapist equally in order to resolve the conflict for which the client is seeking assistance.

Very importantly, feminist therapy does not promote the use of labels or diagnoses unless the client chooses to seek or determine their own diagnosis (McEvoy & Ziegler, 2006). There is a focus on establishing a strong self concept by restructuring and enhancing personal beliefs about identity and at the same time understanding the importance of social transformation within one's self.

There is a continued analysis of social and gender roles with an exploration of how roles function, which will serve the client best and which are more fluid or require change. By making gender issues transparent, women are both empowered and changed as they engage in actively understanding how certain issues affect their behavior (Mahaney, 2007). Encouraging women's empowerment, communication, assertiveness and self-esteem helps them discover how to break free from some of the traditional roles that they may feel are hindering their growth and development. With gender being a primary focus, therapists must understand and be sensitive to how psychological oppression and socialization influences identity development, and in particular the stereotypes derived from traditional views on gender which can affect one's identity be them male, female or transgendered (McEvoy & Ziegler, 2006).

As another way to empower and help women to feel greater support in their lives, feminist therapy encourages and inspires those in treatment to incite social change, strengthening

their sense of self as they are able to see that they are connected to a greater whole (Israeli & Santor, 2000). There is an impetus within this therapy to prevent psychological distresses and inappropriate behavior in both genders by not only helping to change the individual's situation or mindset, but to also change the way our culture and society views gender issues.

In looking at the development and expansion of feminist theory within the past forty years, we see an increased understanding and evolution from it focusing on fixing gender biased issues to a model of practice that uses gender, social location and a strong emphasis on the egalitarian model to understand human difficulties (Brown, 2004). By changing how society and individuals define gender and the roles ascribed to either sex, we are better able to take on the issues that female clients live with (Johnson & Worell, 1997).

The goal of feminism today is to honour feminine attributes in a way that embraces all aspects and facets of femininity rather than promoting the idea that women need to embrace masculine behaviours (Gonzalez, 2004). Feminist theory encourages omitting theories that hold onto sexist notions that have contributed to the ways women have been unfairly treated, while not abandoning core psychological theories that have been effective (Guindon, 1998).

The History of Trauma Therapy

History. Over the past century, trauma therapy has evolved considerably. In the 1890's Sigmund Freud made the correlation that what was termed "hysteria" was linked to early psychological traumas (Herman, 1992b, p. 12). He also postulated that hysterical symptoms could be alleviated when the traumatic memories and feelings beneath these were put into words (Freud, 1896). This mode of therapy was referred to by one of Freud's first patients as the "talking cure" (Herman, 1992b).

Sigmund Freud was one of the most well known psychotherapists to connect early childhood sexual abuse with neurosis in later life. In 1896 he published a report based on 18 case studies called “The Aetiology of Hysteria”. He believed strongly in his findings and stated, “I therefore put forward the thesis but which can be reproduced through the work of psycho-analysis in spite of the intervening decades…. I believe that this is an important finding, the discovery of a caput Nili in neuropathology” (Freud, 1896).

Hysteria was one of the most common disorders of the time (Herman, 1992b). By saying that it was linked to early childhood sexual abuse pointed to the fact that this form of abuse was happening at epidemic rates. The reflection this gave to the society Freud was a part of, possibly even implicating those he knew and respected, caused a backlash of ostracization for himself (Gray, 2013). In a letter Freud wrote to his confidant Wilhelm Fliess dated May 4th, 1896 he described the reaction of his professional peers, “I am as isolated as you could wish me to be: the word has been given out to abandon me, and a void is forming around me” (Masson, 1984). His peers and the dominant culture of the time did not accept his theory on the effects of sexual abuse.

One can only hypothesize exactly what then happened for Sigmund Freud but we are aware of the social pressures from his peers he was experiencing after publishing his ideas on hysteria. In looking at the political environment at the time he published this document, it’s interesting to note the rise and evolution of the Suffragette’s movement where women were mobilizing to bring women’s rights to the forefront. The question arises, would Freud be seen as a supporter of women’s rights with his new findings? It would certainly not help an aspiring young professional to align with (at the time) such a controversial movement. Of course this is all speculation but worth exploring empathetically with unclouded judgment.

By the first decade of the twentieth century, Freud (1925) claimed that the clients he saw with effects of hysteria that had remembered their accounts of sexual abuse were untrue. "I was at last obliged to recognize that these scenes of seduction had never taken place, and that they were only fantasies which my patients had made up" (Freud, 1925, p. 34). Counter to his earlier findings that "…at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience…" (Freud, 1896, p. 203). The inquiry and research into sexual abuse, trauma and the study of ways to cope and heal were halted for decades after this.

The dominant ideas and theories of psychology that would permeate therapy for another century would be based on women's reality being stifled. The views of Freud developed into fundamental understandings in the field of psychology. For years the attitude and belief among leading psychotherapists was that early traumatic events did not play a pivotal role in the later development of neurosis in women (Herman, 1992b). It is a wonder what trauma therapy would look like today if back in 1896, Freud's first findings on the links between trauma and sexual abuse had been explored, accepted and understood further.

In 1974, Doctors Alfred Freedman & Harold Kaplan published the *Comprehensive Textbook of Psychiatry*. Although now updated and edited, this is a highly regarded textbook used by students studying the profession of psychology and psychotherapy around North America. In the 1974 edition, it stated that "incest was extremely rare and did not occur in more than 1 per one million people" (1974, p. 1536). It then stated, "Such incestuous activity diminishes the subject's chance of psychosis and allows for a better adjustment to the external world….The vast majority of them were none the worse for the experience" (1974, p. 1536 as cited by Van der Kolk, 2014, pg 141). This is just one written example of the beliefs at the time. This perspective ignited an out-cry from the feminist movement of the 1970's and women began

speaking out about trauma, abuse and how it had affected them through life. A shift in perspective was about to occur.

The Effects of War. With the rise of war and combat veterans returning home after WWII with symptoms of PTSD, psychologists began to look again at trauma and its effects. However, the war brought much needed help to the economy and within society there was a stigmatization of shame in not being able to contain the effects war trauma created. Those returning home with symptoms of trauma were listed as not being fit for military duty (Herman, 1992b).

The idea that war veterans could suffer similar symptoms to women and children who had experienced domestic abuse brought a much needed correlation and moved the scientific world into more research and acceptance around all types of trauma (Herman, 1992b).

When similar symptoms of trauma and the effects it caused started showing up again with Vietnam veterans, trauma research and study started gaining more attention. At the time, there was no formal diagnosis for the effects of trauma. How do you treat something that is not fully understood? In 1980 a shift in the way trauma was looked at happened when the diagnosis of Post-traumatic Stress Disorder (PTSD) was accepted and published in the Diagnostic and Statistical Manual (DSM) III of the American Psychological Association (Van Der Kolk, 2014).

With this acknowledgment of the psychological effects of trauma, the stigmatization and shame that accompanied it was lightened, albeit slightly (Van Der Kolk, 2014). The diagnosis of PTSD was then adopted by the American Veterans Association as a possible side effect of combat soldiers returning home; veterans were finally able to access needed services to help relieve their painful symptoms. It would appear that taking care of soldiers had a higher

precedent than admitting that domestic and childhood abuse was as prevalent as it was and had just as damaging if not worse consequences. Although finally, trauma was being discussed and solutions for caring for those that suffered from its effects were being looked at.

A New Diagnosis. The research and publications of Judith Herman (1992b;1997), Bessel Van Der Kolk (2014) and Peter Levine (1997) have had a large influence in pioneering and revolutionizing the way trauma is dealt with in psychotherapy. The effects of trauma are still being studied to this day and it is recommended that therapists working with patients displaying signs of trauma be cautious in pathologizing symptoms within the medical model of mental illness (Coco et al., 2011). The history of trauma with each client needs to be assessed carefully in order to establish the relationship between symptoms and trauma history (Van Der Kolk, 2014).

The current movement within the field of trauma therapy is advocating for the use of new terminology and diagnostic criteria within the DSM to expand on PTSD (Courtois, 2004; Herman, 1992a; Roth, Newman, Pelcovitz, Van der Kolk, & Mandel, 1997). With renewed understandings of trauma, Developmental Trauma Disorder (DTD) (Van Der Kolk, 2014, p. 264) describes the symptoms resulting from early exposure to trauma and abuse over a period of time and the ways in which it affects people developmentally. Other diagnoses that have been advocated for inclusion into the DSM to address the affects of interpersonal trauma, are Complex Post-traumatic Stress Disorder (C-PTSD) outlined in 1992 by Judith Herman and Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Ford, 1999; Pelcovitz et al., 1997). Before the publication of the DSM 4 in 1994, a research group of 19 professionals that included Judith Herman and Bessel Van Der Kolk advocated for the inclusion of these diagnoses. They were supported by current research findings and strong evidence based understandings (Herman,

1992b). These new diagnoses have been written about in many mainstream journals and publications (Courtois, 2004; Herman, 1992a; Pelcovitz et al., 1997; Roth et al., 1997; Van Der Kolk, 2005; Zlotnick et al., 1996), yet none of these were included in the DSM-4 or DSM-5, published in 2013 (Herman, 1992).

In light of this fact, the question arises: how do you treat someone for whom there is no diagnosis? In order for trauma victims to be fully represented and not pathologized with various misdiagnoses, a clear understanding and diagnostic criteria need to be included in this manual that is used by almost every institution dealing with social welfare. "When there's no relationship between diagnosis and cure, a mislabeled patient is bound to be a mistreated patient" (Van Der Kolk, 2014, p. 124).

> This was a tragic exclusion. It meant that large numbers of patients could not be accurately diagnosed and that clinicians and researchers would be unable to scientifically develop appropriate treatments for them. You cannot develop a treatment for a condition that does not exist. Not having a diagnosis now confronts therapists with a serious dilemma: How do we treat people who are coping with the fall-out of abuse, betrayal and abandonment when we are forced to diagnose them with depression, panic disorder, bipolar illness, or borderline personality, which do not really address what they are coping with? (Van Der Kolk, 2014, p. 107)

Because the history of psychotherapy's understanding of trauma and how it affects one has been to focus on symptoms rather than the cause, it is important to take a feminist perspective; honouring the victim's experience and not pathologizing and mislabeling a person displaying the effects and symptoms of PTSD.

> The tendency to blame the victim has interfered with the psychological understanding and diagnosis of a post-traumatic syndrome. Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the victim's abusive situation to the victim's presumed underlining psychopathology. (Herman, 1992b, p. 116)

Political Underpinnings. When taking a feminist approach and working to understand the evolution of trauma therapy, we also take into consideration the political underpinnings that were happening at the time (Brown, 2010). It is apparent that the way trauma has been understood and interpreted and *what* traumas have been accepted follows a tight line with the interests of the dominant culture procured at the time (Herman, 1992). Whether it be soldiers needed for war or the sexual interests and exploitation of children and women, (Estés, 1992; Herman, 1992b; Steinem, 1995; Van Der Kolk, 2014); there is a direct correlation with the inequalities people experience and the needs and wants of the dominant culture. This behaviour of entitlement creates a power imbalance that does not serve the whole of society. However, as our society shifts and opens to understanding trauma and its effects with compassion instead of control, diagnosis and treatment plans can be adapted to serve in a way that remove barriers to healing. When a need for healing is accepted by an individual, barriers in the system only serve to re-traumatize and take away hope of the survivor.

Psychopharmacology. Many debates have ensued about the advantages and precautions of using drugs to alleviate the responses to trauma. An interesting response to this is found in Bessel Van der Kolk's book *The Body Keeps the Score* (2014):

> The theory that mental illness is caused primarily by chemical imbalances in the

> brain that can be corrected by specific drugs has become broadly accepted, by the media and the public as well as by the medical profession. In many places drugs have displaced therapy and enabled patients to suppress their problems without addressing the underlying issues. (Van Der Kolk, 2014, p. 25)

He, like many trauma therapists advocate for the empowerment of the client, and that it is the therapist's responsibility to encourage this. Although sometimes, pharmacological assistance *is* needed for stabilization and emotional regulation, all too quickly are members of the medical community concerned with alleviating symptoms instead of finding the root of the ailment.

> When we ignore the (power people have within to overcome trauma), we deprive them of ways to heal from trauma and restore their autonomy. Being a patient rather than a participant in ones healing process, separates suffering people from their community and alienates them from an inner sense of self. (Van Der Kolk, 2014, p. 27)

Three Stage Model of Trauma Therapy

Judith Herman first published the three-phase model of trauma therapy in 1992 in her book '*Trauma and Recovery*'. It is a person-centered model of trauma therapy using a feminist approach that honours the experience of the victim. Of greatest importance in this approach is creating safety and stabilization for the client to securely explore and later transcend the effects of trauma and symptoms of PTSD. Within it, she describes the healing process of people who struggle with a combination of problems related to abusive or traumatic experiences in their past. This model has been adopted and expanded on by other leading trauma psychologists including Bessel van der Kolk (2014), Cathy Malchiodi (2015), Peter Levine (Levine & Frederick, 1997)

and Christine Courtois (2004). Because so many theorists, researchers and clinicians support this perspective, it is sometimes referred to as the Consensus Model (McEvoy & Ziegler, 2006).

Stage One: Safety and Stabilization. This stage involves working toward internal and external safety for the client. It begins by building a therapeutic alliance and relationship with the therapist so the client feels safe to move forward. Some areas that may be focused on in this stage are understanding the impacts of trauma and violence, personal self-care, addressing problems with alcohol or drugs, depression, eating behaviors, self-harming behaviors, physical health, panic attacks, dissociation, and especially developing and strengthening skills to increase one's capacity to manage and minimize unhealthy responses to painful and unwanted emotions and flashbacks (Herman, 1992). Through learning these skills, the client becomes more secure in the internal power they hold to heal.

Tapping into and developing one's own inner strengths, and any other potentially available resources for healing, is very important in the healing journey. Relationships in the client's life may be explored to ensure that they are safe and supported in these (McEvoy & Ziegler, 2006). Treatment goals are also discussed with a focus on various approaches that may be used to assist in reaching these.

During this stage of therapy, discussing a client's memories should not be the focus of therapy but a means to achieving safety, stability, and greater ability to take care of oneself. Especially if memories of abusive experiences are repressed, it is important in the first stage of recovery and treatment that they are not discussed or processed (Herman, 1992). Of course, everything is not always so perfectly ordered and sequential. It may be necessary to discuss parts of disturbing memories when they are disrupting one's life so the client is able to manage them, and understand that these memories are affecting their ability to feel safe.

There is a delicate balance within the therapeutic relationship that needs to be observed; by going too fast when working with trauma survivors, the therapist may be put in the role of perpetrator if they present as intrusive or investigative in their manner and approach. However, by going too slow, the therapist may put themselves in the role of the passive bystander who sees, but says nothing (McEvoy & Ziegler, 2006). Both of these approaches can recapitulate the trauma within the therapeutic setting.

> Because the tasks of the first stage of recovery are arduous and demanding, patient and therapist alike frequently try to bypass them. It is often tempting to overlook the requirement of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is avoidance of the traumatic material, probably the second most common error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance. (Herman, 1992)

Once these 'stage-one' goals of building capacity for personal safety, genuine self-care, and healthy emotion-regulation have become standard operating procedures, great progress and many new choices become possible.

Stage Two: Remembrance and Mourning. When safety and stabilization have been achieved, trauma therapy moves into the second stage, which addresses the deeper impact of trauma by processing and integrating the traumatic experiences. It becomes a time of grief and mourning (Herman, 1992) as clients begin to deconstruct negative beliefs that have formed within them as a result of the trauma (Roth et al., 1997), and work to develop positive schemas or beliefs (McCann & Pearlman, 1990).

As this stage continues, clients work to alleviate their post-traumatic symptoms by actively intervening when they arise (Briere, 2002). By reviewing and discussing memories that have happened in their past, they begin to lessen the emotional intensity that is brought on by these memories. This can only be done once the client feels safe, resourced and secure. Through this experience, the client also begins to revise the meanings for their life and identity. They reconstruct the effect their traumas have had on them. They are able to face their experiences, which could also include mourning for experiences they did not have but wished for like secure attachment or love (Van Der Kolk, 2014). It is in the therapeutic relationship that this can be explored as the client fosters the ability and inner resources to accept their life and feel strength within to deal with pains of their past.

However, sometimes after the first stage of therapy has laid out a foundation of safety and stability, a client may discover that thinking and talking about painful memories is not necessary to achieve their goals. If they find that the memories are no longer disrupting their life, the therapist needs to honour what the clients feels they need and be sensitive to their reasons for not wanting to explore the trauma.

For those who choose to direct their attention to the disturbing memories that are still disrupting their lives, several memory-processing methods can be used including Eye Movement Desensitization and Reprocessing (EMDR) (Van Der Kolk, 2014, p. 183). In chapter three, I will discuss further the theoretical aspects of EMDR and a resource image that were woven into the art directive I used in stage two: remembering and mourning.

Stage Three: Acceptance and Reintegration into Ordinary Life. The third stage of recovery focuses on reconnecting with people, meaningful activities, and other aspects of life. Perhaps best stated by Judith Herman (1992), “this is a time for reconnection with others and

with ordinary life" (p. 155). During this stage, the therapist becomes a sounding board as the survivor practices new learnings and behaviours and builds new experiences (McEvoy & Ziegler, 2006). By this point they will have developed their internal strengths and resources. When the therapy moves into this stage where the therapist listens and holds the space rather than actively working to help stabilize the client, the client feels more empowered which is one of the main focuses in this feminist based model of trauma therapy (Herman, 1992b).

Common to All Stages. As mentioned, these stages are not always concurrent. The therapeutic process may vacillate from one stage to another and then back again to an earlier stage. The healing journey needs to be adaptive to the needs of the client. Throughout all stages of treatment, it is often necessary to address psychological themes related to one's history of unwanted or abusive experiences. Some of these are core issues that will determine the nature and structure of treatment. They include:

1. Powerlessness
2. Shame and guilt
3. Distrust
4. Reenacting abusive patterns in current relationships

("Herman's Stages of Recovery," n.d.)

When these themes and dynamics are obstacles to safety, self-care, and regulating one's emotions and behavior, they must be addressed in the first stage of treatment before the client is able to move into the following stages (McEvoy & Ziegler, 2006).

With the help of therapy, the client is encouraged to recognize habitual behavior patterns they possess and then shift them so they no longer engage in self-defeating and self-destructive

behaviors that are outside of their conscious awareness. By increasing awareness of these themes and dynamics, the client develops a clearer understanding of them and becomes able to take responsibility for them when they arise, which in turn gives them the capacity to choose new, healthier responses and actions ("Herman's Stages of Recovery," n.d.).

Trauma, Attachment and Attunement

For children to develop in healthy ways, attachment to a primary caregiver is imperative (Bowlby, 1969). Traumatic experiences during this time and especially when at the hands of a child's caregiver, cause disruptions in attachment bonds that may lead to lasting effects into adulthood. "The interplay between attachment and trauma is critical to assessing and responding to survivors of childhood abuse, as is understanding attachment patterns and issues for adult victims of violence" (McEvoy & Ziegler, 2006, p. 21). Therefore, attachment and trauma require equal attention. How does a person's inner reality shape the way they see the world? When looking at early attachment disruptions and the psychological effects they have in adulthood, there is a clear correlation between children that have not had secure attachment bases to those that have (Bowlby, 1988). As humans, our first lessons in self-care are learned by the way we were cared for as children.

> Mastering the skill of self-regulation depends to a large degree on how harmonious our early interactions with our caregivers are. Children whose parents are reliable sources of comfort and strength have a lifetime advantage—a kind of buffer against the worst that fate can hand them. (Van Der Kolk, 2014, p. 84)

John Bowlby (1988), who developed attachment theory, saw this inborn capacity as a

product of evolution. As a child develops a natural communication system with their caregiver, the primary attachment bond is formed. "The more responsive the adult is to the child, the deeper the attachment and the more likely the child will develop healthy ways of responding to the people around (them)" (Van Der Kolk, 2014, p. 84). Bowlby saw attachment with one's caregiver as a survival mechanism where there was a secure base from which the child could feel safe to move out and explore the world around them (1988). Having a safe haven early on promotes self-reliance and cultivates a greater trust in one's sense of self (Herman, 1992b). From the attachment bond, children learn about empathy and that others have thoughts and feelings similar and different from theirs; they develop self-awareness, impulse control and self-motivation (Van Der Kolk, 2014).

For those who have experienced trauma, an interesting dialectic develops between needing attachment and isolating oneself. Judith Herman brought light to this when she said, "The terror of a traumatic event intensifies the need for protective attachments. The traumatized person therefore frequently alternates between isolation and anxiously clinging to others" (Herman, 1992b, p. 56). Children crave the natural protection of a parental figure. When this need is twisted into one that does not bring refuge but instead pain, a major disruption in social interaction develops and one's sense of trust in others is thwarted (Van Der Kolk, 2014). In Bessel Van Der Kolk words, "Terror increases the need for attachment, even if the source of comfort is also the source of terror" (Van Der Kolk, 2014, p. 100).

Often noticed in survivors of abuse is a connection to their captors or abusers that seems to defy logic. This happens to abused children as well as victims of domestic abuse and prisons of war or captivity (Herman, 1992b). So often we hear stories of women allowing their abusive partners to return home even after restraining orders have been put in place or hostages putting

up bail for their captors or wanting to marry or have sexual relations with them or children wishing to stay with abusive parents instead of being put into protective custody. Emotionally bonding with an abuser is actually a strategy for survival for victims of abuse and intimidation (Carver, 2009). This behaviour, sometimes referred to as "Stockholm's Syndrome" (Herman, 1992b, p. 82) points to how attachment disruptions can negate the innate need to protect and care for one's self even in the face of danger. "Attachment between hostage and captor is the rule rather than the exception. Prolonged confinement while in fear of death and in isolation from the outside world reliably produces a bond of identification between captor and victim" (Herman, 1992b, p. 82).

If the foundation of healthy attachment has not been instilled early on, the survivor becomes vulnerable to similar experiences where they are unable to navigate or protect themselves in future assaults. A traumatized person's self esteem becomes continually assaulted by experiences of humiliation, guilt, and helplessness, which cause them to suffer damage to the basic structures of the self. Losing trust in themselves, in other people, and that life is good and worth living further isolates a trauma survivor. As one's sense of self and self-esteem becomes lessened from the effects of repeated trauma, the need for attachment becomes inherently greater than the need for protection.

> Uncontrollable disruptions or distortions of attachment bonds precede the development of post-traumatic stress syndromes. People seek increased attachment in the face of danger. Adults, as well as children, may develop strong emotional ties with people who intermittently harass, beat, and, threaten them. The persistence of these attachment bonds leads to confusion of pain and love. Trauma can be repeated on behavioural, emotional, physiologic, and neuro-endocrinologic

> levels. Repetition on these different levels causes a large variety of individual and social suffering. (Van Der Kolk, 1989, p. 392)

Particularly in the early developmental stages, a child who is being abused by a caregiver will internalize the bad feelings of what is happening to them in order to remain attached to their caregiver.

> By developing a contaminated, stigmatized identity, the child victim takes the evil of the abuser into (themselves) and thereby preserves (their) primary attachments to (their) parents. Because the inner sense of badness preserves a relationship, it is not readily given up even after the abuse has stopped…The inner sense of badness becomes the core around which an abused child's identity is formed, and it persists into adult life. (Herman, 1992b, p. 105)

This is at the core of why people who have been abused often feel it is their fault and why therapists and social workers continue to validate to them that it is not. This "badness" they feel inside themselves perpetuates the idea that they are different from others which in turn creates further isolation and disconnection to their surroundings.

When one's attachment development is disrupted at an early age, the behaviour pattern of fearing abandonment permeates into adult life. This can create neediness in the adult survivor of trauma. This fear of loosing people often accompanies a need to have walls around ones self for fear that it could happen again. A push-pull effect happens within the survivor. This can be mirrored within the therapeutic relationship as well.

Therefore, healthy attachments to others and learning to trust become pivotal in the healing process, as is supporting survivors to build or rebuild supportive relationships in their

lives. “Our attachment bonds are our greatest protection against threat” (Van Der Kolk, 2014, p. 155).

As mentioned earlier, it is important for therapists to empower the client by not dominating the sessions and allow for them to take charge of their own healing process. Empowerment allows for the reconstruction and healing of early attachments or ones that were not fulfilled.

Trauma and It’s Impact

The impact trauma has can lead to a development of symptoms and behaviours that seriously affects a person’s capacity to function in the world. How one is affected by trauma depends on a multitude of variables. Including if the survivor was able to access help when the trauma happened; if their life or the life of another was in danger; if the trauma happened once or continued; and how strong their reaction was and how in control they felt during the event (American Psychiatric Association, 2013). The effects of trauma may lead to acute or chronic post-traumatic stress problems of intrusion, numbing and hyper arousal.

One way survivors cope is through disassociating. This creates challenges for survivors in their ability to see clearly and respond effectively to situations in their present lives. When things become unbearable, the respite they find in addictive and other self-harming activities can become ways the survivor works to resolve and escape their pain. The memories or re-enactments of the event can debilitate a person. Victimization of a trauma survivor further impacts and changes a person’s perspectives on their self-identity, worth, the world, others and their purpose (McEvoy & Ziegler, 2006).

Post-traumatic Stress Disorder (PTSD) or Complex Post-traumatic Stress Disorder (C-

PTSD) has a severe and penetrating effect on a person. They become vulnerable to unexpected and sudden changes in their sense of well-being. Without even knowing what triggered them, they can go from relative calmness to states of hyper vigilance, anxiety, anger, and extreme arousal. A person suffering with symptoms of PTSD and C-PTSD may also be constantly in fear and on guard to their surroundings for fear the attack may happen or something like it again (Herman, 1992b; Van Der Kolk, 2014). The inner anger often felt becomes directed towards themselves or others and is typically a central problem in the lives of people who have been violated, becoming a repetitive re-enactment of real events from the past (Van Der Kolk, 1989). The unconscious process of compulsive repetition of the trauma may provide a temporary sense of mastery or even pleasure, but ultimately perpetuates chronic feelings of helplessness and a subjective sense of being bad and out of control (Herman, 1992). “Gaining control over one's current life, rather than repeating trauma in action, mood, or somatic states, is the goal of healing” (Van Der Kolk, 1989, p. 406).

Recently, there has been extensive research done on how trauma affects the brain in the short term as well as long lasting effects. The area of Neuroscience and Neurobiology are uncovering many new discoveries about trauma and also how the brain has the capacity to heal (Bonnie Badenoch, 2015; Carr & Hass-Cohen, 2008). This field goes beyond the scope of this thesis so I will not be discussing it in detail. However, it’s important to mention that scientific discoveries are being done to understand what happens in the brain when a person experiences trauma (Carr & Hass-Cohen, 2008) as well as research into epigenetics and why some people develop PTSD and others who witness similar traumas do not (B. Badenoch, 2008; Borysenko, 1987). I look forward to more research being shared to explain the impact trauma has on the brain, brain development and multiple-generations of survivors.

Post-traumatic Stress Disorder (PTSD)

PTSD is not the traumatic event itself but rather the symptoms that result from that experience when the individual continually relives the experience in their everyday life. PTSD relates to the range of symptoms that extend beyond the normal time frame in which it is understood that many of these symptoms are common responses to trauma. They could take the form of memories, dreams, smells or sounds that bring the person experiencing them, back to the time when the trauma occurred (Herman, 1992b). It develops as a sense of disconnect from the present world where the memories continue to debilitate the person's psyche (American Psychiatric Association, 2013). Without treatment, PTSD will get worse and the intensity of the experience becomes harder and harder to relive, disrupting the individuals life ("DSM-5 Criteria for PTSD," 2015).

According to the DSM-5 (2013), diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters (a) intrusion; (b) avoidance; (c) negative alterations in cognitions and mood; (d) alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition (American Psychiatric Association, 2013).

PTSD can occur after a person has been through a traumatic event that happened to them directly or to another where the person felt that their life was in danger. The person involved felt a lack of control over what was happening in the moment the traumatic event occurred. The exact causes of PTSD are unknown. People vary in levels of sensitivity and can be affected by traumas in different ways (Herman, 1992b). Traumatic events that could bring on the effects of PTSD symptoms include witnessing a death, a car accident, abuse or neglect as a child, war,

rape, violence or any horrible, overwhelming and uncontrollable event (American Psychiatric Association, 2013). However, not everyone who experiences a traumatic event will develop PTSD. Some factors that tend to increase the likelihood that it will develop are:

- How intense the trauma was.
- If a loved one was lost or hurt.
- How close a person was to the event.
- How strong their reaction was.
- How much a person felt in control of the events.
- How much help and support a person got after the event.

(Department of Psychiatry: University of Michigan Health System, 2015)

In 1980, the Diagnostic and Statistical Manual's (DSM) third edition included Post-Traumatic Stress Disorder (PTSD) in its list of diagnostic criteria for mental disorders. This recognition of traumatic stress was mainly due to the large numbers of American Vietnam war veterans seeking treatment for the lingering effects of stresses they had experienced (Herman, 1992b). At this time, many researchers and clinicians were also linking this diagnosis to describe the effects of other traumas like child sexual abuse and domestic violence. These patients were often extremely difficult to treat with established methods and people were searching for greater understanding in ways to cope and help. However, it soon became apparent that the diagnosis of PTSD failed to account for the cluster of symptoms and characteristics that were often observed in cases of prolonged abuse or captivity, particularly abuse inflicted against children by their caregivers during early and adolescent developmental stages (Courtois, 2004; Herman, 1992b).

There is often a misunderstanding with people that suffer from PTSD, as the symptoms can be similar to those of a psychotic state where an individual fragments and disassociates from their body (Herman, 1992b). For this reason, misdiagnosis is prevalent and as a result, the methods to treat symptoms may not service the needs of the client (Van Der Kolk, 2013).

Complex Post-Traumatic Stress Disorder (C-PTSD)

In 1992, Dr. Judith Herman of Harvard University published 'Trauma and Recovery' where she outlined a new diagnosis, Complex PTSD (C-PTSD) which described the symptoms of long-term trauma. Research shows that trauma affects people in different ways and especially repeated chronic trauma that continues or repeats for months or years at a time where there is an actual or perceived inability for the victim to escape (Herman, 1992b) as in cases of domestic abuse, sexual abuse and prisoners of war.

The symptoms that develop after one has been through repeated traumas such as sexual abuse (especially child sexual abuse), physical abuse, emotional abuse, domestic violence, torture, prisoners of war, victims of sex trafficking, and those who have experienced several different traumas report additional symptoms alongside formal PTSD symptoms from those who have experienced a trauma of a time-limited duration like a car accident or natural disaster (Roth et al., 1997).

Although C-PTSD is similar to PTSD, Somatization Disorder, Dissociative Identity Disorder, and Borderline Personality Disorder (Herman, 1992a, 1992b), it is distinctly different. The current PTSD diagnosis does not fully capture the severe psychological harm that occurs with prolonged, repeated trauma such as psychological fragmentation, the loss of a sense of safety, trust, and self-worth, as well as the tendency to be re-victimized (Herman, 1992; Van Der

Kolk et. al 1997). Most importantly, there is a loss of a coherent sense of self, which is what most pointedly differentiates C-PTSD from PTSD (Herman, 1992).

The six clusters of symptoms that have been suggested for a diagnosis of C-PTSD are:

(1) Alterations in regulation of affect and impulses.

(2) Alterations in attention or consciousness.

(3) Alterations in self-perception.

(4) Alterations in relations with others.

(5) Somatization.

(6) Alterations in systems of meaning.

(Herman, 1992a, 1992b; Pelcovitz et al., 1997; Roth et al., 1997)

People with Complex PTSD may also experience emotional flashbacks. During these moments, a person will not only re-experience the memory but also the feeling they had at the time of the original trauma. They may also experience changes in their self-concept and the way they adapt to stressful events.

It is important to be aware that adults with C-PTSD have sometimes experienced prolonged interpersonal traumatization as children as well as prolonged trauma as adults. The development of a healthy sense of self and others becomes disrupted by these early traumas. When these traumas have been inflicted by attachment figures such as caregivers, family friends or family members during developmental stages, the victims may develop a sense that they are fundamentally flawed and that others cannot be relied upon (Herman, 1992b). This in turn also

affects ones sense of attachment to others, creating attachment disorders that are also characteristic of C-PTSD (Roth et al., 1997). People with Complex PTSD often struggle with attachment issues and are terrified of abandonment (Van Der Kolk, 2014).

Having a clear diagnosis criteria established for the symptoms of C-PTSD will allow practitioners and survivors to understand what path to healing will serve them best. Without this established criteria, people may become mislabeled (Van Der Kolk, 2014). Although something to keep in mind when taking a feminist perspective to healing and said so eloquently by Irvin Yalom (1996) is that, "Labels do violence to people. You can't treat the label; you have to treat the person behind the label" (p. 65). For this reason, my belief is that it is imperative to understand a client's life in a way that holds compassion for healing and an understanding beyond which category they may or may not belong.

Post-traumatic Growth

Post-traumatic growth is defined as the experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with crises occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond the status quo (Tedeschi & Calhoun, 2004). Recent research suggests that people who have experienced trauma and moved through the healing process to master their feelings associated with it, move into what is called "Post-traumatic Growth" (Bolton, 2013). This idea instills greater hope for survival and helps survivors in dealing with shame and blame. As Joseph & Butler (2010) report, between 30% and 70% of individuals who experience trauma report positive change and growth coming out of that traumatic experience.

However, post-traumatic growth is not a direct result of trauma, but instead is related to how the individual struggles as a result of the trauma (Tedeschi & Calhoun, 2004). Survivors of trauma show signs of post-traumatic growth especially in the areas of "…relationships (and) how they view themselves and their philosophy of life" (Joseph & Linley, 2006, p. 338). It is important though, to be aware that even in the presence and development of post-traumatic growth, there can still be distress as both can occur simultaneously.

Vicarious Traumatization

Vicarious traumatization can be described as a transformation of the helper's inner experience, resulting from emphatic engagement with a client's trauma material (Pearlman & Saakvitne, 1995). Vicarious traumatization can be common to trauma therapists. It is important to understand what this is, how it develops and work to establish ways to avoid becoming overcome by working with clients that have experienced trauma. Trauma itself shifts a person's perception of the world around them. Vicarious traumatization acts in the same way.

Preventative factors need to be considered when working with victims of trauma. These include regular self-care, solid professional training in psychotherapy, therapeutic self-awareness, regular self-examination by collegial and external supervision, limiting case load, continuing professional education and learning about new concepts in trauma, keeping a balance between empathy and a proper professional distance to clients.

Symptoms of burnout include apathy, feelings of hopelessness, rapid exhaustion, disillusionment, melancholy, forgetfulness, irritability, experiencing work as a heavy burden, an alienated, impersonal, uncaring and cynical attitude towards clients, a tendency to blame oneself coupled with a feeling of failure (Maslach & Fineman, 2000).

In *Supervision in the Helping Professions: An Individual, Group and Organizational Approach*, Johan Lansen (2000) speaks of symptoms often felt by care workers that go far beyond the regular affects of burnout. Just as their clients may experience symptoms of C-PTSD, so may they after repeated exposure to traumatic stories. An increased feeling of vulnerability has been shown to develop with care workers as regular day-to-day events start to become experienced as threatening. This also shows up in disturbed sleep patterns and nightmares. Caregivers may start to feel alienation and withdraw and isolate themselves as they begin to feel like their friends and family no longer understand them. Overtime, this can persist into feeling disillusioned by humanity and that they cannot gain feelings of security in the world or hopes that what they are doing in their profession is making a difference. These manifestations and feelings are known as vicarious traumatization of the healing profession (Lansen, 2000).

Summary

Within the body of this literature review, I have highlighted the areas of research that have formed the basis of this thesis. By investigating and further understanding trauma and the ways therapy and therapists have historically worked with survivors, a strong foundation of learning has informed and influenced my journey in writing this paper.

My intention in this chapter was to convey how far the area of trauma therapy has come in helping survivors. I also intended to illuminate how hard it has been in the past for therapists and survivors in their quest for recognition of the effects of trauma. Without a societal understanding of trauma and its effects, trauma survivors can often become marginalized and misunderstood. Without a clear and diagnosable understanding of trauma, there can be a focus on managing symptoms instead of healing the initial wounds trauma brings. Through the

feminist lens of my research I thought it was important to illuminate and investigate the political environment of the dominant culture to understand how trauma has been treated historically.

Chapter 2: Art Therapy, Trauma and the Therapist

This thesis is an exploration and discussion on the integration of Focusing-Orientated art therapy, mindfulness and the 3 stages of trauma therapy (Herman, 1992b) into an activity that can function to increase safety and stabilization into healing from trauma and abuse. A key component is the relating of pertinent theory to the process of art therapy in a group setting working with survivors. This activity was developed with a responsive approach and has been researched subsequently to connect with relevant theory.

How can one art activity, which integrates all three stages of trauma therapy help survivors of trauma and abuse, heal? What do we need to look at when working with survivors of trauma to ensure safety and stabilization is established and felt throughout? In this chapter I investigate and expand further on therapeutic approaches used in working with trauma survivors and in particular, the art activity I used which integrates all three stages of trauma therapy.

The precautions that are needed to ensure safety and stabilization for clients are addressed as we explore art therapy and trauma. How to establish safety in a group context and the benefits of work in a group setting with trauma survivors are also explored. Neuroscience will be briefly discussed and how mindfulness practices and working in the here-and-now benefited this group and the way the directive was administered. As mentioned earlier, the 6-step process used in Focusing-Orientated therapy (FOT) underlines the entire directive and is explored in detail within this chapter. Understanding the needs of the clients and therapist are explored as well as ways to contain and strengthen the therapeutic space. Lastly, I will discuss the interconnected themes of empathy, empathic failure and the importance of regular self care in faciliating the therapeutic space safely and effectively.

Art Therapy

Art therapy is a form of psychotherapy that uses the creation of art as a primary mode of expression and communication (American Art Therapy Association, 2013). It integrates psychotherapeutic techniques with the creative process to improve mental health and well-being. Sometimes referred to as creative arts therapy or expressive arts therapy, it encourages people to express and understand emotions through artistic expression and the creative process (Rubin, 2001). By making art in a spontaneous way, one is able to bring unconscious feelings to consciousness (Carpendale, 2009; Moon, 1990). Art Therapy can help a client give expression to their feelings and hidden inner conflicts that they may not have words for (C. Moon, 2010). When clients are then able to associate feelings verbally to the art work created, the therapy speeds up recovery (American Art Therapy Association, 2013).

The American Art Therapy Association goes on to further describe art therapy as being, "… based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight" (American Art Therapy Association, 2013).

Two distinct forms of art therapy are:

1) **Art as Therapy.** Which refers to the enjoyment one receives from creating art either in a group setting or alone. "It embodies the idea that art is in itself therapeutic and that the creative process is a growth-producing experience" (Malchiodi, 2006).

2) **Art Psychotherapy.** Which refers to the creative process that happens when a client and therapist work together to uncover latent or overt feelings that are causing a person

distress using the art expressions to enhance the verbal exchanges between the therapist and client. It "embraces the idea that art is a means of symbolic communication and expresses personality, emotions and other aspects of human experience" (Malchiodi, 2006).

An approach to art therapy that assists a client in free association is spontaneous art making (Moon, 1990). Although I was working with a specific directive with these clients, the intentionality within the directive was for the clients to create spontaneously, what arose from within. By creating spontaneously, one is able to bypass the censor that represses unconscious internal conflicts and brings them to the surface (Carpendale, 2009; Rubin, 2001). It also helps to speed up the recovery process of therapy because it facilitates the expression of unconscious symbols and opens up symbolic representation that may not be able to be brought to consciousness with out the use of art as a tool for communication (American Art Therapy Association, 2013).

This in turn assists in freeing the patient from an over dependence on the therapist. In art therapy and especially in spontaneous art creation, the client is in control and can feel free to create what they want. Because the patient is in control of how they see the artwork and what symbols mean to them, they take a more active role in their own recovery (Moon, 1990).

Symbols and metaphors work to expand consciousness, contributing to healing. They are ways individuals can protect themselves from anxiety filled feelings (Jung, 1933). By using art as a means to access these feelings, one is able to understand issues that are present but may not be apparent (Carpendale, 2009). Spontaneous art enriches and activates the analysis in a therapeutic setting. By recognizing symbols the therapist is able access communication of a

different kind on a deeper level. This in turn facilitates further verbal dialogue in the therapeutic relationship (Moon, 1990).

There is an active relationship between the therapist and the client in art therapy. The client is engaged when they are making art and the therapy goes beyond them just talking about their issues. The work is brought forth in a way that accesses the unconscious and the client is active in revealing what the latent issues are. The engagement becomes social as the artwork is viewed.

Looking at the art also affects the transferences that happen in therapy where the artwork acts as a mediator to the transference (Rubin, 2001; Schaverien, 1999). Transference is a term used in therapy to describe the phenomena of a client transferring their feelings of a particular person in their lives (often from childhood) to the therapist. It can be an extremely powerful tool, helping clients to heal deep wounds. These transferences can be looked at closer when it is represented within the art. This assists in therapy as it addresses certain specific issues arising in the session (Naumburg, 1987). A triangulation occurs between the therapist, client and art work that facilitates deeper understanding and awareness as well as creates a safer environment for the client to look at what was once inside of them, now in front of them (Carpendale, 2009).

As the client creates art, there is an opportunity for catharsis. Catharsis is the Greek word meaning cleansing or purification (Allen, Reber, & Reber, 2009). A catharsis can help achieve a state of liberation from anxiety and stress through the purging of emotions or relieving of emotional tensions (Carpendale, 2009). This can be achieved through the choice of materials used, the intensity to which one creates, movements made during the art making as well as using deep breathing during creation.

Towards the end of an art therapy session, time is often made for a debriefing of the artwork. This can range from the bulk of time in a session to a small amount of time saved at the end. It includes dialogue about the art, reflection of what the clients sees and what stands out to them, what certain pieces in the art mean to them or associations they may have, dialogue about the process of creating and in group work closing circles and feedback for how the art makes others feel. This is a powerful part of the session as the artwork stands as a representation for what is inside the client and as such they are able to look at what has come from inside them with distance and a bird's eye view. The art therapist is not there to interpret the artwork but may prompt various awareness's for the client to ponder.

At the end of the session or groups of sessions, an important part of the art therapy process is the disposal of the artwork (Schaverien, 1999). This can take many forms and different pieces may need different ways for disposal. Sometimes an artwork becomes a resource for the client and they may wish to keep it or even hang it in their home as a reminder of strengths they have within. Other times, the artwork may need to shift from its original state and the client is invited to alter it as they see fit. Destroying artwork can also sometimes have a positive effect or ceremonially disposing of it in fire or burying it in the earth. It is always the choice of the client to how they wish to dispose of the art and an important stage of the art therapy process.

Art Therapy and Trauma

It is important for the client to be the author of their own recovery (Herman, 1992b). The symptoms of PTSD can continue for years so coping mechanisms are needed for clients to take care when they experience these symptoms alone. Art therapy by its very nature puts the

client in the active role in recovery, providing a concrete expression of what is seen inside and a reminder to connect to this strength on the journey to recovery (Rappaport, 2009). The act of making art provides a safe container to hold the felt experience and the art image serves to document the felt sense (Rappaport, 1998). It can also be used to heal by recreating attachment to themselves that may have not been attained in their childhood (Bowlby, 1969).

Cathy Malchiodi is one of the leading art therapists who writes about her work with trauma. The model she uses for working with people suffering from PTSD has been well documented as a very effective approach to helping survivors heal from the impacts of trauma, using art making as the core approach to recovery. She begins with:

1. Establishing a sense of safety.
2. Regulating affect.
3. Reestablishing attachment.
4. Enhancing the brain's executive functions.
5. Reframing and integrating traumatic experiences.

(Malchiodi, 2008, 2011)

Malchiodi (2012) uses a neuro-sequential approach through expressive arts therapies to stabilize the body's responses. Using expressive arts, the body's reactions to stressful events and memories are identified through trauma-informed evaluation and sensory-based activities. Self-regulation becomes accessible as the body reacts to the memories of traumatic events while making art and feeling safe and resourced. This reinforces a sense of safety by reconnecting with positive attachment (Coco et al., 2011; Herman, 1992b). By using the arts to normalize and enhance resilience, the client's inner strengths develop further (Malchiodi, 2008, 2011).

When working with trauma, art therapists need to be particularly mindful of the materials used. The types of materials used will have an effect on the therapy and so introducing unfamiliar and unstructured or ambiguous visual stimuli may aggravate secondary traumatization (Carpendale, 2009; C. Moon, 2010). Although, it is important to trust that the materials chosen by the client are ones they are ready to use to uncover their unconscious elements. However, in the beginning stages of therapy therapists need to be mindful that certain materials can be evocative of traumatic experiences. By checking in regularly with how present, comfortable and connected the client feels, one may avoid this recapitulation into traumatic experiences (Carr & Hass-Cohen, 2008). It is recommended that a plethora of materials be made available and choice be given at all times to help build and instill a sense of trust in oneself and self concept (Carpendale, 2009).

Art Therapy Groups and Safety

Group therapy has proven to be one of the most effective resources for those dealing with trauma (Kanas, 2005). By connecting with others who have experienced similar situations in life, the stigma, shame and feelings of isolation are able to shift from holding one back from experiencing joy in life (Yalom & Lesczc, 2005). For those that have felt isolated by shameful secrets, the opportunity to connect with others in a group is extremely helpful in the healing process.

Irvin Yalom (2005) a leader in the positive effects of group psychotherapy, proposes that the process of therapeutic change “occurs through an intricate interplay of human experiences” which he refers to as “therapeutic factors” (p. 1). In *The Theory and Practice of Group Psychotherapy* (2005), he outlines the key therapeutic principles that have been derived from working with individuals in groups. They are:

1. The Instillation of Hope.
2. Universality.
3. Imparting Information.
4. Altruism.
5. The Corrective Recapitulation of the Primary Family Group.
6. Development of Socializing Techniques.
7. Imitative Behaviour.
8. Interpersonal Learning.
9. Group Cohesiveness.
10. Catharsis.
11. Existential factors.

(Yalom & Lesczc, 2005, pp. 1–2)

According to Yalom, these therapeutic factors are interdependent, represent different parts of the change process, and occur at cognitive, behavioral, and emotional levels (2005). As art therapy also works at these different levels of experience, art making within the context of group therapy is a natural way to promote change. For the purpose of this thesis, I wish to look closer at three of these factors.

Instillation of Hope. Yalom (2005) presents the point that therapy groups invariably consist of individuals "at different points along a coping-collapse continuum" (p. 5). He emphasizes the power of hope instilled in individuals as they observe progress and listen to the testimonials of others in the group. Seeing positive change in others cultivates hope and a sense of optimism in oneself. He posits the idea that "hope is flexible" (2005, p. 5), as it can be redefined to fit current parameters and context.

Art making is an effective way of bringing hope. It is also a proactive gesture that gives life to an experience. In a sense, when we are making art we are recreating our lives. This in turn, puts the client in the driving seat of their own process and experience. Through exploration and play with art materials, the client-artist expresses a range of emotions, gains personal insight that may lead to change, and develops a sense of self-mastery. Art making in a shared space allows for the observation of the personal processes of group mates. Seeing progress in peers instills hope and optimism for one's own progress.

Universality. As expressed by Yalom (2005), it is common for individuals entering therapy to believe that their problems are unique, unacceptable, and more extreme than others'. This belief results in social isolation and a lack of intimate connection in life (Herman, 1992b; McEvoy & Ziegler, 2006). Group therapy offers an opportunity for individuals to realize that their suffering is not uncommon, but rather, universally experienced. Through sharing, being witnessed and validated, individuals feel accepted and part of a community. "As clients perceive their similarity to others and share their deepest concerns, they benefit further from the accompanying catharsis and from their ultimate acceptance by other members" (Yalom & Lesczc, 2005, p. 8).

Individuals within a group through the shared experience of making art can feel universality. As individuals display vulnerability and courage by sharing their artwork with the group, it is empowering to all, and results in a realization that group members share common suffering, and are working toward common goals. Having one's story witnessed helps transcend shame and is the cornerstone of healing when dealing with abuse and trauma.

Altruism. "Group therapy is unique in being the only therapy that offers clients the opportunity to be of benefit to others" (Yalom & Lesczc, 2005, p. 13). Yalom (2005)

emphasizes that individuals undergoing group therapy often hold the belief that they have nothing of value to offer others. Through the group process, members discover the benefits "intrinsic to the act of giving" (Yalom & Lesczc, 2005, p. 13). Group members get to experience both giving and receiving help; they have the opportunity to feel needed and useful, and to gain the satisfaction of offering help to others.

Art therapy in the context of group therapy allows for the cultivation of altruism. Witnessing of group members making art and sharing their individual processes increases empathy, respect, and positive regard for one another. Through receiving and giving support, offering insight, and the sharing of common problems, a group culture that encourages support is built, resulting in group cohesiveness. Group members have the experience of both being held by the group, and holding space for others in an accepting and non-judgmental environment.

Focusing-Orientated Art Therapy (FOAT) - 6 Steps

Focusing (Gendlin, 1978) is an empirically tested and substantiated mode of therapy, allowing the client to get underneath the feelings by giving each one space and honouring, accepting and feeling the emotion behind it; speaking through it instead of about it. It shows the client a way of listening to their inner self. Developing a relationship with this place inside helps them to get into their body where the trauma lives. This empowers them, as they realize that inside they are able to take care of themselves and connect to something within them that supports them when needed (Klagsbrun, 2012). By embodying what founder Gene Gendlin expresses as the *felt sense*, clients become aware of their inner capacity of strength and core self (Gendlin, 1978). By using FOT in conjunction with art therapy, an even deeper understanding and visual representation of what is held inside the body is able to emerge (Rappaport, 2009).

In Focusing-Orientated therapy and Focusing-Orientated art therapy, accessing the felt sense becomes the barometer for how one is feeling. By developing a relationship with it, one is able to evaluate internally how they are feeling and notice more clearly when a shift inside has taken place (Rappaport, 2009). This awareness in the therapeutic session creates lasting effective therapy for the client and gives them the confidence to take care of themselves.

> Focusing is a natural capacity that connects people with their inner knowing that has not yet been formed into words or thoughts. It is a non-analytic process that cannot be accessed through the intellect alone. The process of Focusing involves dipping into and listening to what is palpably felt but not yet sayable. We call this level of experience the *felt sense*. Touching into the *felt sense* opens us to new insights, to a bodily feeling of release, and reveals small steps in the direction of more authentic living. (Klagsbrun, 2012)

Step 1: Clearing a Space. In this first step of Focusing, one checks in to take an inventory of how they are feeling, isolating the things in their lives that keep them from feeling that everything is "all fine" (Gendlin, 1978; Klagsbrun, 2012; Rappaport, 2009). Not everything in a person's life is brought up but three to six "issues" that are on their mind. When the issues are noticed, they are felt in the body with the client giving the location and then imagining placing this issue outside of their body and noting how that feels and where it should be placed. How far away? In a box? Wrapped up? Whatever comes to mind. The issues continue to be placed outside of themselves until they feel like they are ready to stop.

After all the issues have been placed to the side in a comfortable spot away from the client, they are asked if there is a background feeling? Something that is always there but blends

into who they are; like always being tired or always being anxious. There may be something more that is in the way of being all-fine.

A moment is taken after the client feels this all is fine place to resonate with it and really feel it in the body. Mindfulness techniques of tuning into the body are used to breath and take a moment to integrate this feeling throughout the body and psyche (Alexander & Rand, 2009). The client is reminded that the feeling they are experiencing is well-being.

If the client chooses to stop here, they are welcome to as it may be necessary for centering and stress reduction. Every effort is made to use a here-and-now approach checking in with what the client's current needs may be (McEvoy & Ziegler, 2006).

Step 2: Choosing an Issue to Work on and Felt Sense. Once the space has been cleared, the client is invited to check in to see what issue they may want to focus on. This can be one of the issues that had come up and needed clearing during the first directive, or it can be what they feel inside when asked that question; the first thing to pop up. Once they decide on something to work on, they are asked what it feels like in the body, to sense it and locate it. Again, they are directed to breath into this space and feel it in their entire being. By feeling the whole sense of what they are focusing on, they are invited to get a felt sense of the issue.

Step 3: Handle/Symbol: a word, phrase, image, gesture, or sound. By putting a label on the felt sense of an issue and intuitively feeling what word, name, colour or gesture it evokes gives it the opportunity to be handled; moved, held on to, thrown about, whatever the client feels is necessary. The client's capacity to take care of himself or herself is solidified by this acknowledgement. There is a control that is gained in this moment while sorting, coping and dealing with the issue. The client is in control.

Step 4: Resonating. There is space given for the client to double check if this *handle* feels right within, to resonate with it. It may be that something else arises; the client is supported to trust their bodily felt sense that whatever comes up is important. The client then resonates the handle with the felt sense inside that came up when they first checked in on the issue at hand. They are asked if it still feels right. If another handle, word or description arises, they are encouraged to feel this handle against their felt sense for a match to describe it. This part of the directive is repeated until the client feels that their handle matches the initial felt sense.

Step 5: Asking. This stage involves developing a relationship with the felt sense and asking it questions. The client is asked to imagine sitting down next to the felt sense of an issue with complete acceptance, compassion and non-judgment. There is a strength that is formed in this stage as the client separates himself or herself from the feeling the issue brings up within them. When they are able to hold this space with query, acceptance and compassion, they develop a greater capacity to hold other traumas or issues within their life. The questions posed to the felt sense at this point in the directive are to help it open and create a shift in the way it makes the client feel (Gendlin, 1978; Klagsbrun, 2012; Rappaport, 2009). This could be described as the most poignant stage of focusing because an actual physical shift is felt in the body with how a client understands and relates to the issue they are exploring. They are asked to get to the crux of the situation, to hold perspective on why the issue holds such power within them and what they need for it to pass. There is a forward direction in this stage to imagine what their life would be like if this situation was resolved and what resolution would look like to them. As outlined by Laury Rappaport in *Focusing-Orientated Art Therapy* (2009), “The creative imagination is activated to see one’s way around a stuck issue, feeling, or dilemma” (p. 39).

Step 6: Receiving. This final stage is about accepting what the felt sense had to say in response to the questions posed and welcoming these messages in deeply with compassion and openness. However odd the messages may seem, it is important for the client to not judge or reject them but give them space to be. This stage comes with a bodily release; within the body a shift, acceptance and understanding is felt inside.

Eye Movement Desensitization and Reprocessing (EMDR)

As described in a workshop I took with Judith Sciano, EMDR is a psychotherapeutic intervention developed by Francine Shapiro (Smucker, 2000; Van Der Kolk, 2014) used to help with the symptoms of PTSD using mental images. Judith Sciano adapted this process to work with created imagery in an art therapy context. Bilateral sensory input is used as the client shifts their gaze from right to left, looking at two different images they have created; one of a resource image and one of the issue afflicting them. The paintings are similar in size and hung at the same level. Standing behind the client, the therapist taps on each corresponding shoulder, to the rhythm of the client shifting their gaze. The goal of EMDR therapy is to process distressing memories, reducing their long lasting effects and allowing the person to develop more adaptive coping mechanisms (Feske, 1998). EMDR has been proven effective to transform traumatic memories into non-traumatic ones and a person doesn't need to talk about them in detail (Malchiodi, 2015).

Resource Image

A client can create a resource image in session or outside of session. Alternatively, an amulet or token that a client already owns can function as a resource object. The idea of a resource image is that it holds a power beyond the physical object it is (Schaverien, 1999). A

resource image can bring strength and inner power to a client when working through difficult issues in life. When created in session, a resource image is a reminder of the beauty and strength a person has within him or herself. Clients can use resource images as a stabilizing presence when dealing with traumatic memories.

A resource image can symbolize many things to a client and it is important to be aware that it is the client's interpretation of that image which holds the power. This can often represent a higher power to the client as a protector, which is discussed in the art directive we will explore more in chapter 4. In art therapy a resource image may sometimes be created in a previous session and used in subsequent sessions. What happens to the resource image after therapy has ended also holds meaning. A client is often invited to put the image up in their home as a reminder of their internal strength.

Empathy and Empathic Failure – Self and Other

Empathy has been described as "the ability to see one's self in another's position and to understand their emotional state" (Gallese, 2003 as cited by Carr & Hass-Cohen. 2008, p. 73). However, it is important to differentiate from what is a feeling of another and what feeling belongs to the person feeling the empathy. It not only means sharing the feelings and emotions another is feeling but to "have the cognitive capacity to take the perspective of the other person while keeping self and other differentiated" (Jackson, Meltzoff, & Decety, 2005, p. 771, as cited from Cohen & Carr 2008, p 73). This complex cognitive capacity allows an experience of self and other as connected yet differentiated (Carr & Hass-Cohen, 2008).

When a person is not able to differentiate between what feelings belong to them and which belong to another, we have empathetic failure (Carr & Hass-Cohen, 2008). This happens

when a person feels the pain of another's situation to the extent that they actually start to feel like it is happening to them; their affect regulation becomes disrupted.

Client Needs

Paramount before administering this activity was the importance of knowing how the clients were feeling emotionally. Remembering traumatic events without the support of resources in place may activate and trigger a person to go back to their traumas recapitulating them and fragmenting the individual (Herman, 1992b).

> Under which conditions might a memory be a healing force and when might it be destructive? When might it generate self-inflicted pain and unnecessary suffering?...Traumatic memories tend to arise as fragmented splinters of inchoate and indigestible sensations, emotions, images, smells, tastes, thoughts, and so on. These jumbled fragments …are perpetually being "replayed" and re-experienced as unbidden and incoherent intrusions or physical symptoms. The more we try to rid ourselves of these "flashbacks," the more they haunt, torment, and strangle our life force, seriously restricting our capacity to live in the here-and-now (Levine, 2015, p. 4).

Without the first stage of Safety and Stabilization being achieved, it can be dangerous for a client to delve into the memories of their trauma. As mentioned earlier, an acute awareness of how the clients were feeling during the process of the directive was imperative to not recapitulate their traumas but rather to experience them once they had felt resourced enough to face them. It was not until this stage was achieved that the second and third stage of the trauma therapy could begin.

Therapist Self-Care

One of the central challenges for therapists working with traumatized victims is the impact of bearing witness. The concept of vicarious traumatization was first looked into by McCann and Pearlman (1990). Nowadays, it is common knowledge that trauma counsellors can expect intrusive symptoms similar to post-traumatic stress reactions. These can affect their worldviews as well as beliefs about themselves (McEvoy & Ziegler, 2006). Henri Nouwen (1972) articulates this eloquently in his book *The Wounded Healer* when he says, "Who can listen to a story of loneliness and despair without taking the risk of experiencing similar pains in his own heart and even losing his precious peace of mind? …Who can take away suffering without entering it? "(p. 72).

Due to the intensity that all three women in this group had experienced in their past, I was careful internally hold their stories in a way that did not affect or overwhelm me emotionally. Although, there were times in sessions when feelings arose for myself, they quickly passed and moved through me; not sticking in a way that would affect me after the session was over. Techniques I used to accomplish this were mindfulness practices, regular exercise after sessions, and an acceptance and understanding of my own sensitivity and empathy towards others. I had also been doing my own art therapy previously and concurrently to working with this group. Weekly supervision was another protective factor. My understanding of ways to avoid experiencing vicarious trauma came from further study of research done with Neuroscience, Neurobiology, mirror neurons, empathy and empathetic failure (B. Badenoch, 2008; Borysenko, 1987; Carr & Hass-Cohen, 2008; Porges, 2011). This was true for the period of time working with the group I facilitated. However, during the research of this thesis, which spanned a year and a half, I experienced vicarious trauma congruent with diagnosis criteria I write about at the

end of Chapter 1. This prompted me to personally research ways to avert vicarious trauma.

Summary

This chapter began with the foundation of theory that has informed my use of the art directive, “Let me be free: in 1, 2, 3”. I’ve included the benefits of working in group sessions, using a Focusing-Orientated art therapy approach, the power of resource images, and the needs of both client and therapist. Within this discussion I include precautions to ensure safety and stabilization, which is of pivotal concern when working with trauma survivors. Understanding these precautions is helpful to avoid recapitulating traumatic experiences and supporting clients instead to explore the trauma in a way that they feel resourced.

I began with a clear explanation of what art therapy is, and how it was administered in this setting. By highlighting the psychotherapeutic properties of art therapy, a distinction can be made between what art therapy is, and what it is not, and the great benefits it can have when working with trauma survivors. Because art therapy bypasses the regular modality of talk therapy through expression without words, a greater movement towards healing is able to happen within a client subconsciously. Since traumatic memories can sometimes be difficult to talk about, creating a feeling in the art instead of talking about it can be a non-threatening way for a client to bring expression to these experiences.

The benefits of physically creating a feeling within the art, one that is inside and looking at it with the perspective of it being outside of one’s self is an advantage of art therapy. This perspective can help a client see things differently then they may have before creating the art.

Taking this approach one step further, a Focusing-Orientated therapeutic modality helps clients locate where in the body the traumatic memories are stored. This empowers clients to

move towards an un-judgmental acceptance of their experience. By accepting these feelings related to historic memories, the clients become increasingly able to release them from the body so they are no longer affecting them unconsciously in the present. In this way, using a Focusing-Orientated approach supports clients to experience a physical shift both internally and externally.

When framing these approaches with the needs of client and therapist, a safe container to hold and explore traumatic memories is formed. As is stated throughout this thesis, before therapeutic work can be done effectively, safety and stabilization need to be the main focus in working with trauma survivors.

By thoroughly investigating the therapeutic factors of art therapy and trauma, it is my intention to provide a deeper understanding of the various considerations that have informed this art directive.

Chapter 3: Mode of Inquiry

This thesis is an exploration and discussion on the integration of Focusing-Orientated art therapy, mindfulness and the 3 stages of trauma therapy (Herman, 1992b) into an activity that can function to increase safety and stabilization into healing from trauma and abuse. A key component is the relating of pertinent theory to the process of art therapy with survivors in a group setting. This activity was developed in a responsive approach to the needs of the group during an art therapy session.

How can one art activity, which integrates all three stages of trauma therapy help survivors of trauma and abuse, heal? What do we need to look at when working with survivors of trauma to ensure safety and stabilization is established and felt throughout? In this chapter I will explore the mode of enquiry used in this thesis, described as an Interpretive-Hermeneutic Art Making Model. I also describe and expand on various intentions during the administration of the art directive I named, “Let me be free: in 1, 2, 3”.

The data for this thesis was collected through a thematic analysis, drawing out the themes related to relevant theory to illuminate the benefits of the art directive used. Although I followed the format of Laury Rappaport’s (1998) art directive, I altered my approach and the materials used, to support the needs of the group throughout the session. In particular, I chose to use materials that symbolically strengthened attachment to a secure base. It was not until after I finished working with this group that I began my research, particularly in the area of Focusing-Orientated therapy.

Above all, my approach in researching the material and in my writing was to acknowledge the *impact* trauma has rather than the *illness* or *disorder*. Through this exploration,

I hope to move the conversation from “*What is wrong with you?” hat is wrong with you?”* to “*What has happened to you*?”

Interpretive-Hermeneutic Art Making Model

Interpretive-hermeneutic understanding is born from the recognition that all human experiences are both rich and complex. When working with this model, art becomes defined as a system of communication. It is the expression of knowledge a person has to their relationship with the social world around them (Pearce, 1983 as cited by Haywood Rolling Jr., 2013). Symbolic conveyances through art making communicate the ways in which people experience the world in the here-and-now and are sustained within it (Haywood Rolling Jr., 2013). “Interpretive-hermeneutic understanding is rooted in a historical encounter and concerns itself with personal experiences of being here in this world” (Palmer, 1969 p. 10). Interpretive-hermeneutic understanding allows one to stay open to the experience of another without making judgments based on past experiences or learning. It holds the notion that within the mystery of an experience is a connection we all share if we are able to clearly see it with unclouded eyes. This too is how the interpretive-hermeneutic investigator develops a therapeutic relationship. This approach creates a relationship that honours the experience of the client, allowing them to accept and integrate their experiences so they may manage and hold them without judgment. By taking an interpretive-hermeneutic approach, the therapist models an important attitude of wonderment that will help a client stay open to understanding their past in a way that offers dissolution of shame. When we become self reflective enough to realize that our dominant ideologies offer minimal help in assisting us in coming to know the phenomenon that lies before us, we become more open to the experience of others and ourselves. “Within an interpretive-hermeneutic research tradition, the intent is not to develop a procedure for understanding, but to

clarify the conditions that can lead to understanding" (McManus Holroyd, 2007 p. 1).

This approach resonated with the research I have done within this thesis, as my intent was not to examine the participants I worked with but rather to examine the experience of trauma as a whole and how it and survivors have been understood and dealt with in our society. "Above all else, hermeneutics proposes that there are no such things as measurable behaviours, stimuli, and associated responses. Instead, investigation is prompted through such things as encounters, lifeworlds and meaning" (Van Manen, 1977 p. 205). Interpretive-hermeneutic research acknowledges that one can never hope to discover everything and recognizes that all resulting understanding will never be complete.

The Development of the Directive

Important aspects in my adaptation of the original art directive (Rappaport, 1998) were materials used and ways in which I incorporated attachment theory, mindfulness exercises, mandalas, journaling and ceremony. Although I initially had a plan for the sequence the directive would follow, I changed it in response to client needs in the moment.

Specific to the directive I used was the way in which participants were led through the second stage of "Remembering and Mourning" (Herman, 1992b). Incorporating Van Manen's (1990) approach of researching the lived experience, the needs of the clients in every moment were responded to. This was how the activity developed.

As mentioned earlier, of critical importance before delving into the second stage of the art directive was a need for safety and stabilization. My intention was to invite this with the materials used which was why I laid out a large piece of black paper with a large white circle glued securely in the middle in front of each participant. The black paper represented the

foundation, base and container, framing the mandala. It was thick and made of house wrapping tarpaper. Having the white mandala securely attached represented attachment to the participant's foundation and further served as a symbol for grounding and feeling a stable base. The frame of black surrounding this white circle represented structure and stabilization. The frame also symbolized a container to hold their experiences within the art.

As the participants worked through the stages of the art directive, they were invited periodically to become aware of their breath, check inside themselves and feel their feet on the ground. Connecting with the body through mindful intention and deep breaths helps stabilize the parasympathetic nervous system (Richardson, 2016; Van Der Kolk, 2014), resulting in a more relaxed state. There was a strong focus on connecting to their resource image when feelings of anxiety would present themselves as well. This helped facilitate greater internal strength as the intention was to allow the women to move through the stages with a sense of empowerment. This is typically a feeling that is lacking in survivors of trauma and abuse (Van Der Kolk, 2014).

Psychotherapeutic Modalities

Psychotherapeutic modalities and theories used in this art directive included mindfulness techniques, Focusing-Orientated Therapy, and art therapy. Approaches taken were psychoanalytic, Jungian, humanistic, person-centered, feministic, strength based and self-psychology. The directive's focus and path was based on a three-phase model of trauma intervention sometimes called the consensus model (McEvoy & Ziegler, 2006). Bessel van der Kolk et al. (1997), Judith Herman (1992b) and Christine Courtois (2004) are amongst leading trauma psychologists who have helped develop this model.

Safety and Stabilization

Safety and stabilization is of pivotal importance in this three-stage model. For this particular group of women, it became clear that safety and stabilization needed to be integrated throughout the activity by checking in continuously with participants, assuring that they felt safe and resourced enough to move onto the other stages. Following the three-stage model does not require that the stages be concurrent. They are fluid and can at times move from one to the other and then back again (Herman, 1992b). It is important for the therapist to stay present with a client working through trauma to assess what may be needed for them at different stages (McEvoy & Ziegler, 2006).

A Mindfulness Exercise

At the beginning of the activity the participants were guided in a mindfulness exercise. This had been done in other sessions with this group and so they were familiar with the process. Within this mindfulness meditation, they were directed to find within their body, their own inner strength or felt sense. In Focusing-Orientated Psychotherapy, accessing the felt sense becomes the barometer for how one is feeling. By developing a relationship with it, one is able to evaluate internally how they are feeling and notice more clearly when a shift inside has taken place (Rappaport, 2009). In this art activity, the participants were guided to access this inner felt sense as a way to feel their own strength and power inside. They were encouraged to ask it questions and listen to the messages it had for them.

The felt sense as described by Eugene Gendlin (1978) is not felt in the mind but rather in the body. By locating where in the body it is, and sensing what it looks like, feels like and

messages it has to say, a client develops a greater capacity to trust their own internal knowingness (Rappaport, 2009). This was the motivation behind this mindfulness exercise.

Intentionality of the Art Directive

Resource Image. Choice was given to the women at every opportunity with the intention of developing a stronger connection to their inner knowing and strength by cultivating trust in themselves. When participants had a handle on what their felt sense looked like they were then asked to draw it on an 8" white paper circle using any material they choose. This became their "resource image" (Schaverien, 1999) and was placed to the side while they continued to explore their past experiences that brought them to therapy. By having a resource image of the felt sense that lived inside them now outside of them, they concretized it (Schaverien, 1999). Drawing what they felt inside and creating space to reflect on it, helped in developing a greater capacity to feel safe (Richardson, 2016) which was the foundation of this directive.

As discussed in chapter two, a resource image (Schaverien, 1999) gives clients something to ground in that reminds them of a place of peace within themselves. There is an empowerment that is evoked as the client creates a resource they once only imagined inside. By moving this resource from inside one's self to outside where it becomes tangible, a deeper sense of internal strength in instilled (Schaverien, 1999). During the process of art making it is advised for those dealing with intense memories of trauma to shift their focus to something that brings them joy. The resource image can bring just that. By moving the bodily feeling from the resource image to processing of distressing memories, the intensity of those memories, feeling and sensations lessen.

Shifting the Gaze. This process of moving one's physical and internal focus from the resource image to the trauma reminded me of Eye Movement Desensitization and Reprocessing (EMDR). I personally, had experienced positive shifts in self when using this modality during my training. Although EMDR was not used in this directive, the underlining premise of the theory was incorporated by shifting ones gaze to a more resourceful image when feelings of anxiety arose in the clients during this stage of processing and creating.

Spiritual Protector. Sometimes a resource of what we see within ourselves is not enough. The participants were familiar with a place of peace and strength inside themselves, however, they all seemed to resonate more clearly with a resource outside of themselves. Because they mentioned relating deeply with a protective source beyond themselves that they connected to for strength, touching in with that resource was encouraged throughout this directive. After they had created their resource image, they were given the option to create an image that represented their spiritual protector in their life. Members of the group had mentioned the term spiritual protector in previous sessions so I was aware that spirituality played a part in each of their lives. In response to the needs of the group, it was deemed helpful to support this step before moving to the second step of acknowledging the negative messages that resided inside.

Reframing and Integrating Traumatic Experiences. After the women felt grounded with their resource image and protector image, they were then able to delve into the second stage of *Remembering and Mourning* (Herman, 1992b). By focusing on the resource image that was now outside of themselves, they were invited to feel resourced enough to explore aspects of the trauma and its impact. However, by assessing the needs of the group at this point in the session, I responded by altering the directive from remembering details of trauma to connecting to their

feelings inside that kept them from feeling peace, however that looked for each participant. They were again reminded to feel and access the strength that brought them to where they were in that moment. The approach taken here resonates with the model Cathy Malchiodi (2008, 2011) offers in trauma therapy mentioned in Chapter Two of this thesis, related to her fifth stage of trauma therapy; *Reframing and Integrating Traumatic Experiences* (Malchiodi, 2008, 2011).

Working with C-PTSD. Within my mode of enquiry in administering this activity, an awareness of C-PTSD and how these symptoms show up and can be alleviated was continuously observed and attended to when possible. In working with C-PTSD, it is important to stress what was then and what is now, giving the client the opportunity to separate the past from the present so they are more capable to face triggers that may prompt PTSD symptoms (Herman, 1992b; Van Der Kolk, 2014). Vacillating throughout the art directive but especially in stage two, participants moved between feeling resourced and feeling the intensities of emotions that the trauma had caused. The effects of C-PTSD and PTSD are negated by:

> Not (only) describing what (was) felt in the past but reliving those feelings in the present. The therapist must help the patient move back and forth in time, from her protected anchorage in the present to immersion in the past, so that (the client) can simultaneously re-experience the feelings in all their intensity while holding on to the sense of safe connection that was destroyed in the traumatic moment. (Herman, 1992b, pp. 177–178)

With the help of therapy, a client begins to recognize habitual behavior patterns and then shift these so they no longer engage in self-defeating and self-destructive behaviors that are outside of their conscious awareness (McEvoy & Ziegler, 2006). By increasing awareness of these themes and dynamics, the client then develops a clearer understanding of them and

becomes able to take responsibility for them when they arise, which in turn gives them the capacity to choose new, healthier responses and actions (Herman, 1992b). “Fears that are faced, even if the act is difficult, lead to transformation of attitudes, leaving you with an increased sense of self-worth, control, and inner strength” (Borysenko, 1987, p. 209). As participants created their final drawing in stage three of what life looked like in the future without the memories of trauma, they were choosing a new life.

Summary

The mode of enquiry used in exploring this art directive facilitated an open awareness of what was happening in the session and allowed the restructuring of the directive when needed. By keeping open to what was happening in the here-and-now, I was able to respond in a way I may not have been able to had I been using another model. Using an interpretive-hermeneutic art making model put the emphasis on the details of what was happening in the moment and allowed me to facilitate this group without an agenda of how things needed to be.

Through the use of a resource and protector image that the clients created themselves, they were able to feel a power outside of themselves that actually originated within. This became a pivotal strength for all participants as they explored distressing memories. Invited to look to their resource image when needed and taking the time to notice their breath, allowed participants to feel stronger facing issues that had before debilitated them.

When clients expressed a need for more safety or stabilization, I responded by inviting them to connect with a spiritual protector. For the directive to be effective in working with the symptoms of C-PTSD it was important for clients to safely oscillate between the distressing memories of trauma and feeling secure and stable in the present moment. This became the crux

of alleviating their distressing C-PTSD symptoms. The goal was for participants to feel that the memories of their past were not occurring in the present (Herman, 1992b).

The intention of using mindfulness throughout the session was intended to frame the structure of the art directive in a way that tapped into the internal strength of participants. The exercise of tapping into the body through mindfulness resonated with the foundation of theory that describes trauma being stored within the body and to access and move it, one needs to feel and be in their body (Van Der Kolk, 2014).

The development of the directive evolved in the here-and-now with a responsive approach to clients needs in the moment. This facilitated my own ability to stay mindful and present as the session unfolded. The research I did following my experience with this group further illuminated the importance of trusting the process, and staying acutely aware of the needs of the clients in session.

Chapter 4: The Process: Let me be free: in 1, 2, 3

This thesis is an exploration and discussion on the integration of Focusing-Orientated art therapy, mindfulness and the 3 stages of trauma therapy (Herman, 1992b) into an activity that can function to increase safety and stabilization into healing from trauma and abuse. A key component is the relating of pertinent theory to the process of art therapy with survivors in a group setting.

In this chapter the activity and the process are presented as the data for discussion. Both the naming of the activity and the research cited in this thesis occurred after the art directive was given. This chapter describes the process and verbal directions given to participants in this art activity. I also discuss what arose in discussion during the follow up session with clients one week after the art therapy experience.

Art Directive

The directive was inspired by Laury Rappaport (1998) who has been forefront in developing a Focusing-Orientated model of art therapy. Through discussion in supervision, including some ideas from my supervisor and my own personal reflections, this directive was developed and presented to a group of women survivors. The sequence of the directive follows Judith Herman's (1992b) three stages of trauma therapy beginning with:

1. Safety and Stabilization
2. Remembering and Mourning
3. Reconnecting and Reintegrating into Ordinary Life

Art materials used included:

- Thick black paper. (2' x 2')

- White paper circle glued securely. (18”diameter)
- Two white paper circles. (6” diameter)
- Abundance of black and white circles in center of table. (6” diameter)
- Coloured construction paper.
- Scissors for every participant.
- Glue sticks.
- Writing device: pens, glitter pens, and markers.
- Pre-cut collage images.
- Paints, crayons, oil and chalk pastels.

This was used in the third of four art therapy sessions I facilitated with a group of three women involved in a program to assist trauma survivors get back into the work force. As the art therapy intern, I was asked to facilitate three-hour art therapy sessions once a week for four weeks. The group met three times a week, eight hours a day, with three different counsellors offering support in addition to the art therapy sessions. The program lasted for eight weeks in total with additional support for participants afterwards. When I was first introduced to the group they were into their fourth week so safety and stabilization within the group had already been established.

As was custom with this group, everyone first sat down and went around the circle checking in with how their previous week had been. The women were anxious to know what the art therapy directive would be. I explained the directive and how it corresponded to Judith Herman’s (1992b) three stages of trauma therapy. I then asked if anyone needed anything to make them feel safer in the space before we began. One woman asked for the window to be closed because she could hear men outside working and did not feel safe exploring the directive with any male presence around. Creating a safe space was pivotal in working through this

directive; the window was closed. After all members had expressed feeling safe, they were invited to take a deep breath and settle into their seats to become present in the moment.

Prior to the participants coming into the room, I laid out square sheets of thick black paper (2’ x 2’) with a white circle (diameter of 18”) glued securely in front of every chair. Two white loose paper circles (8” diameter) that were not glued to the page were also placed in front of the work areas on top of the larger white circle. There were additional smaller black and white loose paper circles in the center of the table. Next to each participant’s work station were ample art materials including glue, scissors, markers, glitter pens, pastels, crayons, and coloured construction paper. Time and attention were put into setting up the room and materials in a way that felt organized and abundant. The intention was to create a safe and inviting space to create and explore.

1. Safety and Stabilization

The participants were first guided in a mindfulness exercise at the beginning of the activity and invited to find within their body a felt sense of their own strength (Gendlin, 1978; Rappaport, 1998, 2009). They were familiar with this process, as it had been done in previous sessions as an opening exercise before going into the art. This was described as the place they all had inside themselves that had kept them safe in the past, given them the strength to be where they were in the present, and to make changes to help themselves. The focus here was on their inner strength and capacity for self care.

They were asked what this place looked like and where it was located in the body (Rosenberg et al., 1985). The questions I asked at this point, prompted the women to develop a relationship with their felt sense and inner knowingness. They were invited to ask *it* questions

and note the answers they would hear back. I intentionally created a short pause at this point to support them in inviting further inner dialogue. I then asked again if their felt sense had anything else it wanted to tell them. The intention here was to encourage them to create space between themselves and their inner strength (Rappaport, 2009).

Once they were given time to feel this place and space within their body, opening up dialogue and a relationship with it, they were asked what it looked like and if there was an image that arose. With this image in their mind, they were then asked to slowly open their eyes if they had closed them, coming back into the room and create what they had seen or a representation of it on one of the small white circles. This was placed loosely on the top of their black frame with large securely glued white circle. Participants were given a reminder to breathe and really feel the image they were creating that had come from inside. Mindfulness was again encouraged to assist the participants to stay in the here-and-now by breathing and feeling what the image was within their body at that moment.

After spending some time with their image and focusing on the idea and notion that this strength came from within, participants were asked to look at what they had drawn and breathe that into themselves. With this deep breath they were invited to feel the connection of what they saw in front of them also being inside of them, a resource that they could now look at for a reminder (Schaverien, 1999).

At this point participants were given the option if they wished to, to connect with a higher power they believed in. They were then asked to create a representation of this connection on another of the small black or white mandalas provided. The intention in this part of the directive was to offer them a further sense of protection. Participants were encouraged to take another deep breath to feel grounded and secure, cultivating bravery to move into the next stage.

2. Remembering and Mourning

The participants were then asked to pose the question to themselves, “What comes in the way of me feeling the strength I felt while creating the first image of my felt sense?” Another pause was given to invite an inner dialogue before participants were asked to write down or draw the thoughts or words that came up when they asked themselves this question. They were given the option to use either the blank, smaller, unattached black and white mandalas in the center of the table or to rip or cut pieces of the coloured construction paper provided; all participants choose the latter method of ripping or cutting the heavy construction paper and wrote out words that kept them from feeling connected to their inner strength. This exercise was intended to support participants to create a dialogue with their inner strength and about strengthening that relationship so they would feel empowered to call on it when needed. They then placed these words at a distance from their felt sense image on the canvas provided.

A moment was given for the women to take a look at these words and their positioning in relationship to the center resource image. They were invited again to take a deep breath and go within, feeling these messages that had come up in their body and where they may have originated. They were directed to not glue these pieces down but just notice the feelings in the body when they were moved closer and farther away from the center resource image. This is how the directive sounded in session:

> “*Using small pieces of paper provided or ripping pieces of coloured or white paper, write down these things that keep you from connecting to your power; the messages that do not serve you but continue to come up blocking this beautiful image of strength that has come from inside you. What are these messages? Loosely place them on your large mandala around your resource image. Take a deep breath and*

look inward again. Where do these images live? Where did they originate? Now look at your resource image and breath again. Look inward and imagine it in your core, burning brighter with every breath."

Another pause was given to feel and acknowledge the feelings that arose breathing deeply and then shifting the gaze to the resource images created.

The participants at this point were showing signs of some emotional distress with a couple of them having tears well up in their eyes. They were reminded to look to their resource image (Schaverien, 1999) or protector image and take a deep breath to help them to feel more resourced and grounded. After they did this the anxiety in the room subsided considerably as they all began breathing deeper with noticeably more relaxed body postures. They were reminded that they were safe in this moment and safe to face any of these negative messages with the strength and power that came from within them. Participants were encouraged to take a step further with each breath to understand and deeply accept what came in between them feeling their inner power at all times. The intention here was to allow for a release from the pieces that came in the way of them living the lives they wanted.

3. Reconnecting and Reintegrating into Ordinary Life

The third and final stage of this directive focused on moving from feeling the feelings these women held inside that had disrupted their happiness, to imagining and creatively creating what their life would look like with these messages, feelings and memories removed. This process was about reconnecting and reintegrating into ordinary life through the art. The women became empowered as they physically created within the art, what they wanted their future to be.

"*Do not glue down the negative messages, they will be removed when you are ready. With strength and the resiliency that lives inside you, imagine what your life would be like without these. Imagine the space and grace within you that beams when these negative thoughts are no longer a part of your body. With the envelope provided, put these words and negative talk inside, removing them from your mandala so all that remains is your resource image.*"

Invited to take another deep breath and feel connected and centered in their seat as well as fully resourced, participants were asked to imagine what their life would look like without these negative messages. While connecting to their inner felt sense they were instructed to look inside themselves and feel an image within that depicted this feeling. A pause was given for them to breathe again, creating space and time for this image to arise. They were then asked to completely clear the canvas in front of them, placing the words to the side of their canvasses or in an envelope made from the small circles in the center of the table, and then create what it was they saw inside on their large white mandala that had been glued to the black square base. While creating, they were encouraged and invited to feel the joy of life without the confines of negative belief patterns that had become instilled within them so long ago.

They were then asked to allow for a release from these chains that had bound them. By creating this last image they were encouraged to imagine a future that fitted the changes they were working on. It gave them a visual representation that came from within of what they wanted in life. The focus in this stage was instilling hope and connecting to the strength within to achieve this; knowing that this hope, power and strength came from within each one of them and was possible again and again.

After the participants had finished creating this final image, they were invited to take a moment of reflection connecting again to their felt sense and inner strength with deep breaths. They were invited to ask this place inside them if it had any more messages for them and in particular, what more it wanted them to know for them to know they were supported and could have their final image of life as they had just created it. Another pause was given and they were encouraged to feel the strength within themselves to face and transcend their negative beliefs.

> "*With your image of what life would be like once your negative beliefs are removed, connect once again to your first image of your felt sense. Breathe deeply and feel again this place inside of yourself that holds the image of your felt sense. Continue the dialogue with this space inside of you. What more does it have to say? What more does it want you to know for you to know you are supported and can have your final image of life as you have created it? Feel the strength within yourself to transcend these negative beliefs. In your journal or paper provided, write out any messages you feel from this strength with you."*

Finally, they were directed to write out any messages of support they received from their inner strength in either their journal or paper provided.

We ended the art therapy session with another mindfulness exercise inviting the women to fully feel the process and discovery the art directive offered them. They were directed to once again come back to their felt sense and strength inside, locating exactly where it was in the body. An invitation was given for the women to allow this strength within them to be all that they were and be fully embodied. With their negative beliefs placed securely in their envelopes, it was now time to discard them as they saw fit.

> "*Breathe again into this place inside and feel it growing and getting brighter; feel it growing into your entire being pushing beyond the space it comes from and permeating beyond into your blood, your muscles and finally reaching your skin. Allow this strength within you to be all that you are. Your negative beliefs have been placed securely into your envelope and now it is time to discard them.*
>
> *In a ceremonial fashion, take this envelope and discard of it as you wish. This can be done in a fire where you watch the messages you have held onto burn into ash. As the fire burns feel the brightness of the flames ignite your strength within and watch it become stronger and stronger and brighter and brighter. As the fire cools and the messages of the past turn to ash, imagine taking the light, heat and power that these messages once held and transforming that into strength. If felt called to, bury these ashes in the west where the sun sets and know that through your experiences you have been transformed and just as the sun sets so does your past and in the morning you will again be reborn unto a new day."*

Although no one shared their art work in the closing circle of the group, participants were invited to share what the experience had been like for them and what insights they learned from it. They were encouraged to take their art home and dispose of it if they wished or keep it for further reflection. There was also a suggestion for participants to journal about their experience and any other feelings that may arise once they had the art with them at home.

Follow-up

I had one more session with the group a week later. During the opening of this last session, participants were asked to share any further reflections or discoveries from the art

directive they may have had during their week. They all expressed that they had felt lighter and stronger after the session even though moving through it had been difficult at times. Women in the group described that they had felt further empowered when issues arose during their week and they were reminded of their inner strength by looking at their resource image at home. Some spoke about making art at home and even with other family members to help feel grounded and calm.

They spoke about a shame that had been lifted by experiencing the powerful effects of the directive in a group format, where some participants were able to be more transparent about their feelings with friends and family members afterwards. They spoke of feeling more understanding and compassion for others, especially family members who had also experienced trauma. One woman even spoke about sharing parts of the directive with a friend who was going through similar difficulties of past traumas. And finally, there was a consensus among group members of a greater connection to a higher power after our session.

Of greatest importance, I felt, was that group members spoke of a renewed inner motivation they felt to change their lives. They related this feeling to the experience of creating their final image.

Summary

The art directive “Let me be free; in 1, 2, 3” integrates Focusing-Orientated art therapy, mindfulness and the 3 stages of trauma therapy (Herman, 1992b) to increase safety and stabilization and healing from trauma and abuse.

The female participants were led through the three stages of Judith Herman’s (1992b) model of trauma therapy using art as a means to express their feelings and help in their journey

of healing. A strong focus on what each participant was feeling in the body was acknowledged and honoured as they created the art. Important too in this art directive was the group context and that the women felt that they were not alone in this process; within the group as well as connected to a higher power they believed in.

Integrating the three stages of trauma therapy (Herman, 1992b) with Focusing-Oriented art therapy (Rappaport, 2009), allowed clients to access trauma that has been stored in the body (Richardson, 2016). For myself, keeping open to the needs of the group assisted in developing the directive in a responsive way. Confirmation that the activity facilitated a deep level of healing was observed in both the verbal and physical effects during the art therapy session, as well as in discussion with the women a week later. Through administering this art directive, it became evident to me that connecting to a resource greater than oneself can be of great importance when working with trauma survivors.

Chapter 5 Discussion: Themes Connecting to the Theory

How has the art activity "Let me be free; in 1, 2, 3", which integrated all three stages of trauma therapy as outlined by Judith Herman (1992b), helped the women of this trauma group heal? In what ways did the precautions taken to ensure safety and stabilization assist in the exploration of the traumas? In this chapter, I will review the data in order to illuminate the benefits of the art directive process by drawing out themes and linking them to theory. Through the exploration of these benefits, I have grouped them into the following themes: Connection to Inner Strength, Wishes and Hopes for the Future, Acceptance and Strength to Transcend Past Traumas, Discarding Limiting Beliefs, Re-visiting Trauma when Resourced, and lastly, Healing Attachment Wounds. Each theme is described with direct reference to the women's experience.

Connection to Inner Strength

Accessing the felt sense was pivotal within this directive and was done as a way to cultivate the inner strength needed for the women of this group to explore the feelings that trauma had left them with. We did this throughout the session from the beginning with the mindfulness exercise, again when creating a resource image and as the art directive process continued the women were reminded to connect to their resource image or inner strength.

When accessing their felt sense, participants were encouraged to notice this area, be with it and listen to what it had to say. This was the inner strength within the client and an important part of the therapy that took place. Space, time and pauses were given for this inner knowingness to be felt within their bodies. They were asked where it was located, what it looked and felt like and to sit with it in a friendly accepting manner, without judgment. By developing a relationship with this felt sense, separate from other parts of self, they become more resourced

and able to access their own inner strength outside of therapy. They were encouraged to ask it questions throughout the session and use it as a ground within themselves. This also encouraged participants to feel empowered by the fact that therapy and healing was coming from within them. It was validating to hear the women speak in our follow up session about a newfound strength they had felt was cultivated inside after the directive.

Wishes and Hopes for the Future

The participants were invited to imagine a future without the affects of the traumas they had experienced. Through the art making process, they were given the time and space to create what they wanted their lives to be. By creating their life through art, they mirrored the strength and vision they had within. Creative visualization affirmed the lives they wanted. An increased empowerment occurred as the women brought forward this image and story that came from within. This was now something inside themselves, which they could access at times of need. This in turn gave them further hope and reassurance that they were strong enough to handle future issues and that life would be okay.

There was also a forward movement in their decisions and hopes for the future. By looking forward to a new life, they felt resourced to remember this new path and transcend the symptoms of trauma that they had been experiencing. As they changed their patterns and felt more connected to the world around them, their focus began to shift from their experience of depression and the symptoms of C-PTSD. Through moving into and out of their pains, they were embarking on creating a new reality.

Looking at wishes and hopes for the future can bring up a lot of feelings for someone who has reverted to the hope of death at times of extreme distress during C-PTSD symptoms.

Since suicidal ideation often accompanies the symptoms of untreated C-PTSD, it is very important to address and honour these feelings when they arise in the client. Although no one discussed suicidal ideation within our session, deep pains and discomfort were evident within the art and art making process. When I noticed this increased discomfort, I encouraged participants to look to their resource or protector image.

I was aware not to push for an instilment of hope but rather to allow participants to decide what they needed to feel hope. Through the art making process there were times that I could have stepped in to highlight hopes for participants. However, this would not be congruent with a feminist and trauma informed approach on how an instilment of hope is created. The need was for participants to find within themselves, an instilment of hope. As they all worked through the difficult stages of the art directive, an inner strength surfaced that assisted them all in finding their own personal hope. Because this came from inside and not from another person, the strength was learned and instilled in a way that could be accessed in the future. Bringing the feelings they had of hope into the here-and-now by concretizing them in the art fostered greater awareness to activate these when needed.

The instillation of hope brings imagination for a new future. It gives the client something to focus on and work towards. Through the art making in the third stage of this directive, the women used creative imagination to see a future without the limitations they had felt in life and drew or painted what that looked like. The act of taking a pause to feel this image in their body and breathing that sensation in, created new neuropathways that facilitated a shift in a deeply felt way (Richardson, 2016). By giving the participants the opportunity to think into the future and make wishes for what they wanted, a sense of hope began to develop and a renewed excitement for life.

In the follow up session the participants showed growth and understanding in the healing process when they described what had happened when they took the art home to reflect on it further. They said that this helped them feel greater strength inside when issues arose outside of therapy sessions. The women also spoke of choosing to make art on their own at home and then journaling about the process they felt through creating the art. This is an example of how the women took care of themselves in a new way that helped them know they were strong enough to face the future. Not only did they speak of the art therapy process as being beneficial for themselves, they were able to move beyond their own pains and help others they knew that were going through similar struggles in life. One woman described her experience of helping another as being very empowering and that through this act of service she felt she was moving from being a victim of abuse to a survivor.

Acceptance and Strength to Transcend Past Traumas

By working through the stages of trauma therapy outlined by Judith Herman (1992b), participants had the opportunity to become more internally resourced while they remembered, mourned and integrated experiences from their past. Through this process a non-judgmental acceptance of the past began to develop. This was not necessarily the same as forgiveness, which may touch on various worldviews, and can at times leave clients feeling that their trauma is less validated. It was instead, a personal power that was evoked as clients began to believe that they had the ability to transcend these traumas from the past and that they no longer needed to take up such a big part of their lives in the present. As the art therapist intern, it was important to validate the injustice in the client's experience and to affirm that it was not their fault, and work towards acceptance of this.

There may also be guilt that the client holds as a result of others around them being hurt when they were not able to help or may have even assisted in the hurting (Herman, 1992b). These feelings are all validated and held with the same reverence as traumas that they have experienced. It is important for the feelings to be accepted without judgment and that the client understands that they did the best they could. An acceptance of everything needs to be honoured (Daniluk & Phillips, 2004).

As the participants titrated between their resource images and acknowledging the feelings that disrupted their happiness, they were better able to accept the past. The intention with this stage of the directive was for the participants to foster internal strength when remembering disturbing memories so that they would be able to face these when they arose outside of session. Self-regulation became accessible as the body reacted to the memories of traumatic events while making art and feeling safe and resourced. Although this stage of the directive appeared difficult for participants, they all commented afterwards that it was not as difficult as they thought it was going to be. In the follow-up done a week later participants said that they were feeling like they could handle the disturbing memories of their past in a way that felt like they were more in control.

By integrating past emotions felt during times of duress, the participants were encouraged to create within themselves, a greater capacity for strength. By doing so and locating where in the body these painful emotions and memories were stored, they were able to shift the intensity of them. Through this art directive, these trauma survivors faced what had afflicted them while connected to their own inner power and so altered the feelings they had come to accept as debilitating.

Discarding Limiting Beliefs

By facing the limiting beliefs that had plagued these women, they were able to understand how these beliefs held them back from inner peace. Especially noting where these beliefs came from and in fact, that they did not belong to the women but were based on experiences from their past, gave them perspective on how unnecessary they were to them. By writing these negative messages down, they were able to give space to them and see them as separate from themselves; this also gave the women further control in what they chose to do with them. This step corresponds to the fifth step in Focusing: Asking (Gendlin, 1978; Rappaport, 2009). By adopting a sense of non-judgment and sitting *with* the limiting beliefs, tolerating them with understanding, there is space to separate where they come from and recognize that they are not who the person is. This further facilitates a shift in perspective to how one relates to and interacts with these limiting beliefs.

An important intention in this art directive was to allow for the limiting belief messages to be moved at the will of the participants. The purpose within the art making process was for the women to feel within their body the emotions that arose when these negative beliefs were placed closer or farther away from their resource image. This mindfulness was meant to cultivate strength for awareness in the future when these messages may arise again. When participants were asked to move the negative messages closer to their center image and then farther away, noticing the feelings that arose in their body as they did this, a sense of empowerment was evoked. This part of the activity was meant to show the women how the limiting beliefs were affecting them now and that they had a choice to move them closer or farther away from the place inside that gave them strength.

The last part of the art directive was for participants to put the negative messages and limiting beliefs they had written out in an envelope where they would be contained. An invitation was given to discard them how they saw fit after the session with a suggestion to journal the process; spending the time they needed to part with these limiting beliefs in a meaningful way. This invitation was offered to increase the benefits of the art directive by having the participants, outside of session, take care of what they needed for happiness and healing by letting go of limiting beliefs.

Re-visiting Trauma when Resourced

For those who have experienced trauma and especially repeated or prolonged traumas, a common theme is isolation. This is caused from the residue trauma leaves including a deep sense of shame (Herman, 1992b) and an inability to trust others (Van Der Kolk, 2014). Connecting to resources outside of one's self becomes extremely important when working with trauma as this re-establishes trust and strength within. Resources can be internal or external, but it is essential that the client feels they are important enough to ask for support.

It was noticed during the exploration of this art directive that a keen awareness of what was happening in the here in now for every participant needed to be closely observed. As an example of this, the group members indicated that they didn't feel ready to look at what was getting in the way of them feeling peace inside themselves. The response of the ATI at that point was to honour the feelings and invite participants to call on a protector that was close to them; to take the time needed to connect to this protector and only moves forward when they were ready. Given that all three women believed in a spiritual power outside of themselves, this calmed them and gave them the strength and resource needed to continue with the following steps.

In order to reestablish affect and overcome the intensity that traumatic memories bring to those suffering with C-PTSD, clients need to regulate their emotions by revisiting these memories when they feel resourced and safe (Herman, 1992b). The purpose of having the participants create a resource image and then also a protector image in the first stage of safety and stabilization, gave them strength and helped them trust that they could manage revisiting these memories at a time they felt resourced. By vacillating the internal felt sense from resource or protector image to looking at aspects of trauma, difficult memories can be processed in a way that regulates affect and minimizes the effects and symptoms of C-PTSD (Richardson, 2016). The intensity of the memories begin to dissolve and the client has a greater framework for what was then and what is now which puts the trauma in perspective so they no longer feel that they are in harm (Richardson, 2016). As the women moved through stage two and into stage three where they created an image of what their future looked like without limiting beliefs, they were able to see a perspective where they were safe from the infringements of traumatic memories.

Healing Attachment Wounds

Attachment theory as outlined by John Bowlby (1969), states that disruptions in our early developmental years with attachment to our primary caregiver leads to attachment difficulties and needs in later life. By recreating bases of attachment with the art materials in therapy, clients were given an opportunity to repair their own attachment needs (C. Moon, 2010). Recreating attachment scenarios within the art also stabilizes an individual, making them feel more at ease and secure in the therapeutic space and relationship (Carpendale, 2009).

Ways to heal attachment patterns symbolically within the session through this art directive were considered throughout. It began with the materials; a large black square base representing the foundation, base and container framing the large white circle glued securely on

top representing self. With the white circle representing self securely attached to the black foundation, the intention was for the mirroring of self within the session and to create a representation of safety and stability. In the follow up session, the participants described feeling more grounded and connected to their true self after the experience of the art directive.

Attachment was also symbolically worked on when the participants wrote out the painful things that held them back from feeling peace within and then loosely placing these messages on their white circle. Because participants were instructed not to attach the messages to their artwork and instead keep them loose, they were able to symbolically control what was attached to them and what they choose not to have attached. This empowered the women to recreate their own attachment stories and have power over what controlled them.

Summary

The themes identified in this chapter that emerged from this art directive illustrate the benefits experienced by the group members.

The focus in the art directive on connecting to an inner strength supported the process for participants to take care of themselves in times of need. Through creating a relationship with inner resources, skills were strengthened to help manage the symptoms of C-PTSD as they may arise in the future. As described at the beginning of this thesis, healing comes from within (Herman, 1992b). Without internal strength and access to a resource, symptoms of C-PTSD can continue to be debilitating for those who have survived trauma.

By moving the dialogue within the art directive to wishes and hopes for the future, a forward movement occurred whereby participants were able to create the life they wanted within the art. They did this after they had acknowledged the limiting beliefs originating from trauma

that had held them back from happiness. Their hopes for the future were created in a space where they felt freed from their past. This further facilitated a shift from the memories of trauma and symptoms of C-PTSD that had stopped the women from differentiating the feelings of what happened in the past and what was happening in the present or future.

As the women came to accept and hold their histories without judgment, alleviation from the effects of the traumas became possible. By accepting what had happened and framing it as something from their past, participants were able to feel more trust in their capacity to transcend the effects of trauma. This change occurred on many different dimensions of their being; mentally, emotionally, physically and spiritually. It allowed for a discarding of limiting self beliefs and negative messages originating from the trauma, and how it had been understood historically.

Of pivotal importance in this art directive was the ways in which limiting beliefs were attended to and released. By looking deeper into where these messages and beliefs may have come from, strength was formed. By identifying where these messages originated and locating where in the body they lived, participants were able to get underneath the messages so they no longer held the weight they once did. As participants faced the limiting beliefs that had come in the way of them experiencing happiness in the past, they were able to move through the stages of trauma therapy outlined in the art directive to a place that felt more orientated to the life they wanted.

By revisiting trauma when survivors feel resourced builds the ability and strength to face memories of the past and also future issues that may arise in a way that will not destabilize them. Circumnavigating their traumas during the art directive by looking at the origins of limiting beliefs was only done once all the women in the group felt safe, secure and resourced. During

this stage of the directive, the bravery and strength the women expressed feeling in that moment, gave them the resources to shift the patterns of disempowerment over their past. It was encouraging to hear participants express in the follow-up session how they had felt more grounded and resourced when issues and symptoms of C-PTSD came up after their experience of the art directive.

Symbolically, the art materials and art directive process provided participants with a positive attachment experience that may not have been available in their early years. I was intentional in providing art materials and verbal directions that facilitated the participants having subtle but successful attachment experiences in the art making. It was also my intention for participants to ground in the feeling of being present and feel an attachment to the here-and-now instead of being pulled into the past by the memories of their traumas. This seemed evident as participants described their week between sessions wherein one was able to support a friend with similar painful memories.

By exploring the themes related to the theory of this art directive and illustrating the benefits that were observed and named in the follow up session, my hope is for the reader to appreciate the deep internal healing this directive facilitated. I encourage all therapists to delve into the new developing areas of trauma therapy and recognize symptoms that are related to traumatic experiences. Trauma affects so many people and working with it by understanding how symptoms are related to the trauma, will create a movement of healing that helps the world in a way I believe needs it.

Conclusion

My observation from having used this art directive is that using a Focusing-Orientated method of therapy combined with art therapy was of great benefit to these women as they worked through the affects of trauma. As so many pioneering trauma therapists will agree, trauma is stored in the body and in order to release it, time and care need to be taken in accessing the body in a mindful way (Briere, 2002; Herman, 1992b; Levine & Frederick, 1997; Malchiodi, 2015; Rappaport, 2009; Richardson, 2016; Van Der Kolk, 2014). Although working with survivors of trauma can be at times challenging, by staying present to what the needs of the clients are and adapting to these in the moment, a therapist is able to assist survivors in moving beyond the effects of PTSD and C-PTSD.

The women's reflections on this activity support the discussion throughout this paper and research that has been done using a body focused modality to relieve the symptoms of trauma and abuse (Briere, 2002; Herman, 1992b; Malchiodi, 2015; Van Der Kolk, 2014). To hear that the women felt further empowered and able to take care of themselves when issues arose out of session, confirmed that the therapy was working. "The first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery" (Herman, 1992b, p. 133).

An interpretive-hermeneutic art-making model as a mode of inquiry was especially formative in allowing the process of this directive to evolve as it did. It supported me to stay attuned to what the needs of the participants were moment by moment and to trust in their process.

Clearly, the activity was of value to this group and I would recommend it for others doing individual or group art therapy when exploring symptoms of trauma or other issues clients face in life. I would suggest that further research be done to explore its use with a wider population of individuals suffering from C-PSTD.

Throughout the research of this thesis I was inspired to realize how experiences of trauma can support a person into further self-discovery that can in tern benefit their life. The information gathered during the follow-up session illuminated examples of this post-traumatic growth. Of course, trauma is something no one should have to go through. However, as I experience people who have overcome symptoms of trauma and now thrive in life in new and profound ways, helping others as well as themselves, I feel a renewed hope for survivors. I intend to explore the area of posttraumatic growth further.

My journey into the research of this thesis has occurred over a span of a year and a half, although much of my understanding on the subject has come from my own personal experience with trauma. During my research, I realized that we are on the verge of many new discoveries in the area of trauma therapy and ways to heal. It was hard not to include them all in this body of work.

Especially interesting to me was the area of Epigenetics and Neuroscience. Epigenetics describes the effects of generational trauma and how DNA actually changes with trauma passing its effects through the generations (B. Badenoch, 2008; Borysenko, 1987). Neuroscience opens an entire new study as well as brain functioning is now being researched and ways to alleviate traumatic memories through neuro-feedback. I found Bessel Van der Kolk's (2016) recent work to be incredibly interesting and forefront in the field of trauma therapy and neuro-feedback exercises to heal the brain from trauma. Steven Porges (2015) is another researcher I have found

to be on the cutting edge with his neuro-scientific research into the polyvegal theory. I recommend readers of this thesis to explore his work further. There have also been studies by Joan Borysenko (2016) relating to the connection between the brain and gut, and how changing one's eating habits can actually aid in healing symptoms of PTSD. This is all fascinating research that goes beyond the scope of my enquiry but has excited me to further explore, trauma and ways to heal from it.

Through the reading of this thesis, my hope for the reader is that you will feel inspired to further question the impact of trauma and how we, as a society can work to help each other to heal.

Appendix A

I am including two poems that I have found inspiring and comforting in working with my own personal history of trauma as well as with this group. These were not shared with participants since I found John O'Donahue's poem after the sessions and wrote the other poem also after the sessions. When connecting to others, especially through the shared experience of art making, I have found an allowance for further acceptance of self.

For Someone Awakening to the Trauma of His or Her Past

By John O' Donohue

For everything under the sun there is a time.
This is the season of your awkward harvesting,
When pain takes you where you would rather not go,
Through the white curtain of yesterdays to a place
You had forgotten you knew from the inside out;
And a time when that bitter tree was planted
That has grown always invisible beside you
And whose branches your awakened hands
Now long to disentangle from your heart.
You are coming to see how your looking often darkened
When you should have felt safe enough to fall toward love,
How deep down your eyes were always owned by something
That faced them through a dark fester of thorns
Converting whoever came into a further figure of the wrong;
You could only see what touched you as already torn.
Now the act of seeing begins your work of mourning,
And your memory is ready to show you everything,
Having waited all these years for you to return and know.

Only you know where the casket of pain is interred.
You will have to scrape through all the layers of covering.
And according to your readiness, everything will open.
May you be blessed with a wise and compassionate guide
Who can accompany you through the fear and grief
Until your heart has wept its way to your true self.
As your tears fall over that wounded place,
May they wash away your hurt and free your heart.
May your forgiveness still the hunger of the wound,
So that for the first time you can walk away from that place,
Reunited with your banished heart, now healed and freed,
And feel the clear, free air bless your new face.

O' Donohue, John: To Bless the Space Between Us: A Book of Blessings. New York : RandomHouse, 2008

Appendix B

A Flower's Transformation

By Charmaine Husum

A Flower emerged one day
After all her Petals had fallen away
An image of Self with core burning bright
Illuminated this lonely stem
Turning darkness into light

Each early morning
While the earth still hid the sun from sight
This secluded stem and center
Would light up the night

Breathing deep, the energy
Held fast on the other side of the world
This cosmic force drawn into the earth
From this flower without pedals

To grow roots only known to a tree
And one day, that is exactly what she would be
With flowers of her own
Offering shade to those who needed it

But in the beginning, frosts and harsh winds
Threatened her survival
And she questioned if her faith in life
Was stronger than the impermanence that confronted her.

Yet each early morning
In the hours called ambrosia

With certitude of heart and a knowingness so clear
The growing trunk again breathed in
All the love, care and protection
It’s sun forever held

For even out of sight
Or hidden by the vastness of the planet
The flower was always connected
To the love that helped it grow

Charmaine Husum
June 2, 2016

Appendix C

On Pain

By Kahil Gibran

And a woman spoke, saying, "Tell us of Pain."

And he said: Your pain is the breaking of the shell that encloses your understanding.

Even as the stone of the fruit must break, that its heart may stand in the sun, so must you know pain.

And could you keep your heart in wonder at the daily miracles of your life, your pain would not seem less wondrous than your joy;

And you would accept the seasons of your heart, even as you have always accepted the seasons that pass over your fields.

And you would watch with serenity through the winters of your grief.

Much of your pain is self-chosen.

It is the bitter potion by which the physician within you heals your sick self.

Therefore trust the physician, and drink his remedy in silence and tranquility:

For his hand, though heavy and hard, is guided by the tender hand of the Unseen,

And the cup he brings, though it burn your lips, has been fashioned of the clay which the Potter has moistened with His own sacred tears.

Kahil Gibran, 1994. *The Profit.* Alfred, A Knopf: New York.

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