BRINGING INTO PRESENCE: CLIENT EXPERIENCES OF SPEAKART, A GROUP THERAPY FOR COMPLEX TRAUMA

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Abstract

This qualitative study explored the experiences of women who completed an art therapy group for the treatment of difficulties related to complex trauma. Increasingly, treatments that address problems with self-organization (emotion regulation, self-concept, and relationship difficulties), in addition to classic symptoms of post-traumatic stress disorder, are recommended for individuals with complex trauma histories (e.g., Courtois & Ford, 2016). To date, evidence for the effectiveness of art therapy for complex trauma is limited but promising (e.g., Gantt & Tinnin, 2007; Pifalo, 2006), and process studies are non-existent. No study to date has examined client experiences of art therapy, with the goal of understanding how it is helpful (or not) from the client perspective. The present study aimed to address this gap, through a qualitative investigation of SpeakArt, a 12-week group offered through a hospital-based trauma therapy program. Ten participants completed interviews, conducted after their initial group session, about their goals, expectations, and concerns about the group. A second post-therapy interview invited participants to review a written summary of their initial interview, reflect on their experience of the group overall, and identify personal changes that they attributed to SpeakArt. The post-therapy interviews were analyzed using grounded theory techniques, applied from an interpretive-constructivist stance (Charmaz, 2006; Rennie, 2000). The analysis yielded four conceptual domains, comprising participants' experience of art therapy and associated shifts: (1) Negotiating (Un)safeness in the Present; (2) Bringing 'It' Up; (3) Witnessing the Invisible and the Invalidated; and (4) Transferring Transformation. A core category and heuristic model was also developed, describing two participant pathways in the group and a dynamic relationship among the four domains. The core category, Bringing into Presence*,* refers to processes of *integrating* old/trauma-related memories and emotions, and *creating* new meanings and adaptive

responses. It is concluded that these integration and creation processes are contingent on experiencing intrapersonal and interpersonal safeness in group, and are mediated by the material, visual, and interactive nature of art-making in a group setting. Bringing into Presence as a concept is discussed and expanded on with reference to literature on integration in trauma recovery, relevant concepts from the psychotherapy process literature, and complex trauma conceptualization.

Dedication

To the children in my life
Including and especially those stuck in adult bodies
May you be healthy, may you be safe
May you always be free to create art and make magic

Acknowledgments

I am grateful to this study's research participants, whose vulnerability and generosity of time and story made this project possible, and made it richer than I ever could have hoped.

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Chapter 1: Introduction

The Backstory

In the Fall of 2016, I began a practicum placement in a trauma therapy program providing services for people (primarily women) with histories of childhood interpersonal trauma. On the first day, touring the hospital wing that housed the program, we stopped by a large room whose walls were lined with colourful paintings and collages, shelves stacked with sculptures and boxes and piles of art materials. In an otherwise sterile, institutional setting, the room was alluring, and I was intrigued. My supervisor and the art psychotherapist each agreed to add co-facilitation of an art therapy group to the training plan. I didn't know it at the time, but the seed for this study was firmly planted on that first day. The actual idea for it, as a research endeavor, germinated many months later. Observing the group through the lens of a clinical psychology doctoral trainee, with no art therapy training and a research background in psychotherapy processes (specifically, the micro-shifts in how people express emotional experience in narrative form), I had observed that something therapeutic seemed to be happening in this weekly art therapy group, but it appeared different enough from my existing models of what psychotherapy is, and how psychotherapy works, that I did not understand what I was seeing. And—with the curiosity of a process researcher—I wanted to understand.

The present study grew from that planted and germinated seed. In psychotherapy process research, we use a variety of methodological frameworks and associated research tools and methods to attempt to describe and understand various facets—behavioural, psychological, interpersonal—of what happens during therapy, and the association between these process factors and "outcome," i.e., their predictive value of the therapy's efficaciousness. In the process-outcome literature, outcome is predominantly defined according to the degree of symptom

reduction over the course of therapy, or by changes in participant/client diagnostic status, and most of this research has been undertaken using diagnosis-specific samples, drawn from controlled clinical trials comparing manualized treatments. There are alternative frameworks for examining psychotherapy processes and efficaciousness. For example, qualitative and mixed-methods analyses of therapist and client experiences of therapy, offer a way of understanding the events and processes in therapy that are of greatest significance to those directly involved in it.

This study is a qualitative investigation of clients' experiences of an art therapy group for people with histories of childhood trauma. It is, on one level, about art therapy and complex trauma. The questions it asks about art therapy and clients' experiences of it, however, are framed by a person (this writer) who is primarily interested in psychotherapy, the psychological and relational processes that unfold in therapy, and the particular psychological and relational challenges that shape those processes, for clients with complex trauma histories and their therapists. The remainder of this chapter reviews relevant background literature. First, I summarize the current state of the complicated, evolving, and often-polarized landscape surrounding diagnoses related to complex trauma, and the evidence base for various approaches to its treatment. Second, I review several process considerations for working with clients with developmental trauma histories. Next, I summarize the putative relevance of art therapy for clients with trauma exposure, and review the evidence for its effectiveness. Finally, I outline this study's research questions and rationale for addressing them using a qualitative approach.

Literature Review

The Complicated History of Complex Trauma

"Complex Trauma" and its Sequelae. Judith Herman (1992a) first coined the term complex trauma, referring to repeated exposure to interpersonal harm such as abuse and neglect

in childhood, and the long-term psychological difficulties often experienced by survivors. These complex trauma sequelae, first identified by Herman, include difficulties with emotion regulation, problematic interpersonal relationships, negative views of self (e.g., worthlessness, self-blame), altered attention and consciousness (e.g., dissociation), maladaptive belief systems, and somatic distress (Courtois & Ford, 2016; Herman, 1992a; van der Kolk et al., 2005). These difficulties, most of which have since been termed "disturbances in self-organization" (DSO; Maercker et al., 2013), are considered a unique consequence of an individual's response to sustained *relational* trauma. Exposure to potentially traumatic events creates a physiological demand (threat response), and individuals respond to that demand, cope with the stressor, by drawing on the resources available to them (Hobfoll, 1989). Complex trauma is thought to lead to a breadth of difficulties in psychological, physiological, and interpersonal function because, in the case of relational trauma during developmental periods, the traumatic stressor itself also erodes, or renders unavailable, the resources that children depend on to cope with the demands of the threat response—i.e., social relationships that support development of a sense of self, and emotion-modulation and relational capacities (Cloitre et al., 2013; Ford, 2015).

The earliest conceptualizations of complex trauma referred to developmental trauma, i.e., exposure during childhood or adolescence to repetitive, prolonged harm or neglect by a caregiver or responsible adult (Herman, 1992a; Courtois & Ford, 2009). The age-of-exposure criterion has since expanded to include adult exposure to relational traumas of a repeated, severe, prolonged, or multiple type, such as domestic abuse, torture, human trafficking, and refugee and genocidal experiences (Herman, 1992b; Liddell et al., 2019; Palic et al., 2016). These experiences are associated with similar psychological and physiological consequences as complex developmental trauma. By their nature, they also entail significant loss of access to social resources, compared

to single incident and non-relational traumas. That said, there is evidence that cumulative relational trauma in childhood is more strongly linked, vs. repeated adult exposure, to complex trauma sequelae (Cloitre et al., 2019; Vang et al., 2019).

In the research literature and clinical settings, use of the term "complex trauma" has frequently confounded exposure to traumatic events themselves, with the sequelae of difficulties that can result from those experiences over the long term (e.g., Courtois, 2008). The lack of clear and consistent terminology—consider that "complex trauma" is often used interchangeably with "developmental trauma" and "child abuse"—is confusing, and some argue it has hindered efforts to advance the theoretical and empirical conceptualization of traumatic stress disorders and treatment (Landy et al., 2015). This confounding of language may be a consequence of the lack of clear diagnostic status (and hence, a convenient label) for the difficulties arising from complex trauma, despite a clinically-driven need to distinguish it from related disorders, such as post-traumatic stress disorder (PTSD). It may also be a consequence of the idiosyncratic and complex presentations, in clinical practice, of individuals with complex trauma histories; exposure to relational trauma is not only associated with the DSO first described by Herman (1992a), and PTSD symptoms, but additional psychiatric difficulties such as mood, anxiety, dissociative, and substance use disorders (reviewed in Wilgus et al., 2016). Finally, evidence suggests that the severity and complexity of psychiatric presentation is associated with the number of types of traumas to which an individual was exposed, rather than the number of incidents (Briere et al., 2008; Cloitre et al., 2009), thus the confounding of terms may reflect a correspondence between complexity of the traumatic exposure history, and the complexity of subsequent difficulties.

There has been disagreement (e.g., DeJongh et al., 2016; Karatzias & Levendosky, 2019; Resick et al., 2012; Wolf et al., 2015) as to whether the constellation of difficulties associated

with complex trauma represents a syndrome distinct from PTSD and other overlapping syndromes, such as dissociative disorders and borderline personality disorder (BPD). Much of this debate hinges on clinical utility, i.e., whether diagnostic classification meets three considerations: consistency with providers' mental taxonomies; parsimony of symptom profiles for ease of clinical application; and prognostic value for treatment planning (Reed, 2010). The question of clinical utility has not been definitively answered, as evidenced by ongoing expert debate (e.g., Achterhof et al., 2019; Cloitre et al., 2020; Ford, 2020), and by divergent decisions about the inclusion of a new diagnostic category, Complex Post-Traumatic Stress Disorder (CPTSD), in the most recent versions of the world's two principle diagnostic classification systems.

Complex Post Traumatic Stress Disorder (CPTSD). In the past decade, clinical need to describe the difficulties associated with complex trauma, not captured by earlier conceptualizations of PTSD, motivated revisions to the classification of stress-related disorders. The North American classificatory system, the Diagnostic and Statistical Manual of Mental Disorders, responded in its most recent, 5th edition (DSM-5) by re-classifying PTSD as a stressor-related rather than anxiety disorder, and by expanding the symptom profile of PTSD. New PTSD symptom categories include negative alterations in condition and mood such as persistent negative beliefs about the self, and persistent negative emotional state. Many authors (e.g., Landy et al., 2015) who oppose the need for a separate diagnostic category (i.e., CPTSD) argue that PTSD, as conceptualized by the DSM-5, adequately captures the difficulties associated with complex trauma exposure. Where it does not, they argue that existing, often comorbid diagnostic categories already exist, such as dysthymia, generalized anxiety disorder, and BPD. In addition, there is evidence suggesting that existing gold-standard PTSD treatments

are helpful for people with complex trauma histories, obviating the need for a separate diagnosis for treatment-planning purposes (Landy et al., 2015).

In contrast, in 2018, the World Health Organization (WHO)'s International Classification of Disease, 11th edition (ICD-11), included a revised classificatory system for stress-related disorders that recognizes CPTSD as distinct from but related to PTSD. The diagnostic construct and its symptom structure were defined based on large-scale trials assessing symptoms associated with complex trauma exposure (van der Kolk et al., 2005) and clinician surveys and expert consensus (Cloitre et al., 2011). The ICD-11 defines PTSD as a fear-based disorder, characterized by the presence of three symptom categories: re-experiencing (intrusive memories, flashbacks); avoidance of psychological and/or situational reminders; and persistent sense of threat (hyperarousal, hypervigilance). CPTSD, meanwhile, is characterized by persistent disturbances in self organization (DSO) as well as the fear-based symptoms of PTSD (Karatzias et al., 2017; Hyland et al., 2018; Shevlin et al., 2017). To meet ICD-11 criteria for CPTSD, individuals must exhibit the three PTSD symptom categories, as well as the three categories of DSO symptoms: affect dysregulation; negative self-concept; and disturbed relationships. The two categories of symptoms are understood to be intrinsically related in CPTSD presentations, according to the ICD-11 conceptualization (Cloitre et al., 2020).

Empirical support for CPTSD's construct validity was based on numerous large-scale latent class, latent profile, and confirmatory factor analyses (reviewed in Brewin et al., 2017). Collectively, these provide considerable evidence that CPTSD, as defined by the ICD-11, is distinct from its most closely related diagnoses, PTSD and BPD. The ICD-11 conceptualization of CPTSD has been criticized on two counts. First, some have argued that symptom presentations associated with complex trauma are overlooked by the ICD-11 criteria (Ford,

2020). Second, it requires that individuals meet criteria for the three, fear-based symptoms of classic PTSD, even though the analyses that provided evidence of construct validity for CPTSD also showed a sizeable class of individuals who present with high disturbances in self organization (DSO) but low PTSD symptoms (e.g., Knefel et al., 2015; Liddell et al., 2019; Palic et al., 2016; Perkonigg et al., 2016). By defining CPTSD as the presence of intrinsically linked PTSD and DSO symptoms, the ICD-11 excludes those who present with significant DSO only, and potentially undermines efforts to establish treatments that prioritize those difficulties, which predict distress and functional impairment in this population (Cloitre et al., 2005; Karatzias et al., 2017; Palic et al., 2016).

Accordingly, Ford (2019, 2020) calls for greater theoretical clarity in the conceptualization of complex post-traumatic stress. PTSD has widely-accepted theoretical coherence as a fear-based disorder, comprised of persistent adaptations to the experience of existential threat (personal, physical safety) such as altered responses to threat cues and attempts to avoid further harm, that occur when individuals' episodic memory of the traumatic event is triggered. In contrast, Ford (2019) argues, CPTSD might gain theoretical coherence if conceptualized as an adaptation to interpersonal betrayal, resulting in pervasive damage to self-concept, affect dysregulation triggered by vulnerability in relationships, and shame. In this conceptualization, the construct validity of complex PTSD hinges on discriminating it not from PTSD, but from other disorders involving problems with self-regulation and coherence, notably BPD, depression, and dissociative disorders (Dorrepaal et al., 2012; Ford, 2019, 2020).

The present study's participant sample was not, as part of the research process, formally defined by any psychiatric diagnoses, for two reasons. First, this study was designed and executed in the period overlapping with the 2018 release of the ICD-11 and official recognition

therein of CPTSD. Pragmatically, tools for CPTSD assessment, such as validated diagnostic interviews and self-report measures, were not available at the time of data collection. Second, and of greater importance, the clinical setting in which this study took place has an adiagnostic culture originating from the program's original feminist, anti-oppressive approach to providing services for survivors of child abuse (see Duarte-Giles et al., 2007). Their services are centered on a population of adults with complex trauma histories, but at the programmatic level, diagnosis of presenting concerns (i.e., presumed trauma-related or trauma-contextualized difficulties) is not required for those individuals to access treatment. In consequence, this study, and the remainder of this manuscript, uses the term "complex trauma" to refer to the shared history of its research participants, rather than any presumed diagnostic status. The terms "CPTSD" or "complex PTSD" refer to the diagnostic construct being increasingly used in the broader clinical practice and research systems.

Complex Trauma and Psychotherapy

Evidence-based PTSD Treatments. The most recent American Psychological Association (APA)'s Clinical Practice Guidelines recognize the following 'gold-standard' treatments for PTSD: cognitive-behavioural therapy, cognitive processing therapy, cognitive therapy, and prolonged exposure. They also recommend eye-movement desensitization and reprocessing (EMDR), and narrative exposure therapy. These treatments directly target core PTSD fear-based symptoms of hyperarousal, re-experiencing, altered beliefs, and avoidance, by working with the episodic trauma memory and/or with the beliefs and emotions associated with a specific traumatic event (Bisson et al., 2013; Foa et al., 2009). Some critics of the APA PTSD guidelines (e.g., Courtois, 2018; Dominguez & Lee, 2017; Henning & Brand, 2019) contend that there are problems with the guidelines. For instance, the randomized controlled trial (RCT)

evidence upon which these treatment recommendations are based lacks ecological validity, as RCT samples are non-representative of clinical populations with complex trauma histories presenting for treatment in community settings (Spinazzola et al., 2005). Furthermore, the recommended treatments do not address presenting concerns that characterize complex trauma (i.e., DSO), and under-emphasize the importance of quality of life, suicide risk, drop-out, comorbid conditions, and functional impairment, relative to reduction in PTSD symptoms, as metrics for efficaciousness (Henning & Brand, 2019).

Individuals with complex trauma histories who have a PTSD diagnosis often show reductions in PTSD symptoms in response to these treatments (reviewed in Landy et al., 2015). On the other hand, outcome heterogeneity is high (Karatzias et al., 2019). Furthermore, there is evidence of higher adverse outcomes such as drop-out and symptom worsening (reviewed in Dorrepaal et al., 2014; Lonergan, 2014). Other factors predicting poor response to evidence-based PTSD treatment include deficits in verbal memory, notably narrative encoding (Wild & Gur, 2008), and over-modulation of emotion, such as numbing and dissociation, which are more common among those with complex trauma histories (Lanius et al., 2010; Lanius et al., 2012). Finally, while most evidence-based PTSD treatments entail trauma memory processing, some recent RCTs and meta-analytic studies have brought into question the long-held assumption that trauma memory processing is necessary, and that trauma-focused treatments are more effective than nonspecific psychotherapy interventions, for treating PTSD symptoms (e.g., Erford et al., 2016; Foa et al., 2018; Lenz et al., 2017; Schwartze et al., 2019).

There is limited evidence as to how well PTSD treatments address other difficulties experienced by those with complex trauma exposure. A recent systematic review and meta-analysis (Karatzias et al., 2019) examined evidence for the effectiveness of evidence-based

PTSD treatments (CBT, exposure, and EMDR), on three DSO symptoms targets: affect dysregulation, negative self-concept, and disturbed relationships. The analysis concluded that there was low- to moderate-quality evidence that these treatments had promising (moderate to large effect sizes) for improvements in self-concept, and relationships, (only a small number of studies reviewed reported on affect dysregulation). The effect sizes were reduced to small or nil, however, when compared to control conditions (e.g., psychiatric treatment-as-usual; counselling), suggesting the importance of non-specific treatment factors. Notably, moderator analyses showed that onset of trauma in childhood was associated with lower effectiveness, further indicating that while evidence-based PTSD treatments are effective for some DSO symptoms, they are less so, among individuals with complex developmental trauma histories (Karatzias et al., 2019).

Modular, Sequential Treatment Approaches. Many experts in the field of psychotraumatology argue that the fundamental distinction between the centrality of fear in PTSD, and DSO in complex PTSD, correspond to a need for specialized treatment approaches that respectively address fear-based symptoms, and self-organization disturbances (Cloitre et al., 2002; Cloitre, 2016; Courtois & Ford, 2016; Ford, 2015; Herman, 1992a). An alternative, multi-modal, staged approach to address the complex constellation of problems—including PTSD symptoms—that survivors bring to treatment is supported by increasing expert agreement (Cloitre et al., 2011) and a growing evidence base, although this remains controversial. For example, DeJongh and colleagues (2016) contend that there is weak evidence that staged approaches improve response to trauma memory processing, and argue that they create unnecessary delays in the treatment of PTSD symptoms.

Proponents of specialized or multi-modal complex trauma treatments have identified three treatment stages: (1) enhancing relational trust, safety, and self-regulation skills; (2) processing trauma by working with event memories and/or trauma-related procedural memories and beliefs as they unfold in the present; (3) engagement in valued activities and relationships, previously impeded by the effects of trauma (Courtois & Ford, 2009, 2016; Herman, 1992a). Often, these approaches have an additive but not necessarily linear structure, based on the logic of addressing, in stages, multiple categories of symptom presentation in individuals with complex trauma histories. This entails development of skills to address interpersonal problems and emotion-regulation, followed by processing of trauma memories and trauma-related beliefs, to address fear-related symptoms. Development of relational and emotional resources is prioritized to reduce distress and improve general function, and in preparation for subsequent processing of trauma material, so that clients are more resourced and able to access *and* reflect on (integrate) trauma-related emotions, memories, and beliefs, without being overwhelmed (Karatzias et al., 2019). Cloitre and colleagues (2010) have demonstrated positive outcomes for a sequential therapy consisting of an initial didactic, skill-training phase to promote affect regulation and interpersonal effectiveness, followed by a trauma processing (exposure) phase. Similarly, recent studies have examined concurrent modular treatments for individuals with comorbid BPD and PTSD, among whom rates of complex trauma exposure are high, and whose symptom presentation closely resembles the categories of difficulties that make up CPTSD. These treatments, entailing concurrent dialectical behaviour therapy to address problems with emotion dysregulation, interpersonal function, and self-concept, and exposure therapies for trauma processing, have shown promising outcomes (Bohus et al., 2013; Bohus et al., 2019; Görg et al., 2019; Harned et al., 2014).

Bottom-up and Relational Treatment Approaches. Whereas the above-described approaches to complex trauma treatment emphasize emotional and interpersonal skills development to address DSO, coupled with structured trauma processing for PTSD symptom reduction, other approaches emphasize therapeutic relationship conditions and work directly with problematic "bottom-up" or nonverbal processes for enhanced self-regulation. They provide relational support for dyadic affect regulation and emotion processing and/or work directly with the body's procedural responses (e.g., Ogden et al., 2006; Paivio et al., 2010; Payne et al., 2015) to enhance autonomic regulation and re-build capacities for pleasure, social engagement, and self-regulation (van der Kolk, 2014). Experiential relational approaches address the putative origins of DSO, i.e., compromised development of and access to social-emotional resources, through the provision of relational security and co-regulated experiential processing of emotions, memories, beliefs, and action tendencies.

For example, sensorimotor psychotherapy (SP; Ogden & Minton, 2000; Ogden et al., 2006; Ogden & Fisher, 2016) integrates verbal psychotherapy with somatic interventions, to target autonomic dysregulation and associated emotions and beliefs. This approach side-steps trauma narratives, and instead processes trauma-rooted procedural memories by working with the body's response activated when clients begin to describe memories and/or problematic patterns in their daily lives that mirror trauma responses. Experiential somatic work in therapy becomes the access point for exploring and transforming associated beliefs and emotions. This work often involves interrupting passive procedural defense responses (e.g., freeze, collapse) that were adaptive at the time of trauma, but remain problematic for survivors; and mindfully accessing active defense responses, and associated primary adaptive emotions, thwarted at the time of the trauma (e.g., fight, flight, cry for help). Recent studies provide preliminary support

for SP's effectiveness for reducing dissociation, depression, and PTSD symptoms, and improving body awareness, self-soothing, and social role function (Classen et al., 2020; Gene-Cos et al., 2016; Langmuir et al., 2012).

Emotion-focused therapy for complex relational trauma (EFTT; Paivio & Pascual-Leone, 2010) similarly emphasizes bottom-up accessing of present-moment emotional experience, for integrative symbolization, reflection, and meaning-making (Paivio & Angus, 2017). In EFTT, empathic relationship conditions and Gestalt techniques facilitate processing of trauma-related maladaptive recurrent emotions, interpersonal schemes, and unresolved issues with attachment figures. EFTT targets maladaptive self-narratives organized around repeatedly-activated feelings of fear and shame, and facilitates access to adaptive emotions that were unavailable at the time of childhood trauma (e.g., anger, sadness, compassion). This is thought to promote improved sense of self, narrative reconstruction, meaning-making, and values-driven action (Paivio & Pascual-Leone, 2010; Paivio & Angus, 2017; Paivio & Angus, 2020). To date, EFTT clinical trials have shown clinically significant improvements in general symptom distress, intrusions, avoidance, depression, anxiety, self-esteem, and interpersonal function (Paivio & Niewenhuis, 2001; Paivio et al., 2010). Notably, these trials included participants with histories of relational trauma, but only a minority met criteria for PTSD. Furthermore, participants were fairly high-functioning, stable, and included on the basis of readiness to work with trauma memories for resolution of issues with attachment figures.

Both approaches (SP and EFTT) work directly with the trauma-related narrative and non-verbal (affective, sensorimotor, somatic) processes that are repeatedly activated in clients' daily lives, contribute to dysregulation and interpersonal problems, and maintain maladaptive beliefs and behaviours. Both approaches help clients activate episodic and procedural memories to

access novel, adaptive emotions and somatic resources that were unavailable during trauma events. Process studies of EFTT have shown that change extends beyond symptom improvement and adaptive behavioural change: over the course of EFTT, client narratives show increased integration, coherence, novel understanding, and re-organization around an agentic view of the self (Angus et al., 2017; Carpenter et al., 2016; Paivio & Angus, 2020). The bottom-up approach shared by SP and EFTT facilitates secure (i.e., modulated rather than overwhelming) access to, and symbolization of, internal experience. In addition, both approaches emphasize the therapeutic relationship as a source of dyadic co-regulation; therapists attune to client somatic and affective responses, to guide empathic reflection and process-guiding interventions that enhance the client's own attunement to their internal experience.

Group Therapy. Guidelines for complex trauma treatment (e.g., Ford et al., 2009) suggest that group therapy is beneficial—beyond the practical efficiency of delivering care to more people at lower cost—because it directly addresses the shame, isolation, and social disengagement that often follow from relational trauma. Interacting with peers in an environment that fosters safety, nonjudgment, honesty, and mutual respect, provides an opportunity to use one's voice and be heard, and to begin to correct lost developmental opportunities for interpersonal growth such as bonding and individuation (Ford et al., 2009). Groups with a significant relational processing component also provide facilitated opportunities to become aware of trauma-related maladaptive relationship patterns, and practice new ways of relating (Duarte-Giles et al., 2007; Huss et al., 2012) that might furnish corrective experiences as expectations of self and others are disconfirmed (Yalom, 1970).

Most of the research on group therapy for this population has focused on establishing the effectiveness of evidence-based PTSD treatments adapted to group format, and of groups that

teach “stage 1” emotion regulation and relational skills. Mahoney and colleagues (2019) recently published the first systematic review and meta-analysis of group therapy for difficulties associated with complex relational trauma. Its principal aim—echoing the primary debate in trauma treatment more broadly—was to compare the effectiveness of interventions involving trauma memory processing vs. staged and/or “psychoeducational” approaches, i.e. those that focused more on emotion modulation and relational skills. They reported large effect sizes for improvement in depression, PTSD, and general psychological distress, for both group treatment approaches. Those involving trauma memory processing had a slightly larger effect size for PTSD symptoms, whereas “psychoeducational” treatments had a larger effect size for depression and general psychological distress. The authors concluded that group memory processing interventions are insufficient to address the breadth of psychopathology associated with complex relational trauma, and that nonspecific group treatments are as efficacious, and may be preferable, for those with more complex presentations (Mahoney et al., 2019).

Mahoney et al.’s (2019) meta-analytic review excluded uncontrolled pre-post and naturalistic designs. A further limitation noted by the authors was that because the included studies assessed symptom reduction as their measure of outcome, the therapeutic benefits thought to be specific to or enhanced by a group therapy format (i.e., as a relational experience or social environment) went unexamined, such as sense of empowerment, normalization, social learning and motivation, and reduced shame and isolation. Indeed, qualitative studies and feedback gathered in the context of uncontrolled pre-post designs, suggest that clients highlight benefits of group therapy including being able to tell their story or “find my voice”, increased sense of belonging, hope, and empowerment, and new beliefs that one is acceptable to others (Chouliara et al., 2017; Fallot & Harris, 2002; Hopper et al., 2018; Mendelsohn et al., 2007).

Group therapy has been conceptualized as an opportunity for clients with complex trauma histories to have alternative relational experiences that correct the sense of powerlessness, fear, shame, and mistrust that results from relational trauma, with experiences of feeling safe, supported, and valued in relationship (Duarte-Giles et al., 2007; Mendelsohn et al., 2007). These are arguably worthy treatment ends in themselves, however there is also some evidence that these types of positive, security-enhancing relational experiences in group are associated with greater symptom reduction. For example, Classen et al. (2017) found that women who participated in a multi-modal, relationally-oriented day treatment program, the Women Recovering from Abuse Program (WRAP; Duarte-Giles et al., 2007), showed pre-post reductions in PTSD symptoms, dissociation, emotion dysregulation, and interpersonal problems, and that participants whose attachment status changed from "unresolved" at baseline, showed greater improvements in those domains.

Ford and colleagues (2009) summarize the challenges that the group therapy format presents for this population. Given that their trauma occurred in a relational context, clients are more vulnerable to being triggered, becoming dysregulated, or having trouble engaging, in a group setting where interpersonal cues abound. The emotional and relational processes that unfold in a group environment may be too intense, and overwhelming, for those with limited skills for tolerating distress and regulating emotion. Furthermore, some participants may be at risk of acting aggressively, which compromises the therapeutic setting for other members, or could lead to "re-enactments' in which group members take on roles of victim, abuser, and/or rescuer. Participants with more severe dissociative symptoms may need additional help modulating the intensity of emotions in a group setting (Classen et al., 2001; Wolfsdorf & Zlotnik, 2001). Among incest survivors participating in a relational process group, factors

associated with poor outcome included: less education; severity of sexual abuse history; lower adjustment scores at baseline; being married; and lack of previous therapy experience (Follette et al., 1991). Other studies have explored how individual client factors predict total group outcome, and suggest that the presence of group members with poor object relations, reactive anger, and difficulties with impulse control, can lead to worse outcomes for the entire group (Cloitre & Koenen, 2001; Piper et al., 2007).

In summary, key considerations in group therapy for complex trauma include balancing individual vs. group needs where the individual's self-regulating capacity represents a risk to group relational safety, and modulating the intensity of emotional and interpersonal processes. The latter is a dilemma of timing and intensity. As Ford and colleagues (2009) conclude,

> Working through the complex emotional dilemmas and tragedies associated with having experienced betrayal, abandonment, or rejection as the result of maltreatment, violence, or neglect can be either overwhelming or therapeutic for group members, depending on the therapists' ability to titrate the intensity for each member. (p. 424)

The very benefits proffered by group format—a chance to be witnessed by peers, to experience validation and support when expressing vulnerable emotions, and to otherwise make up for compromised interpersonal developmental experiences—may be more difficult to access and engage in, for those who could benefit most. The next section outlines some of the more specific psychological and interpersonal process considerations relevant for this conundrum presented by any relational therapy (group or individual), for clients with a complex trauma history, namely, that relationships in therapy are an opportunity to experience and resolve psychosocial dilemmas caused by the trauma.

Psychotherapy Process Considerations. Clients with complex trauma histories typically come to therapy with nonverbal traumatic memory, chronic autonomic dysregulation, and insecure or disorganized attachment-related narrative processing styles. Regardless of therapy approach, these common aspects of a complex trauma presentation simultaneously comprise and complicate important therapeutic tasks including building relational connection and trust, and exploring internal experience for verbal symbolization and organization in narrative form. To promote integration rather than perpetuate autonomic dysregulation, clients must find a bridge from nonverbal experience to words, and from being alone with overwhelming or painful experience, to expressing it and making sense of it with a caring and validating other. This section outlines several key therapy process considerations, given that challenge.

Autobiographical Memory and Integration. A central theory of post-traumatic stress is that traumatic memory is fragmentary, incomplete, and lacking in narrative coherence, compared to normal autobiographical (episodic) memory (see Brewin, 2011). Neuroscientists have argued that because of the body's fear response, trauma memories tend to be encoded as nonverbal fragments of interoceptive or somatic sensations, emotions, and perceptions, that often remain disconnected from narrative or temporal context (van der Kolk & Fisler, 1995; van der Kolk, et al., 2001), and that this faulty memory encoding is an underlying causal mechanism of PTSD (reviewed in Joshi et al., 2019). Furthermore, whereas non-traumatic autobiographical memories are *declarative* (conscious, verbal, and available to imaginal recall), trauma memories tend to be *procedural*, which means they can be triggered automatically, out of conscious awareness, and set off affective, sensorimotor, and cognitive responses that may lack an apparent stimulus in the present (Herman, 1992a; van der Kolk et al., 2001). Over the long-term, repeated triggering of affective and autonomic responses, in the absence of a coherent explanatory (narrative)

framework for those responses, contributes to chronic re-experiencing, under-control or avoidance of emotion, hyper- or hypo-arousal, and reinforcement of maladaptive core beliefs about self and others (Cloitre et al., 2005; Ogden et al., 2006).

Accordingly, a major goal of many trauma-focused therapies is to integrate nonverbal procedural memories and emotion responses into a coherent narrative framework, for heightened regulation, self-coherence and meaning-making (Paivio & Angus, 2017). In experiential approaches, this may involve, but does not necessarily require, episodic trauma memory processing. Present-day trauma-related behavioual, somatic, and affective patterns (activated procedural responses to trauma cues) also provide a focus for integration, and may be more accessible or relevant for many clients. Integration requires reflective, top-down processing of affect and somatic arousal, however complex trauma survivors often have a narrow "window of tolerance," i.e., they can be easily triggered into states of hypo- or hyper-arousal, in which their capacity to reflect on and make sense of bottom-up information is compromised (Ogden et al., 2006; Siegel, 2003).

Attachment and Reflective Dialogue. The pervasive interpersonal and self-regulation difficulties that characterize complex trauma can also be understood as disruptions in normal development. Emotion regulation skills, core beliefs about ourselves and others, and approaches to forming close relationships develop in the context of childhood attachment relationships (Bowlby, 1969; Calkins, 2004; Cassidy, 1994; Dykas & Cassidy, 2011; Schore, 2001). When childhood trauma involves attachment figures, secure attachment and associated developmental processes are compromised, including basic relational trust, the ability to regulate emotion, attention, and behaviour (Lyons-Ruth & Jacobovitz, 1999), the ability to differentiate one's own mental states from those of others (Fonagy & Target, 1997), and the ability to reflect on and

dialogue with others about emotional experiences (Holmes, 2001; McLean et al., 2007). Extensive developmental research has shown that we learn to symbolize emotionally-salient experience through interaction with attuned caregivers who mirror vocal tone, gesture, and facial expression (Gergeley & Watson, 1996; Stern, 1985), label emotions with words (Meins et al., 2003), and scaffold children's capacity to recall and story personal events through everyday conversations (Fivush et al., 2006; Nelson, 1993). Each of these caregiver behaviours is associated with attachment security, whereas attachment insecurity and disorganization is associated with poor verbal autobiographical memory recall capacities, reduced use of mental state language (Brown et al., 1996), and deficits in mentalizing (interpreting the mental states that underlie the behaviour of others) in late childhood (Fivush et al., 2006; Reese & Cleveland, 2006; Welch-Ross, 2001).

Adult attachment researchers also have demonstrated a link between autobiographical memory and narrative processes and attachment security (Main et al., 1985). Individuals with insecure or disorganized attachment styles, predominant among those with attachment-related trauma and among clinical samples (Bakermans-Kranenburg & van Ijzendoorn, 2009), tend to construct personal narratives about attachment relationships that are either incoherent, tangential, and flooded with details, or overly generalized, sparse, and lacking content-affect congruence (Main et al., 1985). The narratives of people with complex trauma histories also are characterized by lower linguistic indicators of mentalizing or "reflective functioning," i.e., reflection on the mental states underlying their own and others' behaviour (Allen, 2013; Fonagy & Bateman, 2008; Fonagy & Target, 1997, 2005). Recent research has shown that these narrative processing features have an impact on discourse in psychotherapy, irrespective of narrative content. Clients with insecure and disorganized attachment styles consistently use language in

patterned ways that restrict their own and/or the therapists' attunement to the clients' internal state (Daniel, 2011; Talia et al., 2014; Talia et al., 2015) and impede alliance rupture repairs (Miller-Bottome et al., 2019).

Alexithymia. Conceptualized as an individual-differences trait, alexithymia refers to difficulty identifying and labelling feelings, difficulty distinguishing between emotion and somatic arousal, constricted imagination, and a tendency towards externally-oriented thinking (Nemiah et al., 1976). There is a strong association between alexithymia, complex trauma exposure, and the severity of trauma symptoms (reviewed in Frewen et al., 2008; Svenja et al., 2014). In particular, among those with complex trauma histories, alexithymia is related to dissociation (Elzinga et al., 2002), autonomic dysregulation (Declercq et al., 2010), self-harm (Paivio & McCulloch, 2004), and loss of executive control (Frewen & Lanius, 2006) when exposed to trauma cues. Alexithymia predicts poor response to psychotherapy, which may be explained by the impact of alexithymia on the therapeutic relationship, including difficulty with intimacy, self-disclosure, and interpersonal responsivity (reviewed in Ogrodniczuk et al., 2011). Despite presenting a barrier to communication and attunement in therapy, there is evidence that alexithymia itself can improve over the course of therapy (Classen et al., 2017; Grabe et al., 2008; Ogrodniczuk et al., 2012).

Art Therapy

Like the emotion-focused and somatic approaches to treatment outlined in the preceding section, art therapy offers another experiential way of working with trauma-related affect and associated meanings, by providing a concrete way to symbolize nonverbal experience. Art psychotherapy has been defined as:

> A therapeutic process based on spontaneous or prompted creative expression using various art materials and art techniques such as painting, drawing, sculpture, modeling (clay or substitutes), collage, etc. It offers a nonverbal language to express emotions and focuses on the way the client works and creates. The artwork products document the therapeutic process, enable their creators to hold a dialogue with themselves, and are lasting objects that can be related to for a long time. At the heart of art therapy lies the healing power of the creative process and the special communication that takes place between the client, the artwork, and the therapist. (Avrahami, 2006 p.6)

It is important to note a distinction between art-as-therapy and art psychotherapy; the former is characterized by its nonverbal nature and consists primarily of the use of art materials to express thoughts, feelings, and memories (Schouten et al., 2015). In contrast, art psychotherapy (used interchangeably with "art therapy" in this manuscript) integrates art-making with traditional psychotherapeutic verbal exchanges, relational processes, and reflection about the art process and product (Wadeson, 2010).

Relevance for Complex Trauma. For individuals with PTSD, art therapy is thought to assist with arousal modulation, and provide a way to gradually access trauma memories and express associated emotions (Collie et al., 2006). Furthermore, consistent with a multi-pronged, staged model of treatment for complex trauma, art therapy interventions may target a broader range of treatment goals which encompass many of the 'disturbances in self-organization' experienced by those with complex trauma. Common art therapy tasks and goals include: facilitating expression of present-moment thoughts, emotions, and physiological states; promoting narration of life events and expression of internal experiences during the event; promoting exploration of the impact or meaning of trauma on subsequent behaviour, self-

perception, worldview, and relationships; facilitating management of behaviour, affect, stress, physical reactions, and other symptoms; and facilitating integration of trauma-related experiences and patterns into one's life history (Rankin & Taucher, 2003).

The following sections outline how art therapy is thought to ameliorate the aforementioned intrapersonal and interpersonal process difficulties faced by many treatment-seeking complex trauma survivors, which are elaborated in the following sections. It provides a nonverbal way to access, explore and symbolize psychological experience, as a stepping stone to verbal symbolization and meaning-making. Furthermore, the nature of the art materials and art-making process may provide a way to concretize, externalize, and contain associated distress and maladaptive relational patterns. Symbolization and containment promote engagement with trauma material—including gaps in memory, the felt sense, textures, or rhythms of experience that elude words, and contradictions in experience, that might otherwise remain unacknowledged or compartmentalized. Once rendered concrete and visible, this material can be apprehended for meaning. Making trauma-focused art thus has a "witnessing function" (Laub & Podell, 1995) that promotes self-coherence and connection to others.

Nonverbal Symbolization. Trauma may be understood as the inability to process information symbolically (van der Kolk & Fisler, 1995). Avrahami (2006) argues that in the absence of words, art provides an alternative set of symbols, a language of line, colour, form, texture, shape, and composition, to mediate between nonverbal experience and narrative form, or between internal and external worlds. These visual symbols provide a means to integrate nonverbal experience without requiring it to be immediately linear or verbally coherent:

> "Art therapy is effective for trauma survivors…because it provides a path where none existed previously" (Gantt & Tinnin, 2009, p.151).

Furthermore, art has the capacity to represent complex relationships among sensory memories, competing action tendencies or meanings, and dissociated parts. In short, art-making is a nonverbal means of accessing procedural memory fragments and symbolizing them, for heightened understanding, regulation, and meaning-making (Avrahami, 2006; Gantt & Tinnin, 2009; Talwar, 2007).

Many individuals with trauma histories have generalized difficulty identifying and labeling feelings, distinguishing between emotion and somatic arousal, constricted imagination, and a tendency towards externally-oriented thinking (i.e., alexithymia). Research on alexithymia and psychotherapy suggests interventions that promote emotion awareness and symbolization of internal states enhance treatment response (Taylor & Bagby, 2013). For example, guided attention to somatic cues (Vanheule et al., 2011) and art therapy (Heiman et al., 1994) provide intermediary (non-verbal or concrete) symbols for emotions.

Containment, Flexibility, and Buffering. Because the visual arts entail working with and producing physical objects, art therapy also creates the possibility of reflecting on it from a distance, and the possibility of acting on the concretized experience (e.g., manipulating or altering it). This may foster a sense of agency or control (Avrahami, 2006) or help clients to develop playfulness and flexibility (Huss et al., 2012). The concrete and finite nature of the art materials may provide psychological containment, enhancing client safety to explore internally. In contrast, verbal exploration in traditional therapeutic relationships may feel less contained and less safe, leading to emotion dysregulation and overwhelm, or difficulty engaging beyond a superficial level. Those with a deep mistrust of others, or living in chronic isolation or shame, may find it easier to interact with others indirectly, with art as the intermediary (Huss et al., 2012). Furthermore, artwork may serve as a mediating object for client frustration, fear, anger, or

disappointment that might otherwise play out through the therapeutic relationship, i.e., as transference, rupture, or "resistance" (Wadeson, 2010).

Witnessing or Reflective Function. Laub and Podell (1995) describe interpersonal trauma as empathic failure, a breakdown of the most basic person-to-person recognition and respect. Furthermore, abuse and violence deviate from cultural norms, expectations, and available language. There may be a corresponding breakdown in communication between survivor and their self-observing reflective capacity (or "internalized other," from a psychodynamic perspective). Many survivors might experience this as a "latent, but powerful and ever-present feeling of nothingness" (p.992). In other words, there is no capacity to *represent* the trauma experience, to oneself or others; no opportunity to witness and be witnessed. To come to know (acknowledge, articulate, understand) the trauma and its impact, survivors' self-observing reflective capacity must be developed or re-engaged. Art making, and art objects, have a witnessing function, placing the maker (survivor) in the role of witness for self-observing reflection. This is inherently dialogic, as "art does not 'communicate' meanings; it generates them in receptive minds" (Rose (1995) *in* Laub & Podell (1995), p. 992). Art generates a dialogic process whereby the maker/observer can make meaning of the art, and trauma material can be incorporated into one's personal narrative.

Throughout the lifespan, self-narratives provide an organizing structure and psychological resource to make sense of unfolding events (Bruner, 1987). Our self-narratives are affect-regulating, action-guiding, and provide a means of connecting to others for support (McAdams & McLean, 2013). Many clients seek therapy because of distressing discrepancies between felt emotions, actions, and their autobiographical sense of self. As outlined in the preceding sections, complex trauma clients enter therapy with numerous trauma-related affective

and sensorimotor responses that are dissociated from any declarative memory or personal narrative. Therapeutic change and meaning construction occur through the narrative organization of internal experience, for heightened emotional self-regulation, reflective understanding and self-narrative reconstruction (Angus, 2012). Importantly, art can accommodate gaps, confusion, contradiction, missing pieces, and incoherence. These may be represented through form, colour, texture, composition, so that these core aspects of the lived experience of trauma (as opposed to a factual, chronological account of events) may be witnessed and contextualized for meaning and integration into their self-narrative. (Laub & Podell, 1995).

Empirical Support. Past versions of the International Society for Traumatic Stress Studies' (ISTSS) guidelines for treatment (e.g., Foa et al., 2009) identified visual art therapy as potentially helpful for symptoms including depression, dissociation, hyperarousal, re-experiencing, and alexithymia, and for improved emotional control, body image, and relationships. The guidelines stopped short of including the creative therapies as an evidence-based intervention for traumatic stress, due to the lack of robust, controlled efficacy studies, and for the same reason, art therapy was not included in more recent iterations of ISTSS guidelines for CPTSD and PTSD (e.g., Cloitre et al., 2011; Bisson et al., 2019). Indeed, there is a single published systematic review of art therapy for traumatized adults (Schouten et al., 2015) which identified only four comparative outcome (treatment vs. control) pre-post design studies. None of the four studies distinguished between PTSD and complex trauma presentations, and because of the strict experimental inclusion criteria, most lack ecological validity. For example, two of the four reviewed studies' samples comprised non-treatment-seeking undergraduates, reporting trauma symptoms, who received brief, directive art-as-therapy interventions (e.g., colouring mandalas). Both studies reported a small effect size but statistically significant reduction in

trauma symptom severity and anxiety. Two other studies included treatment-seeking adults, and art psychotherapy, and reported significant decreases in anxiety, re-experiencing, and depression symptoms, with moderate effect sizes for pre-to-post changes (Schouten et al., 2015). These sparse but promising findings underline the need to further explore how art psychotherapy, integrating art-making with traditional relational and verbal processing elements, may be beneficial for individuals living with complex post-traumatic distress.

While controlled experimental findings are sparse, other forms of evidence collectively support the use of art therapy for complex trauma. First, a number of naturalistic, uncontrolled pre-post designs have examined art therapy for adults with complex trauma presentations. Gantt and Tinnin (2007) reported pre-post outcomes for a two-week intensive therapy for $n = 78$ outpatients with complex trauma exposure and (DSM-IV) diagnoses of PTSD, Dissociative Identity Disorder, and/or Dissociative Disorder Not Otherwise Specified. The treatment included psychoeducation followed by narrative- and art-based exposure work. There were significant baseline to follow-up reductions in self-reported PTSD, dissociative, and general psychiatric symptoms, as well as alexithymia. Forty-five percent of participants attained recovered status, 44% attained "improved" status, and 8% were unchanged, based on individual criteria for recovery established at a baseline diagnostic interview (Gantt & Tinnin, 2007). Becker (2015) conducted an exploratory ($n = 6$) naturalistic study of group therapy integrating grounding skills, art therapy, and narrative exposure for adults with complex trauma histories, and reported large effect sizes for reductions in trauma symptoms and depression, from baseline to post-therapy and at one-month follow-up.

In addition, a recent pilot study examined the feasibility and effectiveness of an 11-week, trauma-focused art therapy for adults ($n = 11$) with (DSM-IV) PTSD diagnoses and a history of

complex relational trauma (Schouten et al., 2019). The treatment included three phases: early sessions focused on reducing stress and increasing a sense of control and safety; middle sessions focused on expressing traumatic and positive memories through art; and later sessions promoted reflective integration of earlier sessions, and meaning-making. Results indicated that seven participants showed clinically significant reductions in self-reported PTSD symptom severity, whereas four individuals showed increased symptom severity. The authors noted that compared to the seven who improved, those four participants had histories of earlier (developmental) trauma exposure, reported higher instances of traumatic exposures, and had comorbid severe depression and/or personality disorder diagnoses (Schouten et al., 2019). Although the study did not include any measures of difficulties with self-concept, relationship function, or emotion regulation, it is quite possible that those individuals, given their history and complex clinical presentation, experienced greater difficulties with these DSO which may have hampered the mechanisms through which PTSD symptoms decreased, in other participants.

Other forms of evidence include the numerous case studies published in art therapy books (e.g., Carey, 2006) or journals (e.g., Skeffington & Browne, 2014). Indirect evidence might also be drawn from controlled trials examining the effectiveness of art therapy for traumatized children and adolescents (reviewed in Eaton et al., 2007; van Westrhenen & Fritz, 2014). For example, art therapy integrated with CBT and group interpersonal processing was associated with significant reductions in anxiety, dissociation, and other PTSD symptoms among female child and adolescent survivors of sexual abuse (Pifalo, 2006; 2007). Adolescent inpatients randomly assigned to a 16-week (one hour/week) trauma-focused group art therapy showed significantly greater reductions in PTSD symptoms, vs. those assigned to an arts and crafts control group (Lyshak-Stelzer et al., 2011). Notably, both of these studies went beyond art-as-

therapy, by using a trauma-focused frame for art-making, or integrating art interventions with psychotherapy.

Finally, qualitative studies of art therapy for trauma have primarily involved graphic or verbal analyses of the art produced by complex trauma survivors, or interpretations of that art. One visual-qualitative analysis of graphic forms across 225 images revealed significant differences in the images created by traumatized vs. non-traumatized adults, providing support for the premise that art-making facilitates access to and symbolization of nonverbal trauma material (Spring, 2004). Qualitative analyses have largely focused on survivors' verbal interpretations of what their art symbolizes (e.g., Clukey, 2003; Eisenbach, Snir, & Regev, 2015). Torstenson (2005) conducted a phenomenological analysis of therapists' experience of doing art therapy with trauma survivors. One recent qualitative study examined pilot experiential group interventions involving structured, directive visual arts and theater games, for adolescent and adult survivors of human trafficking living in a group home (Hopper et al., 2018). Interventions were organized according to weekly themes and skill-building tasks pertaining to trust, self-regulation, relationships and boundaries, parts of self, personal power, and orientation to the future. Thematic analysis of participants' written session evaluations, and facilitators' session observation notes, indicated a number of positive shifts as a result of the group. These included: increased trust; feeling one's experiences normalized; sense of connection to others; increased awareness of one's regulatory state; increased access to positive emotions; increased self-compassion; and heightened sense of being in control. Collectively, these qualitative studies enhance our descriptive understanding of the art objects produced by trauma survivors, of therapists' perspectives on art therapy, and the general areas of benefit perceived by young women survivors of trafficking, and their group facilitators. No published studies to date have

examined, in depth, clients' experiences of engaging in art psychotherapy, and client's perceptions of and explanations for any associated transformations (e.g., symptom reduction, new understanding).

The Present Study

Intervention Setting

"SpeakArt" is a 12-week, nondirective and relationally-oriented group art therapy for adults with histories of complex developmental and adult trauma. It is offered through a publically-funded outpatient trauma therapy program at Women's College Hospital in Toronto. The program follows a multi-modal, staged approach to trauma recovery. Clients typically begin with a psychoeducation and skills group, then access further services depending on individual needs, goals, stability, and readiness for group work. Other group services offered include art therapy, sensorimotor psychotherapy (see Classen et al., 2020), relational process groups, trauma memory processing groups, groups oriented around specific behavioural goals, as well as time-limited individual psychotherapy and psychiatric consultation. A stand-alone intensive 8-week day-treatment program ("WRAP", mentioned above) is also nested within the trauma therapy program (see Classen et al., 2017; Duarte-Giles et al., 2007).

SpeakArt (SA) is designed to accommodate clients at all stages of trauma therapy, including lower-functioning clients whose current interpersonal or verbal skills preclude their participation in other treatment services. The underlying premise of SA is that trauma-focused art-making is:

> A way to approach getting to know and share ourselves, in a context that […] invites play, exploration and artistic/psychological experimentation, discovery, meaning-making, and expression. Therapists facilitate verbal sharing to minimize interpretation and nurture

the development of a personal artistic voice and witnessing, via creative, non-evaluative reflection on all artworks and art-making processes. (Stern, 2017; unpublished manual)

Visual art-making is interwoven with verbal elements, including a check-in, a verbal prompt, and reflective discussion of the art-making process and art objects. SA session structure and content is described in further detail in the Method chapter.

Rationale

Art therapy is thought to provide a framework that helps clients externalize and contain distress, and to provide an intermediary buffer for interactions with therapists or group members that might otherwise be overwhelming. Its visual-tactile nature is thought to provide a bridge between nonverbal trauma material (fragmented sensory and procedural memory) and verbal-cognitive processing. Collectively, these factors may help clients represent their trauma-related experience, so it can be witnessed by self and others, and organized in narrative form for understanding and meaning-making. Despite accumulated naturalistic, qualitative, and case-study support for the benefits of art psychotherapy for trauma, and consistent explanations among art therapists regarding *how* it may be helpful, there is little robust empirical evidence for its effectiveness and the purported mechanisms of change (Kapitan, 2012).

No study to date has systematically examined client accounts of what they experience in group art therapy over time, and their perception of the benefits and challenges of art psychotherapy for difficulties associated with complex trauma. This study aimed to address that gap. Collecting client narratives (through interviews) was chosen as the most direct way to gain an understanding of what they experienced while making art in a group therapy setting. Furthermore, given the nature of the 'disturbances in self-organization' (e.g., altered systems of meaning, negative self-concept, pervasive relational and emotion regulation difficulties), and the

inherent complexity and idiosyncrasy of clinical presentations, it made sense to elucidate client perspectives on the question of how art therapy is helpful (or not). Interviews allow for sufficient space to let participants define which aspects of their complex lives and difficulties, and which experiences in therapy, are of greatest personal significance and central to the question of whether and how therapy is helpful. Finally, many of the sequelae originally defined by Herman (1992a)—such as disturbances to clients' systems of meaning, and sense of self—are inherently qualitative and narrative in nature, suggesting that any shifts in those difficulties, may also be best captured in narrative form.

Because the research questions (listed below) pertained to participants' descriptions of and perceptions about change over time, I used a two-interview design, drawn from the Narrative Assessment Interview method (Hardtke & Angus, 2004; Angus & Kagan, 2013). Participant accounts of their experience in art therapy were collected at two points in time: after the initial session, and at the end of treatment. The purpose of the initial interview was to engage participants in a process of articulating their reasons for enrolling in the group and their expectations, hopes, and concerns about therapy, that would in turn serve as an anchor when reflecting on experiences of change over time, in the post-therapy interview. Participants were given a written summary of their initial interview at the post-therapy interview, in order to ground and enrich their post-therapy accounts of changes, and the significance of any changes. In most qualitative studies of participant perceptions of change in traditional/verbal psychotherapies (e.g., Constantino & Angus, 2017), clients and their therapists develop a language for, and have ongoing dialogue about, change over time, which the client presumably draws on in the research interview. The two-interview strategy was particularly important for the present study given that SA is a group art therapy, with relatively limited opportunity for clients to talk about and make

sense of change over time. The interview design and procedure will be outlined in further detail in the next chapter.

Research Questions

This qualitative study examined clients' experiences of group art therapy for adult survivors of childhood trauma. The goal was to better understand how art-making in a relationally-oriented group therapy context might contribute to complex trauma recovery. It was guided by the following research questions:

1. What processes or experiences in SpeakArt do clients perceive as challenging, significant, or helpful?
2. Do clients perceive and attribute to SpeakArt any meaningful personal changes, e.g., shifts in their: thoughts/beliefs; attitude towards therapy; feelings; actions; relationships; view of self; understanding of trauma; understanding of the impact of trauma?
3. According to clients, how did SpeakArt contributed to those shifts?
4. What do clients' experiences and understanding of art therapy, and associated shifts, reveal about the nature of post-traumatic transformation/healing, among those with complex trauma histories?

Chapter 2: Method

Study Overview

This study investigated clients' experiences of participating in group art therapy for complex post-traumatic stress. What is it like to engage in trauma-focused group art therapy? How does making art in a group setting promote post-traumatic healing or transformation? What do participant experiences of group art therapy reveal about the nature of complex post-traumatic recovery? I wanted to understand, and generate a rich description of, participants' subjective experiences of doing art therapy for trauma, and the impact it had on their lives. Towards that end, I conducted baseline and post-therapy interviews with a sample of women who participated in SpeakArt (SA), an outpatient art therapy group offered by the Trauma Therapy Program at Women's College Hospital in Toronto, Canada, and analyzed the transcripts of the post-therapy interviews using techniques from the grounded theory method of qualitative analysis. This chapter begins with an outline of the epistemological stance and corresponding methodology that framed this study, including an explanation of the role of reflexivity, and a statement of my positioning in the context of the phenomenon of interest (art therapy for trauma). Then, I detail the method itself, including the tools and two-interview procedure used to collect data, the therapy under investigation, participant characteristics, and the steps involved in the analysis process.

Methodology

Assumptions about Knowledge and Knowing

Willig (2012) contends that rigorous qualitative researchers must clarify their view of the epistemological status of their raw research data, as well as the status of the findings that come from analysis of that data. In terms of the former, I approached this study with the premise that

participants' experience of SA was *not* a fixed, discrete entity, conveyed through and residing in the interview data and waiting to be discovered through subsequent analysis, as in realist approaches to knowledge (Braun & Clarke, 2006). Rather, I assumed that participants' experience as expressed in their interviews was co-constructed, and emerged through interactive reflection and dialogue between us as researcher and participant (Ponterotto, 2005). Meaning was conferred onto experience through this process, rather than transposed from the participants' mind, into the interview, for subsequent unpacking by me (Willig, 2012). The co-constructive process began with the initial formulation of research and interview questions. It intensified as each participant put their experience into words while relating to me and responding to those questions during the initial and post-therapy interviews. Co-construction was most apparent in many participants' struggle to articulate complex emotions about what happened in SA during the interviews; and it was made explicit when some participants stated that they had reflected on and made sense of aspects of their experience for the first time, in the interview. It continued through the analysis phase, as I developed categories and concepts to try to capture the meaning of their words.

The relativist status of people's constructions of their experience, and our attempts to understand them, have been called the "double hermeneutic" of social scientific inquiry (Giddens, 1976). This term refers to the layers of interpretation that make up our social world; people perceive their own experience through meaning frames and any attempt to understand it, by a researcher, occurs through another meaning frame. When we construct meaning from others' words, we are interpreting an interpretation. In summary, I see participants' experiences in SA as relative, their narratives of that experience in SA as co-constructed, and aimed for interpretive *understanding* of their experiences. At the same time, I adopted a systematic

approach to data analysis that aimed to produce a useful and trustworthy interpretation of participants' subjective worlds, of the meanings they made of their actions and experiences in SA. While it is impossible to know someone else's experience from within their own interpretive frame, in just the same way as they perceived it, people are capable of communicating something about their experience that will resonate with others who have similar lived experiences, and allow for mutual understanding (Rennie, 2000).

My approach thus entailed a dialectical balance between: (1) the relativist nature of the meanings people make of their experience and its co-constructed expression in research interview form; and (2) the realist nature of knowledge generated through a methodical (systematic, internally-validating, and self-corrective) analysis of that interview data. This epistemological position—in the middle of relativism and realism, and holding in either hand the value of each—was formulated by Rennie into a methodological stance for grounded theory (Rennie, 2000) and for qualitative research more generally (Rennie, 2012), called *methodical hermeneutics*. Rennie, among others (e.g., Charmaz, 2000, 2006; Henwood & Pidgeon, 2003) acknowledges that both relativist and realist knowledge are inherent in grounded methods for qualitative analysis, which require interpretation of meanings conveyed through narrative. Methodical hermeneutics begins to reconcile the apparent tension therein, by formulating how method can be applied to interpretation in a systematic, self-correcting way that generates trustworthy new understanding.

Methodical hermeneutics draws heavily on Peirce (1965), who challenged the prevailing view that scientific knowledge is generated through hypothetico-deductive inference: observing the world; using existing knowledge to generate hypotheses; then testing those hypotheses with the observed data. According to Peirce, deduction is a tautology and therefore cannot generate

new knowledge. Rather, new knowledge is generated through induction and abduction, the "imaginative creation of a hypothesis" (Peirce, 1965 *in* Rennie, 2000 p.489). Abductive inference is a discovery process that begins with making observations about a phenomenon (induction), then using creativity to generate plausible explanations that account for the observation (abduction). Hypotheses are discarded or refined if they fail to account for subsequent observations, and in this way, new knowledge is generated. Rennie (2000) argued that grounded qualitative research is analogous to Pierce's conception of abductive scientific inquiry, even though it is concerned with meanings, and interpretations of interpretations. A grounded qualitative analysis entails creating categories that express one's understanding of interview text. This process (which will be described in greater detail at the end of this chapter) involves countless iterations of: observing experiences as conveyed through chunks of narrative; creatively generating categories, or hypotheses about the concepts and meanings embedded therein; testing those hypotheses (categories) against other chunks of narrative; and refining the hypotheses, concepts, and meanings accordingly. If the interpretation does not fit the whole, then it is discarded. This process—moving back and forth between the meaning of a unit of text and the meaning of the whole, to assess the fit of one's interpretation—is self-correcting and internally-validating. In this way, the method leads to a more reliable, valid interpretation of lived experience, and allows for interpretation to contribute to scientific knowledge of human experience (Rennie, 2000, 2012).

Methodical hermeneutics—and this study's overall design and rhetorical aims—are also informed by Pragmatism (Dewey 1938/1991) and Symbolic Interactionism (Blumer, 1969). According to these schools of thought, reality is ever-changing; meaning and knowledge are constructed through acting on ideas and interacting with others, and are relative to the

perspectives of those who produce it; validity is a matter of consensus among a community of inquirers; and knowledge generation is ultimately about communicating information that leads to action (Fay, 1996 *in* Rennie, 2000; Henwood & Pidgeon, 2003). Accordingly, pragmatic methods seek and incorporate the perspectives of those involved in knowledge production, e.g., researchers and participants, and consider the usefulness of research outcomes. In this study, utility of findings was inherent in the types of research questions I asked, and it is my hope that the findings might inform clinicians who seek to enrich and then apply to treatment their understanding of clients' experience of complex trauma and related difficulties, and how they shift through art therapy. As the analysis unfolded and a hierarchy of categories took shape, my clinical-pragmatic stance became more evident: the final model tentatively suggests a pathway or process which begins with status-quo difficulties with interpersonal safety and emotion dysregulation, moves through emotional experiencing and relational witnessing, and ends with adaptive new actions and meanings.

Reflexivity

Researcher subjectivity is not only an inevitable part of qualitative research, but a crucial tool; it is part and parcel of the human capacity for empathic understanding and interpretation of others' expression, and according to Charmaz (2000), allows us to pursue meaning as a form of knowledge. Given that the inductive-abductive process of knowledge production occurs through the researcher's own interpretive frame, reflexivity is a crucial part of methodical hermeneutics. By disclosing one's own personal context, biases, and location *vis-a-vis* the phenomenon of interest, the qualitative researcher helps readers appreciate and determine for themselves how the researcher's interpretive frame shapes the analysis (Willig, 2012). I acknowledge that my values, pre-existing knowledge, and personhood were intrinsic to the co-construction of meaning in this

study's interviews, and the interpretive understanding offered up in the analysis results. Accordingly, I reflected on and examined my own positioning and decision-making process throughout the study design, data collection, analyses, and write-up phases. Where appropriate and necessary for context, these reflections are included in the text. In addition, the following section offers a brief statement of my positioning relative to various facets of the phenomenon of interest: art, trauma, trauma therapy, and psychotherapy change processes. In keeping with my methodological approach and according to recommended reporting standards (Levitt, 2020), I write in the first-person throughout the remaining chapters. By making my voice explicit I hope to increase the transparency of my role in creating the findings presented here. Otherwise, the remainder of the method chapter has been formatted according to the norms and standards of most clinical psychology research reports.

Position Statement

I am a 37-year-old, mixed-race, Canadian woman who walks through the world with the privilege of a White appearance, advanced education, good health and physical ability, and financial security. I grew up in an extended family that included several artists, and was encouraged to make art as a child, often in the company of others. My memories of art-making are happy ones, and given the opportunity I will dive into art making with others, in my adult life. I know my way around various media, and also know that you do not need fancy supplies to create art. Nowadays, I do not make art often, and do not think of myself as an artist, but believe we become artists as soon as we set out to express creatively. I do see myself as a maker; I sew, I knit, I make gifts, I bake bread. Making became important during my clinical training, when I entered the psychotherapy world of nonlinear progress and intangible results; I think I make because it is grounding and reassuring to work with my hands, to work skillfully through a

sequence of steps, to transform raw materials into a useful or beautiful object. Together, I think these experiences of creating art and making stuff have given me an appreciation of creative process, and perhaps a bias towards viewing the experience of making as more valuable than the product, and the act of expression as more important than the aesthetic properties of whatever got expressed.

I do not have a personal history of the type of complex relational trauma experienced by the participants in this study. I have never been a client of group therapy, and I have never accessed publicly-funded mental health services. This means that if I have any "insider status" (Dwyer & Buckle, 2009; Josselson, 2013) in relation to the phenomenon under study, it pertains to my clinical experience, in the role of therapist. Indeed, at all phases of the study, but particularly during interviews, and interpreting interviews, I was conscious of the fluctuating presence of my clinical lens. I did not try to bracket it entirely or discard it, because the content knowledge and empathic skill that are part of that lens, were also tools for interpretation. I think I was more sensitive to meaning and nuance in participants' words, because I am used to listening to people with complex trauma histories, and also have knowledge of the health systems in which this study's participants have sought treatment.

As a clinical psychologist in training, I encountered clients with complex trauma histories early, and often, and my training increasingly specialized in complex trauma and related diagnoses. Over a five-year period (that also encompasses all phases of this study), I trained in a variety of models and approaches to trauma treatment, under the supervision of psychologists whose beliefs about and approaches to trauma formulation and diagnosis varied extensively. I have worked in settings ranging from adiagnostic, relationally-oriented inpatient and outpatient programs, including the one in which this study took place, to clinics requiring DSM diagnosis

(e.g., PTSD, BPD, persistent and severe anxiety, mood, substance use disorders) and provision of manualized, evidence-based treatments for those diagnoses. Across these settings, clients presented with the same histories, the same problems. Attempting to navigate and reconcile differences in approach has at times left me confused and full of doubt, and I have spent a lot of time thinking about the limitations and advantages of various approaches to formulating and working with complex trauma sequelae, and coming to appreciate their shared principles.

Clinical skill, identity, and confidence aside, this means that I brought to the analysis a lived appreciation for the complexity of our field's approach to helping people presenting with difficulties related—or possibly related—to traumatic experiences. While it has been challenging to bounce between supervisors' and settings' differing approaches, I think my own biases have become tempered. When I designed this study, I had a bias against diagnosis, against manualized treatment, and towards pacing therapy slowly lest you re-traumatize a traumatized client. I now believe that: there is no one right way; trauma and trauma treatment are fundamentally complicated and idiosyncratic; clients are at once resilient and vulnerable; the rigid, closed structure of manualized treatment is useful in the right circumstances; and many people need, and want, other approaches. I retain a preference for prioritizing the relationship as a way to help people feel safe enough to approach and understand their experience in the moment, as the locus of meaning and potential change, particularly for those with developmental relational trauma.

I am aware of an assumption embedded in the way that much of the mental health system and some treatment approaches conceptualize PTSD and trauma recovery. It is assumed that "safety" is a resource, and feeling safe is a default normal (or pre-trauma) state, which individuals can reclaim through therapy. According to this view, recovery entails learning to differentiate past from present, learning to recognize and then regulate trauma-rooted responses

so that they do not "hijack" an objectively safe present moment. One problem with this view is that it risks privileging external appraisal of safety over indicators from one's internal, subjective experience. This could perpetuate the disconnection from and mistrust of one's embodied experience, that often result from complex relational trauma. Another problem with this view, from a social justice perspective, is that oppressed people are not safe in an oppressive system, therefore chronic fear-based responses (dissociation, aggression, angry defensiveness, submission, avoidance) may be better understood as necessary in the present, rather than leftover, persistent, now-maladaptive trauma survival strategies. That perspective, in turn, is problematic. First, it fails to recognize that systems are always fluctuating, and that degrees of oppression and degrees of safety also vary, and that oppressed people may be able to access or develop resources that provide them with relative safety in certain contexts. Second, it may preclude the development of more-adaptive, more-effective defense responses, by validating the need to keep using whatever survival strategies an oppressed person has relied on to date.

As you will discover in the pages to come, participants' subjective sense of safeness in SpeakArt, or lack thereof, was a central thread in their experience of the group. As the analysis progressed I repeatedly grappled with the above-described ways of thinking about safety, feeling safe, and trauma recovery, in an attempt to see, and account for, their influence on my interpretation of participants' experiences of safety. The findings include concepts and processes pertaining to "safety" that are consistent with the field's dominant conceptualization of safety as an attainable resource; they also capture the fluctuating sense of unsafeness, in the present moment, experienced by some participants, and factors that appeared to contribute to feeling unsafe. I have been transparent here so that readers can gauge for themselves, the extent to which unchecked assumptions and biases about safety may have shaped the findings.

As for art therapy, I am unfamiliar with its underlying theories, and lack formal training in its practice, apart from my experience observing and co-facilitating a weekly SA group in the year prior to data collection. That was a privilege and a pleasure, and quickly became a puzzle to be solved. Facilitators make art alongside participants; the one time I engaged with the prompt on a personal level, it was so evocative that from then on, I focused on the demonstrated technique rather than the prompt content, in order to stay present in my role. This study is not an ethnography and I did not use participant observation—I was never in the studio with study participants, during their group participation—but my memories of SA served as an experiential template for interpretive understanding, as I interviewed participants and later developed conceptual categories during the analysis. When participants described what it felt like to make a mess with paint, or search for materials, or the way they moved around the space, and the sense of time pressure, their stories came to life in my mind, aided by my own vivid sensory memories of the group. Aware of this—and mindful that no two groups are ever the same—throughout the analysis I stayed close to participants' own words where possible, to make sure the categories being developed and their central concepts were grounded in the lived texture of *their* experiences in the group, not mine.

My time in SA left me intensely curious about what was going on inside, for clients, as they made art. It was clear that a lot was happening, because the room was full of activity, and emotional charge, and clients who shared their art spoke from emotion. But it looked and smelled and sounded and felt different than what I knew of psychotherapy. I wanted to know what was happening, and this study was conceived. As stated in the introductory chapter, the research questions are rooted in my background in psychotherapy process research and humanistic-integrative clinical training roots. This study is about art therapy, yes, but it is about

the particular art therapy group that piqued my curiosity—one called *speak*Art. My interest in SA has primarily been an interest in how people apprehend and tell the *story* of their experience, in visual tactile material form. I have always been interested in narrative, and how people organize, reconstruct, and share their experiences, through personal storytelling. At the graduate research level, I pursued this interest as it pertains to narratives in psychotherapy, and narratives about psychotherapy; this work is a major part of my personal positioning relative to the topic.

My graduate research, supervised by Dr. Lynne Angus, is founded on the humanistic premise that people seek therapy when their self-narratives cease to align with lived experience, and fail to function as a basis for flexible meaning-making and emotion modulation; in therapy, clients process, verbally symbolize, and make meaning of felt experience to create new, adaptive self-narratives. We have developed, and applied to videotaped psychotherapy sessions, a behavioural coding system that captures clients' minute-by-minute shifting between distinct types of narrative-emotion processes that are associated with clients' outcome status in the context of randomized controlled trials. These 'storytelling modes' (or process markers) are differentiated by the presence of indicators of emotion under- or over-modulation, content-affect coherence, reflective stance towards experience, and the presence or absence of status-quo interpersonal themes and actions, and novel adaptive actions and meanings. The coding system ("NEPCS") and its underlying Narrative-emotion Process model (see Angus, 2012; Angus et al., 2017) are thought to reflect the process of moving towards heightened integration of emotional experience into personal narrative, towards greater self-coherence and adaptive function.

In addition, I completed a qualitative study investigating clients' "corrective experiences" (Alexander & French, 1946) in treatment for generalized anxiety disorder (Macaulay et al., 2017). It used the interview protocol upon which the present study's was partly based (see

Constantino & Angus, 2017), and through that project I gained experience in qualitative interviewing and conducting analyses using grounded theory steps and principles. That study left me with a strong impression that the story of how therapy is helpful and/or not helpful is inadequately conveyed by our field's more common outcome measures and pre-post designs. I also finished that study with the belief that clients' narratives about what happened and how it was/was not helpful, does not end when therapy ends. Rather, their understanding of therapy and its position within their overall personal narrative, may shift and grow with them over time, as new understanding and changes and skills built during therapy, interact with their unfolding life experiences. In that study, participants reported reaching new understanding and making new connections in the interview process, as a result of storying their experience of therapy. I went into this study expecting the same thing to happen, as participants reflected on and consolidated what they experienced in SA, and was careful to invite that type of reflection and expression of new insights, without adding my own interpretation at the time of the interview.

These two areas of graduate research inspired and informed my perspective as I strove to understand clients' experiences in SA. It occurred to me at some point that an implicit research question has been: to what extent does telling the story (i.e., in its traditional, verbal sense) matter? When I pose the research question "What processes or experiences in SpeakArt do clients perceive as challenging, significant, or helpful?" I think I am wondering, in part, how art-making and art-sharing helps clients access, symbolize, and make sense of their emotional experience, and whether this will cohere at all with the models I already have, for understanding psychotherapy process and change. Early in the analysis, I noticed that my existing categorical framework for understanding clients' change process, from the NEPCS, was there alongside as I interpreted clients' words and developed categories for the themes therein. For example, some

early categories were partly defined according to whether their themes and significance for participants pertained to status-quo beliefs and actions, or new actions and meanings; the NEPCS clusters its process markers in a similar way. The final model has echoes of the Narrative-Emotion Process model, and echoes of the concept of 'corrective experience.' I do not believe this reflects an imposition of existing frameworks on clients' narratives (i.e., a 'failure to bracket')—or if it does, I do not believe it is problematic. Rather, I think the echoes suggest logical, possibly universal features of what can happen in therapy: people become more aware of and articulate longstanding, stuck, problematic patterns; they feel and name their feelings; they (hopefully) arrive at new understandings, new ways of relating to themselves and others, new ways of acting in the world. I have been thorough and transparent here, so that you may decide for yourselves the extent, and significance, of any bias in the analysis.

On a more practical level, my research and clinical training have emphasized empathic attunement to clients' unfolding present-moment experience, and responsivity to their linguistic and nonverbal indicators of opportunities to deepen or contain emotional experiencing, reflect on it for understanding, explore cracks and tensions, or elaborate on subtle, emerging new actions and meanings. This was useful during the interviews—I know how to get people to describe and reflect on their experiences—but it also meant I had to be very careful not to 'do therapy' in my role as interviewer. My strategy for navigating that tension is elaborated later in this chapter.

Method

Overview

This study investigated clients' experiences of participating in group art therapy for complex post-traumatic stress. It was a qualitative study, based on semi-structured interviews administered to a community (convenience) sample of women with histories of developmental

trauma. The details regarding the participant sample and study procedures are described in the remainder of this chapter; an overview is provided here to orient the reader. My overarching goal was to understand clients' experience of group art therapy and their perception of how it was helpful (and not helpful) for growth/recovery from complex post-traumatic stress.

These questions were addressed by eliciting client narratives of their experience in SA, and associated shifts, through two semi-structured interviews adapted from the Narrative Assessment Interview protocol (Angus & Kagan, 2013; Hardtke & Angus, 2004) and the Patients' Perceptions of Corrective Experiences in Individual Therapy interview (PPCEIT; Constantino et al., 2011a; Constantino & Angus, 2017). To enhance the depth and richness of post-therapy narratives, I conducted an initial interview to gather a narrative of client goals, hopes, concerns, and expectations at the outset of therapy. A "summary sheet" of the initial interview transcripts was prepared and offered to participants during the post-therapy interview, as a springboard for reflection. The initial interviews were also conducted with the aim of helping participants develop rapport and a sense of safety with me, thereby promoting a "deeper" subsequent post-therapy interview (Charmaz, 2000). I conducted a modified grounded theory analysis on the post-therapy interview transcripts. In addition, I administered pre-post measures of client symptoms and emotion processing. The pre-therapy measures were used to further characterize this community sample, as context for the qualitative findings.

For any single participant, the above-described steps of data collection and analysis occurred in a linear fashion. For the sample as a whole, however, the data collection and processing steps occurred concurrently, due to the rolling-entry nature of SA (described below), and therefore, of participant enrollment. For example, the first post-therapy interview was conducted on the same day as the seventh initial interview. When the final initial interview was

conducted, four participants had completed all study activities. All data were collected between February and November, 2018. Initial interview transcription and summary sheet preparation for all participants was completed prior to starting transcription of the first post-therapy interview. Post-therapy interview analysis began in December, 2018 and was primarily conducted between July, 2019 and January, 2020.

The sample, participants, measures, interview protocol, and analysis procedures are described in greater detail below. The study was reviewed by and received approval from the institutional Research Ethics Boards of York University and Women's College Hospital.

Procedure

Sample. SpeakArt (SA) is a visual arts-based group psychotherapy, delivered under the umbrella of a specialized trauma therapy program at a publicly-funded hospital in a major urban centre in Canada. SA was delivered as usual for the duration of this study; on any given week, the group comprised a mixture of research participants and clients who were not participating in the study. SA clients include adult (primarily cis-gendered women) survivors of childhood trauma (physical abuse, sexual abuse, emotional abuse, neglect), who experience ongoing difficulties as a result of the trauma. The majority of clients receiving services also report a history of adult trauma exposure. Clients accepted into the group have already completed at least one other service offered by the hospital's trauma therapy program, typically, an "entry-level" trauma psychoeducation and skill-development group. Some clients, however, begin SA after they have completed other program services, such as the intensive day-treatment program (WRAP; Classen et al., 2017; Duarte-Giles et al., 2007), other groups (e.g., Classen et al., 2020; Langmuir et al., 2012), or individual therapy.

Recruitment. Participants were recruited from clients accepted into SA between February and July, 2018. When clients were accepted into the group (intake process is described in the Participants section, below), the facilitator informed them of the ongoing research study. Clients were invited to meet with me to learn more about the study, using their preferred means of contact (in-person meeting immediately following the assessment; follow-up phone call; or email). I contacted potential participants accordingly, and explained the study in detail, highlighting risks and benefits. Participants were provided with a copy of the informed consent form (see Appendix A) and asked to review it. Research appointments to complete questionnaires and the initial interview were scheduled for the same day as the participants' first session of SA. I met with participants prior to their first session, and acquired written informed consent to proceed. Participants then completed a demographics questionnaire, and self-report measures of clinical and emotional function.

Sixteen clients were enrolled into SA during the active recruitment period. Of these, 13 expressed interest in the study and met with the researcher, and 12 provided informed consent to participate. Of the 12 participants enrolled in the study, 11 completed the group and all study activities. One participant dropped out of SA after attending three sessions, and did not respond to invitations to complete the post-therapy interview. Analyses were conducted on data collected from the first 10 participants who completed all study activities. These 10 participants comprise the sample described in the remainder of this chapter.

Treatment. SA is a 12-week, 105-minute weekly art psychotherapy group. It was developed by a psychotherapist and art therapist with a psychodynamic training background, based on her experience working with this population through the Women Recovering from Abuse Program (WRAP; Duarte-Giles et al., 2007). Asked to elaborate (after data analysis was

complete) on the theoretical underpinnings of SA, she described having "a preference for what is called, in the art therapy field, 'spontaneous art,' as opposed to thematically-directive art-making. Spontaneous art has roots in psychoanalytic therapy, especially the principle of non-directiveness…[because] how can I the therapist possibly be the authority on what this person needs to explore, express, make?" (E.M. Stern, personal communication, May 11, 2020). Stern went on to describe the function of verbal prompts, given her overall non-directive approach to therapy. "There was a need for some kind of shared starting point, given the many stresses in the room for clients who don't know each other, are just coming together, and may have a lot of anxiety about making art, and are working under time pressure, to have some kind of shared starting point." Prompts were also crafted to encourage "embodied" versus "diagrammatic" drawings. The former, according to Stern, "entail metaphoric expression and symbolization of layers of experience, whereas the latter are visual translations of some [pre-formed] idea or concept" (see Schaverien, 2005). In summary, prompts were used towards relational and experiential ends: to give a group of people a place to begin, in their co-occurring, shared exploration and expression of idiosyncratic experiences.

Clients enter SA on a continuous-enrollment basis, with one client joining the group and one client terminating approximately every other week. Group size is capped at eight clients. There are two facilitators and up to one student observer or co-facilitator. Sessions are held in a group room that is used for art therapy as well as other programming (e.g., staff meetings, other groups, team supervision). The room is equipped with diverse art supplies, a sink, large conferences tables, and an easel. There are windows along one wall, a whiteboard on another, and the other two are lined with shelves, cubbies, and cabinets of art supplies and client art. Sessions include the following six elements (as described in Stern, 2017).

Scribble-in. (5-10 minutes). The session begins with a brief scribble, introduced as a way for clients to arrive in the room and check in with themselves. Clients are asked to let their hand make whatever marks it wants to make, using any dry medium, and try to let go of thinking, planning, or interpreting. After 5 minutes, facilitators and clients share their scribbles to introduce themselves and check in. This usually includes a brief reflection that may or may not link current psychological state to the marks on the page.

Review of Group Rules and Safety (5 minutes). Next, group rules and guidelines are reviewed as needed, e.g., if a new group member has joined, or if the facilitators need to address anything.

Prompt and Demo (5 minutes). The facilitator introduces the week's prompt. The purpose of SA is *not* to invite episodic trauma memory depiction. Rather, prompts are broadly linked to intrapersonal and interpersonal difficulties that comprise complex trauma sequelae, and are designed to be evocative. Some prompts present a dialectic, i.e., oppositions with which trauma survivors typically struggle in their daily lives (e.g., "I can/can't connect"). The facilitator may explicitly and briefly link the prompt to trauma, which serves to normalize it and invite private reflection on the theme's personal relevance. Next, a facilitator demonstrates an art medium and technique for exploring the prompt. The suggested mode of art-making is often specific to the prompt, and selected to promote experiential processing (action) that is thematically consistent with the prompt. For example, "I can/can't mess up" might be paired with painting using tools that have limited potential for controlling the paint. The prompt "There's a gap" might be paired with a demonstration of tearing or severing materials to depict loss, rupture, or absence. Prompts are meant to be starting points for exploration through the process of art-making and the art materials (vs. the art being guided by pre-conceived ideas or

interpretations of the prompt's personal relevance, as in "diagrammatic" art-making, described above). Prompts used over the duration of the study are presented in Table 1.

Making Art (45 minutes). Clients are encouraged to approach art-making in an open and exploratory way, allowing the art to develop as they engage with the prompt/medium. Clients are told that they can choose to engage with the prompt using a different medium than the one demonstrated, or to completely ignore the prompt. Facilitators generally make art alongside clients, while also observing clients' process, providing support if a client becomes dysregulated, and offering guidance with the use of art materials.

Table 1.

Prompts used over the duration of participant enrollment in SA

Prompt	Demonstrated technique and medium
This is what my voice sounds/looks like	Breathing in and out, start to draw a line…
What I was given, what I made of it	2 ragged pieces of clay; 1 remains what I was given, one becomes what I made of it
I can/can't take up space	Start with outline of part of body
Full and Empty	Start with any bag/box/container
I'm divided	Spliced collage
I can/can't mess up	Blind paint
This where I come from/this is where I'm going	Line linking two points
"A chapter…"	Paper booklet
I am/I am not opening up	Folded paper toy
It's invisible	Pastel/paint resist
I'm on a bridge	Link between two points, objects
It's coming to the surface	Tin foil mask/casts
What I look like on the inside	Abstract
This is what happens when I slow down	Practice slow making or fast making, any medium
This is how I take the plunge	Clay
I do/do not have boundaries	Frame/tape structure
I'm on the inside/outside (I feel in/out)	Play with edges/on/off page
This is what I show/hide	Layers
This is what I can say/can't say	Pastel resist
This is the frame I want/need	Frame/tape structure
This is my shield/protection	Sculpture/building
This is how I put myself together	Assemblage—string, tape, glue, staples
I am one/I am many	Freeform printmaking tempera/folded paper

Speaking (40 minutes). Clients are invited to show their art and say something about it or the process of making it. They can choose to decline or receive feedback. Group members are invited to share what they see in the work and their response to it. Group members are asked not to comment on the artistic quality of the piece, to merely interpret it symbolically, or to interpret what it means for the art-maker. This often evolves into a dialogue or conversation with repeated exchanges between the maker and the group.

Scribble-out (5 minutes). Clients and facilitators prepare to leave by creating a quick scribble. The scribble could represent some aspect of their experience in group, that they want to take with them or leave behind. Sometimes in lieu of a scribble, clients may modify their art to represent what they want to take away or leave behind (e.g., tear it in half, throw it away, cover up part of it). After the scribble, clients may check out by briefly sharing what they are taking away or leaving behind.

Therapists. Over the duration of the study, there were two SA facilitators. One was in her early 50s, identified as first-generation Canadian of Jewish-European descent. The other, in her late 30s, identified as European-Asian, and had been born and raised in Western Europe. Both facilitators were masters-level registered psychotherapists; one was formally trained as an art therapist (Stern), the other had additional registration as a psychological associate. They had a combined 30 years' experience with the Trauma Therapy Program.

Data collection. Immediately prior to their first session of SA, study participants completed a demographics questionnaire, questionnaires about their treatment and trauma history, and baseline self-report measures of symptoms, general functioning, and emotion processing. The initial interview was conducted 30 minutes after participants' first session. Immediately after their final session, participants completed post-treatment measures of

symptoms and emotion processing. The post-therapy interview was conducted between five and 14 days after participants' final SA session. Follow-up questions were sent to select participants by email, and they responded in writing within one week of the post-treatment interview.

Measures

Demographics and treatment history. A data collection sheet included questions about age, gender, relationship status, education, ethnicity, employment status, and other past or current mental health treatments. See Appendix B.

Traumatic Experiences Checklist (TEC). The TEC is a 33-item retrospective self-report measure that screens for trauma exposure, with an emphasis on various forms of child abuse and neglect (Nijenhuis et al., 2002). The TEC has good internal consistency and test-retest reliability, and established criterion validity (Nijenhuis et al., 2002). Respondents indicate whether they have or have not had a number of potentially traumatic experiences. For each endorsed item, respondents rate on a five-point scale how much impact the experience had on them, from "None" (1) to "An extreme amount" (5). In addition, respondents indicate their age at occurrence of any endorsed event, its duration and/or frequency, and to specify their relationship with trauma perpetrators. Scoring typically uses these items to tally and weight the trauma exposure, depending on age of occurrence and relationship with perpetrator, which generates a "score" for severity or extent of childhood abuse and neglect. Questions about age, duration, and frequency of exposure were eliminated from the questionnaire used in the present study, because we sought descriptive information about exposure to type of trauma only, and wanted to minimize the extent to which participants had to think about and report trauma details, given the lack of follow-up clinical interview. See Appendix C.

Life Stressor Checklist-Revised. (LSC-R). The LSC-R screens for lifetime occurrence of 30 stressful or potentially traumatic events (Wolfe et al., 1996). It includes five follow-up questions for any endorsed events, assessing: age, duration; degree of threatened harm or death; experience of helplessness, fear, or horror; and impact of event in the past year. As with the TEC, the LSC-R was implemented to gather simple descriptive information about exposure to other potentially- traumatic events not included on the TEC, and as such, it was adapted for the present study. Any items that duplicated TEC items were removed, and all follow-up questions except "impact in the past year" were removed. The remaining list of 17 items covered a range of experiences including adult abuse and assault, serious illness, and non-relational potentially-traumatic events (e.g., natural disaster, car accident). For endorsed items, participants rated the impact of the event from "none" (1) to "an extreme amount" (5). See Appendix D.

Impact of Events Scale-Revised (IES-R). The IES-R assesses symptoms of traumatic stress during the previous week (Weiss & Marmar, 1997). A revision of the original IES (Horowitz et al., 1979), it is one of the most highly-used self-report measures of traumatic stress (Bardhoshi et al., 2016). It has 22 items representing intrusion, avoidance, and hyperarousal symptoms. Respondents indicate the extent to which they have been bothered or distressed by symptoms, from "not at all" (0) to "extremely" (4). Total scores range from 0 to 88, with 33 as a recommended cut-off score indicating likely PTSD (Creamer et al., 2003), although the IES-R is not DSM-correspondent. Previous research has reported strong internal consistency, convergent and discriminant validity, and test-retest reliability (Bardhoshi et al., 2016; Creamer et al., 2003; Weiss, 2004). The IES-R is typically administered in reference to an index trauma. Because the proposed study's sample includes survivors of complex trauma (i.e., repeated incidents and/or

multiple types of trauma), participants were instructed to respond to questions with respect to "the incident(s) or experience(s) that cause you the most distress." See Appendix E.

Outcome Questionnaire (OQ-45.2). This 45-item questionnaire was designed for repeated tracking of general progress over the course of psychotherapy (Lambert & Finch, 1999; Lambert et al., 2004). Repeated measurement was intended to provide clinicians with an assessment of overall progress, deterioration, or no change. The OQ-45.2 assesses a wide variety of common symptoms and problems that are not diagnosis-specific. Respondents rate on a 5-point scale the extent to which an item is true for them over a recent period of time, from "never" (0) to "always" (4). The OQ-45 generates a total score, and scores for Symptom Distress, Interpersonal Relationships and Social Role Function subscales. Good internal consistency and construct validity have been demonstrated (Boswell et al., 2013). See Appendix F.

The 20-item Toronto Alexithymia Scale (TAS-20). The TAS-20 assesses alexithymia according to three domains: difficulty describing feelings; difficulty distinguishing between emotions and body sensations; and externally-oriented thinking (Bagby et al., 1994). Respondents rate their agreement with items on a 5-point scale, from "strongly disagree" (0) to "strongly agree" (4). It has good test-retest reliability and internal consistency (Bagby et al., 1994; Taylor et al., 1992). See Appendix G.

Difficulties in Emotion Regulation Scale (DERS). The DERS includes 36 items that assess six domains of difficulty with emotion regulation (Gratz & Roemer, 2004). Domains include: non-acceptance of emotional responses; difficulty engaging in goal-directed behaviour; impulse control difficulties; lack of emotional awareness; limited emotion regulation strategies; lack of emotional clarity. Respondents indicate how often each item applies to themselves, from

"almost never" (1) to "almost always" (5). Good internal consistency (alpha = .93) and high test-retest reliability (r = .88) have been demonstrated (Gratz & Roemer, 2004). See Appendix H.

Participants

Group Referral and Enrollment Pathway. The majority of clients accessing Trauma Therapy Program services are physician-referred. Clients complete an intake interview, which includes assessment of history of developmental relational trauma and associated mental health difficulties. Most are streamed into a stage-1 psychoeducation and skill-building group. After completing it, they may request to be waitlisted for additional group or individual services, such as SA. Of the 10 participants in the study, nine followed this pathway; all nine had completed the stage-1 psychoeducation and skills group prior to SA, and two had completed other group programming. One participant came to SA along a different pathway; she was waitlisted after she completed WRAP, the intensive day-treatment program, to which clients self-refer.

The SA group facilitator met with waitlisted clients for approximately 45 minutes to screen for eligibility, discuss fit between the group and the clients' goals or presenting issues and the group, and assess current safety/stability. This intake meeting occurred anywhere from two weeks to three months prior to beginning group. Criteria for enrollment in the SA group were: (1) Age 18 or older; (2) Completion of at least one previous TTP service and referral by its facilitators; and (3) Interest in participating in arts-based trauma-specific group and identification of specific goals for group. Clients did not need to have prior experience with art-making, although some did. Exclusion criteria for enrollment in SA were: (1) Suicidal behaviour in the past month; (2) Engagement, in the past month, in any coping strategies (e.g., substance use, self-harm, eating disorder) deemed by the intake therapist to be severe enough to interfere with

regular group participation and attendance. An additional exclusion criterion for participation in the study was: previous clinical relationship with the researcher.

Demographics and Treatment History. Participants included 10 women, with an average age of 42 years (range 29-50). Seven (70%) self-identified as White. Although employment status was not included in the demographics questionnaire, most (9/10) participants spontaneously disclosed it at some point during the study. Of those nine, two were employed full-time, two were returning imminently to full-time work after a period of receiving disability benefits, and five were unemployed and receiving public assistance or disability-related benefits. All participants reported that they had previously participated in some form of individual counselling or psychotherapy, and five indicated that they were currently receiving some form of individual therapy in the community. The nature of the latter varied; one woman said she saw a private-practice psychotherapist twice monthly, one had weekly sessions with a resident psychiatrist, and three others described occasional meetings with a case worker or community agency counsellor. All participants reported previous experience of group therapy. At a minimum, this included one previous (8-10 week) skills and psychoeducation group with Women's College Hospital Trauma Therapy Program. Others reported additional group therapy experience in various settings, including day-treatment group programs, relational process groups, skills groups, and inpatient group programming. I did not ask directly about previous psychiatric inpatient experience, however three of the 10 participants spontaneously mentioned at least one previous hospitalization. Seven reported that they were currently taking psychiatric medication, while two others had taken it in the past.

To protect participant anonymity, potentially identifying details such as workplace, career, birthplace or residence, and any other specific biographical or clinical information, have

been omitted or superficially modified throughout this manuscript. Each participant was given a pseudonym, which is included in Table 2 along with demographic information. To further orient readers to the sample, brief biographical descriptions will be presented in chapter 3.

Table 2.

Participant Demographics

Pseudonym	Age	Relationship Status	Ethnicity	Education	Employment Status
Rose	41	Divorced	South-Asian, Asian, White	Bachelor's Degree	Returning to full-time work
Pat	37	Single	White	Graduate Degree	Unemployed
Magda	40	Divorced	White	Some College	Unemployed
Nicole	39	Single	White	Bachelor's Degree	Full-time
Gabrielle	48	Single	White	High School	Unemployed
Brenda	48	Single	White	Some College	Unemployed
Kim	50	Divorced	White	Bachelor's Degree	Returning to full-time work
Felicia	35	Single	Black	Some College	Did not specify
Diane	50	Single	White	Bachelor's Degree	Unemployed
Zahra	29	Single	Middle Eastern/Arab	Bachelor's Degree	Full-time

History of Traumatic Experiences. Table 3 presents the sample's frequency of endorsement of various traumatic experiences before the age of 18 (based on 23 items from the TEC), and lifetime traumatic experiences (based on 16 items from the LSC-R), and the mean and range impact ratings. Notably, 80% of participants reported sexual abuse, 90% reported physical abuse, 90% reported emotional abuse, 90% reported emotional neglect, and 90% reported family psychiatric, financial, or substance use problems, before the age of 18. In terms of childhood polytraumatization, 70% of participants reported experiencing neglect, emotional abuse, physical abuse, and sexual abuse; 20% had experienced neglect, emotional abuse, and physical abuse; 10% reported sexual abuse only. In adulthood, 80% of participants reported serious financial problems (not enough money for food or shelter), and 80% had experienced sexual assault.

Table 3.

Frequencies of endorsement of traumatic experiences

	Type of Trauma	*n* endorsing (by perpetrator type)				Impact range	Mean impact
		Immediate family	Extended family	Non-family	Any		
TEC item #	**UNDER 18**						
12-14	Emotional neglect	9	7	8	9	1-5	4
15-17	Emotional abuse	9	7	5	9	3-5	4.4
18-20	Physical Abuse	7	3	6	9	3-5	4.3
24-26	Sexual abuse	3	4	6	8	2-5	4.2
21-23	Sexual harassment	1	4	6	6	2-5	3.8
1	Having to look after parent(s) or sibling(s) as a child				6	2-5	3.5
2	Family problems (psychiatric; addiction; poverty)				9	4-5	4.67
3	Loss of parent or sibling as a child				3	4-5	4.67
4	Serious bodily injury				3	3-5	3.67
5	Threat to life from illness, injury, accident				2	2-5	3.5
6	Divorce of parents				3	3-5	3.67
7	Threat to life from another person				3	5	5
8	Intense pain (e.g. from illness, injury)				6	3-5	3.83
9	War-time imprisonment, deprivation, loss, injury				0	-	-
10	Second-generation war victim				1	4	4
11	Witnessing others undergo trauma				8	3-5	3.88
LSC-R item #	**LIFETIME**						
1	Been in a serious disaster (e.g. earthquake)				0	-	-
2	Been in a serious accident				4	3-5	3.75
3	Witnessed a serious accident				7	3-5	4.3
4	Close family member sent to jail				3	2-5	3.67
5	Been separated or divorced from spouse/partner				4	2-5	4.25
6	Serious money problems (not enough food/ shelter)				8	4-5	4.75
7	Had serious mental or physical illness				6	2-5	4.83
8	Had an abortion or miscarriage				6	3-5	4.17
9	Separated from your children against your will				1	4	4
10	Responsible for care for someone with serious disability				4	4-5	4.5
11	Someone close died unexpectedly, suddenly				7	4-5	4.6
12	Someone close died				7	3-5	3.67
13	Robbed, mugged, physically attacked as an adult				7	3-5	4.29
14	Sexually harassed as an adult				9	3-5	3.67
15	Sexually assaulted as an adult				8	4-5	4.67
	Other*				2	3-5	4

Note. Frequencies are based on a sample size of $N = 10$. Mean impact ratings are based on a scale from 1-5. *One participant indicated "experience of war/political conflict as an adult" (rated impact = 3). One participant reported "wrongful imprisonment and abuse from jailors" (rated impact = 5) and "confinement with rape and robbery" (rated impact = 5).

Clinical and Emotional Function. Baseline measures of clinical and emotional function included the IES-R, OQ-45, DERS, and TAS-20. Measures of central tendency for these scales and subscales are described below in the context of relevant clinical cut-offs or mean scores in community and clinical populations.

General symptom distress and interpersonal function. At baseline, the average total OQ-45 score was M=93.9 (SD=19.7), and scores ranged from 64 to 123. In treatment-seeking populations (see Beckstead et al., 2003; Lambert & Finch, 1999), a cut-off score of 63 indicates clinically significant distress and dysfunction; 100% of the sample was above this cut-off. The average Symptom Distress subscale score was M=56.9 (SD=14.1), and ranged from 33 to 79. All but one participant (90%) were above the clinical cut-off score of 36, indicating significant symptoms common to anxiety, affective, and adjustment disorders. The average Interpersonal Relations subscale score was M=20.2 (SD=4.7), and ranged from 15 to 18. Every participant was at or above the cut-off score of 15, indicating clinically-significant difficulties with loneliness, interpersonal conflict, and family or marital problems. The average Social Role subscale score was M=16.8 (SD=3.9), and ranged from 11 to 22. Eight participants (80%) were above the cut-off score indicating clinically-significant difficulties in social roles (e.g., parent, spouse, employee), such as conflict or distress fulfilling the role, or overwork.

PTSD symptomatology. The average pre-therapy IES-R score was M=48.10 (SD=13.0). The presumptive cut-off score for a likely PTSD diagnosis has been variably reported in the literature; a cut-off of 33 corresponds with PTSD diagnosis based on other self-report measures (Creamer et al., 2003). Cut-off scores as low as 22 (Rash et al., 2008) and as high as 44 (Blake et al.,1995) have been cited as having optimal correspondence with clinician-administered diagnostic interviews. A recent study of 3,313 Balkan war refugees established that a cut-off of

34 had excellent diagnostic sensitivity corresponding to structured clinical interviews (Morina et al., 2013). In the present study's sample, individual scores ranged from 30 to 63. Eight individuals (80% of the sample) were above Morina et al.'s cut-off score of 34, and six (60%) were above 44, the most conservative published cut off score for a probable PTSD diagnosis.

Emotion Dysregulation. The sample's average total DERS score was M=107.7 (SD=21), and scores ranged from 71 to 140. For comparison, the literature has reported mean total DERS scores of: M=77 among female undergraduates (Gratz & Roemer, 2004); M=87.44 in a sample of female undergraduates who reported engaging in deliberate self-harm (Gratz & Roemer, 2008); M=99.3 in a sample of marginalized individuals presenting for therapy at a low-cost urban clinic (Rudenstine et al., 2018); and M=101 among people people seeking treatment for comorbid BPD and substance use disorders, the majority of whom reported childhood sexual, emotional, or physical abuse (Gratz et al., 2008). Higher scores reflect greater difficulty with emotion regulation, indicating that most of this study's sample reported experiencing non-acceptance of emotional responses, difficulty engaging in goal-directed behaviour, impulsivity, lack of emotional awareness, limited emotion regulation strategies, and lack of emotional clarity, exceeding that which is seen among most clinical populations.

Alexithymia. The average baseline TAS-20 score was M=59 (SD=16.6), and scores ranged from 30 to 82. Although alexithymia is conceptualized as a dimensional construct, the authors of the TAS-20 suggest cut-off scores for identifying high and low alexithymia, derived from construct and convergent validation studies (Taylor et al., 1992). In this sample, five participants scored above 61, the cut-off for high alexithymia, and two participants scored below 51, the cut-off for low alexithymia.

Semi-structured Interviews

The protocol for the initial and post-therapy interviews were informed by the *Narrative Assessment Interview* (NAI; Hardtke & Angus, 2004), and the *Patients Perceptions of Corrective Experiences in Individual Therapy* interview (PPCEIT; Constantino et al., 2011a; Constantino & Angus, 2017). The NAI was designed to track changes in clients' self-perception from pre- to post-therapy in the treatment of depression, as reflected in changes in their self-narratives.[1] It is a brief, semi-structured interview conducted after the first session of therapy, at post-treatment, and at follow-up. At the post-treatment administration(s), participants are shown a written summary of portions of their initial interview and asked to reflect back on those pre-treatment responses. Hardtke and Angus (2004) and Angus and Kagan (2013) argue that this structured reflection provides further opportunity for clients to consolidate or even extend changes in their self-narratives. The PPCEIT was designed as a research tool for exploring clients' first-hand accounts of transformations and "corrective experiences" (Alexander & French, 1946; Castonguay & Hill, 2012) in therapy. Participants are asked to identify any shifts (in views of self, life, emotions, behaviours, and relationships) experienced over the course of therapy, and to provide a narrative account of the experiences in therapy to which they attribute those shifts (Constantino & Angus, 2017).

This study followed a truncated NAI procedure. During the post-therapy interview participants were presented with, and asked to reflect on, a written summary of portions of their initial interview. The post-treatment interview content was based on questions adapted from the

[1] "Self-narrative" refers to macro-level personal narrative, the individual's "overall life story, in which discrete events are placed in a temporal sequence and are meaningfully organized along a set of intrapersonal and interpersonal themes" (Hardtke & Angus, 2004, p.253).

PPCEIT. A pilot version of the post-treatment interview protocol (without the initial interview or summary sheet) was tested on three interviewees prior to beginning recruitment for this study. The initial and post-treatment interview procedures are described below; see Appendix I for full protocols.

Initial interview. The purpose of the interview conducted at the outset of therapy was to support and enrich the post-therapy interviews and their subsequent analysis. It was intended to foster relational rapport and security to enhance depth during the second interview. Furthermore, it facilitated sharing a narrative of participants' position at the outset of therapy, i.e., their hopes and goals for SA, concerns and fears about group, expectations for art therapy, and their understanding of how SA fit with previous or ongoing therapy. This pre-therapy narrative became both an explicit (through the summary sheets) and implicit shared context for reflection, during the post-therapy interview.

Procedure. Initial interviews lasted 40-111 minutes (M=64 minutes). All interviews, with one exception, were conducted immediately after participants' first session of SA. One interview was conducted in two parts, immediately before and immediately after the participant's first session, due to transportation and scheduling difficulties. Interviews were conducted in the primary SA facilitator's office. Interviews were audio-recorded and transcribed verbatim. I conducted all interviews.

The initial interview questions were selected to invite a conversation about participant expectations, concerns, and goals for SA, to serve as a baseline reflection point during the subsequent post-therapy interview. The initial interview procedure followed a semi-structured protocol, based on these guiding questions:

1. What was your experience of the first session today? What stands out?

2. What led you to begin SA?
3. Is there a reason you sought *art* therapy, specifically?
4. What are you hoping to get out of this? What are your goals for the group?
5. Do you have any concerns or fears about doing this group? (Probe for concerns about making art; being in a group; being in a trauma-specific group)
6. How do you see SA fitting with other therapy you've had, or with your 'journey' so far?

I typically began interviews by inviting participants to describe their experience of the first session. Adopting a 'guided-conversation' approach (Kvale, 1996), I responded to salient elements of participants' responses with summary reflections or further questions, to gather more detail or clarify meaning. Interviews tended to unfold in a natural and spontaneous way, often arriving at questions and topics from the interview protocol, without having to pose protocol questions as-written. All questions were nonetheless asked explicitly to ensure full "coverage" of the topics of interest (e.g., "is there anything *else* you are hoping to get out of this?").

I made notes immediately after each interview, with observations about relational processes, non-verbal behaviour, a brief description of any artwork that was shown, and overall emotional tone. In most cases, I also noted something about the participant's overall style, e.g., whether they were reflective, forthcoming vs. guarded, abstract vs. specific, tangential vs. focused. I made these notes automatically (perhaps revealing that these dimensions are part of the lens through which I see narrative, perhaps out of clinical habit). Later, these notes often proved to be a helpful reference for making sense of the interview transcript.

Relational stance. Josselson (2013) has described the qualitative interviewing process as fundamentally relational. She writes,

> Your stance as the researcher/interviewer is to be holding firmly to two ropes: one the rope of the conceptual question (what you, the researcher are doing the interview for), and the other the rope of engagement with the participant—the human relationship in which the interview unfolds. If there are moments where your handholds on the ropes feel tenuous or in danger, always let go of the conceptual question rope and hold on to the rope of your relationship with the interviewee […] You can always go back later and pick up the conceptual question rope. (78)

Josselson's two ropes metaphor was my guiding image for the interview process, particularly the initial interviews. I anticipated that the relational rope, given the population and setting, would need more attention—i.e., that it might be fragile and tenuously held throughout the interview rather than at moments. To enhance rapport and participants' sense of safety, I attended carefully to the interviewer-participant relationship and to participant emotional arousal and indicators of autonomic dysregulation. In practice, this meant that the initial interviews were quite loosely-structured, and that I used empathic reflections and explicit validation more frequently than may be typical for qualitative interviewing. At the same time, I was careful not to "intervene" as in a therapist role, e.g., by attempting to alter participant understanding or perspective, offering interpretations or evaluative statements, or attempting to deepen participants' emotional arousal (Suzuki et al., 2007).

There was one exception to this "no intervention" principle. Informed by pilot interviews, prior to completing baseline questionnaires, the potential for being triggered and emotionally dysregulated was discussed, and we agreed on a plan for grounding. Specifically, participants were asked questions like:

- What happens when you are triggered or emotionally overwhelmed?

- Are you aware of it when it is happening? Do you dissociate?
- How will you know, and how will I know, if it is "too much?"
- What helps when that happens?
- Is it ok if I remind you to do that, or guide you through doing that, if needed?

Based on this discussion, I tracked participant emotional arousal, occasionally checked in about how the participant was doing, and—as needed—intervened to ground or regulate participants. The scope of these "interventions" ranged from a gentle reminder to take a breath, to pausing the recording and guiding one participant through a five-senses grounding exercise for several minutes. Out of 10 participants, five were given some form of support of this type. As interviewer, I found it helpful to remember that we had a shared purpose to conduct an *interview* about a particular phenomenon or field of experience, and that my role was to keep us on track towards that end. This occasionally meant that I needed to say things that felt or sounded like what I would say to a client in therapy. I aimed to do that with internal clarity that I was "intervening" only to pull us back to, or keep us within, the agreed-on framework for the interview.

Summary Sheet preparation. After transcription, the initial interview transcripts were reviewed to prepare a written summary sheet for use in the post-therapy interview. Summary sheet preparation included the following steps:

1. I read through the transcript and highlighted passages that addressed the following questions:
    a. *What are your goals for SA? Are there any changes you hope to see in yourself?*
    b. *What concerns or fears do you have about doing trauma therapy and/or about doing SA?*
    c. *What are your expectations for SA?*

The interviews were semi-structured and prioritized rapport and flow over interview structure. Therefore, some of the relevant passages followed a direct interview question, but material also arose elsewhere in the flow of the interview. Relevant passages were thus interspersed throughout the transcripts. I highlighted passages throughout, but chose only those passages in which the content clearly and explicitly answered the above-listed questions.

2. Next, working through the above questions one at a time at a time, I collated the relevant passages. Participants often spoke repeatedly about the same idea; all relevant passages were included, irrespective of repetition or location in the participant's overall narrative. This resulted in a list of statements in relation to each of the three questions.
3. Working down the list, I grouped similar ideas and then selected one direct quotation illustrative of each distinct idea. If the client spoke repeatedly about the same idea (e.g., mentioning their goal of "increased self-understanding" more than once), I chose the quotation that seemed most illustrative, evocative, or concise.
4. Quotations were lightly edited for readability. Filler words (e.g., like, uh, um), non-verbal utterances (e.g., laughter, sighs, tears), false-start sentences, stutters, and incomplete words were removed.
5. Lengthy quotations were "gisted," i.e., shortened to capture their essential meaning.
6. Quotations were compiled into three separate summary sheets, with headings: *What are your goals for SA? Are there any changes you hope to see in yourself?; What concerns or fears do you have about doing trauma therapy and/or about doing SA?; What are your expectations for SA?*

The completed summary sheets had between one and five ideas or gisted statements for each of the three topics. All participant summary sheets are included in Appendix J.

Post-Therapy Interviews. The purpose of the post-therapy interview was to generate rich client narratives of their experience in SA and their perception of how it was helpful for post-traumatic growth/recovery. The summary sheets from the initial interviews, and examples of participant art, were used during the post-therapy interview as points of reference to encourage reflection on specific experiences in group, and changes over time.

Procedure. Post-therapy interviews lasted 91-152 minutes (M = 108 minutes). All interviews were conducted between five and 14 days after the participant's final session of SA, either in the same location as the initial interview (the facilitator's office) or in the art studio. I asked participants to bring the art they had saved, or a photo of any significant pieces that could not be saved or easily transported to the interview. They were not given specific instructions about how to set it up for the interview; some participants spontaneously spread their art out so it was "on display"; others kept their work tucked away and only pulled out works as they arose in the flow of the interview. One participant kept her artwork in a bag at her feet; throughout the interview, she brought pieces out and held them in her lap, looking at them while she spoke about them, but she never turned her artwork around to show it to me. Interviews were audio-recorded and transcribed verbatim.

The post-therapy interview questions were selected to elicit participants' descriptions of their experience in SA, reflection on any associated shifts in self, behaviour, thoughts, emotions, and relationship patterns, and descriptions of specific experiences in or elements of SA that they think contributed to those shifts. In keeping with the NAI procedure, the summary sheet of participant goals or hopes was used as a starting point for reflection. I opened the post-therapy

interview by saying, "*As a way to begin, I want to offer this [summary sheet] as a reminder of where we started, three months ago. One of the many things we talked about in your first interview was your hopes or goals for the group. This is a gisted summary of what you said at that time.*" Participants then read their summary sheet. If participants did not spontaneously respond to the summary sheet content (most did), I used the general prompt, "*what's it like to read that, now*?"

After participants responded to the summary sheet, I reflected back or made further queries about salient elements of their response. This served as a "way in" to the remaining interview questions. The remainder of the interview followed a semi-structured protocol, covering these questions and prompts:

1. Please tell me about your experience of SA. How was it for you, what stands out?
2. Of all your artwork, which was the most significant piece for you? What made it significant? Please walk me through the making of it.
3. Have you noticed any shifts in how you see or understand yourself since beginning?
4. Have you noticed any shifts in problematic thoughts, emotions, behaviours, or relationships?
5. Have you noticed any shifts in how you perceive your trauma and its impact on you? (OR: What have you discovered, if anything, about your trauma and its impact on you?)
6. Please tell me about the specific experiences in SA that you think contributed to [shifts described in response to 3-5]. [Typically asked directly after any shift was identified].
7. Can you point to anything specific that occurred in your interactions with group members or the facilitators, that was meaningful or unexpected?
8. Did anything surprise you based on your expectations going into group?

9. Looking at [thinking about] your art all together now, what story does it tell?

Once participants responded to the initial summary sheet, a "guided-conversation" approach (Kvale, 1996) was again followed, such that different interview questions and topics often arose naturally in the flow of the interview. The post-therapy interviews were relatively more structured and consistent than the initial interviews. All interviews began with the summary sheet, included explicit questions about shifts that were immediately followed by questions about specific related experiences in SA, and the penultimate question was always, "Looking at all your art now, what story does it tell?" Participants were then asked to reflect on their experience of the research interviews.

The summary sheets of baseline fears/concerns about SA, and expectations for SA, were offered to some participants as a reflective device over the course of the interview. I chose to use these additional summary sheets if and when something emerged in the post-treatment narrative that had a clear thematic link to the content of those summary sheet sections.

Based on themes in the first several post-therapy interviews, additional questions were asked of subsequent participants, if the themes did not spontaneously arise. These included:

1. What did you struggle with?
2. What makes a piece of art or an experience of art-making "deep"?
3. What made SA "safe" (or not)?
4. The concept of witnessing has come up in other interviews. Does that word resonate when you think back over your experience?
5. The concepts of choice and freedom have come up in other interviews. Do those words resonate when you think back over your experience?
6. Did you go back to any pieces and change them, later on, maybe at home?

7. Think about times you made a decision about whether to share your work. What went into that?
8. What went into any decision to comment on others' work?
9. What role did the group/the presence of others have in your experience?
10. Would you do anything differently, if you could go back/if you could have more sessions?
11. What was missing? What didn't work for you? What could there be more of, or less of, in SA?
12. Will you be making art, going forwards? How, why/why not, why is that important to you?

I used "client-centered questioning" (Kvale & Brinkman, 2009) to get at participant's experience (thoughts, feelings, meanings). This meant asking questions about or prompting descriptions about what happened, what that was like, how something is/was important or significant, and what was "happening inside" at the time. Questions were delivered from a stance of sensitive acceptance, curiosity, and interest. As with the initial interviews, I attended carefully to the interviewer-participant relationship, perhaps with slightly less emphasis on Josselson's (2013) "relational rope," and more attention to the "conceptual rope" (i.e., the interview question), compared to the initial interviews. Grounding support was not offered—because it never appeared to be needed—during any of the post-treatment interviews.

Analysis

Post-therapy Interviews. Each interview was transcribed verbatim and any potentially-identifying details disclosed during the interview were removed or concealed. A research assistant completed seven of 10 transcripts; I transcribed three. I reviewed all transcripts to

ensure accuracy and consistency, and to get a "sense of the whole," prior to coding. Interviews were analyzed in the order in which they were conducted, with one exception. The very first interview conducted was challenging: Gabrielle was guarded and her narrative was vague, abstract, sparse, and often difficult to follow. This was my sense during the interview, and it held true after I transcribed it. By the time I began the analysis, I had conducted other interviews and was well into the "hermeneutic circle" (Kvale, 1983; Rennie, 2000), as each one seemed richer and contributed more substantially to my (albeit early) sense of emerging themes. For this reason, I decided not to begin open coding and category construction using the abstract and somewhat confusing material from Gabrielle's interview. Instead, I began by analyzing the interview that had been conducted 2nd, and Gabrielle's was ultimately the 5th interview analyzed. For clarity, the numbers in this chapter reflect the order in which interviews were analyzed.

The text was analyzed using a modified grounded theory approach, drawing on the methods described by Glaser and Strauss (1967) and Rennie (2000). I used the iterative steps of data coding, comparison, and writing conceptual memos, that were first outlined by Glaser and Strauss (1967) and have traditionally been applied with the aim of developing theory (i.e., "Grounded Theory" method, proper). These steps have since been recognized as foundational to most qualitative methods, including those with descriptive and interpretive, rather than theory-building, aims (i.e., "grounded theory lite"; Braun & Clarke, 2006). The goal of this study was more in line with the former; I sought meaning-rich answers to my research questions, obtained by using an interpretive lens to understand participants' stories of what happened for them in the group. As such, this analysis was "grounded" in participants' narratives of their experience, through systematic application of relevant steps according to the grounded theory method. This study did not use theoretical sampling or simultaneous data collection and analysis, the core

strategies of classic grounded theory that are particularly important for studies which aim to develop theory.

This study's methodological frame, methodical hermeneutics, also informed my approach to category creation (Rennie, 2000). I aimed to create categories, and identify relationships among them, that were experience-near, and that remained experientially resonant even at the more abstract or conceptual higher tiers of the hierarchy. Rennie and Fergus (2006) articulated an approach to categorizing that entails attunement to the embodied, felt patterns of experience conveyed in the text. Charmaz has also described this as a process of preserving "images of experience" (2000, p. 526) in the analysis, rather than distancing from experience through progressive abstraction of categories and concepts. In synthesizing these approaches, my goal was to use grounded theory steps to systematize the process of moving from raw text through to abstracted, organized, clinically-relevant categories, while retaining experience-near meanings and descriptive richness.

Process of the Analysis. First, I divided the transcript into "meaning units," (MU) or segments of text delineated by a change in meaning, detected by the reader while holding in mind the research questions and the whole text (Giorgi, 1985). Some MUs overlapped or were contained within larger ones. In the next step, called "open coding," I created a gisted or slightly abstracted verbal label capturing that MU's content and meaning. Each MU was coded with at least one of these "lowest-level" categories, and sometimes as many as three. Some of the early categories consisted of gisted summaries of surface content; others were created by attempting to resonate empathically with the most salient threads of meaning in that unit of text (Rennie & Fergus, 2006). Each subsequent MU was compared to extant categories, and then I revised those categories, or created new ones, to capture the meaning conveyed in that MU. As categories were

generated and revised, previously-analyzed MUs were periodically revisited to ensure good fit. This process, called "constant comparison," was used help ensure the categories were grounded in the text.

In the next step, I began to develop a categorical framework by clustering the lower-order categories into successively higher-order categories, according to shared experiential themes, meanings, and concepts. In practice, this occurred alongside open-coding, in an iterative process; I moved from step one to step two, then back again, as I worked through successive transcripts.

After the 4th transcript was open-coded, I undertook a complete review of the tentative categories and subcategories that had been developed to that point, and created firmer higher-order conceptual categories, at increasing levels of abstraction, to start to synthesize the lower-level categories (Charmaz, 2000). Extensive conceptual memo'ing was done at this stage to capture my observations and hunches and questions about the emerging categorical structure. In addition, the category system was audited by my supervisor after the 1st and 4th transcripts had been coded. Auditing involved review of the emerging categories, their definitions, and discussion of my ideas about relationships among categories. Auditing was *not* done in order to verify categories against someone else's view of the data or to promote objectivity, i.e., we were not seeking "consensus among raters" which is often a goal in qualitative analyses undertaken from a realist approach (Willig, 2012). Rather, auditing promoted methodical rigour by inviting articulation (documentation and discussion) of the analysis process, stimulated my thinking, and encouraged conceptual clarity during the analysis.

The 5th, 6th, and 7th transcripts were then open-coded, in tandem with further development and revision of the higher-order categories and relationships among them. After this step, the system of categories ran four levels deep. I had articulated several clear higher-order categories

and several smaller, shallower categories that felt conceptually rich, but remained difficult to locate in relation to each other. The category model was audited again at this stage, which helped me identify some critical questions regarding the relationships among categories; in particular, we began to question whether several shallower categories were in fact dimensions (or poles) of a higher-order concept. As a result of this auditing round, I also observed that participant representation varied along those dimensional categories.

After open-coding the 8th and 9th transcripts, categories solidified, and the relationships among them became clearer, as well as a way of clustering them further into a discrete number of main categories, or "domains." Furthermore, only a handful of new lower-order categories emerged from the 8th and 9th transcripts, and they fit into the existing analysis by adding more dimension, and helping to differentiate, concepts that had already been articulated. Accordingly, I decided to open-code one more transcript, to test whether the tentative main categories and their organization held up. The final transcript added rich examples to concepts that had already been identified; there were no new categories identified above the lowest level. This suggested that the analysis was "saturated" i.e., categories appeared well-developed in their properties and dimensions and provided a full representation of the depth and breadth of participant experiences in SA (Charmaz, 2006; Corbin & Strauss, 2008).

The first stage of analysis, open-coding of interview text, yielded 734[2] lowest-order categories, based on 1242 meaning units. These were grouped into 112 second-order categories according to common experiential themes and concepts, which were in turn grouped into 47 third -order categories. Some of these third-order categories were further clustered into higher-order (fourth and fifth) categories, however others were neither distilled further, nor clustered with

[2] An additional 105 lowest-order categories were not included in the final model

other third-order categories. Instead, in the overall model that was starting to emerge, they were "promoted" one or two levels, keeping pace with other, further-distilled fourth and fifth-order categories. Promotion reflected the salience of those concepts within participants' narratives. Similarly, some fourth-order categories were promoted to fifth-order. Those promotions meant that once the model was finalized, categories had uneven depth, i.e., different numbers of tiers (ranging from four tiers to six tiers deep). For clarity, from this point forward, the presentation of results is oriented from the top-down, and I have labelled the model's tiers nominally instead of using the ordinal number. The analysis ultimately included (from the top-down): one "core" category; four "domains" a level below the core; 11 "categories" a level below the domains; 44 "subcategories" a level below the categories; and 52 "sub-subcategories" and "properties"[3].

Interpretive memos were kept throughout, beginning (prior to recruitment) with a reflection on my previous experience in the role of SA co-facilitator, to promote clarity, tracking, and bracketing of my own assumptions and biases throughout data collection and analysis. Memos were written regularly throughout the interview, transcription, and analysis stages of the process. During the analysis process, memos were used to elaborate and track the processes involved in category generation, as well the meanings and characteristics of each category, assumptions, and identification of possible relationships among categories, and to pose and tentatively answer questions about the categorical structure.

[3] These numbers do not match the ordinal counts provided at the beginning of the paragraph, due to promotion of some categories.

Chapter 3: Results

Overview

This chapter presents results of the grounded analysis, a model that describes clients' experiences of making art in trauma-centered group therapy and perceptions of how it promoted transformation of trauma-related patterns of emotional experience and action. First, to orient readers, I introduce the individual participants whose narratives constitute the raw material from which the model was developed. Next, the hierarchical taxonomy of categories is presented, beginning with the core category, then four main categories (or, "domains"), their categories, and subcategories. The categories describe the concepts and lived texture of participants' experiences and perceptions of SpeakArt (SA), i.e., what happened in the group, what it meant, and how it was or was not helpful. Categories are defined and illustrated with excerpts from participant interviews; quotations were lightly edited for clarity. Finally, I revisit the core category and propose a heuristic model that identified a conditional and sequential relationship between the four main categories. This aspect of the model will be illustrated graphically, and through in-depth examination and reframing of select subcategories.

Introducing the Interviewees

As I came to know each participant through their initial interviews and brief off-the-record interactions, it seemed that they were each coming to SA from a very different place. As expected, they had different life histories and stories and socioeconomic status. But they also brought to SA, and this study, a wide range of trauma-related problems, differing understanding of how their problems were related to trauma, and variable treatment histories, and goals and fears and expectations for SA. In other words, SA was a single shared point on otherwise highly variable post-trauma "journeys." Some, but not all of the variation and range of their journeys-to-

SA is captured in the summary sheets that bridged initial and post-therapy interviews.

To orient readers to these individuals, I have provided a snapshot description of them and what I know about their journeys-to-SA. To construct each description, I reviewed participants' summary sheets and participant-specific memos, and culled the most relevant goals, hopes, expectations, or fears that each participant expressed at the outset of therapy. Ten participant descriptions are presented in the following paragraphs; they also include any salient aspects of their personal situation and clinical history disclosed over the course of the study. In addition, I included a brief description of the artwork that each participant identified as her "most significant" piece; many of these will be revisited later in the chapter, as part of interview excerpts that illustrate categories. My approach to writing these snapshots was intuitive rather than systematic, and is intended to convey a sense of the person, before we turn to categories and concepts. Participants are introduced in the order in which their interviews were analyzed.

Rose, 41, enrolled in SA hoping that art would help her find language "beyond the words 'good' or 'bad'" to describe what she is feeling. She also wanted to let go of self-judgment and perfectionism. Rose disclosed a complex medical and psychiatric clinical history and felt that after extensive treatment aimed at "symptoms," she was finally ready to "start addressing the root of my issues," i.e., trauma, through programs like SA. She also felt scared of the vulnerability of "taking off the mask" and sharing her artwork. Rose's most significant piece was a sculpture of tangled electrical wire that showed her story of being trapped by, and attempting to get free from, trauma sequelae over the years.

Pat, 38, is a single mother coping with long-term physical health problems. She enrolled in SA seeking greater self-understanding, which she hoped would help her trust herself and make "better life decisions." Pat shared that she had painful previous experiences of individual

therapy; she described repeatedly getting "stuck in a dark void wordless place" in therapy, unable to identify or articulate what she was feeling, made worse by a sense of pressure to change and to please therapists. She hoped that making art, without the pressure to find words and the relational dynamic of individual therapy, would help "shine a light" into that "dark void." Pat's most significant piece featured a pile of red feathers on a canvas board painted sky blue; the feathers were bound to the board with twine. She made it in response to the prompt, 'this is what my voice looks like.'

Magda, 40, is a recently-divorced mother with a physical disability. Prior to being referred to SA, she had dropped out of trauma-informed individual and group therapy programming, because of difficulty managing dissociation in-session. She struggled with a sense of "always spinning out of control," and hoped to gain tools for grounding herself and coping with distress through art-making. Magda also wanted to work on her "self-abuse" and tendency to judge herself and others. Magda's most significant piece was a clay heart.

Gabrielle, 48, had always struggled to articulate herself, and hoped art-making would help her find words for "slippery" thoughts and feelings. Gabrielle had substantial previous therapy experience (primarily cognitive-behavioural), and saw SA as "gentle" preparation for more intensive trauma work, a way to let trauma-related feelings "bubble up" rather than "washing me away and making me dissociate." Gabrielle was concerned about "taking up too much space and stepping on people's toes" in group, but also wanted to build confidence in speaking up for herself. She worried that she would be "all wrong" in group, and that no one would like her. Gabrielle declined to identify a most significant piece; all of her artwork consisted of coloured-pencil or chalk pastel drawings on 8.5 x11 white paper.

Nicole, 39, had minimal experience of therapy prior to SA. She described feeling "stuck" and disconnected from herself, and hoped that SA would help her connect to a "voice that wants to speak, from a place that has no vehicle." Nicole described herself as a high-achiever and perfectionist who was good at hiding the "imperfections and ugly stuff" behind a façade. She feared that exposing what was hidden, in SA, would result in "judgment and persecution." Her most meaningful piece featured words (about the experience of being bullied) written in oil pastel that were revealed or concealed by layers of paint and other materials.

Brenda, 48, had never been able to work because of mental health problems, and experienced significant poverty. She alluded to difficult prior experiences in group settings, and was concerned about being able to relate to others and express herself in an "appropriate" way. Brenda's goals included not judging other people or their art; "becoming a better listener"; gaining a new tool to acknowledge her feelings; and enjoying the company of others. Brenda's most significant piece—which she worked on for at least six of her twelve weeks in group—was a miniature reproduction of a sculpture housed in a major art gallery, made with the intention of reminding herself of happy times visiting the gallery as a child.

Felicia, 35, was hesitant to enroll in SA, as she had had negative relational experiences in previous trauma-focused therapy groups. She worried about feeling invalidated and silenced, not fitting in as the only Black woman, and feeling overwhelmed by "the weight of other women's need to take up all the air in the room." Felicia saw herself as an artist, and hoped that making art in SA would help her shed the pressure and self-judgment that came with trying to financially support herself in a creative field. She also hoped to practice "having a voice and speaking […] my truth" by sharing her art with the group. Felicia said she did not make any artwork that stood out as significant or meaningful to her.

Kim, 50, is a recently-divorced mom who hoped to "get some me time" and give herself "permission to play" in SA. She had completed several other trauma-focused groups and individual therapy, and enrolled in SA feeling "ready to go deeper." Kim was interested in archetypes and mythology, and through SA, she wanted to "gain access to deeper symbolic understanding" of her own story. She was concerned about making mistakes and inadvertently offending or hurting others in group. Kim's most meaningful piece was a clay house, which she said depicted stability, home, and safety in her body, and was decorated with numerous symbols from mythology and the natural world, e.g., an eagle for "victorious freedom."

Dee, 50, enrolled in SA expecting the art-making to be "light." She wanted to "re-awaken" the enjoyment she found making art as a child, which had been "lost in the suffering and survival focus" of the intervening years. She also hoped to gain comfort being around other people, and perhaps take the risk of sharing something of herself or "making a connection." Dee described herself as "extremely guarded," was concerned about being overwhelmed by others' emotional pain, and feared the vulnerability of sharing her art, because "I do not break down in front of other people." Dee's most meaningful piece was a drawing inspired by scenes from Pink Floyd's *The Wall*. She explained that the album's themes of bullying, persecution, and self-protective isolation, tell her life story.

Zahra, 29, enrolled in SA with a unique longer-term goal: to use art and a visual social media platform to publicly share her story, as a sexual abuse survivor. She explained that through this project, she hopes to find meaning in what happened to her, transform pain into beauty, and empower other women. Towards that end, Zahra saw SA as a "training ground," an opportunity to learn how to "visually map" trauma-related experiences through art. She was concerned that fear of judgment and perfectionism would be barriers in SA; and also feared that

she would lose confidence in her project "if people don't get [my art]." Her most significant piece was a paper sculpture of herself, the head pulled back and down inside the torso, weighed down by a long tangle of ropes hanging from the mouth. It was made in response to the prompt, 'this is what I can/cannot say.'

Model of Group Art Therapy for Complex Trauma

The grounded analysis resulted in a six-tier hierarchy, in which subordinate categories furnished the properties of the next highest order of categories. This chapter is structured to formally present the top four tiers of the model, i.e., core, domain, category, and subcategory. The two lowest tiers of the hierarchy ("sub-subcategories" and "properties") constitute the building blocks, or qualitative properties, of the experiences and concepts that make up the top four tiers, and are not individually, explicitly identified and explained. Rather, they are conveyed through the definitions and illustrations of each subcategory. In the final section of this chapter, select sub-subcategories will be examined more closely.

The core category emerging from this analysis of clients' experiences of group art therapy for complex trauma, Bringing into Presence*,* comprised four domains: (1) Negotiating (Un)safeness in the Present; (2) Bringing 'It' Up; (3) Witnessing the Invisible and the Invalidated; and (4) Transferring Transformation. The first domain, Negotiating (Un)safeness in the Present, corresponds with events in and elements of SA that promoted an experience of relational safety and belonging, or lack thereof. Safeness was not conceptually distinct from the other three domains, rather, it pervaded participants' accounts and appeared to have a conditional, facilitative relationship with the other three domains, as if safeness shaped everything else that happened in SA. The second domain, Bringing 'It' Up, includes participants' experiences of coming into contact, through art-making, with emotions, sensations, action urges,

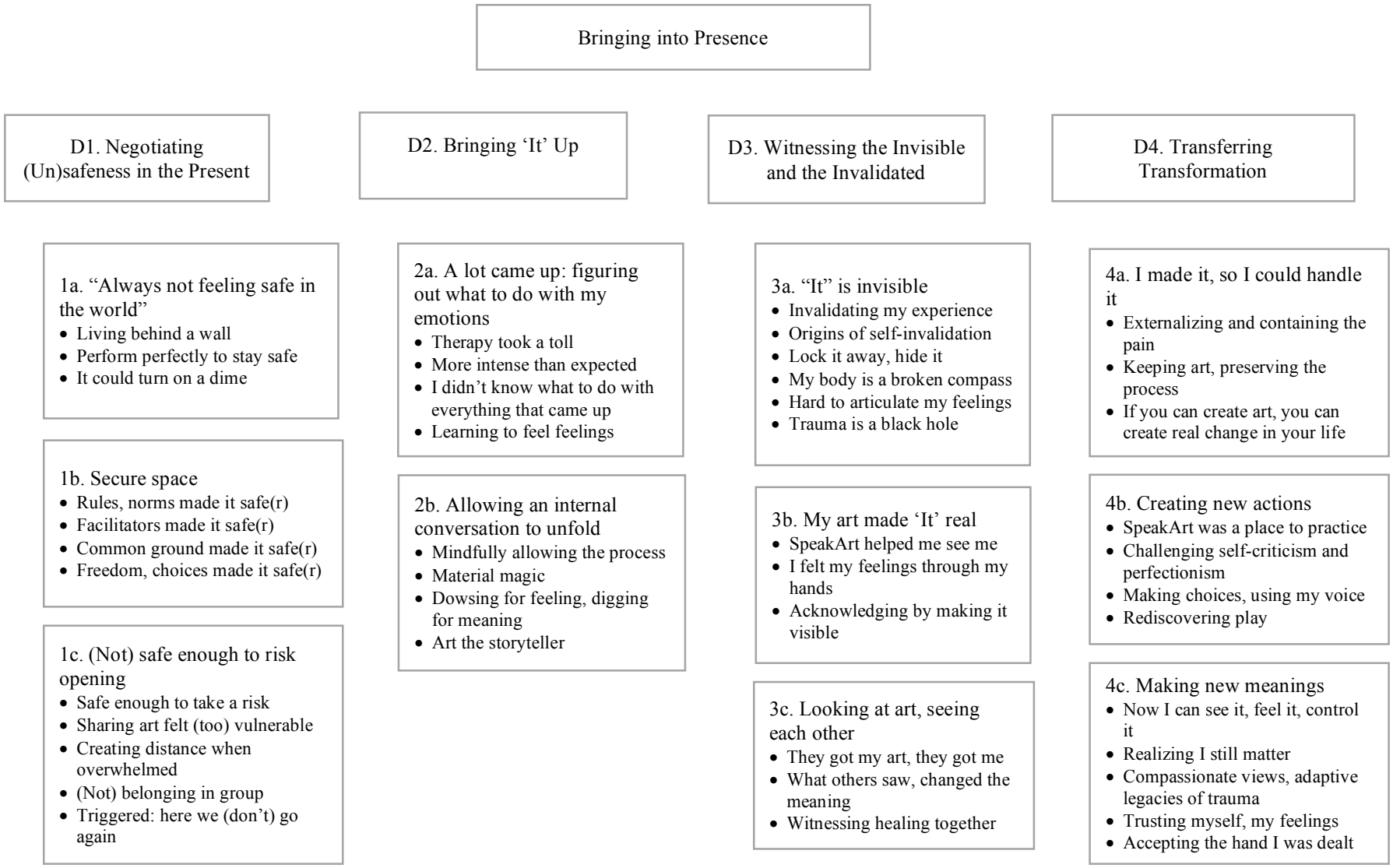
memories, and beliefs, that had previously been outside of their awareness, or were otherwise unavailable, unacknowledged, or actively avoided. The third domain, Witnessing the Invisible and the Invalidated, captures the intrapersonal and interpersonal consequences of rendering internal experience visible and tangible through art. These included heightened self-understanding and validation of the experience of trauma and its impact. The fourth domain, Transferring Transformation, includes various ways in which participants used art materials, art-making processes, and the group environment, to manifest new, adaptive ways of responding and acting in the world, and the re-conceptualized views of self and trauma that resulted from these and other new experiences in SA. The core category is presented first, followed by each domain of experience, its categories, and subcategories. Figure 1 illustrates the four-tiered hierarchy.

Core Category. Bringing into Presence

The core category, Bringing into Presence, refers to a central, multilayered process that ran through participant experiences of negotiating safeness and risk, entering into dialogue with their emotions, such that (previously) invisible and invalidated parts of their emotional experience could be witnessed, and creating transformation through the externalized, concrete, and dynamic loci of art materials and group interaction. The through-line (core) concept, *Bringing into Presence*, refers to the way that making art in a group setting *mediated contact with* emotionally-charged experiences, so that they were available to be witnessed and transformed. Traumatic experiences entail destruction. Something fundamental to healthy existence was threatened, altered, taken away, harmed. Something happened, that was too overwhelming to make sense of, and so the destruction persists as absence: dis-associated, unprocessed emotions, often experienced as chaos or a numb blankness. Participants' narratives of what happened in SA and how it helped, included a recurrent thread of something-becoming-

Figure 1.

Model of group art therapy for complex trauma



real. Making art in a group therapy setting gave shape, substance to the "vacuum" of invalidated or dis-associated trauma experiences, i.e., participants actually felt emotions for the first time with the help of evocative prompts and externalized, material, visual art-form. Making art in a group setting also involved substantiating change—having materials to manipulate, a social microcosm or practice field to take action in—so that new and more adaptive possibilities, could be made real.

In this trauma context, the concept *Bringing into Presence* thus refers not only to mediated contact. It also includes mediated integration and mediated creation: making art in a group setting helps correct dis-association, fosters integration, by providing a means to make contact, witness, and transform emotional experience. Making contact, witnessing, and transforming allude to Domains 2, 3, and 4 of the model, respectively. Domain 1 contributes to *Bringing into Presence* the concept that participants required a sense of safety to open up to what was happening in the moment and attend to their unfolding experience in the group.

Domain 1. Negotiating (Un)safeness in the Present

Safety was a theme that pervaded participant narratives, and always, directly or indirectly, referred to relational/interpersonal safety. The concept of *safeness* refers to participants' perception and felt sense of being more or less safe in the group environment. "Safeness", as opposed to the term "safety," points to the subjective nature of feeling safe, an experience that included belonging, and the absence of criticism, rejection, judgment, or other relational harm. Safeness (and by definition, its opposite—unsafeness) was shifting and uncertain; a clear connection to external conditions, such as the presence or absence of observable threat, was not a given. *Negotiating (Un)safeness in the Present* includes three categories. Participants brought to SA longstanding experiences of lacking safeness, *Always Not*

Feeling Safe in the World, in their daily lives and relationships. From that status-quo (un)safeness, participants described specific properties of the group's structure and operations, that forged a *Secure Space* and made them feel safer in the room. Participants also described how safeness impacted how they engaged in art-making, art sharing, and relating to others, specifically, the extent to which they risked opening up to present-moment intrapersonal and interpersonal experiences, *(Not) Safe Enough to Risk Opening*.

Category 1a. "Always Not Feeling Safe in the World"

Participants described a generalized, pervasive, status-quo experience of feeling vulnerable and lacking safeness (felt safety) in their relationships and daily lives. Within their narratives, references to pervasive unsafeness, and related behaviours, typically contextualized the significance of feeling safe in SA, or of difficulty finding safeness in SA.

Living behind a wall. For most (8/10) participants, always feeling not-safe meant a pattern of living in isolation and attempted self-protection. Having rigid barriers, i.e., not letting anyone in, having few relationships, and mistrust of others, was typically linked to a sense of loss or missed opportunity to engage with the world. For example, Gabrielle described "Hiding ....Trying to be safe. Like it's comforting and kind of sad at the same time. [crying]. Because I'm safe, but I'm also in a bubble. So I'm not experiencing all of the wonderfulness and colour and splendour of the world." Dee was aware of how living behind a wall had implications for her experience of the group environment in SA. She reflected,

> I have a lot of boundaries and I don't step outside of them and I'm quite convinced that my boundaries are well earned and that in most cases they- they serve me very well. So, […] I'm much better one-on-one and that's, it's always like, I just don't know if that's ever gonna change.

For Nicole, Pat, Rose, and Magda, the wall entailed presenting a façade to convince others that they were happy, successful, and healthy, which minimized the risk of judgment or invalidation

of pain. Zahra maintained this front out of the belief that other people "wouldn't be able to handle it if I was real with them." Finally, the experience of living behind a wall included what Brenda called "living behind a plexiglass screen," a sense of being separate from others, unable to relate or connect, because of fundamental differences in life experience, related to trauma, that were invisible and incomprehensible to "everyone else" (Zahra), i.e., those without a trauma history.

Perform perfectly, to stay safe. For six participants, never feeling safe in the world included pervasive fear of making a mistake. This was described as a longstanding need to perform, be perfect, and avoid mistakes, and a preference for clear rules and expectations, as a way to avoid negative attention, i.e., rejection, criticism, punishment, and resulting shame. The following excerpt illustrates these properties:

> My whole adult life has been very structured, and structure is comfortable and familiar. I have an inkling, this vague feeling, that left to my own devices I will end up doing something wrong, offending someone, being inadvertently bad, and that's something I've carried my whole life. So if I know the rules, and I know exactly how to behave and what to do, I can do it. And then I can feel calmer and happy and be perfect. (Nicole)

Typically, participants described a need to be perfect and perform well, as context for their fear of making a mistake in SA and associated discomfort with the freedom presented by art-making.

It could turn on a dime. Six participants also described living with persistent sensitivity to signs of conflict or threat, mistrust of objective signs of safety, and always feeling slightly uncomfortable and on-edge. As Pat said, "It's hard to be in the world not feeling safe. And *knowing* you're safe at the same time, mentally knowing it, but your body saying, you're not safe!" Explained as a longstanding way of being in the world, it was also part of several participants' experience of the group. They reported vague discomfort in response to perceived

tension between other group members, being hyper-aware of others' movements, mood, and actions in the room. For example:

> There was one lady that was very triggering, made me very….uneasy, to even physically be in the space with. Especially her like level of negativity and anger and stuff, made me very uncomfortable. But, I just pick up other people's energies more than maybe others do. (Magda)

In addition, participants described heightened readiness for the "manufactured safety" (Nicole) in the group to abruptly fail, and become unsafe. As Dee reflected,

> The environment was safe, [group members and facilitators] definitely set the tone beginning every session, there was a lot of discussion about non-judgement and that sort of thing. So it definitely wasn't, like, the environment wasn't hostile, but for myself it's like, I have in my head that it can turn hostile on a dime. So. I wasn't comfortable.

This subcategory underlines the distinction between safety (the objective absence of threat), and participants subjective experience of safety, that is, wavering between safeness and unsafeness.

Category 1b. Secure Space

Participants attributed safeness to specific characteristics of the group structure, membership, and culture, and associated diminished threat of being judged, criticized, excluded, pressured, or harmed in some other way. Safeness was perceived as a function of four features of the group environment, each comprising a subcategory defined below: the program's trauma focus and a sense of having common ground with others; lack of pressure to change or perform; provision of choices, freedom, and autonomy; and a clear structural framework for the group, consisting of rules, norms, and procedural consistency, that aimed to protect group members from expressions of criticism or judgment, or being triggered by trauma details; and the presence of facilitators to uphold and model norms, and provide emotional support.

Rules and Norms Made it Safe(r). All participants highlighted the importance of clear, consistent group rules, procedures, and norms that promoted fairness and safety. Rules, norms,

and procedures discouraged judgment and criticism (of self, others) and encouraged a specific way to share art and give feedback on others' art: no interpreting; no trauma details; stay focused on how the art makes you feel as the observer. Their presence was perceived as promoting a safer group environment in two ways: preventing interpersonal harm, and creating a buffer around the emotionally intense or distressing material that group members were expressing through their art.

Participants often conveyed the importance of rules and norms through stories of exceptional incidents when they thought a group member had stretched or violated the rules. Sometimes this led to an experience of emotional overwhelm, for example:

> Talking about [art] wasn't too raw, it felt removed because of the guidelines. Which were a good thing, because I don't think I could deal with everybody just...spilling. Like there was one person who maybe went too far, and talked details about a common trigger that I shared with her, which put me into a tailspin. So you absolutely need it in a group like that. (Rose)

Sometimes, the occurrence of rule-bending or a norms-violation itself, rather than the trauma details or interpretive feedback or perceived judgmental comment, seemed to be the cause of discomfort. When Felicia perceived others not respecting the feedback guidelines, or talking for a long time, she recalled thinking, "Oh, so is this how it's going to be?" She then asked facilitators to remind people of the guidelines, "Because that's not what was happening the first three weeks that I was there. It was just, show your art, and you're giving invitation to people to make it all about them." In other words, perceiving that a rule/norm had been violated, caused distress—in Felicia's case, a sense of unfairness. Dee, meanwhile, felt heightened anxiety about impending harm (judgment, criticism) when group members stretched the rules. She recalled,

> One of the things I had an issue with, is that, uh, they encouraged people to look at someone else's piece and speak about what they see and how it makes them feel. To not interpret the art. And it didn't happen all the time, and [facilitator] would always rein it back in, but I felt it would impede my participation because, um, people start moving out

> of 'I' statements and start saying 'you' which is very confrontational, and it really riles me and gets my guard up. And then I just wanna shut down.

This suggests a link to the previous category, participants' pervasive sense that safeness *could turn on a dime*, and highlights both the importance of having safety-promoting framework, and participants' inherent lack of trust that the framework will hold.

Facilitators Made it Safe(r). Not only rules and guidelines, but the presence of a facilitator to explain and reinforce them, made the majority of participants (8/10) feel safer. For example, Magda attributed feeling "safer and no pressure" to:

> Knowing that I'm not going to be criticized, and that it's- it's ok not to be perfect. Because they explain the rules and, then seeing others share and not being judged or pushed to speak, and even seeing like, they do a little bit of protection or stepping in if somebody goes outside of the rules.

Participants reported finding the presence of facilitators reassuring in several ways. First, when guidelines were abandoned or limits got stretched, many participants found facilitators responsive, although there was one exception when Zahra thought "they should have intervened earlier." Second, knowing that the facilitators were "trauma experts" who "knew their stuff" (Brenda) helped some participants feel safer. This contrasted with prior experiences of feeling invalidated or misunderstood in treatment environments, which several participants had reported in their initial interviews. Facilitators modeled how to give feedback that is emotion-focused rather than interpretive, and "modeled and indoctrinated non-judgment" (Rose) throughout every part of the group. Finally, safeness was partially attributed to facilitators' warm, encouraging, and supportive presence.

Common Ground Made it Safe(r). Knowing that the group took place in the context of a trauma-focused treatment program, in a hospital for women, and that all group members shared a trauma history, made most (7/10) participants feel safer. In particular, it felt safer to be genuine

in the room because of the presumed common ground. Rose said that knowing everyone was in trauma therapy "really helped me kind of get over that vulnerability hump and the sharing hump," and Nicole said she felt "braver and more comfortable to expose myself" because of "the common experience that we all have of being from a place of trauma." Common ground also meant less likelihood of being judged or told to "get over it" (Brenda).

Safeness was also attributed to the physical environment of the hospital itself. Brenda and Dee contrasted it with unsafe, old, dirty, under-resourced settings of other publicly-funded programming that they had accessed. Furthermore, Brenda linked entering the hospital environment, to the safeness conferred by common gender and trauma history:

> Part of it is that I feel safe *here.* [R: what is it about *here*?] So this hospital was founded to specifically, um, address *women*'s health needs. So I felt coming in…well, women are the primary focus here, so I felt like automatically, my concerns and opinions or whatever, would be taken seriously, and listened to, because, here I was in this hospital. And then, the 7th floor is the trauma therapy program, so, in addition to all the professionals, even sitting out in the waiting room, um…it's, you know, I can sort of sit there and […] know that I'm in a room with people that, we have very similar experiences.

As illustrated by the above examples, this subcategory captures how SA's trauma focus, and its location in a women-centered environment, signaled 'this is a place for me; in a way that other spaces are not'; and that this signal promoted safeness.

Finally, the relationship between common ground and safeness, was underscored by participants' responses after a biological male joined the group. Of the four study participants who overlapped with him for at least one session, three (Felicia, Dee, Brenda) expressed surprise, resentment, and discomfort in response to his presence. They expressed concern and highlighted the value of a woman-only space for safety and connection. Felicia viewed his presence as an intrusion, and protested, "this work is too vulnerable to be done with a man in the room…can't we have this space?" In summary, the salience of these aspects of common ground,

as features that promoted safeness, suggests that participants' experience of being in the world, as women with trauma histories, is marked by repeated invalidation, exclusion, isolation, or experiences of not being taken seriously.

Freedom and Choices Made it Safe(r). The majority of participants (8/10) attributed safeness to having autonomy and a sense of freedom in the room, which included being given choices and the absence of expectations or pressure to change. First, participants highlighted the importance of being able to choose whether to follow the prompt or not, decide what to make, what materials to use and how to use them, where to work, whether or not to share their work, what to say about it, and whether or not to receive feedback. For example, Gabrielle felt self-conscious of her own "emotional rawness" which sometimes "made it hard to be in the room" because of fear of upsetting others or being judged. It helped that "we're given a prompt, but we are also free to ignore it. So I found that helpful, because it gave me a sense of freedom, like, not too much pressure to go there." While the choice to *not* follow an emotionally evocative prompt enhanced safeness for Gabrielle, the same choice helped Magda approach emotion. She reflected,

> There's total freedom, no judgment, no pressure to do the prompt, or to show your work or speak about it, um, and that whole setting was very different for me, I don't think I've ever experienced anything like that. It's interesting how much…it kind of opened…doors and possibilities, to, feeling all of what I call 'crap,' you know.

Freedom to move around also helped several people (Magda, Nicole, Felicia, Pat) feel safer, as illustrated by this excerpt:

> I liked being able to move wherever I wanted. I'd leave the table and create somewhere else, like go to the windows or by the sink [...] just isolate myself a bit. It felt…like no one else's anger or darkness or fear or, even worse, amazing artistic talent, was going to mess with what was coming up for me, with what I was doing […] with that freedom, it felt like a big open door. (Nicole)

These examples illustrate how autonomy and freedom enhanced a sense of safety: it seemed to grant participants control over what intrapersonal territory they explored and how far they went; as well as some control over interpersonal safety/boundary-setting, i.e., how much they opened to others, as well as their physical proximity to others. This freedom created an "open door," to borrow Magda and Nicole's phrasing, a sense of being able to safely approach and step into their emotional experience.

Finally, being in a *group* environment conferred freedom from certain interpersonal dynamics that made participants feel unsafe, like perceived pressure to perform or change. The following excerpt illustrates this concept:

> Initially, my fear was, I'm gonna start comparing my work to everyone, and judging myself. But it actually, surprisingly, was the opposite, because everyone had a different take on the prompt, so it allowed me that freedom and liberty to be like, I'm just here for me, to share my story, because everyone's doing that. And it was so diverse, like, anything goes. There was no right or wrong. And *so much* freedom. (Zahra)

Rose likewise highlighted how being around others, all creating together, helped her feel free to explore without worrying about being perfect. For Pat, this aspect of the *group* format of SA also meant an absence of the barriers she had experienced in individual therapy:

> It was the group. The group created the safe space I needed to do my work in my own way without having to perform. It's like, one-on-one therapy feels pretty intense. It's a lot of pressure on two people to to identify a problem and fix something. But here, it was up to each of us to use the space and materials however we needed, without any expectation to change. It felt like it was enough to just be in the room as I am, without any expectation of having to *do* anything, or learn anything, or fix anything.

In summary, participants described feeling safer to engage in art-making without "shutting down," to share their work, and be genuine in the room, because the group environment provided freedom to be and do, at their own pace and in their own way.

Together, the first two subcategories of *Secure Space* (*Rules and norms made it safe(r), Facilitator presence made it safe(r)*) entail supportive structure and limits. The concept of a

"framework" comes to mind—a structure (rules-norms) imposed (by facilitators) on the group, to keep it boundaried, to encourage a specific focus and certain actions, and keep other actions out. The framework is also constructed of a *Common ground* of shared experiences of trauma and a specialized institutional space, which provide presumed mutuality and understanding, that makes it easier or safer to be in the room. Finally, the framework creates space within which participants are granted *Freedom and choices*: the framework is spacious/flexible enough, to allow participants to make decisions and explore within it.

Altogether, there seems to be a balancing function of the framework/therapeutic space. It simultaneously: (1) buffered or distanced participants from the intensity of trauma material (no details!) or protected them from possible inter/intrapersonal harm (no judgment!); and (2) helped participants approach instead of avoid, i.e. to contact emotion and engage interpersonally via emotion-focused sharing of work and feedback. This suggests that safeness was fostered through the joint provision of a boundary-setting framework, and freedom to move and explore within those limits. It is as if the framework of rules and norms and limits, promised protection from intrapersonal and/or interpersonal harm, and the simultaneous provision of freedom and opportunity to make choices, without the weight of expectations, allowed participants to explore and approach emotionally-charged experience. Furthermore, the presence and indeed, necessity of facilitators to encourage/enforce the framework, and model exploration, and the presence of others with common trauma histories, enhanced the safeness in exploring and expressing oneself.

Category 1c. (Not) Safe Enough to Risk Opening

The preceding categories described participants' baseline experiences of feeling unsafe in the world and what this meant for SA, and the factors in SA that contributed to safeness by establishing a secure space conducive to exploration. This category is about the various

consequences of safeness, and unsafeness, for participant engagement in the various activities of art therapy (making art, showing and responding to art, relating to others). It begins to answer the question, 'what did safeness enable participants to *do*?' The first subcategory captures the concept of risk and comprises participant accounts of feeling safe enough to engage in aspects of SA that were threatening in some way. Then, four dimensional subcategories describe how participants variably responded to, and made sense of, specific types of events or aspects of SA that invited vulnerability or evoked anxiety. These include: (1) the vulnerability of sharing one's art and whether this was experienced as threatening or empowering; (2) how participants responded when old and problematic relational patterns began to unfold in the group; (3) how participants coped when they felt emotionally overwhelmed in group; and (4) belonging and not belonging in the group.

Safe Enough to Take a Risk. Many (6/10) participants reflected that specific meaningful, new, or helpful experiences in SA entailed feeling safe enough to take risks. Risks taken included trusting oneself, making decisions, exposing vulnerability to others, approaching or staying with painful emotions instead of avoiding them, expressing emotions, letting go of perfectionism, and giving feedback to others. This subcategory overlaps with others—across domains—that describe other meanings and aspects of those risks/actions. It is distinct, and contributes to this domain and the overall model, by capturing the concept of risk-taking. Taking a risk signifies simultaneous vulnerability (to loss, harm, danger) and the promise of some beneficial alternative. For example, Nicole—for whom art-making evoked intense fear of making a mistake—said "I was challenged to work honestly in an environment that felt less comfortable, less safe, and, I did it. It was a win." The remainder of her interview included

numerous examples and reflections on the "win," e.g., she learned that she can tolerate fear without running away, and can drop her façade without people attacking.

Another illustration of the nature of risk-taking in SA, comes from this excerpt of Kim reflecting on her baseline anxiety about giving feedback to others:

> I didn't feel any barriers once I was actually there, I guess because it was very welcoming, it was a very safe environment. And I would just be thinking so much about people's art, and, um, I was urged to do it even though I felt uncertain because, I just felt tremendously inspired and moved by everyone's artwork.

Kim feared making a feedback mistake; the combination of experiencing SA as safe environment, and intrinsic motivation (feeling inspired by art) meant it was safe enough for Kim to risk giving feedback, despite her uncertainty. This subcategory captures the concept that risk-taking in SA occurred when vulnerability was mitigated by sufficient safeness, and the promise of emotional or relational benefit.

Sharing Art Felt (too) Vulnerable. The prospect of sharing one's art with the group invited vulnerability, and evoked anxiety. While most (8/10) participants disclosed that they felt anxious and distressed about sharing significant pieces of art, they responded to that distress in two distinct ways: risking the vulnerability, or avoiding it. At one end of the dimension, for three participants, the sharing and speaking portions of group were experienced as threatening or emotionally overwhelming, as the following excerpt illustrates:

> I just didn't feel very safe doing it. I was really concerned about being able to control my emotions, and I didn't wanna cry [chuckles] you know what I mean? […] It was fine while I was creating my piece, but, um, when it came time to share, or even if somebody else got emotional or said something triggering, I'd have a hard time, like, not breaking into tears. So I'd be biting the inside of my cheek just trying to stay in control. (Dee)

Because it felt too vulnerable, too risky, some participants decided not to share their art with the group, only shared one or two pieces, and/or minimized giving feedback on others' art.

At the other end of the dimension, for five participants, sharing art in spite of the vulnerability felt brave and courageous, and participants reflected on the experience with pride. For example:

> A new phenomenon in this room, like this is brand new for me, and I thought it was fucking brave of me, is people seeing me. Because I've- I'm happy to present a façade, but when I do a piece like *this* and they see what's at the real- like, kinda depth of me, a part of me that I've kept safe, and they're bearing witness to it, that's terrifying…..But they haven't destroyed it, and they haven't hurt me or attacked. So, that's a big shift. (Nicole)

The decision to share art despite feeling ashamed of its content or afraid of others' responses, was often attributed to being able to just 'show' but not 'tell.' For example, Rose shared a self-portrait that depicted themes around pregnancy loss. She reflected, "that was really, really hard. […] I wanted to show it, but I didn't want to talk about it. Like I didn't want to say what it was. Like if you could get it, you get it." Rose felt safer because she did not have to say anything about the piece that she simultaneously found hard to share, and wanted to share. She was aware that people might perceive and understand its themes, the story that it told, which implies that some of her desire to share it had to do with being seen and understood—perhaps a desire to be seen and understood *only* by those who "could get it." This suggests there was some kind of emotional buffering effect of expressing through images and materials, and staying away from words. Furthermore, expressing visually or materially, without the explanatory power of verbal narrative, may also have been a way to communicate only with a specific audience, e.g., those with common ground.

This subcategory was strongly linked to categories, described more fully in Domains 3 and 4, that capture the rewards of sharing ones' work, including disconfirmed expectations that one would be judged, and new experiences of being understood and validated. It exists as a distinct subcategory *here*, in order to capture participants' perception that sharing artwork was

brave, courageous, which speaks to the concept of safeness, and feeling safe enough or motivated enough to do something vulnerable.

Creating Distance When Overwhelmed. This category captures the concept of pulling away or reducing contact with the source of distress, in response to feeling overwhelmed or unsafe. Participants' apparent intentions in pulling away, and the meaning they ascribed to it afterwards, formed a dimension. At one end, creating distance entailed all-or-nothing disengagement from an upsetting situation, or complete avoidance of emotional experience. At the other end, creating distance seemed to involve a responsive, flexible attempt to set limits or dilute the intensity of emotional experience, as a way to stay in the room and maintain participation.

Some participants (4/10) responded to SA by staying emotionally distant, shutting down at the first sign of threat, and consistently avoiding certain aspects of art-making. For example, Brenda described how she "always avoided" following the prompts, because they were "dark." Dee described "just letting others fill the time" during speak/share. She also initially "avoided" making "dark stuff" that explored the themes she wanted to, because of fear of judgment of that darkness; she resolved this by deciding, a priori, that she would never share her work. As described above, Gabrielle usually chose to "not go there" when prompts evoked significant emotion. Felicia said that she "chose not to share myself or open up to people because I didn't like the vibe in the room." She reflected, "I have to be honest and say that after the first three, four sessions, I was...I was not there. I was really like checked out a lot and couldn't wait to leave."

Avoiding, closing off, or "checking out" was attributed to feeling unsafe, either because emotions felt too intense, or there was some perceived relational threat. The narrative segments

when participants described these acts of disengagement were often brief or generalized, and usually conveyed disappointment or frustration at having been constrained by lack of safeness. For example, reflecting on what she would do differently if she returned to SA, Dee said:

> Being so guarded. I'd try and not clam up and shut it out, like when the speaking part was going on, it- it really was like, torture, I kept looking at the clock. So, I would just try and, open myself up a little bit more to that part of it. I didn't give it a fair chance, like I, I cut it off in my own mind and said this is not for me, I do not fit this, this doesn't fit me.

These instances were described with negative connotations, and often, participants had a disempowered, flat, hopeless tone—except Felicia, who is heavily represented in this category, and typically sounded angry or defensive when she described the reasons for her disengagement.

An alternative form of pulling away entailed intentionally and flexibly setting limits or titrating the intensity of emotional experience, to stay in the room and maintain participation when they felt overwhelmed or unsafe. Six participants described how they made a deliberate choice to adapt their behaviour in the room, in order to continue engaging in SA. Responses all had to do with decreasing emotional contact with or proximity to whatever they identified as the source of distress. For example, Pat made two changes when she became overwhelmed by external stressors during therapy: she reduced the emotional intensity of her engagement with prompts, and she paused participation in art-sharing and feedback. Pat reflected,

> When I hit that difficult point, I'd listen to the prompt, and kind of went more surfacey I guess, didn't look for where to dig as deep into the emotional stuff as I was before. And that art ended up being meaningful its own way. […] And, I stopped sharing and commenting, for a few weeks. Like I just pulled right back. And, uh… I think it was really good that I did that. It was like a safety move. And then at the end I kind of came back in a bit more.

Her appraisal of pulling back, as positive and adaptive, also illustrates the concept of titrating intensity to a safe and still-meaningful level, without completely shutting down participation.

For Dee, setting a limit in order to participate occurred when she shared art. First, Dee explained that she made a conscious decision not to share, because of her difficulty managing the emotional intensity of that half hour. This decision, as described above, was avoidant and disappointing for Dee, whose primary goal for SA was to connect more to people. Eventually, towards the end of therapy, she decided to share on two occasions. She recalled, "I shared because it was my last session. And I *even* took comments, which was—because the one other time that I shared I didn't take comments, I wasn't comfortable with comments [emphasis added]." The first time, sharing without inviting feedback made it manageable—and the second time around, feedback was manageable; Dee's phrasing conveys a sense of personal progress.

Moving away from, or visualizing a mental/energetic boundary between themselves and a group member whom they found triggering, also helped participants stay engaged. The following excerpt illustrates this action and the intention:

> I consciously put myself on the opposite end of the room from her, for me to be able to stay… but I was….I was kind of proud of myself, too, to be able to….isolate myself in a space. Like kind of block certain people out to be able to do what I came to do. (Magda)

This example also illustrates the pride and agentic tone that characterized the concept of flexibly setting limits or pulling back. The tone is a sharp contrast with the helpless or defensive tone that accompanied instances of avoiding and pulling away, above. Overall, this end of the dimensional subcategory suggests agency and responsive flexibility; finding solutions that were adaptive in the overall context of participating in a group. As a whole, this subcategory is closely related to *Freedom and choices made it safer,* which captures generalized reflections on the safeness-promoting experience of freedom and autonomy in SA. This subcategory captures the nuances of different ways in which participants exercised that autonomy, and what it meant for safely engaging in group.

(Not) Belonging in group. The *common ground* of gender and having a trauma history contributed to feeling safe(r) (as described above). A similar but distinct concept was the experience of belonging in the group. Like safeness, belonging seemed to stem from, but went beyond, the common ground of trauma experiences. Conversely, experiences of not-belonging were attributed to other individual differences that intersected with or negated the common ground of trauma. Belonging went beyond the safeness created by common ground, in that it involved relational connection, the experience of feeling understood and understanding others, furnished by a perceived shared history of traumatic experiences or post-traumatic sequelae. In this way, safeness from the abstract knowledge that everyone in the group had common ground, may have allowed/been a precondition for the felt experience of belonging.

Belonging was significant as a novel alternative to status-quo experiences of feeling isolated, lonely, or separate from the world, as Nicole expressed:

> Knowing you've found someone in the world, who's been through-- it's like, we have the same battle wounds, the same scars. And that makes me feel less alone, like I found my people, we're a fucked up tribe, but we come from the same place, the same things happened to you that happened to me, maybe not precisely, but, I get you and you get me because no one else, who hasn't been through what we've been through, would get it.

Nicole's excerpt also illustrates how belonging entailed connection and understanding based on common history—in fact, Nicole suggests it can *only* come through common history—rather than, say, empathic validation by someone without a trauma history. The concept that belonging seemed to unfold through this kind of mutuality, or validation and understanding through shared experience, is further illustrated by the following excerpt:

> It feels *real* to be here. Like, in a safe space with people who have gone through the same thing, and we're all sharing similar struggles. When you're out there in the world, no one knows […] my history. So this space, it allowed me to….be. Like, for all of us, there were some days where someone didn't create art because they would break down. Like they were depressed that day or having an anxiety attack or suffering through PTSD. We can't openly express that out in the real world because then we would have to tell our

> story which like, you- can't. Like, do I even want to share it? Am I gonna get the right response? Can you handle my past, there's so much, so probably no. But here it's like, everyone understood, we didn't even need to tell the story. And so on those days there was a shared, kind of- Yeah. Just like, a nod and, okay, we get it. (Zahra)

Note Zahra's (presumptive) use of the collective pronoun, which underscores the centrality of shared experience to the concept of belonging. The above excerpt illustrates another property of belonging, i.e., that it involves (or allows for?) genuineness. Belonging meant she was able to be "real" in the group, was acceptable as her genuine self.

The concept of belonging included three other properties. First, feeling surprised to recognize oneself in others' stories or artworks. Second, feeling the comfort of being less-alone with the challenges of living with trauma-related emotional distress and reactions. Finally, as illustrated by Kim, belonging sometimes included a sense of connecting to a healing journey that others have been on. Reflecting on her entire collection of artwork from SA, which she had displayed during the interview, she said "I feel like I come from, like, a long line of…. of people, doing their healing work. Or tribe. I feel like I found my tribe." This last property is strongly linked to the concept of witnessing, which will be described in Domain 3.

This subcategory is titled '(Not) belonging in SA,' because it was dimensional. Although the common ground of trauma history and gender was perceived as a factor that contributed to feeling safe in the room, three participants—who were all represented in the *common ground* subcategory—felt that they did not belong in the group. They felt isolated and found it difficult to connect to others. Descriptions of not-belonging in SA included references to longstanding experiences of not-belonging in other settings, and associated expectations that one would not be understood or accepted by others in the group. Stories about not-belonging often included a participant's decision to isolate and avoid risking connection, but lacked descriptions of actually being rejected or excluded. This suggests that participants' beliefs that they would not be

understood, or could not connect, may have sometimes functioned as self-fulfilling prophesies, rather than expectations that got confirmed by specific experiences in the room.

The three participants who reported not-belonging attributed it to personal characteristics and socioeconomic differences. For example, Gabrielle felt that SA confirmed something strange and isolating about her. She said,

> I feel like a bit of an oddball. And that kind of came out in my work. Like I felt kind of misunderstood sometimes […] like a few pieces, when I put it up to show, just the look on people's faces, I kind of felt like people were confused by…..…… [R: what was that like?] Good and bad. Like validating and also kind of segregating. Like confirmation [laughter] that nobody gets me […] but it felt a little bit distancing.

Although she did not make this link during her post-therapy interview, in her initial interview, Gabrielle spoke at length about her struggle to effectively express herself, and explained that she thought it indicated she was "on the [autism] spectrum." This confers a different level of meaning to her use of the word "oddball" here, and illustrates how not-belonging may have been a function of perceived sociodemographic or individual differences—in this case, not identifying as neurotypical.

Dee, meanwhile, felt that she lacked the ability to tolerate the emotional intimacy required to connect with other women. She cited a lack of gendered socialization to "warm fuzzies and kumbaya," and explained that because her abusers were girls and women, she had grown up preferring male company. She explained,

> The separateness, that would come out when we were doing the speaking part, um, I'm not really used to, you know I'm more like a man in that, you know, it's not that I don't have emotions, right, it's just that, um….I'm uncomfortable with other people showing their emotion and with myself showing them. So, um, it was difficult to be in that environment for me.

Dee was pained by this barrier; she felt different and isolated in SA because of it, and also found the sharing portion of group unbearably intense and overwhelming.

Finally, Felicia felt separate from the other group members, because of the way that race and poverty intersected with her experiences of trauma and recovery. Not-belonging, and not being given sufficient opportunity to use her voice in over-privileged/White therapy spaces, was a dominant part of Felicia's narrative throughout all of our interactions (two recruiting conversations, initial interview, and post-therapy interview). Whereas most other participants found enough safety in the common ground of trauma to experience connection and belonging, Felicia began and ended SA with the belief that no one in group would be able to understand or validate her experience, because of the ways in which poverty and race shaped the meaning of trauma and her recovery journey. She said,

> [...] trying to claim my space, in a room with people who have had generational security, and don't really understand the impact of having to be in survival mode while you're working on your trauma, because that's always what slips *me* back. When I feel like I'm doing well, when you don't have food or, the area where I live is very dangerous, like someone gets murdered or assaulted in my building, the police, the sirens, you know? And I'm trying to get out of this. So...it's like I'm having compassion for them, but do they have compassion for what it's like to be me? To be people like me? Well…I don't think so [laughs]. To me they seem like they're just in their own world. […] And when they're speaking about other people's art, and they are saying, oh it looks like, you know post-expressionism, and this and this and this, and they're allowed to go on this tangent, which is really ...sounding very pretentious to me...and it takes away from the feelings. […] And then I'm like, nah that's not my style. If it's going that direction I'd rather not say anything. Like just be there, but check out. So in these 12 weeks I'm coming to this idea that, like, this mental health thing really is for people who are…You know? This is not for people like me.

The end of the above excerpt also illustrates how she did not feel safe enough to test this expectation through SA, and instead chose to disengage and isolate in group—as will be further detailed in the next subcategory.

There was something (someone) in between the poles of belonging and not-belonging. Brenda is the only participant represented there; her experience nonetheless feels important to include, because it adds to the relationship among and distinction between the concepts of

safeness, common ground, and belonging. Brenda described how "just" being in the company of others while sharing an activity improved her mood. The pleasure she took in shared activity was contextualized by a status-quo of isolation and loneliness. She attributed being able to enjoy making art in the company of others, to feeling safe in the room. This excerpt exemplifies her (numerous) descriptions of how it felt good to make art with others:

> It's just nice to get together with other people and do something, particularly if you're isolated. It was just nice to, um, sit and do that and feel *safe*. Because I- I don't know, I don't feel very safe around others very often. So any opportunity to feel safe, um, and part of a larger group, doing something that is, um, not anti-social, like it- you know, like just being there, doing my own thing, observing, um….participating, if I choose to or not.

Notably, her accounts of enjoying shared activity did not include specific descriptions of connecting with, relating to, or even interacting with others. Rather, the enjoyment had more to do with being in the physical presence of others while everyone was "doing their own thing," a relief from being alone at home. It is possible that the shared activity even alleviated the challenge of interacting with others—Brenda had elsewhere described her difficulty listening to others without judgment, and forming relationships—which helped her feel better. Brenda's descriptions called to mind the concept of "parallel play" from developmental psychology, i.e., the way that young children first learn to play alongside each other, without playing together.

"Triggered": Here We (don't) Go Again. Seven participants described specific interactions in group that followed familiar and distressing or maladaptive old relational or social-systemic patterns. In some instances, participants explicitly made this link in their interview; other instances in this subcategory entailed participant descriptions of interactions in group, that echoed—to my ears, as interviewer and then analyst—relational problems or relational traumas that a participant had described during her initial interview. This subcategory captures *how* participants described responding to these problematic interactions: either in a new

way, i.e., out of the pattern; or they felt stuck in the pattern, and believed that what unfolded limited their engagement in group or left them feeling unsafe. There is considerable overlap between this subcategory and the ones presented above, particularly involving the *vulnerability of sharing* and *belonging* concepts. What sets it apart is the meanings participants ascribed to how they responded, when old beliefs or relational patterns were triggered by an event in SA.

Four participants described times when they felt "triggered," or noticed the beginning of old relational patterns start to unfold, and then they responded in a way that interrupted the pattern or led to some new outcome. Participants explicitly identified how their response in SA was new or different, and often reflected on how it had felt helpful or surprising, or signalled progress. The following excerpt illustrates how Magda was aware of, but did not act on, the urge to run away that was triggered when she visibly expressed intense emotion in group:

> Especially to do it in front of people, that took a lot…to actually stay, not walk out of the class, not leave...and I wanted to! And to come back the following week? That took a lotta guts. A lot of strength [laughing]. Like, this is not what we do, we don't...*show* emotion, and [laughing] especially negative ones. So uh, it took a lot to, to stay... And to come back. [R: what were you afraid of?].....I guess the regular judgment, like, you shouldn't feel that, or um....the, the big one is, you're not perfect.

This excerpt illustrates Magda's simultaneous awareness of the triggered beliefs about expressing emotions, shame, and an urge to run, and her pride at having stayed in group.

Sometimes the triggering event was more overtly interpersonal. For example, Nicole felt triggered when another group member complained, at the beginning of one session, about the type of feedback that people were giving. Nicole explained:

> I *don't* think I was doing what she was talking about, but in my head, I of course blamed myself. I personalized it in the moment, but what it did was it prompted this- this- response in me. Like instead of just, like, panicked and 'I did something wrong,' and like, swallowing it. [R: what was your response?] 'Fuck this, and fuck you, and don't you dare single me out.' [R: so…anger?] Yeah I guess that's the word, anger [both laugh]. And defiance. So…it's the most meaningful thing I made, and I'm pretty proud of it. I'm pretty proud of how I was able to [express] the real message.

Nicole went on to tell the story of that piece of art, in which she expressed, for the first time, that she had been bullied (note that a fuller description of this piece is revisited later, in an excerpt that illustrates the subcategory, *Acknowledging what happened by making it visible*.) In the excerpt above, Nicole highlighted her simultaneous experience of being triggered—she personalized it—and awareness of the patterned response that *did not* unfold, namely, blaming and silencing herself. Furthermore, she was proud of herself for her alternative and novel response: she defiantly (and without attacking anyone) gave voice to the earlier traumatic experience, of being bullied, that had been triggered by the group member's complaint.

Other types of new responses included: asserting one's need to share work despite fear of taking up too much space and the related urge to make herself small; asking facilitators to reinforce group norms instead of "policing" and criticizing group members; and putting one's therapy goals ahead of fear, by staying in the room instead of leaving to escape the "negative energy" of another group member. All of these experiences shared the elements of noticing a pull to react in one (old) way, and then responding in a different way instead, that felt empowering or adaptive.

Conversely, some participants (4/10) experienced the recurrence of familiar old relational patterns, and responded in a way that seemed to feed beliefs about being excluded, isolated, disempowered, or lacking options. Participants tended to make generalized statements (vs. descriptions of specific incidents) about the way that SA, or people in the group, elicited or perpetuated a problematic, status-quo interpersonal pattern, and related beliefs about self, other, or relationship. For example, Felicia's interview was dominated by a generalized, recurrent complaint about people in the group, exemplified by the following excerpt:

> What I was experiencing a lot is an imbalance of who gets *time*. You know? And it re-plays a lot of uh, your trauma, like […] is there space for you to speak up, is there room, other people are more domineering, other people will hijack your time, you know, am I safe to speak out and to express myself […], that is what I'm feeling, it brings that up for me. Like a replay of elementary school. I wasn't prepared for school, for society, based on my home life. It was always, being afraid to speak, people not understanding, and it kinda replayed itself, in the group. So there's times where I'm like, why am I coming here? Other people are more demanding, and take time, take space, and they're allowed. And I think what irritated me the most, was that…although we all have suffered trauma and [facilitator] said, be respectful of other people's gender, their race, and, the whole list of things to consider about people's differences, um, but it's not really enforced, by the people who facilitate it. Like if someone *is* taking up space and hijacking it.

Felicia felt threatened, unsafe, when old relational themes—not having a voice, others dominating, and authority figures failing to intervene—unfolded in group, when she observed other group members speaking at length and with apparent freedom. As was described above (*not belonging*), this theme had significant racialized meaning for Felicia, which intersected with her trauma-related experiences of not feeling safe to use her voice, in earlier social contexts. Of course, as was illustrated above, Felicia explained that she did not assert her desire to take up her fair share of "airtime" because "I didn't like the vibe in the room," which underscores how this particular trauma- and systemically-rooted pattern won out: Felicia's art remained largely unshared; she did not feel safe enough to meet her (initial interview) goal of practicing using her voice.

Another participant felt that (ending) SA reconfirmed her experience of always being abandoned, all her relationships ending on others' terms. During the interview, Brenda explained the "revenge fantasy drawing" she made—which featured adults who had hurt her, during childhood—and the intense anger she felt, during her final session:

> Now, *with the clarity of hindsight*, I wonder if I was actually sort of feeling, um...angry, like feeling abandoned yet again. The way it sort of relates to what happened to me, um, some stuff in childhood […] So the ending of my participation in this.....it's like, here I am being dumped again, okay time to go away now [...] So I was sort of lashing out, angry at the program and everyone that ever hurt me or abandoned me. And *when I think*

> *about it now, I think it had… always been in the back of my mind*, like for 3 months, knowing this was ending [emphases added].

The relevant thread in this excerpt, is *not* that Brenda felt upset about ending. Rather, prior to the reflective hindsight afforded by the post-therapy interview, she lacked awareness that her anger and hurt was about ending, and lacked awareness that she had been dreading the ending, all along. This suggests that the recurrent relational theme—relationships end, I get abandoned, and have no say—flavoured Brenda's entire experience of SA (not just the final session), but from the background, where she could not understand, process, or interrupt it.

Gabrielle worried that her own emotional distress had a negative impact on others, and in consequence, held herself back from participating as much as she wanted to:

> I'd be in the group, and be like really raw, so that would make it challenging…like just, for my own self-consciousness of my own state. And how like, me being weepy or having emotions close to the surface could affect everybody else. […] Like I worry about affecting other people with my own stuff on days I was overwhelmed by something [R: so what would you do on those days?] I'd try to hunker down, suppress my tears [laughs].

Finally, Dee, Felicia, and Gabrielle also reflected that SA perpetuated a status-quo belief that they are not able to connect to others or don't belong. The concept of not-belonging was elaborated above; where the same passages of text are represented in this subcategory, it is because they exhibit a specific emotional quality or meaning participants made of that experience, i.e. that SA confirmed that belief; and that the belief itself may have hindered engagement in the group in a way that made it a self-fulfilling prophecy, perpetuating a feeling of hopelessness or frustration that one is damaged beyond repair or that support is inaccessible.

This subcategory is about the concept of being triggered into a maladaptive patterned response to relational threat, or feeling safe enough to recognize the trigger for what it is, but not respond as if one is threatened. Instances of the latter were described with a quality of feeling

empowered, relieved, or surprised by one's response. In contrast, instances where the pattern played out, had a "here we go again" quality. This was conveyed because many of the segments of narrative that make up this category consisted of over-generalized statements rather than specific stories, which strongly suggested that those participants had seen their experience in SA through the lens of same-old-story beliefs and expectations, which may have kept them from being open to, present with, and able to respond to experience in the room as it unfolded.

Domain 2. Bringing 'It' Up

During SA, participants had heightened contact with intense or painful emotions and related thoughts, memories, and beliefs. This content was often referred to as "it," or occasionally, "stuff", e.g., "that prompt brought up a lot of stuff" or "SA helped me feel all of it for the first time." Sometimes, participants made it clear that "It" (capitalized, from this point forwards) was directly trauma-related; regardless, It was aversive, and included feelings, sensations, thoughts, memories, and action urges that had previously been experienced at dimmer intensity, were outside of awareness, or had otherwise been invalidated or dis-owned (note that a category of Domain 3, 'It is invisible,' further describes the latter two phenomena). *Bringing 'It' Up* is the domain having to do with (1) what it was like for participants to make contact, in SA, with aversive, emotionally-charged, sometimes trauma-related internal experience (*A Lot Came Up*), and (2) the particular way of engaging, a mode of being and doing as they made art, that evoked and fostered productive engagement with It (*Allowing an Internal Conversation to Unfold*).

Category 2a. A Lot Came Up: Figuring out what to "do" with my Emotions

A Lot Came Up captures participant experiences of feeling more emotions in SA and learning how to cope with, regulate, and engage with what they felt. Participants felt blindsided

and overwhelmed by the intensity of the group, and many reported feeling drained, or more distressed, because of therapy. The emotions and related thoughts, meanings, memories, sensations, and urges that they felt while making art were described as coming up or out, as if from depths, or compartments, from unawareness into awareness. Furthermore, the emergent emotional experience was ascribed physical properties, such as weight, force, pressure, or the tendency to accumulate. Accordingly, many participants felt a distressing need to "do something" with the accumulating and uncomfortable "stuff," but at the same time did not know what to do with it. For many, this contributed to their experience of therapy taking a toll, especially in early weeks. Finally, this category includes reports of learning what to do: to simply allow, tolerate, reflect on, and express what they felt.

Therapy Takes a Toll. This subcategory pertains to capacity to tolerate distress, process emotions, and cope with stress. Doing SA interacted with life demands, and impacted participants' sense of being able to cope with and manage their lives. This suggests the concept of a *cost* of feeling emotional pain and managing external stressors and demands, and that participants had a certain capacity or quantity of resources to furnish that cost. Especially at the outset of the program, most participants (8/10) experienced SA as a drain rather than resource.

Seven participants reported feeling drained by SA, or heightened distress and worsening of symptoms, particularly anxiety, during SA, that they attributed to the emotions brought up in the group. Many felt out of control and unsure of whether they could cope. An added layer of distress came from how participants made sense of this, i.e., bewilderment that something purportedly helpful (therapy) was adding to distress. Nicole illustrated several of these properties when she described how she felt about her first few sessions:

> Everything in my life was already undone. And then in SpeakArt, there was this *undoing* happening. And it was unsettling and frightening and frustrating and I felt angry

> sometimes […] like, are you kidding me universe? This- this is therapy, it's *art therapy*, and here I am…feeling…worse than when I walked in the door. It sucked.

For five participants, SA coincided with acute or ongoing external stressors, in a way that magnified or intensified overall distress and reduced their capacity to cope with either. Pat explained,

> Right after I started group, the van attack happened [crying]. I started having regular panic attacks, every time I left the house, just being triggered. And I had just started this therapy, was really digging deep, so I was already not feeling safe, being me in the world. And then, this incident happens and reminds me that… nobody's safe, anywhere. So dealing with that, the anxiety, we had to try medication, the medications caused problems, problems are just like spiraling […] I persevered, but I thought about stopping because I didn't think I had the support that I needed to keep going.

On the other hand, coming to SA was a relief from external (chronic or acute) stressors, a helpful resource that assisted coping. Brenda described coming to SA as "respite" from caring for her elderly mother and "thinking about everything that was bothering me." Note that she was the only participant who said she regularly ignored the prompts; her narrative conveyed that she made art for pleasure (vs. self-exploration), and came to group to counter isolation. Rose also perceived her weekly SA session as a support or resource, however unlike Brenda she described regularly working on painful emotional material through her art; in fact this is what made SA a resource. She explained, "A lot happened in my life the last 3 months. I'm stable enough with trauma stuff now, but the rest, it was bumpy. But I had this, to come and just…be and feel and get things out, which was good." Together, Pat, Brenda, and Rose's examples illustrate the concept that therapy is productive when it begins from a point of relative stability or capacity; Rose felt "stable" enough to feel and get things out in therapy, whereas Brenda's perception of group as a respite or escape suggests limited capacity for painful internal exploration. For Pat, acute external stressors and the emotional labour she was doing in therapy, exceeded her capacity until she eased off the intensity of her internal exploration in SA.

Similarly, SA was often equated with work. In response to feeling depleted or fatigued by SA (and, in some cases, external stressors), three participants described the importance of taking breaks and replenishing between sessions. There was a rhythm of depleting and refilling, or of undoing and putting oneself back together, from one week to the next; a counterbalancing of work and intensity, with rest and recovery. For example, Magda reflected, "I had to learn to give myself time to...chill, relax after sessions, because it's very draining. People think it's just an appointment, just showing up, but- it's exhausting. It's a lot of work that you don't realize is happening." Conceptually, this is similar to concepts of anabolism and catabolism in exercise physiology; the period of rest and rebuilding, after stress, that allows for growth.

More Intense than Expected. Feeling painful emotions and related internal experience in SA, was more intense than most (8/10) participants expected. The unexpected emotional intensity of SA had a quality of happening *to* these participants, in an uninvited and uncomfortable way; it blindsided them. For example, Pat recalled,

> I went in there with my clear intention to play and explore the materials and have fun and, I don't think I anticipated the weight of it, the importance of the stuff it would bring up and the stuff I would be forced to deal with. I, I didn't really prepare myself for that.

Some (4/10) felt unprepared for the depth and intensity of the group. Nicole reflected, "I was not ready for it, I just thought I would just learn how to…make art." Gabby thought that "Going into it, I didn't think art therapy would be so challenging." Their surprise at the intensity belies an underlying expectation that SA would be pleasurable, light, perhaps more about the art and less about the feelings that art-making evoked.

Part of the shock or surprise was attributed, by participants, to how well they had compartmentalized or avoided the experiences that SA brought them into contact with. Nicole, who initially felt "undone" by SA's emotional intensity, said:

> I think the shock had to do with my own adaptive techniques, I had minimized the impact of trauma. So when these significant things came up from the prompts, I was just taken aback, and I was just shocked and surprised and then particularly, when I started having *memories* … I found that very unsettling. Memories and sensations from when I was a *child*. I guess the smells or the feelings of the materials, the chalk and the paint, all of these things were just [whooshing sound] like some were insignificant memories, but they came back, and I have had zero access to my childhood, for my entire adult life.

Furthermore, for most (7/10) participants, intense and unexpected emotions were evoked by a prompt that initially seemed innocuous but, once the participant engaged with it, led to big, sudden, or even shocking emotional responses or memories. Magda reflected, "Small as the prompts are, they don't seem that triggering. But once the process begins...it brings a lot of different feelings. They evoked big feelings even though they were small. Very big emotions."

Unexpected intense emotions were also evoked through exposure to other people's art. Participants resonated with themes in others' art that reminded them of their own trauma. Kim described this happening to her,

> There were three faces, on three pieces of, 8 by 11 and pastel and … it was drawn over so you couldn't really see the faces […] I just felt, all of a sudden--I saw tremendous crying and sadness in the faces and I felt part of the story. That really triggered me. It caught me by surprise. Um...because the pictures were…all of the crayon and the pastel, were like these attacks, and there was no sense of- it looked like clowns, but they were not smiling. Like mad and just, emotionless, like, the spirit was gone […] And [group member] was across from me. So, it was right in front of me when they showed it. And I guess I just felt, because I had been bullied and, it caught […] a hotspot where- it struck me, all of a sudden, it struck me mid-sentence, where I- I began to, um, I began to cry. And then it was difficult for me to talk.

Sometimes participants (4/10) felt overwhelmed by the emotional intensity of the room, in a more general way. Dee found the art-sharing was "torture" because it overwhelmed her emotionally. For others, just being in the room felt "intense" or "overstimulating," the atmosphere was charged with others' "energy," and being in the room meant immersing oneself in "other people's stuff."

I Didn't Know What to Do with Everything that Came Up. As emotionally-charged memories, beliefs, thoughts came up, five participants experienced it as an accumulating burden, felt a need to do something with it, but did not know what to do with it. Magda described what it was like to start accessing emotion in SA. She said, "I'm carrying all of it, I'm holding all of it, and I'm holding so tight, like […] trying to hold it all! But, you can't hold it forever. Y- you, can't *contain* it forever, sooner or later it's gonna explode." As her excerpt illustrates, this subcategory comprises numerous physical metaphors involving mass, material, accumulation, and action, which suggest that participants' experience of making contact with the apparently ephemeral, psychological "It" was highly embodied. It accumulated with growing weight or pressure or size; It was heavy; It had to be carried.

Furthermore, these participants urgently wanted to "do" something to diminish or let go of It—they wanted to let go of it, put it down, but initially, felt stuck or paralyzed, were not able to act on It, or lacked the support or opportunity to "process" it. As Nicole recalled, "all of this stuff comes up and then I can't unpack it and I don't know what to *do* with it." The urgency suggests both an intensity to what they were feeling, and lack of confidence or ability to effectively process emotional experience. For Pat, "It was all snowballing and I didn't have time and space to process it all so it was just building and building. I needed to debrief, just put the stuff somewhere, instead of just, on my back, carrying it around." Indeed, of the eight participants who reflected that the research interviews provided a valuable opportunity to make sense of and consolidate what happened in SA, four noted that there had been no way to relationally process what happened in sessions, in SA. This underlines the salience of participants' experience of not knowing how to process the emotions evoked by SA, particularly at the outset of their group sessions.

Learning to Feel Feelings. The five participants who described not knowing what to do with a bodily-felt accumulating emotional burden in SA, also reported that they gradually started to allow, identify, make sense of, express, and manage or down-regulate their emotions. This subcategory includes specific incidents during SA and descriptions of generalized shifts towards heightened capacity to allow and tolerate intense emotions.

Six participants described intense and painful emotional responses to a specific prompt or while making a piece of art, and highlighted how they started to notice the feeling, stay with it, and then express or make meaning of it. Rose said that her empty womb piece, described above, "killed me on the inside to do…but it's something that I just needed to do, after I heard the prompt." Descriptions of learning to stay with intense feeling often included a quality of surprise at being able to feel something so intensely, or were contrasted with a status-quo tendency to avoid feeling instead of staying with it. The latter is illustrated by this excerpt:

> Over time and repetition, I found a way through feeling scared. It used to halt me, but I came to realize that it was just something that needed to...the image of a carwash comes to mind, like the car reaches the first thing, and that used to stop me, but if you go through then there's another thing and another but eventually you come out the other side. It used to be, meeting something scary, I would back off, run away. But now it's like, hmm, I feel scared...but it's not going to kill me. (Nicole)

Whereas participants used to feel overwhelmed by emotions that felt extreme and never-ending, or used to dissociate from or avoid feelings, six reported that they learned in SA to tolerate, regulate, and express emotions, felt more connected to and less afraid of their emotional lives, and more in control and effective. Magda said,

> Those prompts, they taught me that big feelings might come up in different settings but it doesn't have to be deadly, or overbearing. [R: How did you learn that?] Just through the....process. Like, some part of the prompt or something somebody shared, all of a sudden, you went from 0 to 100. And then… to kind of stay with it, not run away, not lock it up, not….and...I found out, it lingers, it simmers, during the week. Throughout the week. And it's like, 'OK, I know you're there,' and almost like giving it permission to stay there, but at a distance…It even shifted in terms of, 'I don't have to carry you, you

> can walk next to me. Yeah…you can be there, you can have space, but I'm not gonna let you over…over….overtake, overpower, or destroy me.

This subcategory is strongly linked to other shifts, described in Domain 4, that involve taking adaptive actions based on heightened understanding of emotional experience, trusting oneself and one's emotions, and the emergence of new views of self as in control of emotions. This subcategory captures what it was like for participants to contact, stay with, and process emotion, and learn that it will not destroy them—experiences that constitute the raw ingredients for other (Domain 4) shifts.

Category 2b. Allowing an Internal Conversation to Unfold

This category has two central concepts—having an *internal conversation*, and getting into *allowing mode* i.e., a way of approaching group—that are described in four subcategories. It begins to answer the question of how participants came into heightened contact with previously-inaccessible emotions, in SA. It describes a mentality or approach to SA—a mode of being and doing while making art—that entailed a balance or interplay between open, curious receptivity and responsivity to unfolding experience, and active examination and reflection on the significance of that experience. In this way, participants made contact with emotionally-charged experience (feelings, sensations, urges, memories, beliefs), through a kind of moment-to-moment interplay or dialogue (emergent, engaged, unfolding) with art materials, other people, the space, the prompt, their art-in-progress, finished art, others' art. There's a curious, open, receptive, responsive conversation unfolding, a dialogue between reflective awareness and emergent emotional experience.

Mindfully Allowing the Process. One way of being in the room and making art involved "allowing the process to unfold" (Pat), described as entering a kind of meditative, trusting state in which one follows one's instincts and stays open and curious to wherever the art-making

process goes (8/10 participants). In this state, participants relinquished efforts to plan, control, or analyze. This allowing stance is not entirely passive, rather, participants described intentionally and actively following the materials and their embodied experience (instinct, sensation, action urges), being curious on purpose. Gabrielle, Pat, Kim, and Felicia likened art-making to meditation, or to being "in the zone," in that they became completely absorbed in the moment, in an open and curious way. For example:

> That one day, I felt like I was alone in the room and that feels good, like, where everybody kind of disappears. There hadn't been any other time where I was really getting into, um, that zone. Usually I was so aware of what other people were doing, other people looking at me, watching what I'm doing. (Felicia)

Felicia's description also points to the link between safeness, and allowing mode; on most days hypervigilance and concern about belonging in the group (i.e., *It could turn on a dime*), precluded her from entering "the zone."

Five participants also described *allowing mode* as "not-thinking" or "not-planning" and contrasted it with sessions in SA when they made "thinky art" (Gabrielle) or attempted to make art that matched a planned, pre-imagined final product. In fact, moving from a "thinking" approach to "allowing" mode was a significant transition for some participants during SA; something they described figuring out, learning to do, partway through therapy. Magda explained, "halfway through is just when you're beginning to allow it to do what it's supposed to do. It's like a warm-up and then you finally start allowing the process, the material, the topic...allow yourself to feel, allow yourself to do." These examples suggest that entering into allowing mode required safeness, and promoted shifts in trusting self, relinquishing perfectionism, and reduced self-criticism, which are described in Domain 4.

Material Magic. The physical qualities of materials, the sensations of working with materials, or of using a particular technique, were guides or pathways into emotion. Five

participants described the experience of following the materials to some feeling, or described instances when the sensory qualities or motions of working with materials, suddenly evoked emotion. Magda reflected that focusing on the materials helped her to be more open to emotions that she typically dissociated from. She said, "My hands…you just allow materials and your hands, to do it without analyzing. Like, where is that heart thing, the clay one…I think that was my breakthrough…" She went on to describe how focusing on the sensory qualities of clay, helped her be open to shaping a heart and feeling anger, for the first time, at being hurt by a loved one.

The qualities of art materials helped Rose make "the piece that changed me," a wire sculpture the depicted her "journey" dealing with trauma. She described how the properties of the wires helped her access anger at the impact of trauma sequelae on her life. She said:

> When I was piling those wires up....I don't know. I felt, I wanted them to *sting.* I wanted them to be dangerous, I wanted them to be, like…alive, and angry. Like, this is what I'm dealing with, on a daily basis, and I felt so angry as I made it.

Focusing on the materials and their qualities as the source of guidance, information, or inspiration involved allowing the materials to reveal or take them closer to feeling or meaning, in a way that participants found "magical" or inexplicable. Pat reflected,

> I thought to do a river, and then there just happened to be this blue plastic bag. Like everything that I needed to make the piece that I didn't know I was going to make, was already there. There's something really magical about it. About finding the pieces and putting the pieces together. To make the thing I needed to make, to understand the piece of me that I don't understand yet […] Trusting that anything I needed was in the room, and that what you're making is the thing you need to make.

The "magic" she described hints at the concept of trusting one's inchoate, emergent experience and then acting to express it. As will be further described in Domain 4, materials gave substance and form to the action of trusting and expressing, allowing participants to conjure, gradually,

sensation by sensation, brushstroke by brushstroke, a concrete representation of feelings that heretofore eluded recognition and expression.

Dowsing for Feeling, Digging for Meaning. Most (9/10) participants also described efforts to actively reflect and search for meaning throughout the art-making process. Described as "digging" or working "deeply," this way of engaging was curious and open, but seemed to be probing rather than exploratory. This sub-category includes concepts distilled from participant explanations of how they used weekly prompts, or how they continued to reflect on art after the session ended. Participants described thinking about, sensing into, or "digging under" the words and concepts conveyed by a prompt, in order to locate its personal significance or emotional resonance. Pat described this as "dowsing…trying to sense, to see where the thought or feeling was, to point in the direction of where to dig." Similarly, Kim took time after hearing prompts, to

> […] go inward and really focus, see what resonated - I just closed my eyes and pondered for about two minutes. Just to feel what was coming up…. I was searching, like, for the seed of…what would come up. I wanted it to be authentic and I wanted it to be real so, going inward would take me to a place where I felt the memories or feelings or thoughts, of that prompt.

Reflecting on the meaning of a prompt or piece of art "came after the art-making, most of the time" (Pat). Participants stayed engaged between sessions; allowing and digging for meaning continued to unfold after art-making and art-sharing had ended. Kim said, "it wouldn't just end there. I would take it home and think about it, the process would continue through the week, reflecting and realizing more and more."

This process was distinct from the "thinking mode" (planning, analyzing) described in the subcategories above. Rather, this subcategory describes how that some participants treated prompts and their art as repositories of meaning that had to be uncovered or discovered. The active reflection or digging involved was effortful. "Deep" work in SA was equated with

emotional intensity and personal significance; working "deep" meant "feeling a lot of emotion while making" (Rose) or experiencing something surprising and relevant.

Art the Storyteller. Seven participants equated art objects with stories, and art-making with speaking (or, storytelling). Interestingly, the metaphor of art-as-story, or art-as-voice, was not used to describe expressing oneself to an audience. Rather, it typically conveyed participants' experience of expressing something to themselves; like having an internal dialogue. The following excerpt illustrates this concept:

> The prompt was, 'I can mess up, or I cannot mess up.' Right away I felt excited, like 'let's get messy!' And then I noticed that I didn't want to. I had a visceral reaction to the word 'mess.' I didn't like it […] So I decided, I'm gonna stick with the part that doesn't like the word mess, and have a dialogue with it. Like on the inside, I'm going to stick with it. There's something I object to so much that it makes my stomach tighten up, and that's a *thing* that I know I do in my life, I've compartmentalized my way around everything, and I'm trying to uncompartmentalize things and underst- you know, there's- there's something there to be said, something there is trying to speak, so rather than going, 'Oh, mess, yuck, put it away,' I decided to do the opposite and open it up and look at it and listen to it. (Nicole)

In addition, several participants described including words in significant pieces of art, which took on a different, more tangible or felt meaning, than had those words been spoken. Together with the art-story metaphor, this suggests that making art and looking at or showing art, was a dialogic process: letting previously-dismissed or unacknowledged parts of their own experience speak, and listening to the story told.

Participants' art-as-language or art-story metaphors suggested five properties of the art-mediated dialogue/storytelling, some of which are not shared with verbal-linguistic expression. First, some participants felt that experience was being "translated" (Zahra) into language through art; Nicole felt confused and lost at first in SA, because "putting feelings outside of me in a visual way is *not* my language." Second—somewhat conversely to the first—art was, for others, sufficient unto itself as a storyteller or language. As Brenda said, "we didn't have to say a lot,

because we're saying it through the art." Third, the visual-spatial qualities of an art-story revealed participant's experience of the dialogue itself (i.e., did not just convey story content). For instance, Gabrielle thought that her art was abstract, formless, and hard for others to make sense of, because her emotional experience was "slippery" and "clouded." Magda noticed that the shaky qualities of her brushstrokes/markings revealed how "my body does the talking for me" and matched her experience of intense anger while making that picture.

Fourth, parts of the story could be hidden in plain sight, on purpose, the hiding-on-purpose a meaningful part of the story. Reflecting on her electrical wire sculpture of her "journey battling the invisible chaos" of trauma, Rose explained:

> The wires, there's a bronze one and a silver one, entwined together. The bronze one was like, the trauma that was following me all along, wrapping itself around me and my happiness. And the silver one....was like, when I was light, and free of it. And kind of, by the end of the path, I'd gotten rid of the--the bronze one got stripped away. Even though it was, it's there, still intertwined...um, but I managed to strip it away at the end, there by the flower, it's gone, all the trauma is gone...if that makes sense. But here it's like choking, and- there's a couple of places that show when I tried to separate, but I couldn't, and how I tried this before but didn't quite make it so I had to start again. To anyone, it just looks like a bunch of wires but the placement was very deliberate. And, only I knew the story, but like, you know, that's exactly how it is.

In Rose's example, being the only one to understand those hidden properties of the piece, matched her experience of being the only person to know the story of her "path."

Fifth, participants described how art acted as the other party in dialogues with themselves. Dialoguing with art, one can pause or delay having the conversation (feeling, reflecting on something) by putting the object away. Pat explained that she kept the art made after she had an intense, upsetting response to one prompt, even though

> I don't want to see it and I don't want to talk about it. But...it's in my house and it's there on my shelf, and I'm keeping it there, because I know it's an important piece, but it's like, I'm not ready to talk to you yet.

This property overlaps with, and is elaborated further, in a subcategory of Domain 4 (*Make the pain into something that holds it)*.

When some participants described and reflected on a significant piece of art, they highlighted their use of written words in the art. In all instances, the words are described as potent, expressed for the very first time, or painful to read. Highly charged with emotion, they also tended to be snippets—single words or isolated phrases and incomplete thoughts, rather than lengthy complete reflections or stories. This suggests that the words gained significance *in,* and only within, the visual-spatial context of the piece of art of which they were a part. Furthermore, participants described words in their art as something they had a relationship (dialogue?) with, as if the way the words appeared in the piece, expressed their embodied experience of whatever the word symbolized. To put it another way, using words in art seemed to be an embodied articulation of emotion or meaning, a co-expression of what was felt or lived, and the conceptual symbolization of that experience, at the same time; something that perhaps could only be expressed through this combined use of word and image/form.

For example, Gabrielle described noticing how the loose, light, barely-there way that words appeared in a drawing, matched her recurrent lived experience of being "swept away" by those words, which partially expressed painful beliefs about herself. Magda noted that the way words seemed to "bleed" on the paper fit with the intense pain she felt while making that piece. Nicole described including "unsayable" words in a partially-hidden way; she was invited to do so, by a prompt and demonstrated technique that allowed participants to hide/reveal words. In this way, it was possible for her to express privately, to share without revealing, to maintain the relational and sensory boundary around her words, that allowed them to be written.

Domain 3. Witnessing the Invisible and the Invalidated

Witnessing the invisible and the invalidated consists of reported shifts towards heightened awareness, acknowledgment, and understanding of emotional experience including emotionally-charged beliefs and behaviour patterns. These shifts were contextualized by longstanding patterns of invalidating, dismissing, compartmentalizing, or otherwise living in a way that is disconnected from "It," i.e., trauma-related emotions, memories, and other experiences, status-quo patterns that constitute the domain's first main category, *'It' is invisible*. This domain thus captures the process of witnessing and understanding what had been invalidated or rendered invisible for years. Participants attributed understanding and witnessing, to processes of seeing-touching-validating, *through art,* aspects of experience that had been hidden, dissociated, invalidated. The seeing-touching-validating was possible, because those experiences were expressed in visible and tangible form. The second category in this domain, *My art made 'It' real,* entailed participants' experiences of relating to and making sense of emotional experience through their own artwork. The third category, *Looking at art, seeing each other*, was constructed out of participant descriptions of seeing their own experience reflected back in others' art, feeling validated by others' responses to their own art, and the significance of the act of coming together to witness each other's work.

Category 3a. "It" is Invisible

All ten participants described how traumatic experiences and their impact ('It') were silenced, compartmentalized, invalidated, or made invisible in some way by themselves and others. Negative consequences of dis-association from a major part of their experience included difficulty trusting oneself, difficulty labelling emotions, and a sense of not being fully alive. This

category also includes participant explanations of the historical or functional origins of dis-association and self-invalidation.

Invalidating my Experience. Seven participants described—and a few repeatedly demonstrated during their interviews—a longstanding tendency to invalidate, dismiss, override, or minimize their own emotions and associated needs, as not-real, not important, or "crazy over-reactions" (Rose). This included experiences of ignoring or over-riding emotions and associated needs, criticizing oneself or telling oneself to "snap out of it" (Magda), or "getting stuck in a spiral of self-doubt" (Pat) about whether to respect, or over-ride, emotions and other bodily-felt signals.

Origins of Self-invalidation. Five participants recalled childhood experiences through which they learned to avoid or hide emotion. Some were punished for showing emotion, or others had minimized or dismissed their emotions. For example, Brenda's family responded to expressions of emotional pain with "Why aren't you over it? There's plenty of people in the world that have it worse than you." Alternatively, participants learned through modelling to avoid emotional experience. For example, Magda explained,

> It's just not what we do, we don't...*show* emotion […] I would just shut it down, lock it away, pack it away, bury it, whatever. And, leave it there. I, was never allowed to show emotion so I had to internalize it and, carry on like everything was ok.

Instances of this category typically occurred as explanations for any dis-association, compartmentalization, or self-invalidation that happened in SA, or were provided as context for shifts towards understanding and validating emotional experiences.

Lock It Away, Hide It. Eight participants described experiencing themselves as compartmentalized, involving the sense that some part of their experience was separate and

inaccessible, or had to be hidden from others. Nicole repeatedly described herself as living behind a façade, but she also felt fronts and walls inside herself:

> It's almost like some part of me intentionally ……. *suppressed* it … there's so much that I've lived through that I haven't... connected to or allowed…I haven't *integrated* it. […] It's the perfect adaptive technique, but it's not an integrated person. I am ... quite able to go, 'Oh! okay, here's some stuff, I'm just going to put it behind here,' you know? And that's not what being a human is meant to *be*. It's meant to be more, [crying] full and whole, not locked boxes and filing cabinets of emotions.

Despite having awareness that they had locked away parts of experience, both Magda and Nicole felt stuck, lost, or disoriented by efforts to access and integrate those parts of themselves. As Magda expressed, "It feels like, I dug it so far down that […] I'm kind of stuck, in one position, I don't even know where to begin looking for it." Other reported consequences of a compartmentalized life included constant fatigue, anxiety, and distraction because "pretending you're not in pain, to pass as a normal person, is really exhausting" (Pat). For others, compartmentalizing and disconnecting from emotions meant feeling dull, formless, and lost. For example:

> I feel lost, like I'm floating in an ocean […] I can't feel my body, there's no purpose. I'm just out there in an ocean, no feeling, just bland, I'm not moving, I'm floating, I don't know how to differentiate myself from everything else and everything inside me, and I can't see where I'm going. (Kim)

Most participants represented by this category explained that compartmentalizing trauma-related pain helped them to function, however they viewed it as painful and problematic in its own way.

My Body is a "Broken Compass." Difficulty trusting oneself and making decisions to take action were longstanding problems for six participants, and included difficulty reading, trusting, and acting on their body's signals for pain, safety, and other needs. As Pat described,

> Trauma messes all of that up. Like the compass that we have as human beings to decide who we are and what we need and where to be safe and do what we need to do, in order to exist, trauma messes up the compass. So decisions are murky, and it's like you're just

> guessing most of the time, you're just winging it, hoping the floor is going to be there when you take the next step.

For Pat, Rose, and Magda, trusting their own experience is hard because it is hidden and not shared by others. At other times, self doubt seems to occur when body sensations and signals do not match what the logical mind says to be real or true. Pat explained,

> I get stuck on not trusting that my pain is real. Because it's not visible, and other people can't see it [crying]. So it makes me question, like, maybe I'm not feeling this, maybe I *am* stronger than I feel. Maybe I *can* do more than I am doing…and then I do, and it backfires, and I cause all kinds of problems for myself. And then I'm stuck in this spiral of doubt.

Not trusting their own bodily-felt experiences as a signal of what actions they need to take in response to a situation, meant participants feared "making bad decisions," standing up for themselves, taking action, and lack of confidence in their direction in life.

It's Hard to Articulate my Feelings. Five participants described longstanding difficulties identifying, labelling, and expressing their emotions. For example, Magda described how "as soon as heavy emotions hit me, I *physically* react … my body does a lot of talking for me when I don't have the words, when I don't even know how I'm feeling." As a result they felt confused, mystified, or overwhelmed by emotions, like Rose, who explained,

> I can't articulate my emotions well, with words. There's like a general, I'm really pissed, or this fuckin sucks, but it's hard for me to get to words, like I just, like despair and rage and I cannot think when I am that like out of my normal, out of my comfort zone.

Often, this was included in their narratives as context for the significance of reported shifts in heightened emotion understanding.

Trauma is a Black Hole. As a result of traumatic experiences and related emotions being invalidated, hidden, avoided, or compartmentalized, they (It) took on a quality of "gone-ness" that was nonetheless impactful (harmful or threatening) in its very absence or invisibility. There is something threatening, harmful, distressing, chaotic, unpredictable about It, which

makes it difficult to navigate and cope with life. For five participants, this was conveyed through a variety of metaphors and descriptors specific to the individual, but sharing the above qualities. Pat described "the invisibility of trauma. The gravity of it is invisible. It's a black hole in the universe […] if you don't watch out it will suck you in and you will disappear." Similarly, Rose called her trauma sequelae "the invisible chaos" that "wraps around you and chokes you" and makes it hard to grow. Nicole wondered, "Can you carry an emptiness? Or can you carry a vacuum? It's like a vacuum that I carry inside all the time." One quality of a chaotic invisible vacuum, is that it is simultaneously there and "not real" because of its invisibility to others and, at times, oneself—hence the subcategories above. The invisibility also makes Its impact harder to predict, control, regulate.

Category 3b. My Art made 'It' Real

Through SA, most (8/10) participants reported becoming more aware of, more able to conceptually understand, and/or more able to feel and therefore acknowledge as real, aspects of their experience that had previously been outside awareness, confusing, disconnected, or invalidated. This category describes how traumatic experiences and their present-day impact became more integrated, through seeing, feeling, understanding, and acknowledging the concrete or visual expression of them, in art. The art-mediated process of making "the invisible chaos/black hole" of trauma real (substantive, valid), includes three subtly distinct subcategories, in which art respectively functions: (1) as a mirror, helping participants see and conceptually understand themselves; (2) as a body, helping participants feel aspects of their experience as 'real,' leading to validation; and (3) as a stage or window, through which participants revealed or expressed hidden parts of their experience. All three subcategories capture art-mediated processes of self-validation and integration, but the mediation occurs in different ways. *My art*

made 'It' real was prominent within participant narratives, and was a major contributor to the conceptual development of the model's core category.

"SpeakArt Helped Me See Me." Increased awareness of and ability to label and/or make sense of their own emotional experience and patterns of behaviour, was attributed to having *seen* it externally represented in their artwork. Participants described how something internal-psychological was rendered visible—externalized, made visual—through the specific qualities of a piece of art, such as the colour, form, texture, materials used, or composition. For Zahra, one sculpture helped her to externalize, understand, and regulate a persistent feeling of choking and being dragged down inside,[4] that went hand in hand with depressive isolation:

> I didn't have the word for it, but I was able to express it through art. This feeling that I had, I was able to- now it's in front of me. And when I feel that feeling now, I just look at this, and it makes me feel good because I've processed it and I've...put an object to it, like now my feeling is connected to something, and […] it makes sense. Still haven't clarified *why* I feel it, but…I can…. it makes sense. It's not just a feeling anymore, it's clarity, it's a visual representation of my feeling, which is progress.

Sometimes this process led to labelling the experience with words. Rose began her interview with the story of how she had used drawing to cope with a crisis after SA ended:

> I cannot think when I am that upset. But taking that piece of paper and just, [aggressive scribbling motions] like, gave me time to calm down, and be able to put into words, and work through my problems. […] I looked at what I created and I'm like, there's this, I see that, like ….it was a girl looking into a void, and it made me- I knew that I felt sad, I felt lonely, I felt scared and out of control, like boom boom boom boom, the picture brought words to me. To what I was feeling.

Both examples illustrate how seeing internal-psychological experience reflected back, brought heightened awareness and conceptual understanding, and also illustrate how that was regulating, through the sense of distance and clarity created when the feeling was externalized as art object.

[4] Zahra used these words in the interview, to describe the sculpture (which she also had on display). It was a conical paper figure with its head tipped back, being pulled down inside the torso, by a heavy tangle of fibers, cords, and various other materials.

This category was built from participant descriptions of how art functioned as a mirror, and showed them something about themselves, so that it could be known. Many instances had a quality of revelation; what participants saw in their art, was simultaneously new (newly clear or understood) and familiar, like a part of self being revealed and recognized. The following excerpt illustrates this property:

> I did a lot of hidden things under things under things. This one was where I *saw* how I do that-- I kind of already knew, but with this piece, I could *see* how I'm holding a lot of really dark things and that I intentionally pepper them with lighter things, glitter. And that I mask *all* of it. It's the same thing again and again and again. […] A lot of compartments. My very first piece was a box in a box in a box in a box, within, almost like a shadow puppet stage. I don't have that one here, but when I finished it and saw it, I was like, what the hell is going on? I saw a lot of lines and division and boxes in all my work. And now I understand, that's what I've got going on within myself. (Nicole)

The art-mirror brought heightened conceptual knowledge of inner bodily-felt experiences, through seeing it reflected in art. Within this subcategory, seven participants reported that seeing their experience in their art had contributed to greater understanding of: emotion; related needs (e.g., to self-advocate or set a boundary); trauma-related beliefs; aspects of own identity; and various links between past and present behaviour patterns.

I Felt my Feelings Through my Hands. This category was constructed from participant accounts of how seeing and/or touching their art made some aspects of their emotional experience more real, i.e., actually felt, as a really-lived-experience. The making-real involved a shift *from* something that felt invalidated, disconnected, or was outside of awareness, *to* being able to contact, feel, and know that experience as their own. This process involved touching or seeing some representation of that experience in art or materials, and unfolded on an embodied, physical, sensory level; the concrete, physical or textural attributes of art materials, and the movements of making, were salient. For example, Rose described how (in addition to giving her

words for her feelings), when she was upset, making art helped her "to know *that* I am feeling, because I can feel my feelings through my hands."

This subcategory captures how art functioned as a 'body,' or related to the body in some way, such that participants felt a representation of something (emotion, pain, action urge) in their art object (body proxy) and therefore could feel it more within themselves. Reflecting on her overall experience of SA, Magda said that "physically working with the materials, made my pain real." She identified a specific "breakthrough" session, in which she made her most significant piece:

> I was mixing and playing with clay, just focused on the texture and the weight of it. I had something completely different in mind to do, but I started molding that heart shape in my hands. And then--it literally freaked me, it-- it started with a little crack on the side. See, there. I saw the crack and I'm like, he broke me, he broke my heart. And I just started going at it [laughing]. With the knife. I started stabbing the heart […] It was the first time I allowed myself to feel. It opened up something. Everything, I would just shut it down, lock it away, pack it away, bury it, whatever. But this piece, something shifted.

It is as if the concrete, externalized material form of the art gave the feelings represented therein enough weight to exist and be validated as real.

Whereas the previous subcategory is about art reflecting experience, such that seeing it led to conceptual understanding and clarity, this subcategory describes how art made palpable something that had been invisible, dis-associated, or invalidated, which made it come alive. It is about participants' experiences of heightened feeling and validation of the realness of feeling, rather than heightened conceptual awareness and understanding. This subcategory also places a strong emphasis on the material qualities of art and media, and physical contact with them; touching one's art or seeing the physical qualities of it, facilitated contact with the ephemeral-psychological. As with the previous subcategory, this subcategory has a subtle quality of passive receptivity. Increased contact with experience through art happened *to* the participant;

emotion was revealed, it emerged unexpectedly, rather than being pursued or intentionally activated. The "content" that became real for participants included specific emotions alive in the moment, specific self-states, emotionally-charged meanings and beliefs, as well as more general patterns of experience. The five participants represented in this category were often highly specific about the visual or tactile elements that facilitated feeling-it-as-real, further suggesting an embodied, concrete art-mediated process of self-validation.

Acknowledging by Making It Visible. For most (7/10) participants, it was important to intentionally depict some aspect of their emotional or trauma-related experience. They deliberately made an invisible-to-others, invalidated, or previously-dismissed experience into something visible. In this third art-mediated process of validating the invalid and making visible the invisible, art functions as a stage, or display. This subcategory has a broad quality of personal agency, rather than the passive receptivity of the previous two subcategories in which participants were more like passive recipients of something their art unexpectedly revealed. Here, participants made a conscious decision to use art to display or reveal some aspect of experience that had been invalidated or is invisible to others. Rose reflected on a self-portrait she made, which depicted a pregnant woman in profile, with a skeleton head. Although its main theme had to do with miscarriage and loss, she explained,

> This piece was not just the empty womb. You can't really tell, but it's everything diagnosed, that's wrong with me. There's a tiny little bit of red, you can't really see it see but it's there, on all my pinpoints, everything that's hurt, absolutely everywhere […] Even though people didn't know it, it was cathartic…like all the little bits of red in the darkness in the black charcoal, was like me going, 'these are all my hurts. I might look ok, but I got a shit ton of problems. There's a lot wrong with me, and these are all the things that you can't see.' It was really important to put them.

Rose's example illustrates another property of this subcategory: even though participants described how they chose to show or reveal something, the intended viewer most often seemed

to be the participant herself. As another example, Pat made several pieces depicting her experience of navigating the "black hole" of trauma. She described one:

> I made this box with more objects and things inside that you can open. There's one little box that's taped up that you *can't* open. And inside it is pennies and rocks, so it's heavy. It's like the invisibility, the stuff that, it's the black hole, don't open it, don't get too close to it, but you need to know where it is because it's dangerous. And it's right here.

Reflecting on these pieces (and mixing metaphors), she explained that it felt important to make visible the invisible, instead of looking away from it:

> I guess, the work of trauma therapy is identifying where the black holes are. Mapping them […] Not that I didn't know what happened to me, but […] I was *keeping* it invisible, putting this curtain around it, trying to travel through the universe without looking. But now, pulling back the curtain, identifying where the black holes are, gets me to a point where I can actually talk about it. And move on. The black holes, can't do anything about a black hole in the universe, it's going to be there, you can't undo it. So you'd better know where it is so you don't fall in. Map it out and move forward.

The above quote suggests that the decision to depict something, in art intended for oneself as the audience, was an act of approaching instead of avoiding.

By approaching—using art to intentionally show, acknowledge, and engage with something that happened—participants seemed to adopt an accepting and compassionate stance towards the experience shown in the artwork, as if their witnessing selves were looking at what happened, externalizing it in a way that accepts the experience as one's own while also creating freedom to "move forward." Nicole provides another example of this property. In her interview, she showed me the art she made in response to the prompt, 'this is what I can say, this is what I can't say.' Earlier (Domain 1) I explained that this piece was also prompted by novel defiance and anger that Nicole felt, in response to being triggered by another group member's complaint about how people were giving feedback. It was a mixed-media painting which included written words, some of which were concealed by paint. She said,

> It's not my favourite piece, but it's the most meaningful one. Because um, I'd never written the words that I wrote here. And it scared the shit out of me. But I did it. I don't know who I was saying it to, but I felt like …. I have a right to say things. And, this was the first time in my entire life that I've said, 'I'm being bullied. This happens to me a lot [crying]. This happens all the time.' And it was scary to do, um, but there's this sense of defiance, like by saying it, I will not allow it to be the *only* thing in my life.

Nicole's example illustrates how the experiences shown in these artworks were not surprising or new; they were feelings and events that participants had long been aware of, and were intentionally relating to in a new way, through their artwork.

Category 3c. Looking at Art, Seeing Each Other

During the art-sharing portion of SA, group members acted as witnesses, which contributed to participants' heightened self-understanding, and self-validation. Two subcategories capture how sharing art and feedback was significant: participants felt seen, understood, and validated when others "got" their art; and found new, helpful or transformative meaning in a piece, based on others' responses to it. A third subcategory contributed heavily to the concept at the heart of *looking at art, seeing each other*. It captures how the designated time and space to show, see, and respond to each other's artwork, bestowed significance on the experiences that were depicted in that artwork. This time and space did more than make it possible for group members to witness each other. Granting importance to the art and sharing work, also seemed to foster participants' sense of community in being on a healing journey. This last subcategory also included descriptions of a kind of reciprocal or contagious co-healing through sharing art and feedback.

They Got My Art, They Got Me. Five participants reported that they felt seen, understood, and validated when group members had a visible emotional response to their work, or conveyed through feedback that they could see and understand something in that participant's artwork. Nicole explained, "the fact that you get this, means that you get me […] no life stories

were shared, we don't talk about events, but they saw in my art, what I felt…it felt very…like, validated." There was an interesting property of the experience of feeling seen and validated by group members' response to one's art. Gabrielle, who mostly felt misunderstood and disconnected from the group, described one occasion when she felt seen by someone's response to her scribble-out. She explained, "It was like, *ok somebody in here should understand this*. I showed it and said something about, you know, always being silenced, and wanting to be a child and make noise and stuff. And somebody giggled. She got it. [emphasis added]." Gabrielle's excerpt illustrates how some participants believed that their art (art-story, experience) had been seen, understood, and validated *only because* the viewers also had a trauma history.

What Others Saw, Changed the Meaning. Some (5/10) participants reported that group members' comments or feedback sometimes led to a change, clarification, or deepened meaning of the participants' art and associated personal experience. Feedback seemed to clarify underlying emotions, highlighted adaptive, esteemed aspects of the self, or introduced hopefulness about growth and the healing process. Participants also reported becoming clear about something about themselves, as a result of feedback on art. This was true for Pat, regarding the artwork she made for the prompt, 'this is what my voice looks like.' She explained,

> There was this pile of feathers that I roped down with rope, and I didn't think about it too much. But one person in the group said it reminded them of a trapped bird. And, that really resonated with me. Because I always feel stuck in my body. Like, stuck in the pain and stuck in the doubt and disbelief that this is actually my experience. And then not standing up for myself and not asking for help and...you know…not even trying to escape. Just feeling like you're a bird, so you're a bird. In a cage.

Sometimes receiving feedback was significant for participants, in a way that integrated both the feedback content and the experience of receiving it. For example, when others saw playfulness and whimsy in a piece that Dee shared, she "started to see it myself" and realized "I had, you know, obviously every kid has a sense of whimsy, right, and, [crying] if one doesn't keep that

nurtured, it just falls away." Although Dee described being very private and feared being exposed, she described a heightened sense of loss, as well as relief, that the group had seen whimsy but did not notice her carefully-concealed grief for lost playfulness.

Witnessing Healing Together. Witnessing means being present to see and acknowledge that something happened; in the context of SA it also meant being there to see, acknowledge the impact, the wound, the pain, the internal mark made by something that happened to someone. Witnessing is incompatible with invisibility, and brings the possibility of feeling not-alone-with what happened. Although six participants are represented within this subcategory, only two actually used the term "witness" in their interview. Kim described seeing in someone else's art how "the pain was there, it was still hurting." Reflecting on the significance of that moment, Kim said,

> She was *there*, doing the work. [Despite] the awfulness of her trauma, of all our trauma, she was doing something about it. Right? And we were in that space together, we were able to witness it and, be with it, and she was expressing it. [R: Witness it?] Yeah. So witnessing her, it was her turn, to show us her art. Witness, meaning that, you know, I'm not alone. That someone is there, registering...what has happened. And that you're with someone, that you're not alone. Somebody to witness and acknowledge.

This subcategory captures what it meant to participants to be a witness, and their sense of contributing to and benefitting from something bigger than themselves, i.e., a communal or shared healing/change process.

Four participants felt that they had given something, contributed to others' change process, had a positive impact on others. For example, Zahra reflected on repeated instances when the group had a strong emotional response to her art. She said, "People resonated, you could see they felt my artwork, it was powerful, and I felt better. It made me feel good […] Knowing that I had an impact and I can help." Others felt their role as art witnesses was rewarding. Gabrielle reflected that even though she felt misunderstood or like an "oddball" in

group, she found connection when she provided feedback to others and opened up to their feedback to her work. She explained, "Just being able to share for someone else, and be receptive to them responding…and then it's impactful to hear how people feel about your stuff, so giving that to others felt good." Both examples convey the significance of having aided or impacted others in their respective healing process.

Another property of *Witnessing healing together* was implicit and harder to articulate, and had to do with investment in each other's process and progress, and identification with what each other was expressing. As Zahra explained,

> In the middle, I stopped sharing, I became quiet, I wanted others to share and I wanted to hear them. With one person… She had the scariest, confusing negativity in her earlier artwork. And then all of a sudden it was like, the storm was clear, now there was clarity. And I cried, I felt so proud of her, because I saw her progress, her journey. [R: what did that give you?] To keep going, keep expressing through art, and then….you might notice that you might not need to pick up a black crayon anymore. You've released it all. Now you can pick up another colour. Like that progression of feelings, for me that's what it showed, she had worked through it and was progressing into a lighter place. So…it gave me hope. For myself.

The act of showing art and responding to it, witnessing of each other's process, was more than a transactional or bi-directional, symmetrical exchange between the person showing their art and everyone else. There was something greater-than-the-sum-of those exchanges, a kind of emergent co-healing process.

Finally, it meant something to participants to have a relational space and time carved out for sharing art. It signalled that they (as art makers and showers) are each worthy of time, attention, and response, and that their own responses (as viewers of art) are worthy of everyone's time and attention. Kim reflected,

> We were able to share our own feelings and thoughts, not only about our artwork, but also what we saw in others. And I felt, this wasn't done in vain, there was a lot of meaning in every thought that got shared. So I was given a voice. I was given time to have input, um, and it was always acknowledged, you know, very respectfully. Um....just

> the privilege of being able to show what I've created, that was my time and my space, it was quite sacred. So, that made me feel that I was an important part of the healing process, of not only mine, but everyone else in that group.

The mutual valuing of each other's presence (granting of attention) and experience, stood out as in-and-of-itself helpful in some way; an acknowledgment and validation not just of the experiences being expressed in each other's art, but of each other, as persons, and as persons seeing each other. In other words, it was not just the specific artworks shown and the experiences they represented in material-visual form and the particular feedback that was given on those artworks, that were being attended to and felt into and validated. Rather, by granting art-stories attention, participants' presence in the room, and their post-trauma transformation/healing process, were valued and validated.

Domain 4. Transferring Transformation

Quite early in the analysis process, a theme began to recur, that had something to do with *creating* and perhaps *magic*, with *transforming* what is happening inside and outside, and making something *here* in order to effect a parallel change *there*, like sticking a pin in a voodoo doll—but without the malevolence of that particular metaphor. It had something to do with creating something or acting in a new way on one level of experience, which echoed on other levels, and the echo in turn had its own effect—confidence, feeling empowered, that came from knowing one had created, transformed, "magicked" some change into being. Words failed for months even as the categories capturing the threads of that theme grew and coalesced. Words may be failing now. I decided it is possible that this tells us something about the underlying concept—a transformation, and then a transferral of the transformation to another domain of experience—that, like alchemy, unfolds on a dimension that cannot be seen or measured, or perhaps verbally described.

This domain attempts to capture and describe an elusive, multidimensional transformation process. It includes participant descriptions of new, adaptive actions and experiences in SA. Participants ascribed new actions/experiences to working with concrete materials in a safe group setting, and the heightened emotional- and self-understanding gained from their art. Materials and the group functioned, respectively, as more-malleable, more-manageable proxies for participants' inner worlds, and for the external world of action and relationships. The first category in this domain, *I made it, so I could handle it,* is concerned with the former. Art materials acted as a locus of intrapersonal transformation, such that participants could manipulate what they were feeling/thinking *through* manipulating art materials, and as a result felt more control over their emotional experience. The second category in this domain, *Creating new actions,* captures how SA was like a laboratory or practice field for new actions that participants transferred outside of the therapy studio, a locus of interpersonal transformation. The third category, *Making new meanings,* describes shifts in participants' perception of self, trauma, and their emotional lives, i.e., how they viewed novel experiences and actions in SA, as self-transformational.

The previous domain was all about how art translated ephemeral psychological experience; made it visible and concrete, gave it form outside oneself, so that it could be seen, felt, labelled, and validated. This domain is about participant descriptions of how that translation went a step further, into the realm of creating change, making new types of experiences come into existence, through art-making in a group. I have included numerous and often lengthy interview excerpts throughout this section, to add weight and credibility to my assertion that something akin to magic or alchemy—something difficult to observe and describe—was at play in the room.

Category 4a. I Made it, so I could Handle it

The way that participants acted on or related to art materials and works, transferred to a new way of acting on or relating to their emotional experience. Participants described using materials to make or maintain some intrapersonal shift or new external action, or reflected on how creativity in SA transferred to a greater sense of creative self-agency. This category captures how participants created or transformed something using concrete art materials and outside of themselves, and then experienced a transfer of that transformation: back inside of themselves or to the outside world, at the levels of emotion, belief, agency, action in the world. Three subcategories differentiate *what* was transferred, and the *temporal* link between art-making and the perceived (transferred) shift in oneself.

Externalizing and Containing the Pain. Four participants described intentionally making art to down-regulate distress and gain a sense of control over painful or intense emotional experiences. They used art-making when they felt overwhelmed, as a way of shifting attention and staying present and grounded while continuing to experience their emotions. Rose's story of how she used drawing to manage a crisis after SA ended, described above, illustrates this. She could "feel my feelings through my hands" while scribbling, which "gave me time to calm down and be able to put it into words." Notably, making art to down-regulate did not entail distraction or dis-association from emotional experience. Rather, participants emphasized how their contact with materials, attending to the sensations and movements of making art, helped them to be present with their emotional distress in a way that felt manageable rather than overwhelming. It provided a way of being with, rather than getting away from; being with, rather than feeling more intensely (as in Domain 2, 'allowing mode').

Making art objects helped to symbolically externalize, contain, and/or transform emotional experiences that felt too painful or intense in the moment. Making a container was more than symbolic; it transferred back to a lived experience of decreased emotional intensity and heightened distance from emotional experience. For example:

> You almost take all of that energy, all those thoughts, and you make it into something that holds it. And *minimizes* it from this huge cloud over your head to, it's now, like this foil is containing it, and keeping it. And when I'm ready to deal with it, we'll maybe speak, I'll hold it, I'll do something with it, but the size is drastically different. Manageable. Now I can take a step with it. (Magda)

Externalizing and containing was about putting the pain away. Notably, in all instances, participants described how their intention was to modulate; they put an emotional experience away to make it manageable or keep it for later processing, because in the moment, it felt like too much.

Keeping Art, Preserving the Process. Most (7/10) participants also described using their artwork to preserve, or enhance processing of, emotional experiences and adaptive new actions. Two participants used a piece of art as a "keeper" (container or symbolic representation) of some emotionally salient experience, for future reflection. The experiences that make up this subcategory are not about putting a piece away to modulate distress in the moment, rather, art was kept to preserve some experience that felt important, new, and deserving of additional practice or meaning-making. For example, Pat reflected,

> The art pieces I made are sort of like reminders for myself of the major issues I'm still working through. I can look at the piece I made for 'this is what my voice looks like' and remember that I have to keep practicing to use my voice, and maybe don't need to think so much about the reasons I've been afraid to use it.

Keeping a piece also signalled hope for future changes. Dee said she kept a drawing that depicted painful, status-quo experiences of feeling isolated behind the walls she built to protect her from persecution, "as motivation that I don't have to stay that way….I don't want to be that

person anymore." Nicole made a collage that she saw as light, with humorous themes, but other group members saw serious, dark themes in it. She kept it on display at home, because:

> I'm working deliberately on perspective, because I don't want to feel the burden of sadness and grief and pain so much, so it's a reminder that […] there are things in my life that I think are funny, that other people are like, dark and serious. So it's a reminder to try and practice shifting perspectives.

Participants kept art as a reminder of some new adaptive experience they had in SA, a way of preserving and perpetuating the micro-shift, in the hopes of finding it again.

"If You Can Create Art, You Can Create Real Change in Your Life." Four participants expressed a belief in the self-transformative potential of making art. Specifically, that the capacity to create something from paper, paint, clay, tin foil, means that they have a parallel capacity to create—to make change happen—in their own lives. They reflected that making art revealed or strengthened an inherent capacity, a rarely-used muscle, to make change happen. The concepts of choice, agency, and physically creating something are central here: it is because one *made something with one's own hands*, and because one *chose to make it*, that one now has a sense of power to be able to make other things, change other aspects of one's life.

This transferral of creative power, from art to life, was often specific to the content and themes expressed in a particular artwork. Making a representation of some desirable, new, or adaptive action or personal quality in one's art, conferred belief that it could be manifested, in life. In this way, participants perceived their artwork as both symbolizing *and* instantiating a new, adaptive personal quality or attribute or action. When Rose first described her wire sculpture, she said:

> The prompt was, 'this is where I came from, this is where I'm going.' I made this muddled mess of like wires, all jumbled and twisted, and just, angry. And, one of the wires kind of came out, bubbled around a little bit, and I put a little dainty flower at the end. And..... I don't know, at that moment, I felt more optimistic. It was the first time that

> I felt like, I can come out of this, I can *come out* of, just a complete mess. And that was a big turning point, for me. That piece actually changed me.

Here is another example. In the excerpt, Kim refers to her clay house, made in response to the prompt, 'this is the structure I need,' which she (elsewhere) explained was a home for her "highest self." Reflecting on its significance, she said:

> I did a retreat last week, and, one of the challenges was rappelling off the edge of the hotel, 35-storeys high, and, when he first mentioned it, I felt my whole body blow up in flames because I was so scared...but, I just had to do it. And I- this piece, it gave me, like...the momen--the *permission*, and the *power*, because when I was making it, you see, I felt the power, I felt I could fly like the eagle, I felt I was leading a battalion of Amazons. It's like, these last few months, I've created the new *me.* These images, and these pieces of work, gave me—they helped create this new person where I was able to say yes, I'm- I'm gonna do it.

These examples illustrate how art functioned as more than a symbolic representation of specific changes participants wanted to make. Rather, the act of creating (the symbolic representation of making the change) conferred transformative power, wherein, making it 'here in the studio' (started to) make it real 'out there,' in life.

In other instances, the transferral of creative power was nonspecific; two participants perceived artistic creativity as a way to empower or strengthen their overall sense of personal agency, in general. These passages tended to be more abstract reflections on how the act of creating something from clay, paint, sequins and cardboard, conferred confidence or sparked agency or confidence to take action in life. Felicia reflected on this, when she explained why she sought art therapy, and why she finished SA, despite the relational challenges that she faced in group:

> Art means tapping into ... a part of yourself that was hidden away, like your creative force that got turned off, shunned away, covered up by trauma. Making art taps into the part of myself that has access to anything that I want, like this child-like wonder that you can go after anything, you know? I see that in my niece when she creates, and how she's just imagining how much she can do, and what she wants to do, and when I'm creating, I'm right there with her. And I think if we have trauma as women, to be able to tap into that, even gently, slowly […] You know, after my trauma, it was like I wasn't, I couldn't tap

> into it. I couldn't tap into ideas, for myself. Like, if I can create anything on paper, I can create myself, and that's really what it started to feel like. I can use creativity as kind of a metaphor, you know, for myself. For change, and working towards getting better at something.

By making art, participants felt that they (re-)awakened or strengthened confidence in their ability to take other matters into their own hands. This subcategory is closely related to another subcategory in this domain (defined below), the re-claiming of play, and the perception that it had been stolen or stifled by traumatic experiences and post-traumatic sequelae.

The key concepts that make up this category have to do with externalizing; having something concrete to work with gave control and invited transformative action. An important, more subtle property of this category has to do with heightened agency or action-taking, conferred by a transfer between emotion and art object. What the participant did with their artwork, and what the artwork (symbolically) does with any emotional experience that it holds, seemed to reflect the participant's relationship with the intangible psychological stuff contained therein. The process seemed to be*: I did ___ to the tangible material/image, now I feel able to do the same thing to the intangible feeling, problem, memory, belief that the material/image represented.* By transforming the intangible into something tangible, which could then be altered or manipulated in some way, participants took *action* or made a statement of intent. This transferred back to the participant, and altered how they feel about their emotional experience and their own sense of control and capacity to change.

Category 4b. Creating New Actions

Art-making, art-sharing, and other experiences of interacting with others in group, were seen as opportunities to experiment with and practice new (or renewed) actions, approaches, and ways of relating. In SA, participants faced situations, tasks, and interactions that echoed problematic scenarios and painful interpersonal or intrapersonal patterns from daily life. The task

of creating something and doing so while negotiating shared and limited physical space, materials, and time, presented participants with the germ of problematic patterns, and opportunities to interrupt the pattern or respond in new ways that transferred outside of therapy. In this way, SA was like a laboratory or practice field: a lower-stakes, more-controlled, safer simulacrum of real-life circumstances. Subcategories capture: participants' perception of SA as a place to practice; and several types of responses that participants practiced in SA and put into action outside SA. These include letting go of perfectionism and self-criticism, asserting themselves and making decisions, and rediscovering play.

SA was a Place to Practice. Seven participants likened SA to an arena for practicing new approaches. Art-making provided opportunities to interrupt old action and thought patterns, and build new ones; participants described *practicing* or *experimenting* with a broad range of new behaviours: interrupting self-criticism; being spontaneous instead of planning; making a mess; revealing one's genuine feeling to others instead of putting up a façade; trusting one's instincts instead of entertaining self-doubt; leaving a 'mistake' un-repaired; staying with fear instead of leaving the room; asserting needs; taking up more physical space; using up 'precious' materials instead of leaving them for others; approaching a problem one step at a time; and replacing judgments with compassion for others. These behaviours are captured elsewhere in the model; they also share this category's concept, i.e., participants *practiced* them in SA.

There were two salient properties of the practice metaphors that participants used to describe their activity in SA. First, participants felt that SA was a *safe* place for practice. There is considerable overlap here with the "safe enough to take risks" subcategory in Domain 1; safety was conferred by the secure-space setting as well as the lower-stakes nature of art-making and interacting with group members (vs. higher-stakes real-life actions and relationships). Second,

despite lower consequences in SA, the weight or significance of the practiced action was experienced as *real.* Having real, concrete experiences that challenged their maladaptive patterns helped participants go beyond conceptual understanding, and gain a new template for action or experientially-grounded knowledge.

Nicole reflected on her process of learning to stay with and tolerate the fear she felt—fear of making a mistake, and being judged or ridiculed for it—at the prospect of unstructured art-making:

> It's practice. I knew concepts of, you know, 'reveal your inner truth' and, 'be perfectly imperfect,' [mocking tone] I'm loving Brene Brown's book about being vulnerable, but I have no arena in my life to *experiment* with it, you know? And SA gave me an arena. So, I feel a bit braver, and a bit more comfortable to- to expose myself, um, under the right conditions. And these were the right conditions. [R: can you say more about the conditions?] It's a really…safe environment. It like a- a padded room where no one's gonna get hurt, it's safe. But the feelings were really real. It was a *physical* experience of, feeling intimidated and lost, and confused, and *so scared* of messing up. And over time I found a way through feeling scared […] that's flexing a muscle that I haven't really flexed a lot in my life […] So, that's a shift. Big time. And it's transferable!

She goes on to describe a "transfer," a story of how she recently made a mistake at her new job, and sought help correcting it, rather than acting on her urge to conceal the mistake or quit before anyone noticed. The excerpt above illustrates the concept of safe, 'for-real,' beyond-insight practice afforded by SA.

This new experientially-grounded knowledge sometimes heightened motivation to seek more of the same, because participants had a fuller, felt understanding of the rewards of the new action. Magda reported applying a new approach to problems that she had been practicing in the art room, "taking it one chunk at a time," to a series of unexpected life challenges that she faced towards the end of SA. Pat described how she had acquired, in SA, the experientially-grounded belief and hope that she can trust herself, because she had repeatedly practiced trusting her own instincts and emotional signals while making art, and "now I know it is possible to safely trust."

Making “for-real” (embodied, enacted) changes in SA, led to formation of new experientially-grounded beliefs, a new template, deeper understanding, or expectation that one would be able to have those practiced experiences or do those practiced actions, outside of therapy.

Challenging Self-Criticism and Perfectionism. This category captures participant reports of longstanding patterns of self-criticism and perfectionism that arose for many (8/10), and shifted for some (5/10), over the course of SA. In SA, making art brought some participants face to face with a tendency to judge their work, criticize themselves, avoid “mistakes” and strive for “perfection.” “Perfect” usually referred to perceived qualities of a finished artwork, i.e., it met some aesthetic standard, matched some pre-planned vision, or was made using “correct” technique. It is unclear where these aesthetic standards came from, but most participants who struggled with it in SA indicated longstanding difficulties with self-criticism which may have generalized to art-making. Brenda, for example, said “I'm very critical, so I wasn't…I just kept thinking, you know, I'll probably screw it up, I won't like it, it won't be perfect, it won't be good enough.”

The SA group culture normalized, modelled, and reinforced imperfection; this stood out to two participants as helpful, even crucial, for learning to let go of perfectionism and self-judgment. Rose recalled,

> There was a girl who finished when I started, she talked about how she was holding onto this perfectionism, but one week she played with paints and just like, went crazy. And she said, I wish I'd done that sooner. And I thought, how big of a deal could it be, you know? But then, once I'd gone through it, I’m like, wow. It was a big deal. It was way harder, and way more satisfying, when I finally did. And I was in a room with people who, not only was it ok, it was encouraged, it was *great* when I finally I did it. You know? So that was different, getting that encouragement and reaction to messing up.

In this environment, participants practiced alternative approaches and attitudes towards themselves or their art, such as allowing mistakes without fixing them and interrupting self-

critical thoughts. This excerpt from Magda illustrates both the struggle of working to change perfectionism and self-criticism, and how participants practiced new alternative responses to perceived imperfection:

> It was hard not to be critical. Of myself, my work […] whether it's good enough or not, with the time limit, you have to stop and walk away and not fix it, not judge it. […] Sometimes I had to hold my hands away from it, like, that anxiousness, of you need to fix that, or whatever. And um...to shut down the voices in my head. Saying, 'it's ok, it's- it's good enough, it's- it's enough, like, stop.' So that was a good lesson for me.

Some who practiced making mistakes and interrupting self-criticism, also reported shifts such as new, experientially-grounded understanding that mistakes are not catastrophic, increased self-compassion, decreased efforts to perform perfectly, and embracing mistakes.

Making Choices, Using my Voice. This category includes reports, from all 10 participants, of novel experiences of using one's voice or taking action to assert needs. For some (4/10), these novel experiences transferred to reported shifts in assertiveness outside SA. Participants contextualized significance of assertiveness and taking action, with descriptions of two status-quo tendencies. First, as Gabrielle explained, "safety was not making any noise, not taking up space." Many (6/10) said they learned to make themselves small or stay quiet as a way of staying safe, to avoid notice, prevent punishment or persecution, or prevent invalidation and intensification of emotional distress. Pat explained, "Being quiet is a way of being safe. If I don't tell my parents I'm scared, they can't yell at me. […] I've learned really well to stay quiet. And just to keep myself invisible." Second (as elaborated in Domains 2 and 3), participants described a more global sense of helplessness, inaction, and feeling out of control, due to emotion dysregulation, invalidation, and self-doubt.

One of the main safeness-promoting factors that participants highlighted (Domain 1) was having choices and freedom to make decisions. In addition to safety, being granted autonomy in

SA gave participants a chance to practice deciding, choosing what action to take, and building trust in their own experience and decisions. In particular, the significance of choosing to make a piece (to explore one side of a prompt; to express a certain experience) was meaningful, as a way of taking control. The following excerpt illustrates this concept:

> With the prompts you could go either direction, and I felt that was self-transforming. I could take the prompt and do whatever I wanted with it. [R: what was self-transforming about that?] Because it was *my* art, it's *my* creation. [R: yeah] It's, the footsteps that I've created, the direction that I'm going in, and I choose where I need to go. (Kim)

Being granted freedom and space (safe space) was a precondition that allowed participants to attune to, and then act on their own emotional experience as a signal, and then learn about the consequences of acting on that signal. This process enabled some participants to contact and express anger, often for the first time. For example, Magda's stabbed clay heart, or the "revenge fantasy drawing" made by Brenda, on her last day of SA when she felt upset at being "abandoned yet again." She said the drawing "helped me finally put the blame squarely on the shoulders of the adults [in my family], where it belongs, instead of myself."

It also provided a chance to practice asserting wants, needs, and boundary setting. Of the participants who identified most-significant artworks during their interviews, five described how while making it, they became aware of some strong emotion or meaning, and an associated want or need. Next, participants expressed the emotion, or enacted the associated action urge, through the artwork. This concept—as well as the previous point, about the significance of deciding to make something—is illustrated by this excerpt from Pat:

> The prompt was about boundaries, and when I thought about it, I felt this aggression. So I made a weapon! Not to hurt anybody, but to scare people off [laughs]. I found this paper tube, and put stuff in it to make it loud, and strings to make it look scary when it moved. That was the idea, to have this weapon [shaking, rattling sound] that I can come at people with, to push back, like I knew I needed something to secure my boundaries. Because, I think I knew that my voice was still restricted, I can't yell, but if I have this scary thing to wave, you might not come too close.

Pat's tone was both earnest and playful; the rattling cardboard tube was, at once, a silly prop and a boundary-setting weapon. This excerpt helps to explain its (not-silly) significance:

> It comes back to trusting who I am, and what I need. And knowing that ..... even if I have some doubts, there are decisions to be made. [SA provided] the opportunity to make decisions in a safe place, to decide how and when to explore something, the decision to make visible a certain experience or a certain idea, like the decision to make this stick to keep people away from my boundaries. This is a ridiculous thing to make. But deciding to make it was a decision to acknowledge my boundaries and who I am, within those boundaries.

In summary, deciding to make something involved listening to one's internal signals, and exercising autonomy and capacity to take action or express wants and needs. In turn—for some—this built trust in their experience.

The group format of SA also provided some participants (4/10) opportunities to negotiate competing needs and practice asserting themselves in a relational setting. Gabrielle described struggling with whether to share her work or not, every week, because she worried about "taking up too much space." She said, "Group helped me in my ability to go, ok, I'm gonna have to take the chance. Like being a little selfish. I guess in SA I was practicing that, stand up for myself. Get my voice heard." Nicole, meanwhile, feared using materials that others might want, or messing up the space in a way that would upset others. Towards the end of SA, she "hoarded and then used all the glitter," and reflected that this was "a big deal, to take what I wanted" given childhood experiences of poverty, and her aforementioned concerns about upsetting others.

Rose, Pat, Gabrielle, and Kim reported shifts outside of SA, involving self-advocacy or otherwise using their voices to assert boundaries, express opinions, or prioritize getting or protecting needs. Kim reported that "my voice is different. I can stand my ground." She described a recent conversation with her ex-husband which had gone differently than past encounters in which she had felt submissive. She said,

> I was able to….speak up. I wasn't shut down. I gave my opinions, and sometimes we disagreed, but I was steadier, and he actually let me […] I was my own person, I was autonomous in myself because, this helped me to see who I am. I was given time and space to have my voice heard. [Now] I have the experiential knowledge, that […] there's *value* in my words and my ideas and my thoughts, and I'm less afraid to share them.

Learning how to use art to get emotional clarity and a sense of control over her distress, helped Rose manage intense anxiety about her return to work after long-term disability, because:

> I got clear about what I was feeling and then organized my thoughts, and then I could plan, and figure it out. And then I went, you know what? I *can* control things, [sigh] I *can* ask for the late start on Thursday and Tuesdays […] and then I felt like, ok I have some control over the situation. I can ask for this. So I did, and it was fine.

Finally, Pat reflected, "I'm pushing back more. This experience has helped me stand up for myself more, and just, advocate." She attributed this shift to learning to trust her signals for boundary setting (illustrated above), and to the emotional clarity gained from receiving feedback on her 'trapped bird' piece, which was described earlier:

> There was this incident right after I made [trapped bird], I had a conversation with my LTD caseworker, which is always triggering because I have trauma around being stalked, so disclosing where I am during the day and what I'm doing is, it's terrifying [voice breaking]. So after making this piece, I had to talk to him because my cheque was two weeks late, and […] I just, I stood up to him, and pushed back a little bit. And, for the first time I felt that he...heard me. So, yeah, this piece shifted me. Um, it was a really big deal. On the call and even after, I was physically shaking, my voice was like rattling, I was crying, like I was standing up to him through tears. It was quite a moment. Just by myself, in my home, like just me in all my power. [laughter]. Like ARRGGHH, like I just wanna fight, kind of thing.

As these examples illustrate, participants directly attributed shifts in increased assertiveness to greater clarity about and trust in own emotions, and experiences practicing boundary-setting and using their voice in SA.

(Re)discovering Play. All 10 participants reported that they had fun using the art materials and techniques. Brenda and Magda loved playing with clay, enjoying the weight and

texture of it. Play and fun were perceived as valuable in and of themselves, as inherently good. This quality was usually subtle, and hopefully evident in this excerpt from Pat:

> I had so much fun with the materials and making things. This is one of the most fun things that I made. With the little medicine jars and scrolls of paper, and everything is something different that you can open. This cocktail umbrella. It's hilarious, I love it.

The value of play was given explicit, trauma-contextualized significance by four participants. Some felt they never learned to play, like Magda, who—reflecting on the significance of playing with clay—said, "I never had that growing up I never had that in my life. It was always controlled. I never- I don't have those memories of playgrounds or peers. No freedom, no play." Others perceived play (and fun, pleasure) as something that was stolen by trauma or lost post-trauma. Play was dangerous, it led to punishment, and it was safer to avoid fun and stay quiet. Or the post-trauma focus on survival or other symptoms left no room for play and pleasure: "what I suffered, what I survived, was a...it sort of, sucked the ability to enjoy anything, right out of me. I mean it was, all mental and physical energy went to just trying to survive." (Brenda)

As such, participants universally described needing permission or invitation to play. For Kim, facilitator demos "gave me the *permission* to be wild…to just play…to feel free, that I could do anything," while Gabrielle struggled to "*allow* myself to play," and Nicole reflected, "Being *invited* to work in a new way, to create, and just play—it was so strange" [emphases added]. Participants' framing of play—as something one was granted permission or invited do, that felt strange or new—suggests that play in SA was more than simply playing; participants were re-discovering, perhaps learning and practicing, *how* to play. As Dee explained, "It's sort of a reclamation, of something that, I'd always had in me […] it was taken away, by, um, hard experiences and painful experiences. It got cut off." Thus, re-learning how to play in SA, was also an act of reclamation, much like reclaiming creativity (described earlier).

As a consequence of (re-)discovering or (re-)learning play, two participants described related shifts in their outlook or attitude towards being alive. Brenda reflected that her art "makes me genuinely feel like…you know, I want to be here, I'm glad I'm here, what I'm doing is fun. So… it made me realize that, I haven't lost the ability to enjoy myself." Kim noticed how playfulness had transferred to her daily experience:

> That's another *big* shift. In the [past month], I have been so childlike, and being *free* out there, to just play. My daughter even says, stop, she's embarrassed, like I just want to dance and be silly, and we went to [amusement park] and this is the first year in decades that I went on all the rides, and I felt so free. So this therapy has just [deep breath] really lightened me, and given me, like life force, the spark of joy.

In addition, as has been illustrated elsewhere, three participants found satisfaction and power in the sense of reclaiming a fundamental part of experience (play, pleasure) or part of self (creative spirit) that they perceived as having been stolen by trauma—a sense of triumph or victory.

Category 4c. Making New Meanings

A final category describes participant reports of shifts in how they perceive and understand self, trauma, and their emotional lives. I classified this category in the *Transferring Transformation* domain because participants' articulation of new meanings and views of themselves and trauma seemed to draw on multiple novel experiences in SA and other shifts attributed to SA. This category thus encapsulates higher-level meanings that participants made of those new experiences; i.e., the way participants saw the gestalt of novel emotional, relational, or behavioural experiences in SA, as self-transformational, or the way those other shifts and new experiences transferred to new views of themselves. Subcategories include: having a heightened sense of control over trauma-related distress; trusting oneself; acceptance of the long-term impact of trauma; realizing a positive legacy of traumatic experiences; and seeing oneself as strong, capable, and valuable.

Now I can see it, feel it, control it. Five participants described a generalized shift, involving heightened sense of control over trauma-related emotional distress, behavioural patterns, and beliefs. This shift was contextualized by the out-of-control, unpredictable quality of "It" (i.e., "the invisible chaos" or "the black hole,") and participant's status-quo experiences of feeling overwhelmed by and unable to manage It. For example, Magda said, "It's been like I'm carrying a building on me. Where now, it's manageable. First seeing it, and, and then shrinking it to a manageable size." Magda attributed her heightened sense of control over distress, to being able to externalize and concretize emotional experience.

Rose described a shift from viewing trauma as out of control and chaotic, to viewing herself as in control, which she attributed to two types of experiences in SA. First, like Magda, she reflected that externalizing and concretizing distress through art-making gave her literal control over problems that were invisible and therefore had felt unmanageable:

> I don't know if this makes any sense, but..... a lot of my issues are things that, I don't have control over. And, a lot of my problems are like, you can't see, you can't touch, or I can feel but nobody else can feel […] So, I needed something that I could… I don't know… this is something that I can draw. And see. I can touch it, and I can decide to put it away when I want to. So, yeah. Like I said before, there's some control over it, now.

Rose goes on to describe a higher-order change, the transfer of transformation. Rose indicated that her wire sculpture, which depicted her trauma journey and included a visual "story" of becoming finally free of the strangling trauma wire, had helped her form and then strengthen a new view of herself as being in control of, and therefore free from, the chaos that trauma had caused in her life:

> I'm viewing trauma differently, which was what I needed for it not to be so raw inside all the time. […] I think by physically representing, especially in the wire piece with the chaos, um, giving it a form, giving it physical form that *I* created, actually...helped me.... because now I had control of the chaos and I had the like, I don't know, I created it and I have it, and I'm holding it [...] so that's shifted, I feel like I have a little bit more control over what I choose to...see. Or maybe I see the bigger picture, now. I see the light at the

> end of the tunnel, like the flower at the end of the wire, I see like the chaos that I wreaked on my life, um, like I'm taking control of it, now. It feels like it happened to me before, but now I can kind of ....choose and control what happens to me in the future.

Similarly, Kim described how making art gave her a heightened sense of control and power to "quash" trauma-related beliefs that she is worthless and insignificant. Kim went on to explain that the quashing power came from having greater understanding of where status-quo experiences of shame, powerlessness, and guilt came originated, and from the art she made that depicted personal qualities such as power, strength, perseverance over her trauma.

These three participants' examples illustrate how heightened control or power over distressing or painful psychological experience, is linked to other categories: the clarity gained from being able to better *see* and *feel as real* one's emotional experience (3b, *My art made 'It' real*); transferring emotional distress to an art object that could be touched, manipulated, and therefore managed in some way; and transforming new possibilities into reality, by creating them in art form (4a, *I made it, so I could handle it*). Although not articulated in these excerpts, it is also implied that, a priori to externalizing and containing, these participants also repeatedly made contact with their emotional experience in SA in a way that allowed them to reflect on and related to their emotional experience in those new ways (Domain 2, *Bringing It Up).*

Realizing I Still Matter. One shift in view of self, was a participant's realization that she still matters, i.e., exists, is a person, and has something of value to offer the world. The (often implicit) context for this shift included longstanding, trauma-related beliefs that one is incapable, worthless, has nothing to offer the world, and/or that life is pointless and meaningless. Kim, Magda, Pat, and Zahra are represented in this category, and they attributed the shift to a variety of experiences in SA. First, the perception of having made a contribution to the group, wherein their art, the feedback they gave others, or their voice, was valued by the group, affirmed that

"I'm not a no one!" (Kim). Similarly, experiences of trying new things, creating, and interrupting perfectionism helped Magda challenge deeply-held beliefs that she needs to perform to previous standards, to have worth. She reflected:

> I learned I can try new things, and I have something to say. So, even imperfect, you still have value, you still have a voice, you can still contribute *something*. It might not be the way it was before, but…I matter. Even if I'm broken, I still matter.

For Magda, this shift was meaningful because PTSD and physical health problems related to an isolated adult traumatic event, had reduced her ability to work and perform social role duties.

In addition, feeling more connected to self and emotional experience overall, conferred confidence in their capacity to take action and approach life with purpose. Pat described a new sense of herself as capable, because she made art in SA. This latter example seems simple, but was deeply felt by Pat as proof of her capacity to have an impact, and therefore proof of her worth:

> Like, I can't do my job anymore. But, I'm a kick-ass mom. I can write. And I can make things, really cool sculpture things. So knowing these things about myself is, makes me feel like I am somebody important. Because… I can do stuff, even though I am like disabled or whatever. Like there's things that I can *do* and *make*. There's a point for me being here.

This final example also highlights a link to the category, *if you can create art, you can create real change in your life*; it shares the underlying concept that making, or creating, awakens a sense of purpose and belief in one's capacity to act.

Compassionate Views, Adaptive Legacies of Trauma. Five participants reported new attitudes towards traumatic experiences and their impact. These shifts included descriptions of specific intrapersonal or interpersonal patterns that developed because of trauma and were previously perceived as problems or vulnerabilities, and new views of those patterns, as useful or beneficial, both at the time of the trauma and in the present. Reflecting on SA-related shifts in her tendency to run away from challenges and avoid discomfort, Nicole described realizing that:

> I can't beat myself up for things I didn't know and skills I didn't have. I was formed in an atrocious environment and I learned to run away, be perfect, be silent… Those were the things that I learned, and it also meant that I'm smart and can adapt quickly. So I'm working on looking at it from a kinder place rather than self-punishment.

Nicole highlights the importance of kindness and self-compassion in fostering her new view of avoidance and perfectionism. Compassion also centered in Felicia's view of an adaptive legacy of trauma. Reflecting on her experience of (yet again) not-belonging in group, she said:

> It helps me appreciate, like, my trauma has given me a deep acceptance of a lot of the negative things that happen in life. The painful things. I'm not running away from those things, which helps me have compassion for people who suffer, who are in survival mode. So...it's like having compassion for them, even though none of them seemed to have compassion for what it's like to be, like me.

Felicia described having practiced compassion towards other group members; in her effort to understand the various behaviours that made her feel like an outsider, she drew the conclusion that it came from their own ongoing suffering and attempts to survive. She attributed her capacity for compassion, to having struggled and suffered as a result of trauma, herself.

Trusting Myself, My Feelings. Three participants reported decreased self-doubt, and increased trust in themselves. As the category *Making choices, using my voice* described above, repeated opportunities to practice expressing herself helped Kim feel confident in "standing my ground." She attributed this shift away from "doubting myself" to the experience of trusting and then expressing her own opinions. For Kim, being granted time to express herself, and repeatedly having her opinions listened to and respected (as described in *witnessing healing together*, above*)* helped her start to see her own experience and voice as worthy of trust rather than doubt.

Trust was also attributed to learning in SA that one's emotions and bodily felt experience provide signals or information about how to proceed in a situation, as illustrated by Pat:

> I learned I can trust, that the decisions I'm making are authentic. And to trust my feelings a bit more, trust that when I'm feeling something in my body, it means something. Like it's *actually* something [R: what helped with that?] To trust, you have to feel safe.

> [crying]. And that's not a feeling that I get to feel very often. So I like, I swam in it. I loved it. [20 sec silence; crying softly] [R: And the tears are…?] It's kind of like, a happiness to have felt that, I guess, to know what trust feels like, gives me like a ... a clearer understanding of what I want. What I need to feel safe. To be healthy, to have good relationships, all of that. So, I think just that experience of being free to explore…I could potentially find it again, experience it again, like now I know that that *is* possible for me, to trust. [R: trust what? Or whom?] Myself. Really. And my experience.

Notably, Pat also links the heightened trust in herself and her emotional experience, to the concepts of *safeness*, the role of *freedom and framework* in feeling safe, and the experiential learning that comes from *practice*. She was moved by hope that she will be able to transfer this shift from SA to her life, because she knows now that it is possible, and what to look for.

Accepting the Hand I was Dealt. Magda, Pat, Rose, and Zahra reported increased acceptance that traumatic experiences are part of their personal history, and/or increased acceptance of trauma-related emotional and relational challenges, losses, and other perceived limitations. Rose had previously judged herself for having "crazy over-reactions." When asked about shifts in how she perceived herself or her trauma, she answered,

> In the group, I saw that the feelings I have, it's not just me, I'm not just crazy, or over-reacting. So, I guess, as we're talking through it, there *is* a shift. More acceptance of who I am, and how I am. So rather than saying to myself, 'you're wrong, you shouldn't feel like that, there's orphans in X country that are starving and have bad lives, get over it,' like comparing and invalidating myself …. Instead, now it's like, 'I went through things, other people go through things, I'm not the only one with big reactions. It's ok to feel like that.' And, it's important that we have outlets to express ourselves, that aren't going to hurt us, because for people with trauma, sometimes it's normal to feel like that.

She linked increased self-acceptance to the normalizing effect of being around others with similar difficulties. As was repeatedly illustrated earlier in this chapter, Rose also found that through art-making, she could feel into and then understand her emotions, which gave her a heightened sense of control. The above quote suggest that this control led to increased self-acceptance; control made emotional distress manageable, which made it acceptable to be a person with big emotional responses.

Participants' accounts of increased acceptance included a quality of openness to the future, and were linked to shifts in acknowledging, understanding, and validating emotional experience through SA (domain 3). The following excerpt illustrates these properties:

> Definitely greater acceptance of myself. Like accepting that this is the hand I've been dealt in life, and I'm choosing to play the game to the best of my ability, not to win but to enjoy the game. The medical stuff, being a person with trauma, being a single mom, just accepting all of it, and playing hard…..So, that's been a shift, and something that was part of the work I was doing before, probably since I started counselling in my 20s. I was starting to take baby steps then, but, this art class pushed me further. [R: how so?] Pushed me because it helped me *see* me. Like it helped me experience me... In a safe space. Yeah. Just *seeing* me and understanding me and being more compassionate. With the person I saw, with who I am. (Pat)

Pat perceived the experiential, autonomy-promoting way in which SA helped her access and understand her emotional experience, as the key aspect of art-therapy that furthered self-acceptance more than previous therapies had done.

Making the Model Dynamic

This section elaborates the findings through closer examination of the representation of participants across all categories. This part of the analysis was not planned; in the latter stages of focused coding and hierarchy refinement, it became clear that a subgroup of participants was consistently represented in some categories, and absent or nearly-absent from others. This suggested a conditional or sequential relationship between the four main categories, and a pathway along which a subgroup of participants moved over the course of SA sessions and the overall program, a pathway entailing processes of *Bringing into Presence.*

This final step of the grounded theory analysis presented in the preceding pages, supported identification of the core category, *Bringing into Presence*, and was based on examination of how individual participant accounts of their experiences in SA were differentially represented within the model's four domains, categories, and subcategories. *Bringing into*

Presence describes the dynamic processes linking Domains 1-4, in particular the extent to which feeling safe in the present facilitated the process of making art-mediated contact with dissociated aspects of emotional experience, and—through art-making—re-integrating or transforming it. In the following sections, I provide a narrative description of how the core category emerged through examination of the relationships among Domains 1-4, as revealed by patterns of participant representation across the Domains. This is followed by a fuller description of the core category, and figurative illustration of the heuristic model that traces the emergence of transformative shifts in SA.

Revisiting Domain 1: (Un)safeness as the Model's Gatekeeper

Domains 1 through 4 were ordered that way for a reason: my conceptual memo'ing about the links between concepts implied a sequential flow from a beginning, safety—to a middle, making contact with and witnessing emotional experience and related beliefs and behaviour patterns—through to an end, transforming them. More specifically, *Safeness* facilitated *Bringing 'It' Up*, allowing participants to make contact with their own emotional experiences, entering into dialogue with the emotional residue of past events. That experiencing had to happen in order for it to be engaged with or depicted in art, and thus *Witnessed*—whether by the participant and/or group members—or *Transformed* (acted on, expressed) in some way. Importantly, during the final stage of my analysis, I discovered that this apparently linear, step-by-step progression from Domain 1 to Domain 4 did not occur for all participants. Accordingly, I decided to examine more intensively how participants were individually represented within Domain 1, *Negotiating (Un)safeness in the Present,* particularly category 1c, *(Not) safe enough to risk opening,* because its subcategories had inherent dimensionality involving participants' experience of safeness and

consequent response in terms of how they engaged in group. It seemed like a point at which pathways might diverge.

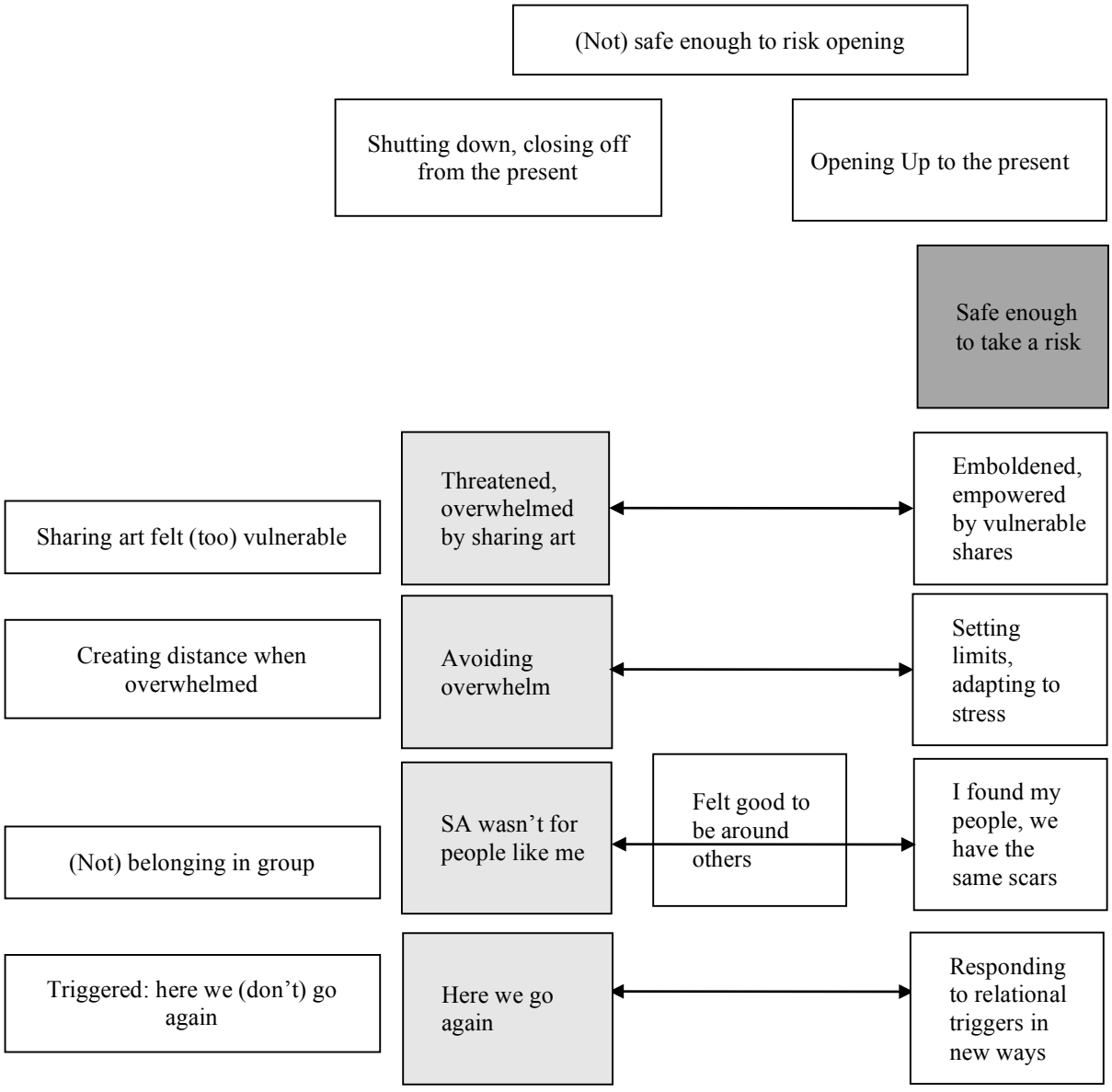
Category 1c, *(Not) safe enough to risk opening,* included four dimensional subcategories that described how participants variably responded to, and made sense of, incidents or aspects of SA that evoked vulnerability and anxiety. Review of their constituent, lowest-order properties suggested that there were opposite poles (or sub-subcategories) at either end of each dimensional subcategory. Four of category 1c's five subcategories were structured in this way. First, *Sharing art felt (too) vulnerable* included sub-subcategories '*threatened, overwhelmed by sharing art*,' and '*emboldened, empowered by share.'* Second, *Creating distance when overwhelmed* included '*Avoiding overwhelm*' and '*Setting limits, adapting to stress*.' Third, *Triggered: here we (don't) go again* included '*Here we go again*' and '*Responding to relational triggers in new ways*." Finally, *(Not) belonging in group* included '*SA wasn't for people like me'* at one end, '*I found my people, we have the same scars*' at the other, and one participant's experience, '*Felt good to be around others*,' somewhere in the middle.

Note that these poles were described and illustrated when category 1c was presented earlier in the chapter; I spelled them out here to re-orient the reader, prior to elaborating another, new conceptual layer. Namely, once the subcategories were laid out in this fashion, I noticed that all the poles at either end had something in common. The opposing poles of each subcategory represented either of two ways that participants responded to feeling vulnerable: (1) opening up to experience and responding flexibly to the moment, *in spite of* feeling anxious and vulnerable to relational harm; or (2) closing off and shutting down, avoiding experiences, or exhibiting rigid reactivity, *because of* feeling vulnerable to relational harm. Indeed, it appeared that the opposing poles of each subcategory could be separated and re-clustered into two new subcategories,

representing '*Opening up'* or '*Shutting down*.' This reorganization transformed the hierarchical structure of category 1c into a matrix, with intersecting subcategories, as illustrated in Figure 2.

Figure 2.

Matrix re-structuring of subcategory **(Not) safe enough to risk opening**



Note. The matrix structure demonstrates opposite poles (or, sub-subcategories) of bi-polar (horizontal) subcategories clustered into new, vertical subcategories. Light grey categories are populated exclusively by one sub-group; dark grey is populated exclusively by the other.

Participants explicitly or implicitly attributed *opening up*, connecting to others, and taking risks to feeling safe enough; whereas *shutting down*, avoiding, and isolating in group were attributed to unsafeness. The difference lay in the perceived balance of safeness: participants felt safe enough to risk being present, or not safe enough to take the risk. Furthermore—perhaps of greater clinical interest—the matrix re-structuring revealed a subgroup of four participants whose interviews contributed, exclusively, to the *shutting down* poles: Brenda, Dee, Felicia, and Gabrielle. This suggested an overall experience in SA, for those four participants, characterized by unsafeness, and reactive pulling away or closing off when they felt vulnerable to relational harm. Conversely, the other six participants were heavily represented in the *opening up* poles of the 1c subcategories. Note that the four participants who tended to shut down, pull away, and close off, were also represented—but far less frequently, as evidenced in the categorization of individual MUs—in some of the *opening up* poles. This provided further support for a matrix structure that captured the dimensional representation of participants' experience of safeness in SA, from (1) *opening up* to (2) *shutting down*, and how this manifested in response to various types of relational vulnerability. In Figure 2, light grey subcategories are populated exclusively by Brenda, Gabrielle, Felicia, and Dee. The dark grey subcategory is populated exclusively by Kim, Magda, Nicole, Pat, Rose, and Zahra.

Participant Representation Across Domains

Next, I examined whether those two emergent participant subgroups were differentially represented, across the other three domains. Table 4 lists all categories and subcategories in the model, updated to cohere with Figure 2 and depict contrasting subcategories of *shutting down* and *opening up* in lieu of the dimensional subcategories falling under *(Not) safe enough to risk opening* that were described above. On the right-hand side of the table, 10 columns—one for

each participant—denote whether that participant is represented in the category. Conveniently (and coincidentally), their pseudonyms in alphabetical order permit a visual grouping of Brenda, Dee, Gabrielle, and Felicia, followed by the other six participants. The table—shaded to do double-duty as an illustrative figure—shows that, after that pivotal *shutting down* subcategory, the other domains and their subcategories are more substantially populated (shaded grey) in the six columns towards the far right (Kim, Melanie, Nicole, Pat, Rita, Zahra). They are sparsely populated in the four left-most columns (Brenda, Dee, Felicia, Gabrielle). Moving down the table, this 'shutting down' group is completely or near-completely absent from portions of each of the model's other three domains.

In Domain 2, *Bringing It Up,* the 'shutting down' group is well-represented in *Therapy took a toll* and *More intense than expected*, which together capture the experience of feeling drained by the group, and of having more intense emotional experiences in the room, than one had expected. They are absent from the subcategories that describe heightened and new contact with emotional experience, and the process over time, of learning what to 'do' with the intense emotions that came up. Their collective absence from *Material magic* suggests a different way of engaging in art-making. Where represented in the subcategories *Mindfully allowing the process to unfold*, the relevant MUs emphasize that mindful allowing was something participants only managed to do towards the end of SA, or in isolated sessions, which they framed as a limitation or better-late-than-never progress. For example, Dee stated:

> I was putting a lot of pressure and judgment on myself the whole time, like I wouldn't go get materials until I figured out what I was going to do and so the creative process never took over, it was just an intellectual process. Whereas the last week, it was the very first time that, I wasn't too sure what to do, um, so I started moving round the room, and I started finding things that I just wanted- and it was the first time where I was sorta letting it come out, naturally, and, if something didn't work like I envisioned it, I just, sort of, winged it.

Table 4.

Participant representation across all categories and subcategories

Category	Subcategory (*sub-subcategory*)	Participant Representation									
		n	*Individuals (pseudonym initial)*								
		(*N*=10)	B	D	F	G	K	M	N	P	R	Z
			(Shutting Down)				(Opening Up)					
Domain 1: Negotiating (Un)safeness in the Present												
"Always not feeling safe in the world"		10										
	Living behind a wall	8										
	Perform perfectly to stay safe	6										
	It could turn on a dime	6										
Secure Space		10										
	Rules, norms made it safe(r)	8										
	Facilitators made it safe(r)	8										
	Common ground made it safe(r)	6										
	Freedom, choices made it safe(r)	8										
(Not) safe enough to risk opening		10										
	Shutting down from the present	4										
	Threatened, overwhelmed by share	3										
	Avoiding overwhelm	4										
	SA wasn't for people like me	3										
	Here we go again	4										
	Safe enough to take a risk	6										
	Opening up to the present	9										
	Emboldened, empowered by share	5										
	Setting limits, adapting to stress	6										
	Found my people… same scars	6										
	Responding to triggers in new ways	4										
Domain 2: Bringing 'It' Up												
A lot came up		10										
	Therapy took a toll	8										
	More intense than expected	8										
	Didn't know what to do everything that came up	5										
	Learning to feel feelings	6										
Allowing an internal conversation to unfold		10										
	Mindfully allowing the process	8										
	Material magic	5										
	Digging for feeling and meaning	9										
	Art the storyteller	7										
Domain 3: Witnessing the invisible and the invalidated												
'It' is invisible		8										
	Invalidating my experience	7										
	Origins of self-invalidation	5										
	Lock it away, hide it	8										
	My body is a broken compass	6										
	Hard to articulate my feelings	5										
	Trauma is a black hole	5										

My art made It real	8	
SpeakArt helped me see me	7	
I felt my feelings through my hands	5	
Acknowledging by making it visible	7	
Looking at art, seeing each other	10	
They got my art, they got me	5	
What others saw changed meaning	5	
Witnessing healing together	6	
Domain 4: Transforming Materials, Transferring Transformation		
I made it, so I could handle it	9	
Make the pain into s/t that holds it	4	
Keeping art, preserving the process	7	
If you can create art, you can create real change	4	
Creating new actions/responses	10	
SpeakArt was a place to practice	7	
Challenging self-criticism and perfectionism	9	
Making choices, using my voice	10	
Rediscovering play	9	
Making new meanings	7	
Now I can see it, feel it, control it	5	
Realizing I still matter	4	
Compassionate, adaptive legacies…	5	
Trusting myself, my feelings	3	
Accepting the hand I was dealt	4	

Note. Participants identified by initial: Brenda, Dee, Felicia, Gabrielle, Kim, Magda, Nicole, Pat, Rose, Zahra. This table was designed with figurative (visual) elements to illustrate a pattern in the data presented therein. Light-grey shading has been used to indicate participant representation at the category level. Dark-grey shading indicates that the participant is represented within a subcategory (or sub-subcategory, for italicized rows). Different shades were used for subcategories and categories, to emphasize the general discrepancy in representation at the subcategory level, between the six right-most participants, and the four left-most participants, who do not appear as consistently in Domains 2-4.

In contrast, other participants highlight it as a shift that happened early or in the middle of therapy, which changed their approach to subsequent sessions. Magda called it her "breakthrough" and Rose reflected that one significant session "just let me, it let me go, it let me be free to just do anything that I wanted to do after that."

Domain 3, *Witnessing the Invisible and the Invalidated,* also shows a discrepancy in representation between the two participant subgroups. It is not apparent in the category that captures status-quo patterns of relating to one's emotional experience in a compartmentalized,

invalidated, or dis-associated way. On the other hand, the 'shutting down' subgroup is nearly absent from the category that describes art-mediated understanding, validation, and acceptance of emotional experience (*My art made it real).* Where they are represented, the relevant MUs are about isolated experiences for the participant and the significance is less clear.

Domain 4 showed uneven, limited, or qualified representation of the 'shutting down' subgroup. Within category 4a, *My art made It real,* they were not represented among the subcategories that capture externalizing and containing distress through art. In terms of keeping artwork, Brenda made and kept a nostalgic reminder of past happy times, and Dee made and kept a drawing of painful, longstanding, and ongoing isolation, to motivate future change. Any kept artwork did not represent a new experience or change they had experienced in SA, unlike other instances within that subcategory, which came from the 'opening up' subgroup. Similarly, Felicia's belief that creating art instantiates the capacity to create other changes in your life was not directly tied to her experience in SA—in fact, that passage was part of her generalized response after the interviewer asked why she thought art was important for women with trauma.

Within category 4b, *Creating new actions*, the 'shutting down' subgroup were represented in the subcategory *Challenging self-criticism* because of MUs that pertained to struggling with perfectionism and self-criticism in SA. Notably, this subgroup was absent from properties pertaining to practicing allowing mistakes in SA, or reported shifts in self-kindness and relaxed perfectionism. Finally, the 'shutting down' subgroup were also nearly absent from category 4c, *Constructing new meaning*. Other than Felicia's reflection that her experience of not-belonging in group and compassion towards other group members for their exclusive or unwelcoming behaviour, had made her realize that her trauma made her a compassionate person,

it is striking that no member of the 'shutting-down' subgroup reported new or re-conceptualized views of themselves or of trauma, as a result of their experiences in SA.

Overall, this suggests that the four participants who described closing off and shutting down, avoiding experiences, or exhibiting rigid reactivity, *because* they felt vulnerable to relational harm, reported fewer of the subcategories and properties that are represented in Domains 2-4, particularly those pertaining to emotion processing, symbolization, and transformation. It is as if they were 'stuck' at feeling unsafe, and therefore had fewer experiences that fit into the remainder of the model; they were closed off from fully engaging with the unfolding present in the room. In particular, they did not report (or reported isolated experiences of) making contact with distressing emotions that had previously been inaccessible or outside of awareness, and learning what to 'do' with those feelings. They did not seem to experience art materials as a guide into the expression of meaningful experience (*Material magic)*, and they had fewer experiences of *Mindfully allowing the process to unfold* (2a). Furthermore—perhaps it is reasonable to say, consequentially—they did not report experiences of art-mediated personal witnessing of their own emotional experience (3b), although they did contribute to the concept of *Witnessing healing together* (3c). Finally, participants who felt less safe in group, reported self-criticism and perfectionism coming up while making art, and did not perceive using art materials, art-making, and interacting in a group setting as a way to practice challenging self-criticism and perfectionism or materially transform experience (4a, 4b).

Conversely, the six participants who comprised the 'opening up' subgroup reflected that they felt safe enough take risks in group, and highlighted specific instances in which they felt safe enough to respond to moments of vulnerability in group, in flexible and adaptive ways. These 'opening up' participants were consistently represented across the model's categories;

their sense of relative safeness, it seems, allowed fuller engagement in art therapy as a means of bringing 'It' up, witnessing 'It', and transforming experience and action through making art and interpersonal interaction.

Revisiting Demographics and Pre-treatment Measures

With the appearance of two subgroups of participants in terms of their representation in the heuristic model, the question arose as to whether *shutting down* vs. *opening up* participants were different in some predictable way. Although the sample size is too small for comparative statistical testing, I reviewed and compiled descriptive measures (means and frequencies) for participants' self-report pre-test measures, and demographic variables. This information is presented in Table 5. It suggests—although there is no evidence of statistically significant

Table 5

Pre-therapy demographics, symptoms, and emotional function scores

Variable	Shutting Down (n=4)	Opening Up (n=6)
Mean Age in years	45	40
Mean years post-secondary education	2	4
Employment status	At least 75% unemployed (1/4 did not report)	33% employed full-time, 33% returning to full-time work, 33% unemployed
Relationship status	100% never married/single	50% never married/single, 50% separated, divorced, or widowed
Polytraumatic exposure	100% reporting neglect, emotional abuse, physical abuse, sexual abuse	50% reporting neglect, emotional abuse, physical abuse, sexual abuse; 33% reporting neglect, emotional abuse, physical abuse; n=1 reporting sexual abuse
Pre-therapy IES-R score	43.75	51
Pre-therapy OQ-45 total score	88.75	97.33
Pre-therapy DERS score	99.5	113.2
Pre-therapy TAS-20 score	54	62.33

differences—that participants who experienced *shutting down* were slightly older, slightly less educated, and reported higher rates of unemployment and never-married status, compared to

‘*opening up’* participants. Additionally, self-reported childhood polytraumatic exposure was higher among those who experienced *shutting down* in SA. Interestingly, their mean reported PTSD symptom scores were lower, as were general distress and functional impairment, emotion dysregulation, and alexithymia scores.

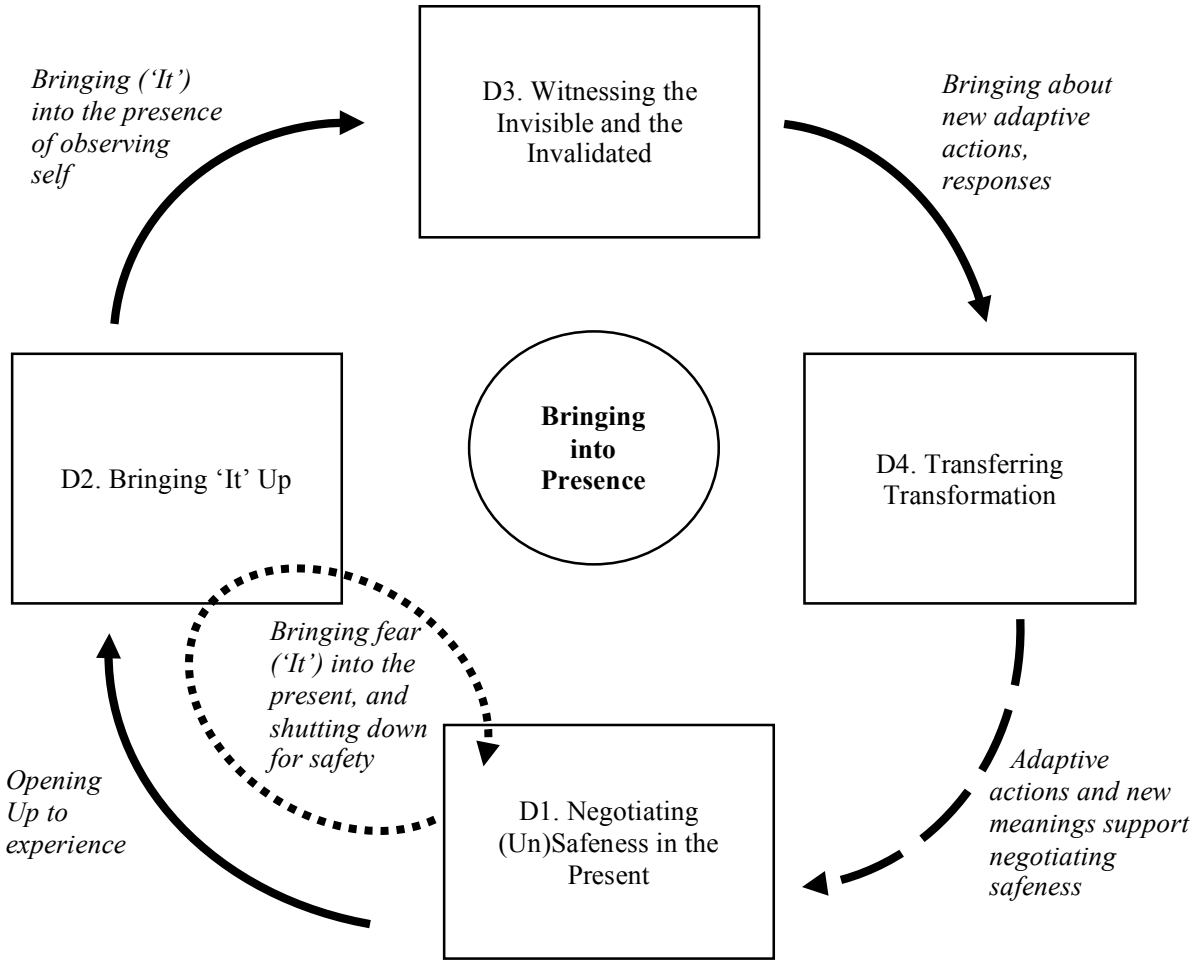
Revisiting the core category: Bringing into Presence

The relationship among the four domains can be understood as conditional on *Opening up* vs. *Shutting down*, and somewhat sequential, within and across domains. The dynamic processes linking domains constitute the model’s core concept, *Bringing into Presence*. The categorical hierarchy presented in Figure 1, at the outset of this chapter, was static; Figure 3 below depicts a re-arrangement of the domains to reflect this dynamic and the core category.

The four domains are depicted in a circle, which begins at the bottom, with the foundational concept of Safeness. (Un)safeness is negotiated in an objectively safe *Secure space*, which is defined by SA’s joint provision of *Freedom and framework*, but is not necessarily experienced as safe due to longstanding patterns of *Always feeling not safe in the world*. In this group art therapy space—beginning to move clockwise, towards Domain 2—*A lot comes up,* and participants find it *More emotionally and relationally Intense than expected,* such that *Therapy takes a toll.* These intrapersonal and interpersonal demands contribute to the ongoing *Negotiation of (un)safeness*. Lacking sufficient safeness, participants are preoccupied, in the present, with perceived threat or a sense of overwhelm, to which they respond by *shutting down*. The dotted circular pathway in Figure Z indicates this process, of ***Bringing* fear and shame (or, ‘It’) into the *Present* SA environment,** and of not feeling safe enough to move beyond a self-protective *shutting down* response.

Figure 3.

Dynamic model of art therapy for complex trauma: the processes of Bringing into Presence



With sufficient safeness, participants risk *opening up* to further exploration of experience as *A lot comes up* (Domain 2). By *Allowing an internal conversation to unfold* they begin to figure out what to do with emotion, or *Learn to feel feelings*: to feel, externalize, express, and symbolize it through artwork, so that it can be *Witnessed* for understanding and validation (Domain 3). In Figure Z, the movement from Domain 2 to Domain 3 represents this process, of ***Bringing*** **(trauma-related) emotional experience into the** ***Presence*** **of one's observing, acknowledging self**, grounded in the secure space of the present.

Finally, with heightened access to and understanding of their emotional experience as rendered in material or visual form, participants are able to manipulate (modulate) it and practice new, adaptive actions within the dynamic relational group setting, such that emotional experience is *Transformed and transferred* from artwork back to self, and from artmaking to actions in the outside world. The movement from Domain 3 to Domain 4 shows this process of ***Bringing about*** **new responses and actions, manifesting them in the *present*, of *Bringing change into Presence.*** When these transformations pertain to modulating emotion, interrupting trauma-related fear responses, and asserting boundaries while making art, they may support participants' sense of being grounded and able to tolerate and effectively respond to intrapersonal and interpersonal challenges in group, enhancing *safeness* and more *opening up* to the present—as indicated by the dashed arrow from Domain 4 to Domain 1.

The phrase *Bringing into Presence* has multiple meanings. The preceding paragraphs suggest two connotations for the word "Bringing": (1) *bringing up* into awareness, some emotionally-charged, previously dis-associated sensations and meanings from past trauma; and (2) *bringing about*, creating or constructing, a new response to or meaning for those experiences. Likewise, "Presence" has multiple layers of meaning, referring to: (1) being in the temporal present, as distinct from the past and from past trauma, such that here and now, there may be room to trust indicators of safety, and risk opening up to unfolding present-moment experience; (2) awareness, the state of being-present-with-experience; and (3) a state of being-in-existence, of having been created or manifested, acknowledged as real. With these multiple meanings, the three-word phrase *Bringing into Presence* acts as placeholder or symbol for the dynamic emergence of multiple processes captured within and between the four domains that constitute this model. At the same time, there is something central, a distillation of the multiple processes

described by these various and layered meanings of those words and illustrated in Figure 3. Distilled, and in the context of this phenomenon of group art therapy for complex trauma, *Bringing into Presence* refers to the process of making art-mediated contact with the compartmentalized, hidden, previously-invisible emotional residue of past (traumatic) experiences, and transforming—again, through artmaking—that residue into something new.

Chapter 4: Discussion

Study Overview

This study investigated the experiences of clients who completed an art therapy group for people with complex trauma histories. Participants were 10 women receiving treatment through a publicly-funded complex trauma therapy program at an urban hospital, recruited upon their enrollment in the art therapy group, SpeakArt (SA). The sample had been exposed to multiple types of developmental and adult relational trauma, and pre-therapy self-report measures indicated that they were experiencing levels of general symptom distress, difficulties in interpersonal relationships and social role function, PTSD symptoms, and difficulties with emotion regulation, exceeding those of most clinical samples.

Semi-structured initial and post-therapy interviews were used to elicit participant narratives of their experience in the group, identification of any changes in behaviour, self-understanding, and relational and emotional function, and their reflections on how the group promoted those shifts. This two–interview design, adapted from the Narrative Assessment Interview method (Angus & Kagan, 2013; Hardtke & Angus, 2004), was used to collect retrospective accounts of therapy and associated shifts that were reflexively anchored in participants' initial (baseline) interview content. Participants were invited to express their expectations, hopes, and fears about group in the initial interview, and then prompted to reflect on a summary of that content, at post-therapy. Post-therapy interview questions were adapted from the Patients Perceptions of Corrective Experiences in Individual Therapy interview (Constantino et al., 2011a; Constantino & Angus, 2017) to elicit participant reflections on significant interpersonal and intrapersonal processes or experiences in group, and associated relational, behavioural, and psychological shifts. Grounded theory techniques, applied from an

interpretive-constructivist stance, were used to analyze the post-therapy interviews. The analysis resulted in a hierarchy of categories and heuristic model comprised of a core category, *Bringing into Presence*, a dynamic and multi-layered process linking the four main categories (domains). Each of these categories will be summarized in the discussion that follows.

The primary aim of this study was to gain understanding of how art therapy is helpful for the healing or transformation of complex trauma sequelae, through clients accounts of their experience in art therapy, and their view of and explanation for any associated shifts. Four research questions were posed to inform the interview protocol and analysis process: (1) What processes or experiences in SA do clients perceive as challenging, significant, or helpful? (2) Do clients perceive and attribute to SA any meaningful personal changes, e.g., shifts in their: thoughts/beliefs; attitude towards therapy; feelings; actions; relationships; view of self; understanding of trauma; understanding of the impact of trauma? (3) According to clients, how did SA contributed to those shifts? (4) What do clients' experiences and understanding of art therapy, and associated shifts, reveal about the nature of transformation/healing after exposure to complex trauma? A secondary aim was to integrate the resulting heuristic model of art therapy for complex trauma, with existing perspectives on complex trauma formulation and treatment, and existing considerations for complex trauma treatment, from the broader psychotherapy process literature. This final chapter summarizes key findings pertaining to these research questions and aims, and discusses them in the context of complex trauma and psychotherapy literature.

Key Findings

This study provides insight into the events, factors, and processes that participants identified as significant in their experience of group art therapy. The findings suggest complex

trauma survivors in group therapy engage in ongoing negotiation of wavering safeness—the subjective experience of safety, which often does not match one's rational or objective knowing that one is safe—on both intrapersonal and interpersonal levels. The core category, *Bringing into Presence*, refers to a central, multilayered process that began with participants' experiences of negotiating intrapersonal and interpersonal vulnerability in group. Those who felt safe enough engaged in art-mediated processes of contacting emotionally-charged experiences, so that they could be witnessed and transformed through adaptive action or expression. For them, the core category unfolded as a process of bringing into presence (into material, witnessable, malleable form) emotions and other trauma-related experiences that had been invalidated or made invisible. Alternatively, lacking sufficient safeness—fearing and perhaps perceiving the recurrence of past experiences of relational harm, and ensuing emotional overwhelm—participants were preoccupied with perceived present-moment threat. For those participants, the core category unfolded as a process of bringing into the present their trauma-related expectancies, emotions, and interpretations, and the protective response of shutting down.

Bringing into Presence and Integration

As traumatologist Bessel van der Kolk puts it, "dissociation is the essence of trauma" (2014, p. 66). Indeed, the experiences that participants were contacting in SA—and, if they felt safe enough, dialoguing with, externalizing and symbolizing, witnessing, and transforming—were often dis-associated, unprocessed emotions, episodic and procedural memories, and beliefs, that had previously been experienced as chaos, emptiness, or a numb blankness ("It"). "It" was *broadly* described as including traumatic experiences, trauma-related emotions, beliefs, memories, and other present-day impacts of trauma. The interviews and subsequent analysis did not clarify the extent to which participants were processing specific episodic trauma memories

during SA, as part of processing, representing, and integrating "It." Participants sometimes referred to memories and specific traumatic incidents when they described their art-making and reflective process. At other times, they described feeling emotions they had previously avoided or been unaware of, or described reflecting on more generalized memory schemas representing complex relationship patterns and views of themselves in their art-making. The activation and recall of specific episodic trauma memories may or may not have been part of that integration process, however participants implied that their status-quo tendency to avoid, suppress, or compartmentalize certain aspects of their experiences was trauma-related, i.e., a longstanding self-regulation strategy that resulted from trauma.

The defining feature of this nonspecific aggregate of trauma-related psychological phenomena, was that participants experienced it as compartmentalized, invalidated, minimized, or made-invisible in some way (hence, calling it "It" or "stuff"), and that it felt unexpectedly intense, even overwhelming, to start to remember, feel, or think about "It." Thus, *Bringing into Presence* entailed giving material-visual substance and form to the "black hole" of invalidated or dis-associated experiences. Making art in a group setting also involved substantiating transformation in response to newly integrated trauma-related memories and emotional experience. In particular, having art materials to manipulate, and a social microcosm to participate in, provided participants with the opportunity to enact new, adaptive responses to the newly-integrated emotions and meanings. The overall model thus describes a process of re-association or integration of old, painful experiences and integration of new, adaptive beliefs and behaviours, which is the goal of all trauma treatments (van der Kolk, 2014).

Domain 1, *Negotiating (Un)safeness in the Present*, in particular captures the dilemma of integration work in trauma treatment: namely, that dissociated trauma-related memories and

emotions are by nature overwhelming, but integration of experience cannot occur in a state of overwhelm or feeling threatened. When overwhelmed or in a state of autonomic dysregulation, self-observing and reflective processing capacities—necessary for emotion regulation and integration—shut down, and clients have increasing difficulty taking in new information from the environment, which makes it difficult to discern safety vs. threat (or present vs. past), leading to further autonomic dysregulation and the activation of defense responses (Ogden et al., 2006; Siegel, 2003). Integration is thought to occur when clients feels sufficiently safe in the present moment, such that their autonomic and emotional arousal is at a tolerable level, allowing for reflective processing of non-verbal, embodied (emotional, somatic, sensory) components of experience (Ogden et al., 2006; van der Kolk, 2014).

In the *Bringing into Presence* model, participants who felt vulnerable and excluded from the group were pre-occupied with the perceived threat of judgment, rejection or persecution, and/or of emotional overwhelm, and responded with self-protective *shutting down* from engagement in the activities of art-making and art-sharing. Those who felt sufficiently safe were able to *open up* to new information that arose during intrapersonal exploration, and were in a state of being able to witness, reflect on and integrate that information, i.e., to process the residue of past trauma from a position of being grounded in present-moment safeness. This study's findings are therefore consistent with other current theoretical models of trauma treatment, which facilitate integration through the provision of relational support to develop clients' capacity for tolerating and modulating autonomic and emotional arousal (Ogden et al., 2006; Cloitre et al., 2016; Courtois & Ford, 2016; van der Kolk, 2014).

Shifts and How Shifts Occurred

Research questions 2 and 3 pertain to how SA was helpful for the difficulties associated with complex trauma. The integration described by the overall model is an account of how SA promotes transformation or growth in the context of complex trauma-related difficulties, through the processing of previously un-integrated memories, beliefs, and emotions for expression or adaptive action, and reflective meaning-making. Integration is both a shift and a process that allows for shifts; it is a fairly abstract concept, a step or two removed from the language of participants' accounts. The subcategories that make up the model also describe, in concepts and language closer to participants' own words, several specific types of shifts that participants attributed to SA, and their perception of how those shifts came about. Shifts and explanations for shifts correspond approximately, rather than precisely, with the structure of the categorical hierarchy: Domains 1 and 2 are comprised primarily of "hows," Domains 3 and 4 include "hows" and "shifts," and all four Domains include categories that capture the status-quo distressing or maladaptive tendencies that participants were shifting *from.* Furthermore, some "hows" entailed various processes, factors, and experiences in SA which are, arguably, shifts themselves.

Shifts Identified by Participants. Domains 3 (*Witnessing the Invisible and the Invalidated*) and 4 (*Transferring Transformation*) include specific shifts in: how participants understand and relate to themselves; engaging in new adaptive actions and ways of relating to others; and shifts in self-concept and the meaning of trauma.

New Understanding and Ways of Relating to Self. In response to heightened contact with distressing emotions that came up in SA, some participants reported a shift from *Not knowing what to do with everything that came up,* to *Learning to feel feelings*. This shift entailed

heightened capacity for emotion modulation: participants described being more able to experience and tolerate intense emotions, which involved allowing, making sense of, expressing, and adaptively down-regulating the intensity of emotion. The category *My art made 'It' real* described reported shifts towards heightened awareness, acknowledgment, and understanding of emotional experience, including emotionally-charged beliefs and behaviour patterns, away from status-quo tendencies to invalidate, minimize, compartmentalize, or avoid feeling. Finally, some participants who engaged in C*hallenging self criticism and perfectionism* also reported increased self-compassion, decreased self-criticism, decreased efforts to perform perfectly, and improved ability to embrace mistakes.

New Actions and Ways of Relating to Others. Many participants described shifts in increased assertiveness, i.e., the adaptive expression of wants, needs, and boundaries. *Making choices, using my voice* included instances of exercising autonomy (making choices) while making art and negotiating competing needs and limits in the group setting. It also included reported novel experiences outside SA, wherein participants self-advocated or otherwise used their voices to establish boundaries, express opinions, or assert their needs in relationships. In addition, making art was experienced as fun and pleasurable, which participants signalled as a shift or novel experience. Specifically, *Rediscovering play* describes how playing in SA was a new and inherently good experience, which most participants gave trauma-contextualized meaning, i.e., that trauma and its aftermath had precluded, interrupted, or stolen their capacity to play.

Shifts in Self-concept and the Meaning of Trauma. Some participants articulated new meanings and views of themselves that arose from making sense of other shifts and novel experiences in SA. As such, these shifts might be considered "higher order" changes, constructed

as participants incorporated other changes into their self-narrative, a process of *Making new meanings.* Some participants described a new view of self as having control and over trauma-related emotional distress and behavioural responses, capable and able to manage what they had previously experienced as overwhelming, out-of-control, unpredictable chaos. Some reported increased acceptance of traumatic experiences and trauma-related emotional, relational, and health challenges, limitations, and losses. Participants also expressed new attitudes towards trauma and reconceptualization of some trauma-related intrapersonal resources and interpersonal patterns as useful or beneficial. Another shift entailed decreased self-doubt and heightened trust in one's own emotional signals, voice, and decision-making. Finally, participants reported heightened self-esteem and new recognition that they are capable and have something to offer the world.

Participant Perceptions of How SpeakArt Facilitated Shifts. The above-described shifts were attributed, by participants, to three features of art therapy or types of experiences in SA. These include: a particular mode of engaging in group that helped bring emotion into awareness where participants could feel and dialogue with it; being able to witness and modulate (art-) externalized emotional experiences; and having experientially-grounded practice and opportunities to translate insight into action. Those "hows" in turn were attributed to the conditions that promoted safety in group.

Safeness as a Precondition for Self-exploration. Participants attributed specific meaningful, new, or helpful experiences in SA to having felt safe enough to take risks in exploring their internal landscape and experimenting with new actions or responses in the external landscape. Participants faced a dilemma as they navigated the vulnerability of exploring and interacting vs. the relative safety of disengaging and avoiding. *Secure space* comprises four

features of the group environment that participants perceived as enhancing their sense of safety and their capacity to take risks in SA: the *Common ground* furnished by the group's complex trauma focus; a lack of pressure to change or perform and provision of autonomy, *Freedom and choices*; *Rules and norms* to protect group members from criticism, judgment, or being triggered by trauma details; and the presence of *Facilitators* to reinforce that framework, and provide emotional support.

Making Contact and Dialoguing with Emotion. Nearly all the shifts described in the previous section entailed new awareness, understanding, and adaptive expression of emotional experience. Thus, contact with emotions—instead of avoiding, compartmentalizing, or otherwise down-regulating—is a fundamental "how." Participants described making contact with (feeling and becoming aware of) previously-inaccessible emotions and related beliefs, memories, and sensations. That is, *A lot came up* as they made art in response to prompts, took in others' art and stories, and interacted with group members. *Allowing an Internal Conversation to Unfold* describes a specific approach or way of engaging in art making, that helped participants to become aware of and engage in dialectic, reflective exploration of previously-inaccessible emotions. This mode of engagement with art-making entailed a balance or interplay between open, curious receptivity and responsivity to unfolding experience, and active examination and reflection on the significance of that experience. Participants described allowing the properties of art materials to guide embodied experiencing, and having a moment-to-moment interplay or dialogue with that experience as it emerged or unfolded through their interactions with art materials, other people, the space, the prompt, finished art, and others' art.

Witnessing and Modulating Externalized Experience. Heightened self-awareness and emotion experiencing and shifts in emotion modulation capacity were attributed to experiences

in SA of relating to and manipulating the visual or concrete correlate of their internal experience, externalized in artform. *My art made 'It' real* describes how the visual-concrete nature of art-making helped participants to see, feel, understand, and validate as real, various aspects of experience that had been hidden, dissociated, invalidated. The seeing-touching-validating was possible, because those experiences were expressed in visible and tangible form (artwork). Similarly, *I made it so I could handle it* describes how the visual-concrete nature of artwork, and the creative process, allowed participants to take various actions to modulate the intensity of their emotions, and gave them a sense of control and self-agency over their emotions as well as the overall change process.

Experientially-Grounded Practice and Change in Action. Shifts in self-concept and new adaptive behaviours outside group were often attributed to having practiced new ways of being and doing. In SA, participants faced situations, tasks, and interactions that echoed problematic scenarios and painful interpersonal or intrapersonal patterns from daily life. The activities of art-making and the interpersonal exchanges that arose in the group format, meant that SA served as a microcosm or laboratory for experimenting with actions that could be transferred to the macrocosm of the participant's life outside therapy and which supported higher-order self-narrative shifts. As an explanation for shifts, *Practice* was closely linked to several features of *Secure space* and feeling *Safe enough to take a risk*: being granted autonomy and freedom to explore allowed participants to attune to and then choose how to act on their own emotional signals. Having real, concrete experiences that challenged their maladaptive patterns helped some participants go beyond conceptual understanding or insight into their trauma-related emotional responses, and gain a new template for action/experientially-grounded knowledge.

Elaboration of Key Findings in Relation to Relevant Literature

Other Models of Integration in Experiential Therapies

The present study offers a model of how participants process and integrate (trauma-related) emotional experience. It suggests that integration of emotional experience occurs by: contacting it through imaginative and embodied engagement with the sensory, material, and visual qualities of artwork; symbolizing and reflecting on it; adaptively acting on it, and making meaning of it. As such, there are several points of convergence between the findings, and other models of integration in experiential therapies.

Emotion-focused therapy for trauma (EFTT; Paivio & Pascual-Leone, 2010) uses empathic relationship conditions and Gestalt techniques to evoke trauma memories and associated emotions, beliefs, and interpersonal schemes for integrative processing, symbolization, and meaning-making (Paivio & Angus, 2017). Process-outcome studies have examined markers of narrative-emotion integration, as measured by the Narrative Emotion Process Coding System (NEPCS; Angus et al., 2017) in EFTT. They indicate that clients enter therapy evidencing overgeneralized memories and undifferentiated, under- and over-regulated emotions that do not cohere with in-session narrative content. Recovered-status clients evidence increasing markers of internal focus, contacting emotions, and being able to engage in self-reflection, symbolization of emotions, and narration of specific memories, while experiencing higher, regulated levels of emotional arousal. In addition, they begin to express reconceptualised views of themselves, others, and trauma, indicating that emotion differentiation contextualized within specific personal memories leads to integrative meaning making and heightened self-coherence. In contrast, unchanged-status EFTT clients persist in showing under- or over-regulated, undifferentiated emotional states, and overgeneralized memory recall, expressed

through narratives that are incoherent or have rigid, black and white, maladaptive content (see Angus et al., 2016; Carpenter et al., 2016; Macaulay & Angus, 2019).

These process-outcome findings cohere with aspects of *Bringing into Presence.* Unproductive process in experiential therapy for complex trauma is marked by clients getting "stuck" in dysregulation and maladaptive, over-generalized old interpersonal beliefs. The process of *Shutting down* in the present study entailed all-or-nothing disengagement (over-modulation) in response to feeling overwhelmed by emotional intensity or perceived interpersonal threat, experiences which were often explained in terms of familiar maladaptive interpersonal schemes (*Here we go again, Not belonging in group).* Participants who evidenced *shutting down* were minimally represented in the categories involved in the rest of the model of integrative processing. In particular, the discrepancy between the *Shutting down* and *Opening up* subgroups was starkest in the subcategories *I didn't know what to do with what came up* and *Learning to feel feelings*, and the categories *My art made It real* and *Making new meanings.* Together, these categories describe processes of accessing trauma-related emotions and memories, symbolizing and reflecting on them, and making new meanings of them—which mirror the NEPCS EFTT findings regarding process markers that differentiated recovered-status and unchanged-status clients. This convergence provides some validation for *Bringing into Presence* as a model of how art therapy facilitates integration of complex-trauma-related experiences.

Body-based treatments like sensorimotor psychotherapy (SP; Ogden et al., 2006) and somatic experiencing (Payne et al., 2015) engage sensation, movement, and the embodied experience of emotions and memories. This is thought to help with "bottom-up" regulation of autonomic and emotion dysregulation. It is also conceptualized as a way of accessing, mindfully observing, and integrating procedural and nonverbal trauma memory. In the present study, the

properties of *Allowing an internal conversation to unfold* and *My art made It real* suggest that participants were activating and mindfully observing, reflecting on *embodied* experience: touching, sensing, and manipulating concrete art materials helped to bring emotional material up into conscious awareness, and helped participants experience it (e.g., *I felt my feelings through my hands*) as opposed to status-quo tendencies to over-regulate (numb or dissociate) or be overwhelmed by feeling. Similarly, *I made it, so I could handle it* and *Creating new actions* highlighted how artmaking helped participants contain or transform emotions, because it gave them something to manipulate, to act on. Embodied practices and therapies—moving, creating, interacting with the physical world, taking action—are crucial for re-establishing autonomic regulation and the feeling of being "in charge of yourself" (van der Kolk 2014, p. 215) as well as for building the emotional awareness required to tell the full story of experience and promote self-coherence (Macaulay & Angus, 2019; Paivio & Angus 2017; van der Kolk, 2014).

In summary, the *Bringing into Presence* model is consistent with therapeutic factors in other experiential-relational approaches, in that it provides evidence that art therapy works by facilitating present-moment experiential access to trauma-related beliefs, memories, response patterns, and emotions, for further processing, symbolization, adaptive expression, and reflective meaning making. An additional point of convergence is that relational safety is a precondition for the vulnerability inherent in trauma memory and emotion activation, awareness, and expression. This study's model diverges from experiential psychotherapies, in a number of ways that are specific to the group and art therapy modalities. First, in both EFTT and SP, the therapeutic relationship is prioritized as a source of dyadic co-regulation, such that therapist empathic attunement and process-guiding responsivity can help clients deepen contact with their experience, without being overwhelmed by it (Paivio & Angus, 2017; Ogden et al., 2006).

Bringing into Presence indicates that in SA, the art-making process—that is, manipulating and dialoguing with art materials and images as well as the group environment—at least partially replaces individual therapist attunement as a source of process-guiding intervention and relational support for co-regulation. (*Not) safe enough to risk opening* and *A lot came up* also suggest, of course, that the group environment and emotional intensity of art making could be a source of overwhelm rather than supportive co-regulation.

(Un)safeness in the Present and Possible Contributing Factors

The process of *Bringing into Presence* unfolded in different ways for the participants in this study. While SA aimed to provide participants with a relatively secure time and space to explore their experience through art-making, participants' status-quo experiences of lacking interpersonal and intrapersonal safety meant that the subjective experience of feeling safe to navigate and explore was not guaranteed. Feeling unsafe or not-safe-enough dominated four participants' experiences of the group; they reported experiencing group as triggering or threatening, and 'closed off,' to stay safe. They remained primarily concerned with managing safety in what they perceived as an insecure space. In contrast, six participants reported feeling sufficiently safe to 'open up' to and stay present with the relational vulnerability and emotional intensity of art-making in a group. These participants used the available resources to explore, and figure out new ways of containing and expressing their emotion. This turned the stimuli, activities, and interactions unfolding within the secure space, into a means for digging, allowing, accessing, expressing, and witnessing emotion, and a practice field, for new, adaptive actions.

Attachment. *Secure Space* consisted of participants' descriptions of how the group's boundary-setting structural framework (rules, norms, procedures, authoritative and supportive facilitator presence) was balanced by freedom to explore and make choices within those limits.

Feeling safer was attributed to that boundaried freedom: the balance made it possible (for some) to take the risks of intrapersonal exploration and interpersonal connection, with the framework promising protection from intrapersonal and/or interpersonal harm while freedom to explore without the weight of expectations allowed participants to approach emotionally-charged experience. Taken together, the subcategories making up *Secure Space* suggests attachment theory's concept that the attachment relationship functions as a more-or-less secure base for the exploration of one's external and internal worlds, and as a source of comfort and emotional co-regulation when distressed (Ainsworth, 1989; Bowlby, 1969).

A considerable body of research has examined the implications of clients' adult attachment styles on psychotherapy outcome (reviewed in Levy et al., 2011) and process variables such as the quality of the therapeutic alliance and overall client engagement (Daniel, 2006; Daniel, 2011; Talia et al., 2014). This work investigates whether, and under what conditions, the psychotherapy relationship—the individual client-therapist dyad, or the group, in group therapy—functions as an attachment relationship (Holmes, 2001; Markin & Marmarosh, 2010). *Secure Space* connotes the function of the developmental environment furnished by childhood attachment relationships, in that the group was experienced as a more-or-less secure base for the processes of *opening up* to contacting, witnessing, and transforming experience or of *shutting down* to stay safe, respectively. In particular, the model suggests that when expectations (of rejection, exclusion, or judgment) imbued participants' experience of the group—when they brought associated fear into their present relational context—the psychotherapy/group relationship functioned as a less-secure base, and participants concerned with self-protection could not freely explore their internal worlds (open up).

Attachment classification was not assessed as part of the present study, however previous research on the Women Recovering from Abuse Program (WRAP; Duarte-Giles et al., 2007)—which operates out of the same hospital, and serves the same client population as SA—reported that 65% to 70% of clients entering therapy had disorganized/unresolved, and approximately 15-18% had dismissing/avoidant, attachment representations (Zorzella et al., 2014; Classen et al., 2017). This finding is consistent with large-scale meta-analytic data on attachment styles among adults with child abuse histories or PTSD (Bakersman-Kranenburg & van IJzendoorn, 2009). Assuming similar proportions among SA clients, and in light of the findings, attachment theory may be helpful way to unpack participants' capacity to use SA as a secure base for internal exploration. Some of the properties of *shutting down* are suggestive of avoidant, attachment-deactivating strategies (pulling away, pursuing self-reliance, low emotional engagement and emotion over-regulation). This is in line with evidence that group therapy clients with dismissing/avoidant styles perceive the group as less supportive (Zorzella et al., 2014), find relatively open group structure to be anxiety-provoking, and may withdraw or avoid connection in response to perceived group cohesion (Chen & Malinckrodt, 2002; Rom & Mikulincer, 2003); and benefit from individual therapy prior to or concurrent with group therapy (Markin & Marmarosh, 2010).

Properties of (*Not) safe enough to risk opening,* meanwhile, are suggestive of the dilemma that defines unresolved attachment strategies, namely, oscillation between competing, incompatible desires to connect and belong vs. the need to protect oneself from perceived threat in the relationship (Lyons-Ruth & Jacobvitz, 1999). Safeness was always in question; participants who engaged in *opening up* did so with a sense of vulnerability and risk-taking, linked to the perception that the group was safe enough, whereas *shutting down* seemed to occur

when perceived threat and vulnerability outweighed any other consideration. Frequently, that threat was thematically laden with not-belonging, fear of judgment, and perceptions that previous experiences of rejection or persecution were happening all over again. This highlights the centrality of feeling supported by and included in the relationship system; when affiliative belonging and support fostered *enough* safeness, participants seemed to resolve the approach/avoid dilemma and use the group to explore and process their experience. *Opening up* clients did not feel perfectly safe, rather, the opening up process was distinct from shutting down in how clients responded to relational triggers, perceived threat, and vulnerability. This is consistent with research that indicates that in a group environment that prioritizes relational safety, disorganized/unresolved clients who perceive the group climate as supportive (Zorzella et al., 2014) use the group as an opportunity to "correct" for interrupted developmental experiences such as exploring emotions without becoming overwhelmed (Classen et al., 2017).

Pre-therapy Characteristics. Results suggested that other individual differences and sociodemographic factors may also have contributed to participants' capacity to use the group as a secure base for exploration. Meta-analytic reviews have shown that older age is associated with poor outcome in group treatments for complex PTSD (Mahoney et al., 2019), and low income, non-White ethnicity, and a greater number of abuse events are associated with poor outcome in some studies of psychotherapy for adults with histories of childhood sexual abuse (Taylor & Harvey 2010). In the present study, participants whose experience of SA entailed *shutting down* were, on average, slightly older and less educated, had a higher unemployment rate, and reported exposure to more forms of abuse in childhood, compared to those whose experience of SA entailed *opening up.* It must be underscored that there is no evidence of statistically significant differences between subgroups of participants. With that qualification, the descriptive

questionnaire and interview data both suggest that the participants who felt less safe in SA were more marginalized, traumatized, and experienced greater pre-therapy functional impairment.

The thematic content of *SA wasn't for people like me* described how three participants attributed not-belonging (and associated unsafeness) in group, to a personal characteristic which had extant meaning, as a longstanding cause of personal isolation and increased exposure to threat and harm. In two cases, *not belonging* was linked to their membership in a marginalized or oppressed social group. This suggests that participants whose lives are less safe because of marginalization and systemic oppression, also found it more difficult to feel safe in SA. The extent to which SA, as a therapy group, may have perpetuated or mitigated oppressive forces that funnel down from society through the mental health system, was beyond the scope of this study's aims. The findings highlight, however, the importance of further research (and practical action) that will make group trauma therapy safer for, and therefore more accessible to, the members of society who may be most in need of it.

Shutting down participants also reported more severe trauma histories, which is consistent with another study that found more severe, polytraumatic exposure was associated with symptom worsening in group art therapy (Schouten et al., 2019). Interestingly, the participants who reported experiences of *shutting down* in SA also had, on average, lower overall symptom distress, lower functional impairment, lower emotion dysregulation, and lower alexithymia scores at baseline, compared to *opening up* participants (again, these are descriptive means and differences may not be statistically significant). Research indicates that alexithymia predicts poor response to therapy in general (Ogrodniczuk et al., 2011). In complex trauma treatment, poor outcome is associated with over-modulation of emotion (Lanius et al., 2010, 2012), as is the combination of severe symptom burden and emotion regulation difficulties (Cloitre et al., 2016).

Outcome was not measured in this study, however if we take the qualitative findings regarding adaptive shifts as an approximation of "positive outcome," *Bringing into Presence* as a model of processes leading to those shifts, and *shutting down* as an indicator of difficulty engaging in those processes, these baseline symptom and emotion function means are the opposite of what one might expect. *Shutting down* occurred when participants were overwhelmed by interpersonal triggers or intense emotions in group. It is possible that those participants' baseline self-report scores, particularly for alexithymia and emotion dysregulation, reflected lower emotional self-awareness and/or less willingness to fully disclose current intra- and interpersonal difficulties.

'Belonging' as the real gatekeeper for *Bringing into Presence*? Herman's (1992a) original writings on treatment of complex trauma emphasized that the value of group therapy for this population, was provision of an experience of commonality, which conferred a sense of belonging, reduced stigma, isolation, and alienation, and increased support and validation. Belonging may be considered a conceptual alternative to attachment in group settings, as a way of understanding how participants' experiences of safeness varied as a function of the relationship conditions. "Belonging" captures the affiliative qualities of attachment, while also leaving room to incorporate sociodemographic differences in the context of other factors and threats (e.g., systemic racism) that might have decreased some participants' experience of safety in group. Indeed, research indicates that group attachment styles consist of internal models of belonging and not belonging to groups based on family, social, and cultural group experiences, which form our expectancies about new groups (Cross & Cross, 2008; Markin & Marmarosh, 2010).

The present study found that *Belonging*—which was not the same thing as having trauma-based *Common ground*—differentiated safeness from unsafeness, and *opening up* from

shutting down. The findings cohere with those of a recent qualitative study that investigated change processes in group therapy for clients with complex trauma histories (Chouliara et al., 2017). The authors triangulated the perspectives of clients who completed group, clients who dropped out, and of therapists, to propose a model of the relational change processes in a group setting. Notably, completers focused on similarities among group members, highlighted identifying with the group as significant, and described a process of developing trust over time as they shared their experience with the group. In contrast, those who dropped out focused on differences among members and felt separate from the group, felt threatened by the group or feared judgment, and held back from sharing. As with the present study, the experience of belonging was central to the safeness dilemma, i.e., to the risk of being judged or otherwise harmed when sharing one's story with the group. Furthermore, the safeness conferred by belonging was also a gatekeeper for other change processes identified by Chouliara et al (2017). The authors proposed a model in which sharing and expressing oneself builds trust, which allows for new experiences of being accepted; validation and normalization of one's experience by the group brings relief and reduces anxiety; and clients symbolize and integrate trauma experiences into their self-concept on the basis of new information taken in through group interactions. Participants who felt that they did not belong, dropped out rather than risk sharing. Chouliara et al.'s (2017) finding echoes the present study's model, wherein belonging furnished enough safeness to risk opening up to the integration of new intrapersonal and interpersonal information.

Safeness, Risk-taking, and Corrective Experiences

Yalom's (1970) canonical work on therapeutic factors in relationally-oriented group therapies highlights how they are a potent setting for "corrective experiences" (Alexander & French, 1946; Castonguay & Hill, 2012). This is echoed by proponents of relationally-oriented

group therapies for complex trauma; for instance, the WRAP program, of which SA is an off-shoot, was founded to provide survivors with an opportunity to learn about complex trauma and develop stabilizing stage-one (self-regulation and interpersonal) skills, in the context of a present-focused relational processing setting that provided opportunities to practice new ways of relating (Duarte-Giles et al., 2007). These potentially-corrective situations, however, are also by nature challenging because relationships evoke circumstances that were painful in the past. It is this similarity between past and present that establishes the potential for a corrective experience, in which the client has a discrepant emotional response in a new relational context (Castonguay Hill, 2012; Ford et al., 2009). The essential components of a corrective experience are that participants have a new, positive outcome that disconfirms their negative expectation of self or other, and that they perceive themselves as having an intentional, positive, agentic role in that outcome (Goldfried, 2012).

This dilemma, and the role of perceived agency in resolving the dilemma in a therapeutic (corrective) way, were apparent in the present study. Participants who risked *opening up* reported that they did not initially feel completely safe and relaxed. Rather, they felt vulnerable, as if a shadow of threat was cast by their history of relational harm. While the threat was felt in the present, it was not so intense as to engulf participants entirely; participants felt *safe enough* to choose (as agents) to engage in intra- and interpersonal *risk-taking*, in the present. The findings also provide considerable evidence that risks taken led to adaptive shifts, some of which might be considered corrective emotional experiences (Alexander & French, 1946; Castonguay & Hill, 2012). For example, sharing one's artwork and being seen and validated, disconfirmed for some participants the expectation that they would be judged or invalidated. Other examples include participants taking the risk of interrupting perfectionism and letting go of mistakes, and learning

that it did not lead to catastrophic consequences, and taking the risk of asserting boundaries or needs despite fear that taking up space would lead to interpersonal harm.

Risk-taking, Expectations, and the Meaning of Feeling Vulnerable or Triggered. We know, from other process-outcome research, that expectations are important in therapy. A large body of research has established that expectations are a "common factor" accounting for considerable variance in treatment outcome (Constantino et al., 2011b; Norcross & Lambert, 2011; Wampold & Imel, 2015). The literature on complex trauma-specific treatment (i.e., anything addressing DSO) emphasizes the importance of helping clients increase mindful awareness of bodily signals and recognition of when they feel emotionally dysregulated or triggered (Ogden et al., 2006; van der Kolk, 2014). Discernment of actual safety (or actual threat) in the present and differentiating it from triggered beliefs and procedural (emotional, somatic) responses that can layer unsafeness onto the present, is crucial for helping clients disentangle past from present, respond effectively to threat, begin to approach and process emotions, and re-engage with healthy relationships and engagement in the world that can counter shame, isolation, and associated negative self-beliefs.

Providing clients with a clear rationale for how to approach moments of wavering safeness, perhaps normalizing being triggered as an opportunity to practice, may be particularly important in group settings, where facilitator resources, such as time and attention, are stretched. Furthermore, in a group, there are likely more, and more intense, interpersonal cues which are potential triggers for the activation of maladaptive/trauma-related interpersonal patterns. This is both the promise and risk of group therapy; such cues are potential opportunities to practice more-adaptive responses to situations that trigger trauma responses. If a client feels so chronically unsafe, or has rapid and extreme reactions when triggered (i.e., has a "narrow

window of tolerance," (Ogden et al., 2006; Siegel, 2003)) and lacks sufficient awareness and self-regulation skill to do the work of discerning past from present, then group therapy may end up perpetuating threat-driven interpersonal behaviour and related beliefs about self and others (Ford et al., 2009). Importantly, this study's findings suggest that it may not only be the extent of threatening/triggering interpersonal cues, and a client's narrow window of tolerance, but also their attitude and expectations, that which determine whether group therapy leads to corrective experiences, or perpetuation of maladaptive relational patterns.

The significance attached to moments of unsafeness—how participants understood (interpreted) and responded to vulnerability—was a central property of *Safe enough to take a risk*. There were two other categories pertaining to similar attitudes towards emotional experience and change: *I didn't know what to do with everything that came up* and *SA was a place to practice*. All of these categories were populated exclusively (or nearly so) by the *opening* up subgroup of participants. Together, these categories describe how participants approached moments of distress and wavering (un)safeness in group, and suggest a change-oriented attitude; an openness to the possibility of learning to "do something" with emotional distress, and a perception that moments when they felt vulnerable or threatened or triggered in SA were opportunities to change, i.e., practice responding differently.

The Alchemy of Integration in Art Therapy

The model of integration proposed by *Bringing into Presence* is specific to art therapy, in that it describes how integration processes are mediated by (or, unfold through) clients' engagement with visual and material symbols for the experiences being integrated. Dissociated parts of self-experience are figuratively re-materialized, brought into physical presence, where they are available for visual processing and integration (self-witnessing) and physical

manipulation or transformation. In the previous chapter, I described struggling to find language, and a descriptive metaphor, for the concept of *Transferring Transformation*.

"Alchemy" was more apt than I realized at the time; the alchemical tradition, as interpreted by modern psychologist-philosophers, captures precisely the concept of transfer of transformation, that is, the way in which actions, creations, and changes made on one realm effect changes on another realm. Carl Jung's writings on alchemy (1963, 1968, 1970) and the literature that followed from it (e.g., Edinger 1985; Rowan, 2001; von Franz, 1980), constitute a highly elaborated, detailed body of work likening the processes and techniques of alchemy, to the processes of personal transformation in psychotherapy. Jung argued that alchemy—the esoteric medieval renaissance practice of transmuting lead to gold, and seeking to discover the philosopher's stone—was a projection of the alchemists' internal, personal transformation towards individuation, or psychic wholeness. Accordingly, alchemical substances, stages, and techniques form a symbolic map for psychological transformation. Jung's work on alchemy offers a central metaphysical premise, which speaks to the particular way in which art therapy promotes integration, as suggested by this study's findings. That is, alchemy is based in Hermetic philosophy's principles of unity and correspondence: (1) everything in existence is part of an interconnected whole; (2) such that if one acts on one level of reality, those actions have a corresponding impact on another level, and vice versa (Jung, 1968).

The Alchemical Principle of Correspondence and Integration. Robertson (2014) reviews the history of the principle of correspondence, and notes that it comes from "Emerald Tablet" scripture associated with legendary figure Hermes Trimegistus. The relevant passages, as translated by Isaac Newton, are:

> *1. Tis without lying, certain and most true// 2. That which is below is like that which is above and that which is above is like that which is below to do the miracles of one only*

> *thing// 3. And as all things have been and arose from one by the mediation of one: so all things have their birth from this one thing by adaptation.* (Robertson 2014, p. 405)

Accordingly, alchemical work is more than just a symbol for (or projection of, or correlate of) change happening on the level of alchemist's psyche: it is a locus for action, of active making-creating-transforming, that has a corresponding effect on the psyche (Robertson, 2014). This distinction is important. The majority of Jungian work treats alchemy as a metaphor or map for psychic transformation, and for the processes and stages that occur in the relational context of psychotherapy. Essentially, alchemy is taken as a symbol for psychic growth and metaphor for understanding what unfolds in psychotherapy. This study's findings, however, suggest that art therapy *is* alchemical, operating in the way that alchemy was a process of transforming the alchemist. The principle of correspondence, "as above, so below," is consistent with how participants made experiential contact with and transformed aspects of the self/psyche that were nonverbal or outside awareness, via manipulation of art materials.

Witnessing the Invisible and the Invalidated describes how art made ephemeral psychological experience visible and tangible, having form outside oneself (as above/so below, as inside/so outside), which enabled participants to see, feel, and validate it as real. *Transferring Transformation* describes participants' reports of engaging in new, adaptive actions and the new self-understanding or meanings that arose from those shifts. In particular, its categories capture how art materials and the group setting functioned as more-malleable iterations of participants' inner worlds and social worlds: as above, so below; as heart and mind, so clay and paint; as relationships in life, so this SA group. For example, *I made it so I could handle it* pertains to how participants' way of relating to or acting on their artwork transferred to new ways of relating to their emotional experience and to the change process. These included being able to externalize and modulate painful emotions; preserving or prolonging some ongoing process of internal

exploration or meaning making; and a strengthened belief in one's own capacity to create, to make change. In each of these subcategories, participants' artwork functioned to both substantiate (symbolize) *and* instantiate (extend, invite elaboration of) personal shifts, because they were actively engaging in the creative/transformative process. Similarly, *Creating new actions* described a correspondence between the group environment/task (microcosm), and the participant's life outside therapy (macrocosm), that allowed participants to experiment with new, transferrable ways of acting and relating. Finally, *Making new meanings* showed a correspondence between participants' experiences of feeling-creating-acting, and their processes of reflecting-meaning making, in that new experiences and actions wrought a corresponding, higher-order change in view of self.

Alchemical Unity, Human Complexity, Meaning, and Integration. Integration means moving towards wholeness by bringing together disparate parts. Most theories of trauma pathology and treatment refer to integration as the re-association of aspects of the traumatic experience that are dissociated because of the nature of traumatic memory encoding (van der Kolk & Fisler, 1995; van der Kolk et al., 2001; Foa et al., 2009), to reduce fear-based (PTSD) symptoms and incorporate trauma memories and associated meanings into one's sense of self (van der Kolk, 2014; Paivio & Angus, 2017). The nature of "wholeness" achieved by the kind of alchemical workings described by Jung, and captured by *Bringing into Presence,* may connote another sort of integrated wholeness, that is not centered on addressing specific episodic traumatic memories, and their emotional or cognitive sequelae, as the barrier to wholeness. Rather, the findings speak to a broader view of integration and a whole-person model of transformation.

For example, participants identified *Rediscovering play* as a significant new experience in SA. They also highlighted the importance of reconnecting to creativity as a fundamental part of themselves, an inherent source of healing or growth that meant it was possible to make other types of changes, beyond making art. Play and creativity are inherently embodied, and often interpersonal, human capacities that pertain to development and health of the whole person. Likewise, participants highlighted how having freedom to make choices and navigate art-making according to their own embodied emotional signals helped to build self-trust and a sense of autonomy and control over their lives, or agency. The importance of play, creativity, and the sense of personal agency that comes from attuning to and trusting one's own emotional signals, are not central to many evidence-based, primarily cognitive behavioural treatment approaches that emphasize processing of traumatic memories and trauma-related cognitions. The perspectives of clients in this study nonetheless suggest that trauma can stifle or steal play, creativity, and autonomy, and re-activation of those capacities can be an important part of post-trauma transformation in the context of art therapy.

In an unpublished master's thesis, Vasquez (2008) traces lines of convergence and divergence between Jungian perspectives on alchemy, and theories of art therapy. Vasquez argues that the alchemical principle of unity or wholeness aligns with the function of symbols (art images) as "metaphoric containers" holding *multiple* layers of meaning, the complexity of which may be beyond rational and verbal ways of knowing. In this study, *Allowing an internal conversation to unfold* and *My art made It real* describe how participants contacted and symbolized aspects of their experience *through* its representation in art form. An important property of these two categories was the way in which participants seemed to discover emotion and associated meanings in their work—as if their art communicated something emergent and

new, rather than signifying or expressing something that was already known. This suggests that they were engaged in a process of symbolizing nonverbal experiences and thereby creating a more differentiated and coherent sense of self. Laub and Podell (1995) have similarly argued that art generates meaning: it represents complex experiences and invites self-witnessing, which engages the maker (or art observer) in a dialogic process of making meaning of experience. *My art made It real* and *Making new meanings* together describe how artwork, as a container for complex wholes, helped participants witness and make meaning by incorporating new (or, previously dissociated) parts of experience into a complex whole.

Play, creativity, agency, witnessing, and the construction of new meanings were a prominent part of what participants in this study experienced as helpful. SA engaged and invited integration of diverse aspects of self-experience, not just those pertaining to disorder, symptoms, and diagnostic formulations. In line with other humanistic-experiential approaches such as EFTT and SP, this speaks to the value of a broader understanding of integration in trauma healing and transformation: as movement towards self-coherence, and the whole self as a creative, playful, autonomous, meaning-making person.

Contributions and Clinical Implications

Bridging Art Therapy, Trauma Therapy, and Psychotherapy Process

This study offers a qualitative, grounded picture of how art therapy, in group format, helps complex trauma survivors engage with, process, and integrate painful and maladaptive emotions and self-schemes. It describes the factors and dynamic processes that clients perceive as contributing to meaningful engagement in group, and meaningful changes in their lives. The Domain-level categories, particularly Domains 2-4, provide grounded, qualitative support for the theorized relevance of art therapy for trauma, as it has been described in the art therapy literature

and was summarized in the Introduction to this manuscript: containment and/or buffering of distress (Avrahami, 2006; Huss et al. 2012; Wadeson, 2010); nonverbal symbolization of experience (Avrahami, 2006; Gantt & Tinnin, 2009; Talwar, 2007); and reflective witnessing (Laub & Podell 1995). But this study's heuristic model went beyond those domains; the concept of *Bringing into Presence* connects clients' negotiation of subjective safeness as they make art in a group context, to their capacity to explore, contact, and integrate various facets of their experience, for heightened self-coherence and adaptive action. The model coheres with current literature on the importance of working within and at the edges of complex trauma clients' capacity to take in information about a stimulus, and make sense of it, i.e., their "window of tolerance" (Ogden et al., 2006; Siegel, 2003). Accordingly, it provides an empirically grounded conceptual bridge between art therapy and the broader complex trauma treatment literature.

The present study differs from previous (qualitative, single-case, and pre-post design) studies on art therapy for trauma, because it was conducted by a researcher with minimal knowledge of art therapy theory and practice. Therefore, it also offers a bridge between the relatively siloed literatures and conversations about art therapy, and (traditional, verbal) psychotherapy, as they pertain to psychotherapy change mechanisms and process factors, more generally. One of the major interpretive frames that positioned my contribution to the findings—as interviewer and transcript analyzer—was my knowledge of common factors (mechanisms of change) in psychotherapy, and of the central concepts and processes involved in experiential therapies. This study offers grounded support for the relevance of those factors and theoretical concepts to art therapy, and of art therapy to those integrative/trans-theoretical ways of understanding psychotherapy. Specifically, it offers a grounded, qualitative bridge between

group art therapy and concepts of attachment, reflective processing and narrative-emotion integration, client expectations, and corrective experiences.

Finally, as a qualitative study based on in-depth client interviews, the present study adds clients' voices to the small body of empirical evidence that suggests art therapy is helpful for those with complex trauma histories. The model describes numerous adaptive shifts, including heightened self-awareness and understanding, tolerance for and modulation of emotion, assertiveness, reduced self-criticism, and altered views of self. Although the findings have limited generalizability, they also outline the types of positive outcomes that may be associated with group art therapy, as well as a conceptual model for how those outcomes may come about. In addition, several negative effects of group art therapy were identified, notably, participants' experiences of overwhelm early in the group, desire for additional relational support and/or opportunities for reflective processing, and disengagement in response to experiences of unsafeness. Notably, the contributions are based in the perspectives of clients, regarding their experience of therapy and their identification of associated shifts in their lives. This type of research amplifies the voice of therapy consumers, which is particularly important given the confusion and complexity—at the levels of health systems and research—surrounding complex trauma conceptualization and treatment delivery.

Method and Methodology

The present study's findings coalesced with the added layer of analysis that examined participant representation across categories. Prior to that stage, the heuristic model looked more or less like Figure 1 as it now stands: the category content from the Domains down was there, and a core category was half-defined, but it lacked the dynamism and explanatory potential of *Bringing into Presence* that came from reconceptualizing *(Not) safe enough to risk opening,*

which in turn brought the relationships among Domains 2-4 to life. I needed to identify *opening up/shutting down* to fully grasp that the exploration and self-integration unfolding in Domains 2-4 entailed negotiation of perceived threat and vulnerability, or negotiating between the residual fear and shame of past relational traumas evoked in the present, and opening up to other sources of experiential information in the present moment.

In any qualitative study, variable representation is expected given the complexity of human experience, and can help flesh out the boundaries of concepts. In fact, this is the purpose of theoretical sampling in Grounded Theory, proper: to collect more data based on emerging concepts and research questions, often by seeking out and including participants whose characteristics suggest that they will add variation to the analysis, or otherwise challenge the assumptions inherent in one's concepts, until conceptual saturation is achieved (Corbin & Strauss, 2008). I did not use theoretical sampling, but analysis of participant representation served a similar function, helping to move the analysis towards conceptual saturation. Notably, the representation pattern went further than helping to construct "opening up" and "shutting down" as two different types of experiences or processes in SA. Rather, it helped clarify a shared, underlying phenomenon: the link between safeness and integrative capacity, which was crucial to identify the processes—or dynamism—linking the static hierarchy of categories that resulted from the analysis, and thus to define the core category.

To the extent that the analysis is received as "sound" by readers, the study demonstrates the value in looking at participant representation across categories as part of the development of grounded models—especially, perhaps, when the phenomenon of interest entails process or change over time. In the broader clinical/psychotherapy research context, asking how change happens is a challenging question to pose in a qualitative analysis, particularly in this field,

wherein change is classically measured through pre-post comparisons, or using diagnostic criteria. Moreover, establishing pathways towards change typically entails inferential testing of mediation models, or systematic behavioural observation over time. The final analysis stage in this study did not aim to do that. Rather, the added layer of analysis began to hone in on the question: how was *change*—the categories that had to do with transformed emotion, new adaptive actions, new meanings, or relief from pain—conceptually related to the other categories of experience? In *this* study, examining participant representation helped to elucidate the process, *Bringing into Presence,* which answers that question.

Complex Trauma Conceptualization

The findings presented in this manuscript illustrate that emotion integration and rich shifts in meaning and adaptive action unfold when trauma survivors are provided with a sufficiently-safe relational framework for open, non-directive, creative, and embodied self-exploration. These shifts pertained to self-organization: new ways of relating to one's emotional life, beliefs about oneself, the meanings made of one's experiences, and consequent ways of relating to others and taking action. In the context of ongoing discussion about how to conceptualize complex trauma sequelae as distinct from related syndromes (e.g., Cloitre et al., 2020; Ford, 2020; Karatzias & Levendosky, 2019) this study illustrates the potential richness and challenge of working with so-called "disturbances in self-organization" (Maercker et al., 2013).

Ford (2019) has called for refinement of complex trauma conceptualization, as an adaptation to interpersonal betrayal resulting in pervasive damage to self-concept and self-coherence, affect dysregulation repeatedly triggered by interpersonal vulnerability, and shame. This study's model of transformative process in art therapy, supports this conceptualization, in that it highlights the pervasiveness of affect dysregulation that arises in response to relational

vulnerability. Furthermore, it suggests that shifts in meaning, self-coherence, and self-regulation, and adaptive action in the world, can arise from embodied, creative exploration within the boundaries established by a supportive relational context. This is consistent with a developmental conceptualization of complex trauma sequelae—namely, that they arise when normative social-emotional developmental supports and processes (attachment relationship's secure base for exploration, relationally-scaffolded co-regulation and assistance with storying experience in coherent narrative form) are thwarted, and can be ameliorated or corrected for, by provision of the same. Similarly, group art therapy (as glimpsed through this study's model) is also consistent with the rationale for relational and experiential approaches to complex trauma treatment (Ogden et al., 2006; Paivio & Angus 2017) which are designed to provide dyadic co-regulated experiential processing of emotions, memories, beliefs, and action tendencies, to rebuild capacities for pleasure, social engagement, adaptive meaning-making, and self-regulation.

In the context of calls for multi-modal treatment alternatives to 'gold-standard' PTSD treatments that focus on episodic trauma memory processing, given a DSO-based conceptualization of complex trauma (Cloitre, 2016; Ford, 2015; Herman, 1992a), this study suggests that art therapy is well-suited to helping clients explore, process, and transform emotions, beliefs, and actions at the level of *self-organization*. Accordingly, it adds empirical support—albeit with limited generalizability and no claims to the causal links that can be drawn in an experimental design—for art therapy as beneficial for this population. Empirical support for art therapy's efficaciousness is important for the plurality of therapy options available, in a treatment landscape increasingly dominated by didactic, skills-based, and cognitive-behavioural approaches. This study's findings indicate that, despite not teaching self-regulation skills, a

nondirective art therapy like SA may address self-organization by providing clients with opportunities for experiential learning, by giving opportunity to approach, understand, adaptively express, and make meaning of live emotions.

Clinical Implications for SpeakArt

Although the sample size was limited for this study, precluding broad generalizations, there were a number of key findings that might inform implementation of art therapy group programming like SpeakArt, in the future. First, as discussed above, the results suggested that participants' attitudes towards unsafeness and risk-taking, including expectations about being "triggered," may have influenced how they responded to experiences of feeling emotionally overwhelmed or relationally vulnerable in SA. These findings suggest that there may be clinical value to educating clients and pre-emptively framing experiences in which they are triggered, and important opportunities for risk-taking and change.

Second, the findings indicate that some group clients may be at greater risk of disengaging from group when they experience unsafeness. Those who are observed to be shutting down may benefit from additional relational support, such as concurrent individual therapy or more substantive or frequent check-ins with group facilitators. Furthermore, some participants who reported shutting down in the present study, reported isolated experiences of taking risks and opening up in their last one or two sessions. This suggests a process of more gradual opening-up (increasing safeness) over time, although an alternative explanation could be that the prospect of imminent termination reduced the relational risk of opening up. Group participants who seem to take longer to engage fully in the group but show signs of increased security and engagement over time, might benefit from a longer therapy (more group sessions).

Finally, many participants reported that they found both of the research interviews to be a beneficial—even a "much-needed"—opportunity to reflect on and make sense of what happened in SA. Some reported coming to new realizations about themselves and about the shifts they attributed to SA, as a result of reflecting on them in the research interviews. This suggests that the benefits of SA, for *all* group participants, may be enhanced by combining group enrollment with concurrent individual therapy and/or intermittent one-on-one sessions, to promote reflective meaning-making and assist with managing safeness (and encouraging risk-taking) in group.

Limitations

Generalizability

The idea for this study began with observation-sparked curiosity about what was happening, on a psychological or experiential level, for women with complex trauma histories participating in an art therapy group, offered by a particular treatment program at a particular hospital. The ensuing research unfolded at that same site. The findings permit an in-depth glimpse at the art therapy conditions and processes that bring clients into presence with their experience, for heightened emotion integration, self-understanding, and access to personal resources for adaptive emotion-informed action. This glimpse, and the findings and connections discussed above, cannot be broadly generalized, due to the location-specific treatment, small size of the sample, and qualitative nature of the study.

It is important to consider that this material was gathered from a sample of women who presented for publicly-funded treatment at an urban hospital. The program is known for its specialized focus on treatment for people with complex trauma histories, and a number of characteristics of that program—and therefore, of this study's sample—qualify and limit the present findings. First, the sample has not been characterized in terms of accepted clinical

diagnostic categories, and the degree of heterogeneity among participants, in terms of clinical presentation, is unknown. On the one hand (and the rationale for design decisions), this fit with the clinical setting's philosophy, which holds that people with complex trauma histories need treatment that addresses the full range of associated difficulties, focusing on unmet developmental goals such as emotion modulation, managing dissociation, self-care, and relational trust (Classen et al., 2017; Duarte-Giles et al., 2007). Privileging a diagnostic lens risks focusing on symptoms without understanding them as manifestations of underlying disturbances of self-organization, and/or risks prioritizing PTSD symptoms while neglecting other difficulties. The disadvantage of lack of diagnostic clarity, is that the heuristic model of art therapy generated by this qualitative study, cannot be directly compared to the majority of other trauma treatment studies, which are designed around PTSD diagnostic criteria as a basis for participation and outcome measurement.

Second, the participants in this study comprised a snapshot of those who present for treatment at the Trauma Therapy Program. The sample had some diversity in terms of ethnicity, socioeconomic status, and age, but it was a majority White, middle-age, educated sample. This limits the conclusions that can be drawn from the findings. In particular, the degree of diversity among participants indicated that there *is* a relationship between safeness and sociodemographic dimensions, however I am not confident that this was fully fleshed out by categories like *(Not) belonging in group* and *Here we (don't) go again*. The lack of theoretical sampling in this study's research design was a limitation in this regard. There was likely insufficient representation to begin to claim that this study's findings describe how race and racism, for example, impede safeness and engagement in mental health care. That topic is a massive, important research gap and policy issue, which should be addressed from a BIPOC-centered

interpretive frame and/or participatory-action, social-justice paradigm, given the White-centered bias in our research and clinical systems.

Third, this study's small sample size—by which I mean both the number of participants (n=10), and the number of therapies (n=1) examined—further limits generalization of findings. The concepts and categories and model presented here, is grounded in this particular sample (this hospital, this art therapy program, these individual participants). SpeakArt is a psychodynamically-informed, nondirective approach to group art therapy; accordingly, the present model of how SA is helpful for people with complex trauma histories, may not generalize to other art therapy approaches, such as those that direct clients to depict trauma memories, or those that teach clients to use art-making as a skill for self-soothing or distraction. Likewise, the findings are not generalizable to individual art therapy.

On the other hand, the research aims did not include making claims about universality of experiences of group art therapy, or to apply methodologies that require random and representative samples (e.g., hypothesis testing). The beauty of qualitative research is that it allows us to identify and understand threads of experience, by zooming in and out to see them in the context of the whole; working at this scale necessitates small samples.

Communicating the Nonverbal, Barely-known, and Vaguely-recalled

It is difficult to get people to talk about highly personal experiences like psychotherapy. It is even more difficult, when you are primarily interested in learning about the nonverbal, internal, hidden aspects of that experience. And it gets more difficult still, when those people have histories of relational trauma, and therefore are more vulnerable to feeling afraid of their listener, afraid of the internal experience that they are being asked to talk about, and are more likely to have difficulty putting words to it. Accordingly, the narratives participants provided

may be considered limited by their own sense of intrapersonal and interpersonal safeness in the interviews themselves and by their degree of insight into their own experience, and the conceptual categories constructed from those interviews may be considered equally limited. Following the study's results, this may mean that the findings are also skewed towards the experiences of those who felt safe opening up (in SA, in the interview); there is comparatively little content contained in the narratives of participants who were shutting down.

The co-constructive process of an interview means the interviewer influences how the interviewee stories their experience. Because of the aforementioned challenges around safety and narrative expression of emotional experience, it may be that I, and my biases and assumptions, had a stronger influence on client responses than would have been the case, with an un-traumatized sample, or had we been talking about less-sensitive experiences. There are power dynamics in a research interview—which may have been exacerbated by my perceived quasi-clinical identity, and these participants' repeated experiences of seeking mental health services in contexts where providers had significant authority—so it is also possible that social desirability was an added element that tipped the narrative construction in the direction of my biases. I was aware of these potential limitations, and tried my best to minimize them while in the interviewer role, but ultimately the interviews and the rich information they provided about participants' experiences in SA, cannot be considered bias free.

In addition, the specific narrative details that gave experiential richness and conceptual depth to the analysis, came from segments that honed in on the story of a particular significant session, interaction, or artwork. At the same time, many participants had difficulty describing specific experiences to illustrate more generalized reflections on SA. Others had difficulty recalling the details of events/artworks that they identified as significant, after several months'

time lapse. Given that the research questions pertained to the nuances of direct experience, a design in which participants were interviewed immediately after significant sessions may have allowed for more accurate and nuanced understanding. That said, the study's two-interview (NAI; Hardtke & Angus, 2004) design with analysis of post-therapy interviews may have given participants sufficient reflective distance to identify the experiences that mattered most to them.

Finally, as explained at the beginning of this chapter, the analysis did not clarify the extent to which participants were engaged in processing specific episodic trauma memories during SA. Instead, the model describes how participants integrated a nonspecific aggregate of trauma-related psychological phenomena, including memories, beliefs, generalized relationship schemes, and emotions, that had been compartmentalized, invalidated, minimized, or made-invisible in some way. Given the centrality of trauma memory processing in theories of trauma pathology and recovery, this lack of clarity regarding the salience of episodic trauma memory processing may be considered a shortcoming of the interviews and analysis, and a limitation of the study. I could have and perhaps should have pressed participants for clarity re: the role of memory processing in their experiences of SA. Had participants been able to specify further, it may have allowed for different kinds of comparisons and conclusions to be drawn about *Bringing into Presence* in the context of traumatology literature. The analysis as it stands captures participants' descriptions of how their trauma-related emotions, beliefs, and memories were organized prior to SA (nonspecific, shadowy, compartmentalized "It") and re-organized through SA (to a certain extent, "It" was differentiated, symbolized, and reflected on).

Directions for Future Research

The present study's findings point to several avenues for future research. First, the findings may be refuted or validated by examining their correspondence with pre-post measures

of similar constructs and other validated indicators of clinical change, in the context of a SA outcome study. Possible measures include diagnostic interview or self-report indices of PTSD and CPTSD symptoms, and related difficulties including dissociation, alexithymia, emotion regulation, depression, self esteem, and problems in interpersonal relationships.

Second, the findings suggest that research is sorely needed on factors that contribute to and detract from complex trauma clients' negotiation of safeness in group therapy, in general, and whether those factors are responsive to intervention. For example, future research could explore the clinical value of intervening (early) to build client expectancies about how to respond to feeling vulnerable, and the value of risk-taking. This line of investigation may be fruitful across group therapies for complex trauma, whether arts-based, relational, or skills and psychoeducation-based.

Given the emergence of apparent subgroups differentiated by how participants interpreted and responded to perceived threat, and considerable evidence linking complex trauma to attachment style (Bakersman-Kranenburg & van IJzendoorn, 2009) and to psychotherapy outcome (Levy et al., 2011), attachment style is one contender for individual factors that might predict clients' responses to vulnerability in groups. It would be interesting to see whether concepts of *shutting down* and *opening up* correspond with client attachment styles. This is a potentially useful line of inquiry, given that attachment is a commonly understood construct with potential to inform clinical practice across theoretical approaches (Slade, 2008), and is straightforward to assess in clinical practice.

Furthermore, the present study indicated that *unsafeness* was partly attributed to the experience of *(not) belonging*, and that not-belonging had to do with individual differences factors or membership in marginalized or oppressed social groups (race, neurotypicality, age,

conformity with gender norms). This points to a need for more targeted qualitative investigations into the dimensions of social identity, belonging, and safeness, and how these interact in group therapy and/or trauma recovery. It also highlights the need to better understand (and then actively address, in clinical practice) minority populations' experience of (un)safeness in accessing trauma treatment. Some specific research questions towards that end include:

- Do clients who identify as racial minorities show improved clinical outcomes when they participate in a group that has higher minority representation among group members and/or facilitators? What about when they participate in a group that is offered specifically, and exclusively, for them?
- Do clients whose personal characteristics or trauma history indicate they are at greater risk of not-belonging and feeling unsafe in group, show favourable clinical outcomes to individual vs. group art therapy? What about a longer course of group therapy, or group services combined with individual support?
- What practical steps (group format, composition, rules and norms, actively anti-racist policies) might further enhance safeness/reduce threat, for group clients belonging to marginalized or oppressed groups?

While acknowledging that I speak from the position of former-trainee, clinician not client, and mostly-White person without a complex trauma history, the clinical program in which this study was conducted seemed more aware of, and actively committed to dismantling oppressive systems, and seemed to do a better job of promoting safeness and client autonomy in discerning safety, than other clinical settings with which I have experience. I make this point only to underscore the need for broader change at the research, clinical practice, and policy levels of the mental health system so that it can better serve those clients who are also more at risk of lifetime

trauma exposure, and the sequelae of mental health problems that follow from it, because of systemic inequities.

Finally, the *Bringing into Presence* model might be refined, and its generalizability extended, through examination of the same research questions posed by this study, among participants engaging in different forms of art therapy. Alternative modalities include art therapy groups focused on skill development or episodic trauma memory processing, and individual art therapy. For example, comparison of findings against a qualitative examination of clients' experiences of directive (skills or memory-focused) art making could elucidate the extent to which SA's use of thematic suggestive prompts, provision of *Freedom and framework*, and the open mode of engagement in *Allowing an internal conversation to unfold*, and shifts in self-trust and agency, were facilitated by clients' ability to choose what they explored and made in group. Additionally, it would be interesting to explore clients' experiences of engaging in a similar nondirective but thematically-prompted art therapy offered in individual format, to explore whether the relational dynamic of *Negotiating (un)safeness* by shutting down or opening up, and the at least partially-interpersonal actions of *Witnessing* and *Creating new actions*, unfold in the context of a dyadic relationship in the same way that they did in a group.

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Appendix A. Informed Consent Forms

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Full Study Title:	Client experiences of group art psychotherapy for complex trauma survivors: A naturalistic mixed-methods study
Principal Investigator:	Eva-Marie Stern, MA, RP (Women's College Hospital) Trauma Therapy Program, (416) 323-6400 ext.4983
Co-Investigator:	Chrissy Macaulay, MA (York University) (416) 323-6400 ext.2305, christianne.macaulay@wchospital.ca

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INFORMED CONSENT

You are being invited to participate in a research study. A research study is a way to gather information on a treatment, procedure, or medical device or to answer a question about something that is not well understood. This form explains the purpose of the study, the activities involved, the possible risks and benefits, and participants' rights.

Please read this form carefully and ask any questions you may have. You may have this form and all information concerning the study explained to you. You will have time to think about whether or not to participate. Feel free to discuss it with your friends and family. Please ask the investigator(s) to clarify anything you do not understand or would like to know more about. Make sure all your questions are answered to your satisfaction before deciding whether to participate in this study.

Participating in this study is your choice (voluntary). You have the right to choose not to participate, or to stop participating at any time. Your decision does not affect your ability to do SpeakArt.

INTRODUCTION

You are being invited to participate in this study because you will soon begin SpeakArt. The study is about how art therapy may be helpful for trauma survivors. More and more research suggests that trauma survivors could benefit from diverse kinds of therapy, because the problems faced by many survivors are complex. Art therapy works with the effects of trauma in a way that is different from traditional types of psychotherapy. This is important because not everyone responds in the same way to the same treatments. Doing research on art therapy could increase survivors' treatment options.

WHY IS THIS STUDY BEING DONE?

The purpose of the study is to understand your experience of SpeakArt and any changes or shifts in your life, in response to SpeakArt. We would like to know what it is like for you to be in group art therapy. We would like to gain your perspective on what aspects of it are helpful (or not) and how they are helpful (or not). We are also hoping to test what effect art therapy has on some of the trauma-related symptoms and problems you may be experiencing.

WHAT WILL HAPPEN DURING THIS STUDY?

You will take part in all aspects of the 12-week SpeakArt group. You will also take part in research interviews, and will complete some questionnaires.

HOW MANY PEOPLE WILL TAKE PART IN THIS STUDY?

It is anticipated that 30 people will participate in this study, recruited from clients accepted into SpeakART. The length of this study for participants is approximately 13 weeks. The entire study will take about one year to complete and the results should be known in two years.

WHAT ARE THE RESPONSIBILITIES OF STUDY PARTICIPANTS?

If you decide to participate in this study you will be asked to:

(1) Complete a questionnaire package on two occasions:

Before you start SpeakArt. The questions will be about:

- demographic information such as your age and education level
- previous therapy experience
- post-traumatic stress symptoms (e.g., feeling "jumpy and easily startled")
- emotions (e.g., whether you "feel out of control when upset")
- your general mental health and wellbeing (e.g., "feeling stressed at school or work")
- high-risk and suicidal behaviour
- whether you have experienced a particular type of traumatic event or abuse.

You will not be asked about details of traumatic experiences. The questionnaires will take 30-45 minutes to complete.

After completing your final week of SpeakArt. Some of the questions will be repeated from last time. They will be about: post-traumatic stress symptoms, emotions, your general mental health, high-risk and suicidal behaviour, and your overall wellbeing and daily function. The questionnaires will take 20-30 minutes to complete.

(2) Participate in 12 weeks of the SpeakArt group

(3) Participate in a baseline interview immediately after your first session of SpeakArt.

The purpose of the interview is to find out more about your goals for SpeakArt, your thoughts and feelings about beginning the group, and your experience of the first session. You will be asked to share your experiences only to the extent that you feel comfortable. The interview will last approximately 30 minutes.

(4) Participate in a post-treatment interview after completing SpeakArt.

The purpose of the interview is to find out more about your experience of SpeakArt, explore whether you found it helpful (or not), and gain your perspective on how it was helpful. During the interview, you will be asked to share your experiences only to the extent that you feel comfortable. The interview will last up to 90 minutes.

We will audio-record both of your interviews. Later, we will transcribe them (type them out word-for word). Then, we will analyze them to try to understand how art therapy may be helpful for trauma, from survivors' perspectives.

(5) Keep your artwork safe (if possible) each week, and bring it with you to the post-treatment interview, so that it can be part of the conversation as you reflect back.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

The potential risks associated with participating in this study are minimal. Strategies have been put in place to reduce these risks. There are no medical risks. The interviews and questionnaires are about sensitive issues and your experiences in therapy, so it is possible that you may become uncomfortable or distressed during the interviews and/or while completing questionnaires. You can choose not to answer any questions that you do not want to answer. If you experience distress, you will be offered grounding resources. Grounding is a technique that can help bring you back to the present moment and reduce distress when you are triggered or emotionally upset. You will also be given the chance to debrief with one of the investigators or, if you prefer, one of the SpeakArt facilitators.

You will be told about any new information that might affect your willingness to continue participating in the study as soon as the information becomes available to study staff.

WHAT ARE THE BENEFITS OF PARTICIPATING IN THIS STUDY?

You may or may not benefit directly from participating in this study. Possible benefits include: the opportunity to reflect on and integrate your overall experience of SpeakArt; the opportunity to reflect on and make meaning of any changes you notice in your mental health and wellbeing; and increased self-understanding. Your participation may or may not help other trauma survivors in the future. There are no medical benefits to you from taking part in this study.

CAN PARTICIPATION IN THIS STUDY END EARLY?

The investigator(s) may decide to remove you from this study without your consent for any of the following reasons:

- The investigator(s) decide(s) that continuing in this study would be harmful to you
- You are unable or unwilling to follow the study procedures
- You leave SpeakArt prior to completing the group (e.g., because of 3 absences)

If you are removed from this study, the investigator(s) will discuss the reasons with you.

You can choose to end your participation at any time without having to provide a reason. If you choose to withdraw from the study, it will not have any effect on your right to continue attending SpeakArt. The information about you collected before you left the study will still be used. If you withdraw voluntarily from the study you are encouraged to contact Eva-Marie Stern, (416) 323-6400 ext.4983.

WHAT ARE THE COSTS OF PARTICIPATING IN THIS STUDY?

Participation in this study will involve one extra visit to Women's College Hospital, for the 2nd interview. You also will spend more time than usual at the hospital, on the first day (approximately 1 hour) and last day (approximately half an hour) that you attend SpeakArt. As a result, you may incur additional public transportation or parking costs. You will be reimbursed up to $24 (total) towards these expenses. Eligible expenses include parking or public transit fares on the days that you are asked to visit the hospital to complete study activities. This does not include days that you attend just for SpeakArt. You will receive the reimbursement at the study visit.

ARE STUDY PARTICIPANTS PAID TO PARTICIPATE IN THIS STUDY?

In recognition of your time commitment for participation, you will receive $20 after you complete or withdraw from the study.

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

You have the right to have any information about you and your health that is collected, used, or disclosed for this study to be handled in a confidential manner.

"Personal health information" is health information about you that could identify you. For this study, we will collect information from you including your name, age, telephone number, the dates that you participated in SpeakArt, and a list of current or previous mental health treatments. The investigators will not access your medical records to collect information for this study.

"Study data" is information about you collected for the study that does not directly identify you. This will include information that you report in the questionnaires about your trauma history and your mental health function, and information about your experience that you report during the interviews.

The interviews will be audio-recorded and transcribed word-for-word. You will not be identified by name on the written transcripts. Any study data sent outside the hospital (including questionnaires and interviews) will be identified with a code, and will not contain your name, address, of any other information that identifies you.

Electronic study data (questionnaire data, interview recordings, and interview transcripts) will be encrypted and stored on a secure server. Physical copies of interview transcripts will be stored in a locked cabinet in a locked room. Only members of the research team will have access to this data. The Principal Investigator will keep any personal health information about you in a secure and confidential location for 10 years, and then destroy it according to Women's College Hospital policy.

Study data that is sent outside of the hospital will be used for the research purposes explained in this consent form. It is possible that the study data may be re-analyzed at a future date by the investigators, in which case your personal health information and confidentiality would continue to be protected.

The investigator(s) and other members of the research team will keep the information they see or receive about you confidential, to the extent permitted by applicable laws. If your responses to the questionnaires or during an interview indicate that you are at imminent risk of harming yourself or someone else, or are experiencing some other serious crisis, your responses will not remain confidential. In this case, the investigators will take appropriate steps to assess risk and intervene to ensure your safety and others' safety. This may require involving other clinicians or the authorities.

Even though the risk of identifying you from the study data is very small, it can never be completely eliminated. The findings may be published in academic journals or books, and presented to professional and general audiences. When the results of this study are published, your identity will not be disclosed. It is possible that word-for-word excerpts from your interviews may be used in presentations and reports. Were this to occur, your identity would be concealed. However, it is possible that you (or people who know you well) might recognize words-in-print, or words spoken in a presentation, as belonging to you.

You have the right to be informed of the results of this study once the entire study is complete. If you would like to be informed of the results of this study, please provide your name, address and telephone number to Eva-Marie Stern, Trauma Therapy Program, 416-323-6400 x.4983.

DO THE INVESTIGATORS HAVE ANY CONFLICTS OF INTEREST?

There are no conflicts of interest to declare related to this study.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You have the right to receive all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction, before you make any decision. You also have the right to ask questions and to receive answers throughout this study. By signing this consent form, you do not give up any of your legal rights.

If you have any questions about this study you may contact the person in charge of this study (Principal Investigator) **Eva-Marie Stern, MA, RP, Trauma Therapy Program, (416) 323-6400 ext.4983**

The Women's College Hospital Research Ethics Board and the York University Human Participants Review Committee have reviewed this study. If you have questions about your rights as a research participant or any ethical issues related to this study that you wish to discuss with someone not directly involved with the study, you may call the **Chair of the Women's College Hospital Research Ethics Board at (416) 351-3732 ext. 2325.**

DOCUMENTATION OF INFORMED CONSENT

You will be given a copy of this informed consent form after it has been signed and dated by you and the study staff.

Full Study Title: Client experiences of group art psychotherapy for complex trauma survivors: A naturalistic mixed-methods study

Name of Participant: _____

Participant

By signing this form, I confirm that:
- This research study has been fully explained to me and all of my questions answered to my satisfaction
- I understand the requirements of participating in this research study
- I have been informed of the risks and benefits, if any, of participating in this research study
- I have been informed of any alternatives to participating in this research study
- I have been informed of the rights of research participants
- I have read each page of this form
- I authorize access to my personal health information and research study data as explained in this form
- I have agreed to participate in this research study

_____ _____ _____

Name of participant (print) Signature Date

Statement of Investigator

I acknowledge my responsibility for the care and well being of the above participant, to respect the rights and wishes of the participant as described in this informed consent document, and to conduct this study according to all applicable laws, regulations and guidelines relating to the ethical and legal conduct of research.

_____ _____ _____

Name of investigator (print) Signature Date

Appendix B. Demographic and Treatment History Questionnaire

DEMOGRAPHIC INFORMATION ID_____

1. Age: _____

2. I identify my gender as:
[ ] Woman
[ ] Man
[ ] Trans
[ ] Nonbinary
[ ] _____ (fill in the blank)
[ ] Prefer not to disclose

3. Current relationship status:
[ ] Never married
[ ] Married or Common-law
[ ] Separated, divorced, or widowed
[ ] Prefer not to disclose

4. Highest level of education:
[ ] Did not complete high school
[ ] High school
[ ] Trade school
[ ] Some college or university
[ ] Bachelor's degree
[ ] Master's Degree or Doctorate
[ ] Prefer not to disclose

5. I identify my racial or ethnic background as (select all that apply):
[ ] White
[ ] Black
[ ] First Nations
[ ] Asian
[ ] South Asian
[ ] Latin American
[ ] _____ (fill in the blank)
[ ] Prefer not to disclose

Please indicate with a [✓] any CURRENT and/or PAST treatments that you have had. If you have never had that treatment, please place a [✓] in the NEVER column.

		CURRENT	PAST	NEVER
1.	Psychiatric medication	[ ]	[ ]	[ ]
2.	Individual counselling or psychotherapy	[ ]	[ ]	[ ]
3.	Group counselling or psychotherapy	[ ]	[ ]	[ ]

Please place a [✓] next to any of the following TTP services that you have already attended:

		COMPLETED	STARTED but DID NOT COMPLETE
1.	Resourced and Resilient group	[ ]	[ ]
2.	Trauma and the Body group	[ ]	[ ]
3.	Relational group	[ ]	[ ]
4	Healing Sexuality group	[ ]	[ ]
5	SpeakArt	[ ]	[ ]
6	Attended Summer Studio	[ ]	[ ]
7	Trauma Recovery group	[ ]	[ ]
8	Building Resources group	[ ]	[ ]
9.	WRAP	[ ]	[ ]
10.	Individual Therapy	[ ]	[ ]

Appendix C. Traumatic Experiences Questionnaire (TEC)

TEC

People may experience a variety of potentially-traumatic experiences during their life. We would like to know:
1) If you have experienced any of the following 26 events while under the age of 18.
2) How much of an impact these experiences had upon you.

First, please indicate whether you had each of the experiences on the list, by circling YES or NO.

If you circle YES, please indicate how much of an impact that experience had on you, by circling the appropriate number:

1 = None
2 = A little bit
3 = A moderate amount
4 = Quite a bit
5 = An extreme amount

	Did this happen to you?		**How much of an impact did it have?**				
1. Having to look after your parents and/or brothers and sisters when you were a child	YES	NO	1	2	3	4	5
2. Family problems (e.g., parent with alcohol or psychiatric problems, poverty)	YES	NO	1	2	3	4	5
3. Loss of a family member (brother, sister, parent) when you were a CHILD	YES	NO	1	2	3	4	5
4. Serious bodily injury (e.g., loss of a limb, mutilation, burns)	YES	NO	1	2	3	4	5
5. Threat to life from an illness, an operation, or an accident	YES	NO	1	2	3	4	5
6. Divorce of your parents	YES	NO	1	2	3	4	5
7. Threat to life from another person (e.g., during a crime)	YES	NO	1	2	3	4	5
8. Intense pain (e.g., from an injury or surgery)	YES	NO	1	2	3	4	5
9. War-time experiences (e.g., imprisonment, loss of relatives, deprivation, injury)	YES	NO	1	2	3	4	5
10. Second-generation war victim (wartime experiences of parents or close relatives)	YES	NO	1	2	3	4	5
11. Witnessing others undergo trauma	YES	NO	1	2	3	4	5

	Did this happen to you?		How much of an impact did it have?				
12. Emotional neglect (e.g., being left alone, insufficient affection) by your parents, brothers or sisters	YES	NO	1	2	3	4	5
13. Emotional neglect by more distant members of your family (e.g., uncles, aunts, nephews, nieces, grandparents)	YES	NO	1	2	3	4	5
14. Emotional neglect by non-family members (e.g., neighbors, friends, step-parents, teachers)	YES	NO	1	2	3	4	5
15. Emotional abuse (e.g., being belittled, teased, called names, threatened verbally, or unjustly punished) by your parents, brothers or sisters	YES	NO	1	2	3	4	5
16. Emotional abuse by more distant members of your family	YES	NO	1	2	3	4	5
17. Emotional abuse by non-family members	YES	NO	1	2	3	4	5
18. Physical abuse (e.g., being hit, tortured, or wounded) by your parents, brothers, or sisters	YES	NO	1	2	3	4	5
19. Physical abuse by more distant members of your family	YES	NO	1	2	3	4	5
20. Physical abuse by non-family members	YES	NO	1	2	3	4	5
21. Sexual harassment (acts of a sexual nature that DO NOT involve physical contact) by your parents, brothers, or sisters	YES	NO	1	2	3	4	5
22. Sexual harassment by more distant members of your family	YES	NO	1	2	3	4	5
23. Sexual harassment by non-family members	YES	NO	1	2	3	4	5
24. Sexual abuse (unwanted sexual acts involving physical contact) by your parents, brothers, or sisters	YES	NO	1	2	3	4	5
25. Sexual abuse by more distant members of your family	YES	NO	1	2	3	4	5
26. Sexual abuse by non-family members	YES	NO	1	2	3	4	5

Appendix D. Life Stressor Checklist-Revised (LSC-R) (Adapted)

People may experience a variety of stressful, potentially-traumatic experiences during their life.
1) Please indicate if you have experienced any of the following events at any point during your entire lifetime, by circling YES or NO
2) If you circle YES, please indicate how much of an impact that experience had on you, by circling the appropriate number:
1 = None 2 = A little bit 3 = A moderate amount 4 = Quite a bit 5 = An extreme amount

	Did this happen to you?		**How much of an impact did it have?**				
1. Have you been in a serious disaster (e.g., hurricane, large fire, tsunami, explosion, earthquake)?	YES	NO	1	2	3	4	5
2. Have you been in a serious accident (e.g., bad car accident)?	YES	NO	1	2	3	4	5
3. Have you witnessed a serious accident?	YES	NO	1	2	3	4	5
4. Has a close family member ever been sent to jail?	YES	NO	1	2	3	4	5
5. Have you been separated or divorced from your spouse/partner?	YES	NO	1	2	3	4	5
6. Have you had serious money problems (e.g., not enough money for food or a place to live)?	YES	NO	1	2	3	4	5
7. Have you had a serious physical or mental illness (e.g., cancer, heart attack, major surgery, hospitalized for mental health problems)?	YES	NO	1	2	3	4	5
8. Have you had an abortion or miscarriage?	YES	NO	1	2	3	4	5
9. Have you been separated from your child(ren) against your will (e.g., loss of custody or kidnapping)?	YES	NO	1	2	3	4	5
10. Have you ever been responsible for taking care of someone with a serious physical or mental disability?	YES	NO	1	2	3	4	5
11. Has someone close to you died suddenly or unexpectedly?	YES	NO	1	2	3	4	5
12. Has someone close to you died (not including those who died suddenly or unexpectedly)?	YES	NO	1	2	3	4	5
13. As an adult, have you ever been robbed, mugged, or physically attacked?	YES	NO	1	2	3	4	5
14. As an adult, have you been bothered by sexual remarks, jokes, or demands for sexual favors by someone at work or school?	YES	NO	1	2	3	4	5
15. As an adult, have you ever been sexually assaulted?	YES	NO	1	2	3	4	5

Appendix E. Impact of Events Scale-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS. Please respond to the items with respect to the traumatic incident(s) or experience(s) that have caused you the most distress and/or that you are hoping to address in therapy. How much have you been distressed or bothered by these difficulties, over the PAST SEVEN DAYS?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real	0	1	2	3	4
8. I stayed away from reminders of it	0	1	2	3	4
9. Pictures about it popped into my mind	0	1	2	3	4
10. I was jumpy and easily startled	0	1	2	3	4
11. I tried not to think about it	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
13. My feelings about it were kind of numb	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time	0	1	2	3	4
15. I had trouble falling asleep	0	1	2	3	4
16. I had waves of strong feelings about it	0	1	2	3	4
17. I tried to remove it from my memory	0	1	2	3	4
18. I had trouble concentrating	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	0	1	2	3	4
20. I had dreams about it	0	1	2	3	4
21. I felt watchful and on guard	0	1	2	3	4
22. I tried not to talk about it	0	1	2	3	4

Appendix F. Outcome Questionnaire (OQ-45)

Impact of Counselling Questionnaire (OQ-45)

Stage of Service: Pre ( ) Session ( ) Post ( )

Date:_____ Counsellor:_____

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and blacken the oval which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, etc.

		Never	Rarely	Sometimes	Frequently	Almost Always
1.	I get along well with others.	O	O	O	O	O
2.	I tire quickly.	O	O	O	O	O
3.	I feel no interest in things.	O	O	O	O	O
4.	I feel stressed at work/school.	O	O	O	O	O
5.	I blame myself for things.	O	O	O	O	O
6.	I feel irritated.	O	O	O	O	O
7.	I feel unhappy in my marriage/significant relationship.	O	O	O	O	O
8.	I have thoughts of ending my life.	O	O	O	O	O
9.	I feel weak.	O	O	O	O	O
10.	I feel fearful.	O	O	O	O	O
11.	After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark "never").	O	O	O	O	O
12.	I find my work/school satisfying.	O	O	O	O	O
13.	I am a happy person.	O	O	O	O	O
14.	I work/study too much.	O	O	O	O	O
15.	I feel worthless.	O	O	O	O	O
16.	I am concerned about family troubles.	O	O	O	O	O
17.	I have an unfulfilling sex life.	O	O	O	O	O
18.	I feel lonely.	O	O	O	O	O
19.	I have frequent arguments.	O	O	O	O	O
20.	I feel loved and wanted.	O	O	O	O	O
21.	I enjoy my spare time.	O	O	O	O	O
22.	I have difficulty concentrating.	O	O	O	O	O

Please continue on reverse

5)

		Never	Rarely	Sometimes	Frequently	Almost Always
23.	I feel hopeless about the future.	O	O	O	O	O
24.	I like myself.	O	O	O	O	O
25.	Disturbing thoughts come into my mind that I cannot get rid of.	O	O	O	O	O
26.	I feel annoyed by people who criticize my drinking (or drug use) (if not applicable, mark "never").	O	O	O	O	O
27.	I have an upset stomach.	O	O	O	O	O
28.	I am not working/studying as well as I used to.	O	O	O	O	O
29.	My heart pounds too much.	O	O	O	O	O
30.	I have trouble getting along with friends and close acquaintances.	O	O	O	O	O
31.	I am satisfied with my life.	O	O	O	O	O
32.	I have trouble at work/school because of my drinking or drug use (if not applicable, mark "never").	O	O	O	O	O
33.	I feel that something bad is going to happen.	O	O	O	O	O
34.	I have sore muscles.	O	O	O	O	O
35.	I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	O	O	O	O	O
36.	I feel nervous.	O	O	O	O	O
37.	I feel my love relationships are full and complete.	O	O	O	O	O
38.	I feel that I am not doing well at work/school.	O	O	O	O	O
39.	I have too many disagreements at work/school.	O	O	O	O	O
40.	I feel something is wrong with my mind.	O	O	O	O	O
41.	I have trouble falling asleep or staying asleep.	O	O	O	O	O
42.	I feel blue.	O	O	O	O	O
43.	I am satisfied with my relationships with others.	O	O	O	O	O
44.	I feel angry enough at work/school to do something I might regret.	O	O	O	O	O
45.	I have headaches.	O	O	O	O	O

Appendix G. The 20-item Toronto Alexithymia Scale (TAS-20)

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.					
	Strongly Disagree	Moderately Disagree	Neither Agree nor Disagree	Moderately Agree	Strongly Agree
1. I am often confused about what emotion I am feeling	0	1	2	3	4
2. It is difficult for me to find the right words for my feelings	0	1	2	3	4
3. I have physical sensations that even doctors don't understand	0	1	2	3	4
4. I am able to describe my feelings easily	0	1	2	3	4
5. I prefer to analyze problems rather than just describe them	0	1	2	3	4
6. When I am upset, I don't know whether I am sad, frightened, or angry	0	1	2	3	4
7. I am often puzzled by sensations in my body	0	1	2	3	4
8. I prefer to just let things happen rather than to understand why they turned out that way	0	1	2	3	4
9. I have feelings that I can't quite identify	0	1	2	3	4
10. Being in touch with emotions is essential	0	1	2	3	4
11. I find it hard to describe how I feel about people	0	1	2	3	4
12. People tell me to describe my feelings more	0	1	2	3	4
13. I don't know what's going on inside me	0	1	2	3	4
14. I often don't know why I'm angry	0	1	2	3	4
15. I prefer talking to people about their daily activities rather than their feelings	0	1	2	3	4
16. I prefer to watch "light" entertainment shows rather than psychological dramas	0	1	2	3	4
17. It is difficult for me to reveal my innermost feelings, even to close friends	0	1	2	3	4
18. I can feel close to someone, even in moments of silence	0	1	2	3	4
19. I find examination of my feelings useful in solving personal problems	0	1	2	3	4
20. Looking for hidden meanings in movies or plays detracts from their enjoyment	0	1	2	3	4

Appendix H. Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

Almost never	Sometimes	About half the time	Most of the time	Almost always
1	2	3	4	5

_____ 1) I am clear about my feelings.
_____ 2) I pay attention to how I feel.
_____ 3) I experience my emotions as overwhelming and out of control.
_____ 4) I have no idea how I am feeling.
_____ 5) I have difficulty making sense out of my feelings.
_____ 6) I am attentive to my feelings.
_____ 7) I know exactly how I am feeling.
_____ 8) I care about what I am feeling.
_____ 9) I am confused about how I feel.
_____ 10) When I'm upset, I acknowledge my emotions.
_____ 11) When I'm upset, I become angry with myself for feeling that way.
_____ 12) When I'm upset, I become embarrassed for feeling that way.
_____ 13) When I'm upset, I have difficulty getting work done.
_____ 14) When I'm upset, I become out of control.
_____ 15) When I'm upset, I believe that I will remain that way for a long time.
_____ 16) When I'm upset, I believe that I will end up feeling very depressed.
_____ 17) When I'm upset, I believe that my feelings are valid and important.
_____ 18) When I'm upset, I have difficulty focusing on other things.
_____ 19) When I'm upset, I feel out of control.
_____ 20) When I'm upset, I can still get things done.
_____ 21) When I'm upset, I feel ashamed at myself for feeling that way.
_____ 22) When I'm upset, I know that I can find a way to eventually feel better.
_____ 23) When I'm upset, I feel like I am weak.
_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.
_____ 25) When I'm upset, I feel guilty for feeling that way.
_____ 26) When I'm upset, I have difficulty concentrating.
_____ 27) When I'm upset, I have difficulty controlling my behaviors.
_____ 28) When I'm upset, I believe there is nothing I can do to make myself feel better.
_____ 29) When I'm upset, I become irritated at myself for feeling that way.
_____ 30) When I'm upset, I start to feel very bad about myself.
_____ 31) When I'm upset, I believe that wallowing in it is all I can do.
_____ 32) When I'm upset, I lose control over my behavior.
_____ 33) When I'm upset, I have difficulty thinking about anything else.
_____ 34) When I'm upset I take time to figure out what I'm really feeling.
_____ 35) When I'm upset, it takes me a long time to feel better.
_____ 36) When I'm upset, my emotions feel overwhelming.

Appendix I. Interview protocol

INTERVIEW GUIDELINES and PROTOCOL

Adapted from the *Narrative Assessment Interview* (Hardtke & Angus, 2004) and *Patients' Perceptions of Corrective Experiences in Individual Psychotherapy* interview manual and protocol (PPCEIT; Constantino, Angus, Friedlander, Messer, & Moertl, 2011).

GUIDELINES

Degree of structure

The interview is semi-structured, and the interviewer should follow the scripted questions and follow-up probes as a guideline rather than fixed script.

- Interviewers should maintain eye contact and rapport with participants, rather than reading the protocol verbatim and mechanistically.
- Interviewers should follow the participant's narrative as appropriate, including tangents.
- Interviewers may jump ahead to later questions or follow-up prompts, out of the order in which they appear, if natural openings arise in the participant's narrative. This may be likely in Parts II-IV.

The interviewer should "aim to strike a balance between affiliative inquiry/exploration and warm autonomy granting with empathic attunement" (Constantino et al., 2011, p.3), keeping the interview to approximately 1.5-2 hours.

Style

"Interviewers should draw on their foundational clinical skills when administering the protocol. In particular, interviewers should use empathic listening skills and genuineness. Further, as is often the case in research interviewing, interviewers will need to combine affiliative probing with responsive reflection and clarification of patient's responses. Interviewers will also have to manage the pace of the interview, which might occasionally call for gentle assertiveness." (Constantino et al., 2011, p.3)

Interviewers should use follow-up probes as needed to elicit rich, reflective participant narratives:

- *Tell me more*
- *Can you think of a specific example?*
- *What did that mean to you?*

Interviewers should provide conditions for open narration and encourage participant disclosure, however, the interviewer should remain neutral regarding narrative content, and avoid evaluative or interpretive comments.

SPECIFIC INSTRUCTIONS

1. Interviews should be audio-recorded. Recording should begin with the interviewer stating the date and the participant's anonymized study ID.

2. Participant art or photographs of their art should be accessible for viewing during the interview.

3. If the participant refers to a specific piece of art during the interview, note which piece it is.

4. Begin with a review of informed consent. Example scripts are included for each of the baseline and post-treatment interview protocol, below.

BASELINE INTERVIEW QUESTIONS

Example script to review informed consent: Thank you for agreeing to take part in this interview. Today I will ask you to reflect on your thoughts and feelings about doing trauma therapy, and your hopes and concerns and expectations for SpeakArt, and how you think SpeakArt might fit in as part of your healing process. This interview will be audio recorded, and transcripts of the interviews will remove all personally identifying information. Please be assured that only members of our research team will have access to these transcripts. For the interview, I have several specific questions, but I will also give you ample time and space to discuss your responses in full and vivid detail. Do you have any questions before we start?

Note: *Questions are in **bold.** Italicized text indicates procedural instructions or question-specific guidelines for the interviewer.*

1. What was your experience of the first session today? What stood out?
This is open-ended and meant to elicit participant's immediate impressions. Minimize prompts for elaboration.

2. What led you to seek art therapy?
Get at why ART therapy, and why NOW. Get at expectation/understanding of art therapy…try to keep it concrete and grounded in experience vs. theoretical/conceptual only.

Cover each of the following themes in whatever order makes sense:

GOALS What goals are you working towards in this group? Are there any specific problems that you are hoping to address? What changes are you hoping to see in yourself?
Get at goals and hopes for therapy…depending on response, may only need to ask a *or* b.

UNDERSTAND How is [problems/goals/concerns about group] related to your trauma?

THERAPY Can you tell me about how this group fits with (builds on?) any other therapy you've had?

TRAUMA THERAPY What is it like for you to be starting a trauma-focused therapy?
Get at previous experiences of and current attitudes towards trauma work.

CONCERNS Did you have any expectations or fears about being in a group? What about hopes?
These might be still-present fears or, if participant indicates relief after 1st session, ask them to elaborate on what they were concerned about prior to this first session). As appropriate, query concerns/expectations that may be specific to being in a trauma-focused *group.*

POST-TREATMENT INTERVIEW QUESTIONS

Example script to review informed consent: Thank you for agreeing to take part in this interview. Today I will ask you to reflect back on and discuss your experiences of SpeakArt. We think you are the best expert on you and your experiences in therapy and, thus, it is very helpful for us to understand as much as possible any important personal experiences that happened to you in and/or as a result of therapy. This interview will be audio recorded, and transcripts of the interviews will remove all personally identifying information. Please be assured that only members of our research team will have access to these transcripts. For the interview, I have several specific questions, but I will also give you ample time and space to discuss your responses in full and vivid detail. Do you have any questions before we start?

Note: *Questions are in **bold.** Italicized text indicates procedural instructions or question-specific guidelines for the interviewer.*

PART I: OVERVIEW EXPERIENCE OF SPEAKART

***We are looking for spontaneous impressions here. Minimize follow-up questions and prompts.*

1. Please tell me about your experience of SpeakArt. How was it for you, what are some things that stand out?

2. Did anything surprise you based on your expectations going into the group?

PART II: WHAT SHIFTED OR IMPROVED

Prompt for specific examples. Ask participants to describe ex. as fully and vividly as possible.

3. Have you noticed any shifts in how you see or understand yourself?

4. Have you noticed any shifts in problematic thoughts, emotions, behaviors, or your relationships since beginning SpeakArt?

5. Have you experienced any shift in how you perceive your trauma and its impact on you? (What have you learned about your trauma and its impact on you?) *baseline Q-UNDERSTAND*

6. What have you learned about trauma recovery and healing? Has anything shifted in your attitude towards trauma work or trauma therapy? *baseline Q-TRAUMATHERAPY*

7. Please tell me what else are you taking away from this experience?

**Share summary of responses to baseline Q-GOALS with participant. Ask*:
8. What is it like now to look back on those goals/hopes that you had when you began?

PART III: HOW SHIFTS OCCURRED; SPECIFIC TRANSFORMATIVE EXPERIENCES

Prompt for specific examples. Ask participants to describe ex. as fully and vividly as possible.

**As appropriate during this section (depending on content), baseline Q-CONCERNS, or Q-THERAPY and ask participant to reflect on their expectations vs. actual experience.*

9. Please tell me about the specific experiences in SpeakArt that you think contributed to [shifts, new understanding, changes, take-aways described in preceding responses]...

10. Can you point to anything specific that occurred in your interactions with group members or the facilitators, that was meaningful or unexpected?

11. Please tell me about the specific prompts, sessions, materials, or artworks that stand out as significant for you?
i.e., challenging, meaningful, transformative, aha-moment, painful, fun, enjoyable, touching, personally relevant, frustrating, confusing…

- **What was meaningful, helpful, or transformative about that/what did you take away from that?**

PART IV: QUESTIONS THAT MAY ELICIT NEW UNDERSTANDING OR CONSOLIDATION

12. Looking at your art now, do you notice or understand anything that was not apparent, at the time you made it?

13. Looking at your art now, all together, what story does it tell?

PART V: WRAP-UP

14. Do you have any final comments or reflections related to the topics we discussed today? Is there anything that seems important for me to understand, that we haven't discussed?

15. How have you found this interview?

Appendix J. Initial Interview Summary Sheets

BRENDA

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- It is another tool, another resource to use, to better my listening skills. Be better at listening to myself, and listening to others.
    - Listen to what my body or my mind is trying to tell me. Listening to the physical signals my body sends, and listening emotionally.
    - Start to acknowledge and experience my own feelings. Because, in my family, emotions weren't talked about, they weren't felt. Particularly unpleasant ones. So, taking the time to slow down, acknowledge them, do my best not to judge them.
    - Listening to myself is the first step to establishing boundaries…It's about listening to my inner bullshit meter. If something doesn't feel right, I don't have to put up with it.
    - Enhance my ability to effectively listen to other people. I am working on being a better listener to others.
- Don't judge other people and their work.
- Sometimes, it's just nice to get together with other people and do something, particularly if you're isolated.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- The only thing that I was consciously concerned about was that it's a new thing. It was the *newness*. Like, I gotta check this out, I just don't know what it's going to be like, and maybe I won't like it. But maybe I will! I think I'm the kind of person that won't jump into something new with my eyes closed. I'll always be a little bit like, I'm going to check things out and see.

What are your expectations for SpeakArt?

- Strong emotions can be brought up. But I find it a fun way to learn to listen to myself. It doesn't have to be all heavy-duty therapy and meaty and dark and complicated. Sometimes it can be like today, just having fun getting my hands dirty in the clay.
- Not everything has to be complicated and deep. I can get as much benefit out of doing something fun, distracting.
- Doing the artwork, sometimes I get so into it that I'm just enjoying it and not really thinking about my feelings except 'Oh I'm having fun.' But coming back to talk about the art and share it with other people, requires you to get in touch with how you feel. Discussing it and the feedback [will help with] coming back to your feelings and acknowledging them and talking about them.
- People are allowed to express themselves as they please, as long as it's appropriate

DEE

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- More comfort in the group environment.
    - Because of the social harm that's been done from my trauma, it's important to start getting out there, but not get into intense relationships with people.
    - Female friendships are not something I've had, or they ended negatively. So I'm hoping…maybe to connect with someone. Ride the elevator together, that little spark of connection with someone you saw last week, get to know each other a little better.
    - I'm trying to learn that if you share parts of yourself, then good things happen. Instead of feeling like...the more that you expose yourself, the more you get abused. So it's practice, lots of practice.
- A little bit more acceptance. Of myself.
- The piece I'm having a problem with, is integrating [the impact of trauma]. This program is an important step. Not putting it aside and putting it out of your mind, but dealing with it, recognizing it, integrating it, realizing that probably for the rest of your life, the trauma is going to have effects on you.
- I really really like to draw, and I got quite good at it as a teenager, and ceramics. I'd get lost in my own world. But as someone ages, and their suffering gets worse, that's what you focus on … So it's a chance to reawaken the creative side. Find the freedom and the self-confidence. I want to get back to it. I'm hoping that this this course will also do that for me.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- I'd prefer to be told at the end of the session what next week's prompt is, I think that would give me time to mull things over, see what's important to me to express.
- I feel pressure to perform, and complete something in the amount of time, and make it look nice…. And immediately placing judgment on myself, like I don't know if I'm going to make a mess of this.
- It felt crowded, for me.
- I'm very empathetic, and compassionate, and other people's words really trigger me. I like it to remain very vague, in order to protect myself.
- My abusers were always women…So I avoided women like the plague, the friends that I did have were male, I wasn't socialized the way most women were. That softness that women have naturally…I had to grow up fast, I never developed it, it wasn't part of who I was. So it's a softer environment than what I'm used to. It feels a little "Kumbaya."
- It was uncomfortable for me to even *think* about sharing. I was ok with the process of creating, I didn't get overly emotional, because I already knew that about myself. The difficulty is in speaking about it, opening up to others…Being able to articulate what the piece meant to me. Because the explanations can be quite emotional and I do not break down in front of people.

- It's a source of pride to me that nobody ever sees me cry… Fear of losing my cool emotionally.
- It’s not the trauma itself, but the effects of trauma, what it's done to me, that I cannot talk about. So I'm worried that ...these limitations are not going to allow me to add value.

What are your expectations for SpeakArt?

- I didn't realize that it rotated. I was looking forward to that community of us all going through the process together, starting at the same time, finishing at the same time. I wasn't disappointed. I was just a little surprised.
- It's up to the facilitators to keep the group norms and it's not my place to say or lead, and I just have to trust that.
- Walking into this clean, calm hospital, sitting in the group of women who despite their experiences, were carrying on with their lives, had educations, had families...it's different from most of the free resources available to somebody like me, where you’re walking into a place where there are needle disposal things on the wall, people drunk on the sidewalk in front. So, what a great environment this is going to be, to be in. To have the time and peaceful environment to get in there and be creative for a bit.
- In my Resourced and Resilient exit interview…I asked for something a little lighter, like art therapy. And I misunderstood that it was *speak* art and that the verbal and the sharing part of it was an important component.
- I know I can get through it and I know I can do it. Any of my reservations about this group are reservations about myself … But I have the self-confidence, and the experience of success in other ways. Keep your eye on the prize.

FELICIA

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- I'm here to heal myself, it's a lifelong journey. I promised myself I would try anything, because each experience shows me something about myself…I will go home, think about how that makes me feel, where does that place me, what can I do…Like adjusting my values, and redefining who I am. That's what I'm doing in this process.
- Art is going to be the way out of poverty, freedom to get out of my current situation…so that can have a lot of weight on me at home, pressure. At home, there's a lot of criticism, self-judgment, inner dialogue that can keep me from creating. So to have a place to go every Friday for 12 weeks, and remove that criticism, just be able to express myself, make anything, no judgment, just flow with whatever I'm feeling in that moment, on that day.
- I want to practice speaking about my art. Having more understanding of who I am and who I want to be in the world, I have to practice speaking about that, owning that. It can't just be something that lives in my mind. […] This is a safe space where I would practice … having a voice […] It doesn't mean everyone is going to hear you or understand you, but that doesn't matter. I have to practice speaking it, because it's my truth, it's how I feel, and I am important.
- I do want to start doing my work on my grief, my grieving work is really important to me. But it definitely is separate from SpeakArt, because it's just so painful.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- Dealing with women with trauma, sometimes they take up so much air, so much space, to the detriment of me not having my space… am I prepared to expose myself to people that are always triggered? You can feel the weight and the heaviness they're carrying. Do I have the capacity to do this again? To open myself up enough to care about what other people have to say, what they're feeling, how their trauma has impacted them?
- The lack of eye contact…only one person had eye contact with me, other people spoke but they wouldn't look at me, like not validating me, not giving me any signals that I'm even in the room. So what's the point of sharing my art.
- When I first got in the room, I felt like I didn't belong there. I felt out of place.
    - Part of it felt because I'm the only black person in the room […] In groups dealing with trauma, in the mental health industry, I seem like I'm always the only one. Even facilitators, doctors, I don't ever meet anybody who knows what it's like to live in my culture, and the trauma that I've faced.
    - Maybe this seat would be better for somebody else that is more compatible to the people in the room, someone who gets them, and they get her, and they're connecting, they want to know about that person, they have a curiosity.

- The other people are describing things that are more raw. My feelings of my own trauma and pain is not as raw. So do I have a space here? Maybe I question the validity of what I have to say, what I can share, what I can bring to the group.
- My journey has taken me into this deeper level that is not easy to explain to people. It's hard to feel authentic, finally being this person I was meant to be, and it doesn't come across well to other people or people don't understand it.

What are your expectations for SpeakArt?

- Women in groups, there's always a social unspoken thing that goes on, some dynamic that I feel, like the hierarchies in a group of monkeys in the jungle. Some feeling of who's in charge, who's popular. I've become very sensitive, hypervigilant to the roles that people play. I try to break through that and try to find my space, but that's a challenge.
- When people speak about their art … I don't have a feeling in response. It takes me time to formulate my opinions or to formulate a feeling. I'm kind of blank, because I'm usually just taking in information, blank, listening. Then when it's time for me to speak, I'm taking everything and trying to think about what to say, and what I feel, and sometimes, there's just not enough time for that.
- [Eva-Marie told me that] the relational stuff from WRAP was not part of SpeakArt. You're always given a choice, you can speak or not speak, you can do the prompt or not, you can show or not show.

GABRIELLE

What are your goals or hopes for SpeakArt, or changes you'd like to see in yourself?

- More confidence to stand up for myself, speak up for myself, articulate myself, not second-guess myself all the time.
- Be gentle with myself that I'm not always going to be satisfied with what I do.
- Allow myself to play.
- Hoping to have more energy, feel more excited.
- Sitting with other people and being understood. Being heard.
- To have an outlet to verbalize and show care for others, and be appreciated for it.
- Using the visuals to touch back on and reach back to when I dissociate.
- Prepare for WRAP by letting things bubble up. Become aware of themes that I can work on in WRAP. More self-awareness. I want to know what my own issues are, that are sometimes hidden from myself, the old scripts running in the background.

What concerns or fears do you have about doing SpeakArt?

- The struggle to balance my need to share vs. taking up space. Part of me is like, 'No! You have to jump in, get your piece.' But I don't want to step on people's toes.
- Uncomfortable things could come up. Having my buttons pushed, or seeing someone else have their buttons pushed.
- Bringing a bad mood into the group.
- The old scripts of 'not good enough' and 'maybe they won't like me.' I'll be too quiet or too talky. Will I be too much? Will I not be enough? Everyone will think there's something wrong with me.
- Fear that I will just draw scribbles that mean nothing, and I won't reap the benefits. And then it's just a heavy weight, and I will become disappointed in myself and more tired.

What are your expectations of SpeakArt (or art therapy more generally)?

- It will be a supportive environment.
- [Previous therapy/CBT] felt like piling up bricks, trying to fit myself into the wrong shaped hole. This feels like I can make my own picture, put together my own vision of what wellness looks like.
- I won't have to speak about details of my trauma. I can let things percolate up and reveal themselves.
- I can give my subconscious tools to describe things without screaming at me and causing me to dissociate and get washed away. Through art I can let things bubble up gently, be on the outside looking in rather than inside being drowned.

KIM

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- I really want to get some relaxation. Just me time. Get out of my house and go somewhere where I have to do art. And have fun.
- Giving myself permission to play, to be playful…to pass this on to my daughter.
- I'm looking to cross my boundaries. Today I used what I knew, I'm kind of timid that way, I just use what I already know. But we could use all different types of materials, so I want to see if I can expand my creativity and cross those barriers.
- I came to SpeakArt now because I've had a good foundation of understanding and learning in Resourced and Resilient and then Trauma and the Body 1 and 2. I built a toolkit, and got a lot of information, a lot of knowledge, to be able to go a little bit deeper. I felt like I was ready for that next step.
- Having a deeper and symbolic understanding of what I have gone through…my overall meaning and voyage and journey. I really want to have meaning, to understand the story that I am going through…So through SpeakArt, maybe I can access it…another voice or message that is being translated from the inside.
- [Having the story] will give me purpose and meaning. It will give me stature. It will give me pride. I'm going to feel comfortable in my skin.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- I think I feel pretty safe, right now. I don't really have any fears. I limited my stressors at home, so I've got the time to soothe myself, and to take care of myself.
- I do have a fear of critiquing someone's art work incorrectly. Just how I phrase it…I may offend someone. Where I accidentally say, 'that is that' when I'm not supposed to identify anything, I'm supposed to just say what I feel, so I have to remember to not be so spontaneous because sometimes things just come out of my mouth, and it's genuine but it's not the language I'm supposed to use. So I always have to remember to say, this is what I feel, what I am seeing.
- Doing something wrong. Or speaking or saying something wrong that's gonna have consequences, or hurt someone.... And then feeling embarrassed about it. So I want to make sure I know the rules, and follow them.

What are your expectations for SpeakArt?

- I think expression through art, we can access the subconscious, and I wanted to use a different form, not just of understanding but also very experiential. Like, feeling and seeing, and creating and forming, and translating.
- Mythology, our connection to our souls…I think that that's the basis of who we really are and, through art, I can see my own mythological being and how I have evolved, and my own mythical archetypal story. So I could work on this project of trying to access some of that through art….it's more available to colours and textures and forms.

MAGDA

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- Gain new tools to help cope, so I don't get to the low dark places as deep as they are now. Any time it doesn't last as long or go as deep as last time, or the worst time, it's a win to me. Anytime I can recover from it faster, it's a win to me.
- Then, hopefully, I will feel stronger, more empowered, more in control. Because it feels like you are constantly spinning out of control.
- To not be as hard on myself on those days, or when those things happen. There's a lot of self-abuse and negative talking, 'you should be smarter, you should be able to, could have, should have, would have...control yourself, manage these feelings better.' A lot of self-abuse. So I want to be more gentle with myself.
- Maybe discover a little bit of the new me. I kept trying to fix myself to be good enough to go back to my old life. And I think I have come to a realization that it might never be my old life. I still haven't been able to fully accept it…but part of me is saying, what if there is a new version of me? A new life. And maybe there's a new hobby or new skill or new career, or whatever else, that all of this is going to bring out.

What are your expectations for SpeakArt?

- Just being in this space helps to shift something. Like where there are colours, or paint, or glitter, something different from your everyday reality. It helps to shift the focus, just a tiny bit. When you are depressed and struggling with post-traumatic stuff, everything around you gets dull and dark. But all of a sudden you see something bright, and it's like, hold on. What's that? It almost reminds you of something from your past, prior to trauma. Like you peek through the window. It reminds you, it wasn't always like this, and hopefully it's not always going to be like this. A reminder to keep pushing.
- Because there's a physical component, it helps to bring me back a little bit. It's not just 2 hours of listening. You have a little bit more freedom to move, or do some kind of *physical* grounding. Mindfulness has just not been as successful with me, but anything physical that I can touch, feel, has been better. It helps me pull out of it faster.
- You don't finish an art project in a second. It takes time. Once you create it, you have a chance to change it. Your perspective or whatever might change or shift and that takes even more time. Even though you think it's done, it's not ever really done … it's ok to leave it there for now, and come back to it. I don't have that ridiculous pressure that I put on myself to fix it or solve it right this second.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- The energy of the people. And if I will be comfortable in the space.
- Tell myself to be open and not to judge it. Even if nothing comes out of it, it's a stepping stone, I can experience a learning type of environment where you never know what is going to happen.

NICOLE

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- I'm very functional, but there's stagnancy. Things are stuck. And I don't know how to move them out, and find freedom after the trauma. And that's what I am hoping to start exploring.
- I think what's happening, is there's a voice that wants to speak, from a place that has no vehicle. That's why I chose SpeakArt.
- It feels like there's an element of humanity, a *je ne sais quoi*, the soul piece, that is [disconnected] from feeling. That's how I function well, but it's not how I'm going to process and become less robotic and more full, more human … So I think maybe I am just trying to reconnect a bit.
- I used to be a musician, I used to perform, but I stopped those arts and now I don't have anything on a deeper level. So I'm trying to free up a little bit of space, express some of whatever it is that I'm looking for. A glimmer of a direction, or a feeling that it is somehow fulfilling. And then know that I want to pursue it additionally, or know that it's not fulfilling and rule it out, and then begin to feel brave to explore other things.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- Fear of exposure to the places that are broken and damaged and messy and ugly. And fear … that others will see it. And fear of what other people will judge me to be, because of what I'm harbouring under the surface.
- Whenever I expose my own imperfections, it's...very uncomfortable and frightening, because I feel like it's creating opportunity for persecution.

What are your expectations for SpeakArt?

- Part of this work is sharing a little bit of what is below the surface. It's not pretty, it's not the polished facade that I've become very good at presenting. It's not that at all.
- If I share [my art], then I will get some information. I'm here for a reason. I'm here for a purpose. I'm trying to access and get to something, and if I only stick to my own limited understanding, then I am not going to benefit from what other people have to say.
- I have come to know this place as a very safe place. I know the rules of this place. No one can touch me. No one's allowed to persecute me, or attack me for exposing vulnerability or darkness […] That can't happen here. It's not just a concept, it's practiced.
- Everyone seems wrapped up in their own shit which is great, because there's not going to be too much attention to mine. It's space to process and navigate things independently. And freedom. There's something freeing about not being the center of attention. Like anonymity, and permission to start exploring.

PAT

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- Figuring myself out at a deeper level. Who I am, why I think the way I think and feel the way I feel.
- To make more meaning out of my art… to understand myself and my life better. Maybe getting to a place where I can be more intentional with my plans. So that I know the next step because I know where I am going, not just because there's a floor there.
- [Greater self-understanding will help me to] be a better human. Be more aware of myself, and my decision making, and my plans for caring for my son, his future.
- I'm excited about using art to do that…not even getting self-understanding *in* the art, but in creating, and in the making of it. Being able to use art this way...just being open to whatever thoughts come to mind with the prompt, with *no* expectation to solve a problem, just have the experience and then whatever comes out of that experience.
- I'm not trying to please anybody in there. It's just me doing work for me, in there. It will be successful dependent only on my engagement in it. If I go and make stuff, and think about it, something will come of it.

What are your expectations for SpeakArt?

- [Previous therapy was] frustrating because of this lack of ability to express myself in words. I can kind of get stuff out, problems, and then a counsellor helps me work through those things. But in terms of dealing with the causes of those things, I can't get there. I can't talk about it or, I don't know what's there. It's like a lack of understanding of what I'm feeling or thinking. And, a fear. It's paralyzing.
- In [SpeakArt] there's not pressure to talk about those things, and because there's not pressure, things might come up.
- Being in a different kind of space and physically doing things, expressing in different ways, I think it might get to that dark void wordless place from another angle. Maybe shine a little light in there. Even if it's just to see a little corner of it.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- Not being able to keep up, physically. This class started and I started the writing group and I started a tai chi class. So all of the sudden, doing three things. So I've been thinking, is this possible for me? Am I going to be able to get through 12 weeks?
- To acknowledge it, to make it more real. To do that work, and then to continue to have relationships with these people, because I need these people, physically I need help. It's a really scary place. Because I'm dependent on people still. I don't want to rock the boat. I just want to...stay under the radar, keep things going.

ROSE

What are your goals or hopes for SpeakArt, or changes you'd like to see in yourself?

- Get over recent art/creativity block, because art is one of my self-soothing tools.
- Let go of judgment and needing to be perfect. Let myself make mistakes, try new things without fearing failure.
- Trauma is at the root of a lot of my issues. I've dealt with the symptoms but I've never really touched or dealt with the trauma in a targeted way. Hoping SpeakArt can be like baby steps between never dealing with it, and being able to talk about it. I want to increase my self-awareness of what I have going on, so hopefully I will be able to better explain it and verbalize it in the future.
- I don't have words for how I feel, beyond: I'm happy, it's a good day, or I'm not happy, it's a bad day. Hoping art will help me put names to feelings and then maybe I'll be better able to articulate what I feel, in individual therapy.

What concerns or fears do you have about doing SpeakArt

- Being vulnerable is hard.
- When I shared my piece today, that part was really scary.

What are your expectations of SpeakArt (or art therapy more generally)?

- [In the past] painting has made me feel better.
- The group structure will guide me, give me ideas or inspiration for what to create.
- It will be a judgment-free, safe space.
- I have been anticipating it and over-the-moon excited about it. There was no overt fear.
- Speaking in front of people is not a big deal, but that's my mask that I put on. Even in groups, talking about personal stuff…it's always been like I was talking about it in the third person. But today, and in R and R, it was raw. I couldn't use my mask, I felt like I really needed to express as me.
- Today I thought I'd make a happy face or a sad face or a dark scribble or a happy scribble. I didn't think I'd go to the depths that I did today.

How do you feel about doing trauma therapy?

- I thought it would be easier. I didn't think it would it would bring up the amount of emotions that it has.
- It really hits home…I have so many tools, but it still feels like yesterday that it happened. And it is still pretty raw. And it still hurts. And it is still uncomfortable.
- It's difficult, but it's something that I want to do. That I need to do, and that I think will help me. I know it will help me.
- At this point, I'm stable enough with the other things. It's taken awhile, but, I'm ready to open it up and start looking inside me and reflect, without using those crutches.

ZAHRA

What are your goals for SpeakArt? Are there any changes you hope to see in yourself?

- To break my perfectionism, in little steps.
- I haven't done art in so long, I'm excited to get in touch with my creative side, and break those barriers, break that creative block.
- My goal is to share my story publicly. On a social platform, hopefully Instagram. I have a strong ability to tap into my emotions and express it in words. I want to be able to map that visually, through art work. I'm here because SpeakArt will help me start this goal.
    - It would be therapeutic for me to get it out and express it…It would make me feel sane. And proud to know people understand. This is what's going to give meaning to my pain. And my loneliness. Because a lot of times I feel alone, in what I feel.
    - I want it to be seen. I don't want any of this to be kept to myself, hidden. That would be wasting my life's purpose…Bad experiences can be translated into beautiful things, through writing, through visuals.
    - Expressing it publicly means helping a community of women feel empowered in knowing that they're not alone. No one talks about it. I want to break that stigma.

What concerns or fears do you have about doing Trauma Therapy, about doing SpeakArt?

- You feel judged, when you express creatively. It's showing such a vulnerable side of me. I am a sensitive person, and I can feel targeted when it comes to judgments.
- Looking around at other people's work…detracts from my own confidence, and I can't focus on what I'm doing. I start comparing, and judging my own work.
- I've always struggled with perfectionism. Sometimes I have ideas but never even start the process, because I get immediately hung up on what the final product will look like.
- I want people to get it, and I don't know if they're going to get it...I might not be able to do it, people won't connect, the ultimate goal of other people connecting with it won't be achieved. If I am not going to help others, there's no point to this.
- I think I would feel very disappointed if, at the end of it, I don't end up doing the ultimate bigger goal.

What are your expectations for SpeakArt?

- One of the things that really excited me about it is how they use prompts. I can express my emotions into words very well. My whole purpose is to map these words, visually. So it's like training ground, she's giving me the prompts, and I'm going to express myself.
- I create art for a reason. There's a reason for each choice, why I use certain colours, why those metaphors…that's what makes me feel like I have talent. Because I can share a story through the little details.

- There were so many colours, lines, everything stacked everywhere, different forms of expression, all the tools and mediums. It felt like I could say whatever I wanted. I felt free, like I can just be anything in here, on a weekly basis, depending on where my emotions and mental state are that day.
- It's going to make sense of why I truly went through what I did. Answer all those questions, where I've asked myself um to a white blank wall, why me? Why do I have to go through this? That's what I'm looking for.