When Language Fails: Using Expressive Arts to Facilitate Being-with When Working with Survivors of Mass Trauma

Adam Harrison

A Dissertation Submitted to the Faculty of
The Chicago School of Professional Psychology
In Partial Fulfillment of the Requirements
For the Degree of Doctor of Psychology

May 17, 2011
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2011

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Acknowledgements

I feel that I must acknowledge, first and foremost, my family for all their love and support throughout my entire schooling career. Without their dedication to my education I would not be the person I am today. Thank you Mom, for instilling in me a love of learning and the desire to never stop asking questions. I know my incessant questions annoyed you at times, but I'm grateful you continued to encourage them rather than making the much easier decision of asking me to stop. Thank you Dad, for believing in the man and professional I would some day become, even when I thought I'd never get there. I am also deeply grateful for your constant encouragement to explore the world around me, while making sure that I knew that I always had a place to come home to.

I also want to thank my dissertation committee for being absolutely wonderful. I honestly couldn’t have wished for a better committee and I doubt I would have survived this process if I had anyone other than you on my side. Thank you Todd, it has been such a wonderful experience to work with you both as your assistant and as your dissertation student. The questions you’ve asked me over the last two years have been the single greatest source of my growth during my time at the Chicago School. Thank you Don, you have taught me so much during our many classes together. It is because of you that I learned to laugh at my failed attempts rather than scrutinize myself for being human. You also emphasized the importance of never losing sight of our human-ness throughout all of our endeavors. Thank you Jill, for every conversation you made time for after our classes. I’m fairly certain you always had someplace you needed to be, but you always found time to talk to me about whatever intervention we presented in class that day. I also am deeply
appreciative for your insight into how to make this protocol actually work. I feel that I have been incredibly blessed for the dissertation committee that I have. You have been mentors, cheerleaders, and wealthy resources of information. Thank you, truly.

I also owe thanks to Abbey Turcotte from the Cancer Support Center for taking the time to teach me the Five Elements Tai Chi so that I could teach it to others. Please know that your caring gesture will be used to help care for others.

I also want to thank Mike McNulty and Father Paul Satkunanayagam, in connection with the Chicago School, for the learning experience they provided in Batticaloa, Sri Lanka. What I saw and experienced there lit a fire in me as a clinician. Before leaving Batticaloa, Father Paul challenged all of us to help his community through our dissertations and our work as clinicians. I never forgot your challenge Father Paul and this dissertation is proof.
Abstract

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The following program is an eight-week trauma-focused expressive arts group protocol designed for clinicians who wish to work with survivors of mass trauma but with whom they do not share a common language. The protocol is structured so that the clinicians can facilitate the group through pantomime and demonstration so that there is a decreased dependence on locating and maintaining translating resources. The protocol was designed by drawing upon the strengths and bridging the weaknesses of several current trauma-focused expressive arts protocols as well as using Hobfoll et al.'s (2007) meta-analysis of the general principles necessary for effective trauma-focused therapy interventions. Ease of use, transportability, and cost of materials were also taken into consideration during the development of this protocol. The result is a largely non-verbal, culturally sensitive protocol that incorporates the promotion of a sense of safety, calmness, community, self-efficacy, connectedness, and hope while working through traumatic events individually and as a group for less than $500.
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CHAPTER 1: INTRODUCTION

It’s early afternoon in January and I find myself on the verge of crying in the back of a van nearly 10,000 miles from my home. I’m not upset because I am so far from home, but rather because I am returning home. I look out the window at the faces of those who invited me and my colleagues into their home for the last two weeks and I can see they feel the same way. I know I will miss them and they will miss me, although no one has said that. In fact, only a handful of words have been said between any of my colleagues and the people we worked with while on this island, yet we feel as if we truly know each other.

As the van pulls out of the driveway and we begin our twelve hour journey across the rugged terrain of Sri Lanka back to the nation’s capital, silence falls upon our van. It is a heavy contemplative silence. In it are feelings of loss and sadness. For what seems like hours, none of us dares to break this solemn moment.

As my sadness begins to reside, one thought occupies my mind: “Why do I feel so distraught leaving these people I don’t even know?” Not only did I spend the rest of the ride to the airport thinking about this, I spent the entire rest of the trip thinking about how this occurred. And despite coming to a reasonable conclusion of why I felt that way I did, I still spend a good deal of my time studying the mechanics of how this phenomenon occurred.

My experience in Sri Lanka begins in December of 2008, when my school announced a course on trauma that included an experiential component of working with survivors of mass trauma. I eagerly attended the initial briefing because the seminar was
to be held on location in Sri Lanka. The course seemed like the perfect opportunity to combine my love for travel with my interest in trauma work.

It was explained during the initial briefing that the purpose of the trip was to train a group of para-psychologists in the eastern region of the country. These “barefoot counselors,” as they are affectionately known in the area, wish to answer the growing need for psychological services in their communities. It became apparent to them following the tsunami in 2004 that the eastern regions of Sri Lanka have far too few counseling resources. I did not find out until we arrived in Sri Lanka that there are only four practicing psychiatrists for the entire country of approximately 21 million people.

The people of Eastern Sri Lanka are often too afraid of seeking psychological services, as it is feared that the government will use the information that is shared with clinicians to cause harm or perpetuate stereotypes of the Tamil people. Patricia Lawrence, a social anthropologist who has worked with and studied the people of Sri Lanka for the last two decades, touches on the political environment of Sri Lanka in her book detailing her work in the country. Lawrence (2003) describes the increasing restrictions that the dominant Singhala ethnic group has placed on the minority Tamil ethnic group as a strategy to “contain the Tamil problem” (p. 4). This puts the people of Sri Lanka in a precarious situation; they can seek services and risk sharing potentially dangerous information with the government or they can choose to ignore the need to get help and live a life that is wrought with distress from symptoms of disorders like Posttraumatic Stress Disorder, anxiety disorders, and depression.
Our expectations as students during the trip was to help the professors prepare materials and examples for the following day’s lecture that was to be presented to the barefoot counselors. Additionally, our time during the day was to be spent working with children in the area who had been orphaned by the tsunami or by the country’s ongoing civil war. We were also given the opportunity to work with some of the children who were participating in rehabilitative services for ex-child soldiers.

The most surprising aspect of the trip was that we were not expected to learn the language of the people with whom we were working. The professors would have access to the limited number of translators for their lectures, but we were expected to just jump into the middle of things and figure them out as the trip progressed. We were reassured during the briefing that the children we were working with wanted to be understood and would find ways of communicating to us when language failed. Being one who enjoys a challenge and the occasional adventure, I signed up for the trip without the slightest idea of the deep relationships I would form there or that my time there would serve as the catalyst for my dissertation.

Upon arriving in Sri Lanka I quickly realized how far away from home I really was. Aside from Coca Cola, there wasn’t a single billboard, sign, shop, or food product that I recognized. For the first time in my life I was illiterate and for all intents and purposes, I was also pre-verbal. My first handful of interactions with our hosts were awkward, to say the least, as I fumbled to find gestures and body language that conveyed my responses to their questions. My first attempt to communicate was to utilize overly exaggerated body language that resembled something from a low budget and poorly cast
play. As the embarrassment faded away, I slowly developed a pool of pantomime movements that I used to ask our hosts things like: “Where is the bathroom?,” “Can I have something to drink?,” and “How much does this item cost?”

As had been predicted during our briefing session back in Chicago, the awkwardness of not being able to verbally communicate quickly passed once we began working with the children in the program’s group homes. The children were very eager to tell us things and they found creative ways of explaining themselves to us in a way that didn’t rely solely on the use of words. I was often dragged outside to sit in the sand where the children readily drew images of what they were trying to convey. My cave-like pictorial responses almost always invoked a laugh from the children. I quickly learned that by pantomiming what I was attempting to draw in an exaggerated fashion I could also initiate a hearty round laughter as well as accurately communicate my intentions to others.

Although I was approaching learning to communicate without words in a somewhat self-deprecating fashion, my responses were becoming more focused as I practiced my newly developing skills. Soon I was able to spontaneously gesture a response that was more often than not understood by others. As I became more comfortable in my surroundings, I began to try different ways of communicating to my hosts. I also watched my hosts very closely and did as they did as they moved about their days. The concepts of mirroring and imitation resonated quite deeply with me as I attempted to learn my hosts’ daily routines.
By the end of the trip I felt a strong connection to two of my hosts. One worked as our driver when we needed to visit the children’s groups homes and the other worked as our cook. I saw both of these men several times a day and when there was time between lectures or when we were waiting for someone to arrive, I spent my time developing my relationship with these men.

In the evenings the men often sat around and spoke to me in broken English, trying to teach me their language. I was able to learn a few basic words as well, because my hosts found great amusement in listening to me struggle to produce the difficult sounds of their language. More interesting to me though, were their local forms of entertainment. When they saw I was interested in learning Cricket, the men darted about the complex we were staying at to find anyone interested in playing a midnight round of the game. Playing cricket with these men on the verge of a monsoon is one of my fondest memories from my time in Sri Lanka. When I think back on why this is the case I think that it is because through learning to play a team sport with my hosts, I felt like a part of their team. The playing of the game only highlighted the connection we had established throughout the trip.

The most interesting lesson I learned while in Sri Lanka was taught to me our facility’s cook. Although he shooed me away from the kitchen on what seemed like an hourly basis, he finally gave into my persistance and allowed me to help make dinner. This was a compromise between the two of us because he felt strongly that I should not be required to cook my own meals since I was his guest and I felt strongly that I should help cook since I was staying in his home.
In the end, I spent two hours peeling, chopping, and sauteing vegetables with him for one of our meals. Although I have four years of experience cooking in commercial restaurants, I re-learned how to use a knife, prepare vegetables, and prepare a whole chicken for broiling. The strangest thing is that not a single word of English or Tamil was exchanged between the two us, yet we understood each other just the same.

Thinking back on my time spent working in Sri Lanka and the question I posed during the van ride home: “Why do I feel so distraught leaving these people I don’t even know?,” I realize my question has several assumptions embedded in it. The first assumption I made was that I could not know someone without using verbal language. I also erroneously assumed that I was not communicating with them because I was not speaking a language we both understood. At the time, I did not consider my gestures and drawings to be forms of communicating with others in the fullest sense of the word.

I feel that both of these assumptions are relatively common assumptions that clinicians make. The client that chooses not to speak to a clinician is the perfect example of how this assumption is made in practice. Many clinicians will often assume that they are not “getting to know” the client because the client is not verbally sharing information with them. This could not be further from the truth. In reality, the client is sharing a great deal with the clinician in this example, such as their resoluteness and ability to commit to a behavior, as well as the possibility that the client has a difficulty trusting others.

I now have a lived understanding that it is possible to exchange one’s thoughts and feelings with others without having to use verbal language. The deep relationship I formed with several of my hosts in Sri Lanka demonstrates that there are a multitude of
ways of being-with others, many of which do not necessitate the use of verbal language. I will discuss the concept of being-with more thoroughly in my review of literature, but it will suffice to say that it is a specific way of validating a client’s experience that promotes therapeutic change. It is with my experiences from Sir Lanka in mind that I decided to research and develop a program for working with mass trauma survivors that does not require the clinician to communicate verbally with those who have endured trauma.

Working with trauma is an inevitable part of being a clinician. Recent statistics suggest that 90% of Americans are exposed to at least one traumatic event during their lifetime (Bonne, Neumeister, & Charney, 2003). This statistic is based solely on the findings of individual cases and reports. What was left out of the data was how many people are affected by events such as war, natural disaster, and extreme poverty. The Sri Lankan government estimated that 98,000 homes needs to be repaired after tsunami hit in 2004 (Oxfam, 2009). Some estimates suggest that nearly one million people were displaced as a result of the tsunami (Reeves, 2009). Despite this research being incomplete, it does serve a purpose of demonstrating the need for to learn how to effectively work with survivors of trauma.

In the light of the ever growing global community, there is a call for clinicians to help survivors of mass trauma from vastly different cultures than their own. This call has been tentatively answered in the past by well-meaning clinicians who approach treating these clients with models of treatment originating from their culture. History has taught us that treatment modalities and even diagnostic formulations vary greatly from culture to
culture. Since not all cultures adhere to one method of assessing and treating clients, the well-meaning clinician who wants to help those in other countries is often perplexed about how to conduct therapy in a way that is most beneficial to these potential clients.

There is a present need for developing a program that will allow clinicians to treat survivors of mass trauma that is respectful of cultural differences in regards to diagnostic impressions and treatment modalities. I feel that by using forms of communication other than verbal language, we can be-with our clients in these diverse contexts in such a manner that we are respectful of the client's cultural norms. By allowing the other to reveal themselves to the clinician through art, movement, and music, I feel that we can help the client begin to heal in a way that is acceptable in their culture. Additionally, the program I intend to develop for this dissertation will greatly reduce the need to learn the language of a culture in order to conduct therapy in the aftermath of a mass traumas. All of these aspects of the program will be addressed in the following chapter when a review of current literature of non-verbal communication, expressive therapies, cultural competency, and the therapeutic value of being-with are examined. Additionally, the program will have at its foundation a phenomenological approach to describing clients' lived experiences in an attempt to better understand their particular experience of the traumatic event.
CHAPTER 2: LITERATURE REVIEW

Cultural Competency

Following the tsunami in Asia in 2004, American counselors rushed to the devastated areas of India and Sri Lanka to help those who survived. Thinking they would help those who endured the tsunami by treating their symptoms of Posttraumatic Stress Disorder (PTSD), the counselors began applying techniques such as Eye Movement Desensitization Retraining (EMDR) and narrative sharing. In the years since the tsunami, people have begun to ask a startling question, “Were they bringing the wrong treatment to the wrong people?” (Watters, 2007). Is it possible that the American counselors applied a treatment for a disorder that is so steeped in Western culture that it ceased to apply to those affected by the tsunami?

The most important aspect of developing a program to work with international survivors is to understand that trauma is a concept that is heavily influenced by one’s culture. As Watters (2007) notes about the tsunami survivors of Sri Lanka,

...it was not the nightmares or flashbacks that most of the population was concerned with. The deepest psychological wounds for Sri Lankans were not on the PTSD checklists; they were the loss of or the disturbance of one’s role in the group.

Is it possible that those affected by the tsunami did not react the same way to the event as those from Germany or Canada would?

The World Health Organization (WHO) has suggested that instead of providing techniques for trauma healing that run the risk of imposing cultural assumptions about trauma and how one should heal from that trauma clinicians should provide “psychosocial support” to those in affected areas (Watters, 2007). While the WHO has
addressed the need to remove cultural bias from our treatment of those who endure traumatic experiences, its suggestion serves only to disway clinicians from providing treatment from those in need of therapeutic services because they have not offered a way to provide culturally competent "psychosocial support." Clinicians around the world are willing to help those who have experienced events like the tsunami in 2004, but now are asking a question that is crucial and as of this date, unanswered: "How does one provide 'psychosocial support' in a culturally sensitive way?"

I feel that this question can be answered by doing the following: by understanding the lived experience of mass trauma, we can begin to put together a set of techniques that will provide the client a space to unfold their experience of the trauma in a way that is consistent with their cultural expectations. Additionally, if the treatment techniques capitalize on physical movement and artistic expression, the clinician will be able to assist the client without having to learn the language of the client they are working with. As the current research will show, using non-verbal techniques for treating trauma has other potential benefits other than allowing the clinician to work with clients who have language and cultural differences from the clinician such as bilateral stimulation (Carlson, 2008; Steele, 2003).

This research will be reviewed in subsequent sections of the literature review, but for the time being it is best to develop a better understanding of what trauma is and how we conceptualize it. Before working with trauma survivors it is crucial to understand some of the key aspects of how trauma affects the mind and body. By establishing a solid
foundation of what trauma is, we can then begin to incorporate the varying other concepts of working with a population of a culture different than our own.

I’d like to begin by setting the parameters for the term *culture*. McLeod (2006) defines culture as the lived experience of being raised by a group of people who share similar values. More specifically, culture encompasses the language people use to communicate to each other, the way their choose to raise their children, or the way they interpret events. Culture also is a system that gives meaning to particular events, such as a birth or graduation from high school. McLeod (2006) goes on to note, “Thus we can view culture then at some level as a conversation about what it means to be human, and how the good life should be defined and lived” (p. 49). A firm understanding that culture impacts our perception of everyday phenomena is crucial to working with people whose cultures differ from our own.

Only by understanding that the way we perceive and interpret an event likely differs from those of different cultures, can we begin to recognize and suspend our own culture’s assumptions. Sturmey and Gaubatz (2003) suggest that, “Clinicians also should consider the impact of adverse social, environmental, and political factors on clients, and work to eliminate biases, prejudices, and discriminatory practices that affect their clients” (p. 51). The process and importance of suspending one’s own cultural assumptions will be discussed in more detail at a later time in review of the literature. For the time being, it will suffice to understand that culture impacts the way people interpret and react to phenomena and that as clinicians we must work to suspend our own assumptions regarding these phenomena.
Defining Trauma Outside of Our Culturally Bound System of Language

Because cultures have different ways of interpreting phenomena, it is important that we establish a working definition of what trauma is if we intend to work with survivors of trauma on an international scale. I would like begin defining trauma by referencing Webster’s New American Dictionary. The dictionary offers two greatly varying definitions for trauma; “1. a bodily injury [and] 2. a mental shock” (Morehead & Morehead, 1995b, p. 694). While this definition is too vague to apply directly to clinical work, it does capture the duality of trauma. Is trauma a bodily or psychological infliction?

Babette Rothchild (2000) feels that trauma affects both the body and the mind. In her book, The Body Remembers, she writes about the disparity between how neurobiologists and clinical psychologists approach treating trauma. She feels that in order to fully treat trauma of any kind, the clinician must address both the physical and psychological aspects of one’s trauma, which appears to be in agreement with the lexically definition of the word. I feel that too often trauma theories, such as Rothchild’s, focus on re-establishing a sense of physical safety when working with those who have experienced trauma. While this does aid the client in beginning to heal from the traumatic event, providing physical safety does not address the fundamental concerns the client may have about the world as being safe.

I purposely chose to use the Webster American Dictionary because I feel that it best captures the American bias of how we conceptualize trauma. This becomes even more apparent when one consults the New American Roget’s College Thesaurus for words associated with trauma. The entry lists “injury; shock” and then refers the reader
cross-reference, “DETERIORATION, DISEASE” (Morehead, 2002, p. 820). This entry implies that an event such as an “injury” or “shock” results in a deterioration that may lead to disease. If these versions of American dictionaries and thesauruses are intended for those attending higher learning institutions, they must be good representative of what we expect those seeking higher education to learn.

These definitions differ greatly from dictionaries belonging to other cultures. One can begin to see this difference by referencing the standard for European English speaking cultures, the *Oxford English Dictionary*. The *Oxford English Dictionary* (2009) defines trauma as, “1. a deeply distressing experience; 2. physical injury (medicine); 3. emotional shock following a stressful event” (AskOxford, 2009, “Trauma”). This definition allows us to capture the emotional reaction to an event that the previous definition did not suggest. While this difference may be subtle, it still demonstrates that people of different cultures conceptualize trauma differently.

The *Oxford* definition of trauma is one that combines the experience of a distressing event with the emotional reaction to that event. This definition moves away from conceptualizing trauma as the external event as the *Webster American Dictionary* suggests and moves towards viewing trauma as an emotion reaction to such events. Again, this difference may appear subtle, but the implications of viewing traumatic events as external factors that have *caused* stress in one’s life differs greatly from viewing traumatization as the relationship between one’s emotional reaction to an external stressor. The latter definition allows clients to see trauma as an active process that one has choice in contributing to. I feel that the shift away conceptualizing trauma as
an external event that *causes* a reaction in one’s psyche needs to be done before clinicians can adequately work with survivors of trauma. By building my program upon an alternative conceptualization of trauma that shifts the clinician’s understanding of trauma to an active process between one’s emotions and the distressing event the treatment provided by my program to clients will address this need that current trauma programs do not adequately address.

While the lexical definition of trauma provides a culturally bound conceptualization of what it means to experience such an event, clinician’s conceptualization of trauma are also influenced by other sources of descriptive and functional definitions. One such definition can be found in the *Diagnostic and Statistical Manual of Mental Disorders fourth edition text revised (DSM-IV-TR)*. The *DSM-IV-TR* (APA, 2000) defines the criteria of a traumatic stressor as:

...involving direct personal experience of an event that involves actual or threatened danger or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person (APA, p. 467).

While this definition captures the duality of how one experiences a threat to one’s body and how that is translated into psychological distress it also places very rigid parameters on what is considered traumatic. The definition continues by stating, “The person’s response to the event must involve intense fear, helplessness, or horror (in children, the response must involve disorganized or agitated behavior)” (APA, 2000, p. 467). Brown (2008) critiques the narrow scope of this definition by pointing out that it does not include events such as humiliation or coerced activities in which one might fear for their safety. Brown and others have suggested that the *DSM-IV-TR* criteria be
expanded to include events other than those that directly cause or threatened harm to one’s body but still present a sense of fear. Brown (2008) espouses the use of alternative definitions of the trauma that would “give clinicians a model for trauma that better supports culturally competent practice” (p. 99). In later sections of this dissertation, I intend to offer an alternative definition that will allow clinicians to move away from cultural biases that the current definitions have been demonstrated to have.

It is impossible to conceptualize one who has gone through a traumatic event as defined above without viewing the client as being helpless and frightened. While the events that qualify as traumatic events by this definition are certainly frightening to experience, the element of being helpless that is embedded in this definition strips the client of their resiliency in the aftermath of the event.

One reason some cultures may find trauma difficult to conceptualize is that trauma lies outside their world view. Janoff-Bulman introduced the theory that many Western cultures subscribe to what he calls the Just World hypothesis (Brown, 2008). The Just World theory espouses that people hold three basic assumptions about the world: “1) the world is benevolent, 2) the world is meaningful, and 3) the self is worthy” (Brown, 2008, p. 99). Trauma, conceptualized from this perspective, is when those assumptions are challenged by life events.

This definition purports that trauma is a challenge to one’s assumptions about the world rather than an event that threatens one’s physical integrity or body-hood. This definition provides the clinician with a less pejorative way of viewing the client’s response to an event. Instead of viewing the client as being helpless or a victim, we can
began to see the client as struggling to reconcile their beliefs about themselves and the world in the aftermath of the traumatic event.

The caveat to using this definition is that not all cultures subscribe to Janoff-Bulman’s Just World hypothesis. Many Eastern and Middle Eastern cultures do not hold the belief that the world is just and fair. For example, the Buddhist concept *duhkha*, or suffering, states that suffering is just as much a part of being in the world as happiness or joy is (Hagen, 1997). The expectation that suffering will occur in one’s life allows those who follow Buddhism to prepare themselves for how they will deal with trauma when it occurs. Buddhism and other Eastern ways of thought, such as Hinduism, teaches that by accepting suffering as inevitable one will greatly reduce the suffering one feels when trauma does occur (Brown, 2008).

Another example of how cultures view trauma differently can be seen in the Chinese character *crisis*. The explanation of the origins of this character has become nearly cliche in many Western cultures. The character has been historically explained as the combination of the characters for *danger* and *opportunity*, leading to the mathematical expression of the word as “crisis = danger + opportunity” (Mair, 2009). This interpretation, despite being incorrect, serves as a mantra in many self-help books distributed around the world. Dr. Victor Mair, a professor of Chinese language and literature at the University of Pennsylvania, explains that the Chinese character for *crisis* while consisting of shapes that resemble both *danger* and *opportunity* actually is defined as an “incipient moment; crucial point (when something begins of changes)” (2009). This definition is nearly identical to the *Oxford English Dictionary* (2009) definition of *crisis*
which is defined as: “1. a time of intense difficulty or danger; 2. the turning point of a disease, when it become clear whether the patient will recover or not” (AskOxford, 2009, “Crisis”).

Again I would like to stress the significance language plays in our conceptualization of trauma. While language allows the speaker to communicate their feelings to another individual, spoken language often times distorts the original content of the what was intended to be said. There are many factors why this occurs, some of which I have mentioned previously, such as cultural differences, but even when speakers of the same culture use spoken language intended messages can be misunderstood or misinterpreted. As Heidegger (2001) points out in the Zollikon Seminars, “Communicato is only one possibility. ‘To say’ [ sagen] originally meant to ‘to show’ [zagen]” (p. 16). The participant in this conversation in the Zollikon Seminars aptly points out that “language and verbal articulation are confused with each other” (Heidegger, 2001, p.16).

Non-Verbal Communication

I agree that too often our understanding of language is constricted to the point that we only recognize verbal communication as language. Harrison (1974) eloquently defines non-verbal communication as “the exchange of information through non-linguistic signs” (p. 25). Miller and Steinberg (1975) build upon this definition suggesting that all communication is intentional: “If there is no intent, there is no message” (p. 35). I feel that these definitions help to broaden our understanding of what is meant by non-verbal communication that also places clear boundaries on what is being discussed.
Writing a message in English for someone would not be considered non-verbal communication because the writer utilized linguistic signs (i.e., letters and words) but arching one's eyebrows in response to hearing one's name called would be considered non-verbal communication.

As can be seen in my example of someone raising an eyebrow in response to hearing their name, Hall (1959) points out that often times it is our non-verbal communication that helps listeners to make an interpretation of what is being said. The person who calls a friend's name and sees their friend raise an eyebrow might interpret the event differently if the friend responded without doing such. The act of expressing an emotion through raising one's eyebrow helped to convey a message to the listener in this example. Hall (1959) gives the example of a politician who gives a speech that is meant to be reassuring but instead is received as upsetting. This is the case because, as Hall writes, "Sentences can be meaningless by themselves. Other signs may be much more eloquent" (Hall, 1959, p. 94). I tend to agree with Hall and others who suggest that things like body-language and facial expression are the most salient aspects of language.

As I mentioned in the introduction of this dissertation, I communicated with my hosts in Sri Lanka without verbalizing my thoughts and feelings. Although non-verbal communication has its own set of limitations, which will be discussed more thoroughly at a later time in this dissertation, non-verbal communication has some distinct advantages over verbalized communication. One particular advantage is that we are how we are in the world. That is to say: "The human being cannot comport himself without language" (Heidegger, 2001, p. 16). Even when we chose not to speak to one another, we are still
communicating a very clear message. As mentioned earlier, the client who chooses not to speak during a session, may be communicating any number of feelings, such as but not limited to distrust, dislike, or disinterest.

The most apparent limitation of non-verbal language is that it can be at times quite ambiguous, what is meant to be received as anger by one person may interpreted as withdrawal by another. Although this would initially appear to be the same limitation inherent to verbal language, non-verbal language has shown to be more universal that its counterpart. While the verbal expression of pleasure in Swahili might be missed by a client who does not speak Swahili, the facial expression and other non-verbal communication is difficult to misconstrue. The work of Silvan Tomkins is based on the understanding that the face is in fact the “key site of emotion” (Harrison, 1974, p. 119).

The work of Paul Ekman has been largely focused on the biological experience of emotions in varying contexts. What Ekman (1994) found is that “There are some common elements in the contexts in which emotions are found to occur, despite differences due to individual and cultural differences in social learning” (p. 16). In addition to demonstrating that there are unique patterns of activity in the autonomic nervous system when one experiences happy, sad, anger, and fear (Ekman, 1994) that are relatively consistent between people of varying cultures, Ekman (2003) has also demonstrated that non-verbal expressions of emotions can be recognized across cultures. In one of Ekman’s first experiments, Ekman showed photographs of actors expressing an emotion, such as anger or sadness, to participants from Chile, Argentina, Brazil, Japan, and the United States. The majority of participants from each culture were able to correctly
identify the emotion, suggesting that non-verbal expressions of emotions may be recognized regardless of cultures (Ekman, 2003).

The most striking aspect of Ekman’s first study is that he designed the experiment to refute Silvan’s claim that emotions were universal and what Ekman’s results supported what that emotions were indeed recognizable across cultures. Many researchers, like Izard, have replicated Ekman’s experiment showing photographs of facial expressions to people of varying cultures and all have arrived at nearly the same results (Ekman, 2003).

Scherer (1994) has also researched the universality of emotions and found that “Emotion antecedent situations are both universal- with respect to many structural characteristics- and culturally specific- due to differences in values, practices, history, interaction patterns, demography, climate, economy, and social structure” (p. 175).

Phoebe Ellsworth’s (1994) work attempts to demonstrate that emotions are universal as a result of the universal demands that humans must face, such as a need for closeness to others, a need for safety, and a need for a sense of being understood by others. The work of Ekman, Izard, Scherer and others has helped to establish that there are many aspects of emotions that appear to be universal, but the rules when to express emotions remains largely influenced by one’s culture and innate personality.

It should not come as surprise that much of what is communicated is often not said. Body positioning, facial expressions, and eye contact are the foundation of the concepts of empathy and rapport. Goleman (2006), who has studied the emotional intelligence throughout his career, describes rapport as “the hidden biological dance that glides along as the subterranean component of everyday interactions” (p. 28).
Goleman (2006) goes on to note, rapport is much more than biological mirroring; it is the experience of being experienced. This can only be possible if the work of Heidegger and Ekman are correct, that we are always communicating who we are through our non-verbal expressions of emotion. Miller and Steinberg (1975) support this conclusion by suggesting, “In its psychophysiological sense, empathy probably occurs most frequently when the empathizer uses multiple sensory channels” (p. 168). My experience of closeness to my hosts in Sri Lanka without being able to verbally communicate confirms that one can communicate much without having to use words to do so.

Knowing this, the program I propose to develop will utilize the expression and subsequent recognition of non-verbal emotions to facilitate therapy with clients with whom the clinician does not share a common verbal language. The main advantage to approaching therapy in this way is that the clinician works to suspend the assumptions inherent to their culture of what trauma is by stepping outside of verbal language and the biases that are typically associated with terms associated with trauma. Because the clinician will not be using such biased terms, such a program will allow the clinician to move away from conceptualizations of trauma as being a “deterioration” (Morehead, 2002, p. 820), mental shock resulting from a bodily injury (Morehead & Morehead, 1995b), or as “involving direct personal experience of an event that involves actual or threatened danger or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person” (APA, 2000 p. 467). I believe that this is one of the shortcomings in the literature on trauma conceptualization that my program will address.
Although using non-verbal therapy techniques can help to suspend our cultural biases, a more culturally sensitive way of conceptualizing traumatic events is needed. After reviewing the literature regarding trauma and trauma theory it is apparent that a more functional definition of trauma. Similar to the beliefs of many Eastern cultures, Existential philosophy believes that suffering is a part of existing in the world. Conflict occurs in one’s life when a person confronts death, freedom, isolation, and meaninglessness, which Yalom (1998) calls the Four Ultimate Truths. Brown (2008) elaborates on this concept by saying, “Culturally competent trauma practice thus includes the possibility that the event, although not directly threatening to life or physical safety, was traumatic because it broke apart an existential system and worldview that had generated a sense of safety” (p. 102).

By re-conceptualizing trauma as an event that leads the client to confront one of their assumptions about the world or themselves, we can begin view survivors of trauma as those who are searching to resolve an existential conflict and not attempting regain a sense of homeostasis that is implied in the previous definitions of trauma that have been discussed thus far. Frankl (2006) also argues for this shift in how we conceptualize our client’s struggles to include an understanding of existential challenges:

A man’s concern, even his despair, over the worthwhileness of life is an existential distress but by no means a mental disease. It may well be that interpreting the first in terms of the latter motivates a doctor to bury his patient’s existential despair under a heap of tranquilizing drugs. It is his task, rather, to pilot the patient through his existential crises of growth and development (p. 103). Frankl (2006) argues in this statement that categorical definitions, like those found in the DSM-IV-TR impede the clinician’s ability to help the client learn and grow from the
challenges present in their lives. His conceptualization of distress as *existential crisis* is helpful in that it shifts our conceptualization of those we work with away from people who have “mental disease” and toward a view of our clients as resilient individuals who have the potential to navigate life’s challenges, albeit with assistance from time to time. This conceptualization not only expands understanding of what is traumatic to mean include events that our clients subjectively experienced as being traumatic, but it also removes the paradigm of negativism associated with one who is *diseased, broken, or deteriorated*.

While I agree with Rothchild (2000) and others that trauma should be treated with multiple modalities that address both the physical and emotional concerns of safety, I feel that the current literature does not address the felt sense of safety that is lost after a traumatic event. I think this is largely the result of a narrow understanding of the word *trauma*. It is not my intent to ignore the regaining of a sense of physical safety after a traumatic event, but rather to integrate our understanding of trauma to include a conceptualization that physical safety is secondary to the felt sense of safety accompanying one’s existential understanding of the world. Babette Rothschild (2000) eloquently states, “Integrated trauma therapy must consider, consist of, and utilize tools for identifying, understanding, and treating trauma’s effects on both mind and body” (p. 3).

Unfortunately, clinicians like Rothschild and others place a heavy emphasis on the goal of returning the client to their pre-traumatic event state of homeostasis. Rothschild (2000) asserts that the traumatic event disturbed the client’s sense of balance
in their life. While I do agree that the traumatic events our clients experience are upsetting, I do not believe that one can ever return to one’s previous state of living. The very nature of experiencing an existential crisis is that one’s view of the world is challenged, often times resulting in a loss of naiveté regarding that particular aspect of being in the world. By conceptualizing trauma as an event that challenges one’s assumptions about the world or about one’s self, it is impossible to return to the state of being in the world before the assumption was challenged by the event.

In the context of my conceptualization of trauma, homeostasis, as Rothchild (2000) intended it, can only be obtained by creating a new balance that results from resolving the existential crisis. Many existential clinicians have argued that achieving a state of homeostasis is not even a desirable outcome in one’s life. Frankl (2006) argues against this “dangerous misconception of mental hygiene” by saying, “What man actually needs is not a tensionless state but rather the striving and struggling for a worthwhile goal, a freely chosen task” (p. 105). With this in mind, my program will not seek to restore homeostasis but will help clients to navigate the existential challenges to the client’s assumptions about the world and themself as a result of the traumatic event.

Let’s examine the scenario of a client who has survived a recent explosion. The client was walking along the streets in their home town when a car bomb was detonated in their proximity. The client was hospitalized for a concussion and was assessed to have no long-lasting physical impairments resulting from the explosion. The client has since had a disturbance of sleep and vivid remembrances of the explosion for the last few weeks and cannot leave their house without becoming intensely anxious. We can apply
our definition of trauma that Roget has provided and conclude that indeed the client has undergone an injury in the form of a concussion as well as shock as reported by their anxiety and difficulty sleeping. This definition does little more than cast a label on a reaction to the event. It offers no understanding of why the client has reacted this way or how to help. We can also apply the American Psychiatric Association’s definition of a traumatic stressor and again conclude that this client meets the criteria because they experienced an event that threatened client’s physical integrity that was accompanied by an intense fear of the event. Once again, this definition offers no insight into why the client reacted this way or how to begin helping the client work through this recent disturbance. If we apply our understanding of Yalom’s existential truths, we can begin to understand that the explosion has provided a reason for the client to confront the inevitability of death. Additionally, the client may feel that world lacks ultimate meaning if “bad things can happen to good people.” The client may also be feeling isolated in the world as they find it hard for others to relate to their experience of surviving/enduring trauma. Using the existential givens to conceptualize trauma, we can better understand that in addition to the upsetting qualities of the event itself, the client’s symptoms that follow the event may be indicative of a deeper struggle to reconcile their previous view of the world with an apparent contradiction in reality as highlighted by the traumatic event.

As Janoff-Bulman (Brown, 2008) suggests in his Just World Theory, trauma is the challenging of one’s deeply held assumptions about the world. In this example, the trauma is not the explosion but the challenge to the client’s assumption about the world
that resulted from experiencing the explosion. This definition shifts our conceptualization away from an event that threatens our physical integrity that results in psychological distress, toward an event that challenges one or more of our assumptions about the world. Similarly, Paul Hogan, the co-founder of the Butterfly Peace Garden in Batticaloa in Eastern Sri Lanka, feels that trauma occurs when “a person’s dream dies; or when it is removed, taken away, trampled, or denied” (Lawrence, 2003, p. 30). Hogan, the artistic force behind the healing properties of the Garden, poetically captures the sentiment that trauma does not result solely from events that challenge our body-hood. What Hogan describes is the existential conceptualization of trauma and how it challenges a belief or dream that is at the very core of one’s existence.

This definition of trauma allows clinicians to conceptualize trauma across cultures, as well as expanding trauma to include non-life-threatening events. The work of the cultural anthropologist Patricia Lawrence provides an excellent example of how one can experience trauma without experiencing a sense of fear for one’s physical integrity. She recounts an experience where she travelling toward the eastern providences of Sri Lanka. The military has had an increasing presence in these provinces since the formation of the rebel group Liberation Tigers of Tamil Eelam, or LTTE. Lawrence (2003) recalls the humiliation one of her companions underwent as a guard arbitrarily instructed Lawrence’s companion to tear their identification papers into pieces and then to eat the pieces while the guard laughed. This instance of coercion certainly does not include any element of direct threat to one’s physical integrity, but it does provide the person experiencing the coercion with an opportunity to call their assumptions of the world into
question. The person in this example might very well have been left wondering, “Why would people do this to one another?” or “Why was I treated in such a way, am I not human?” These challenges to one’s assumptions about the meaninglessness of the world or one’s freedom to choose are the events which I would like to term traumatic.

The Lived Experience of Mass Trauma

Now that I have defined trauma as an event that challenges one’s core beliefs about death, isolation, meaninglessness, or freedom, I would like to explore the lived experience of those who survive mass trauma. Although there is some overlap, survivors of mass trauma have slightly different needs than those experiencing trauma on a personal scale. North (2003) suggests that there are three variables that affect how an event will effect a community when it occurs: the individuals involved directly in the disaster, the disaster agent, and the community itself.

North (2003) and others have divided the disaster agents into three major categories: natural disasters, disasters resulting from human error, and intentional human acts. While events such as tornadoes and suicide bombers are examples that are readily available to illustrate natural disasters and intentional human acts respectively, disasters resulting from human error are more difficult to conceptualize. This is in part because they are less common occurrences than natural disasters and intentional human acts and are also a relatively new form of disaster in the history of humans. The nuclear meltdown at Chernobyl in Ukraine is an example of how an error in the judgement of the safety
team of the plant lead to a disaster that affected a large geographic area surrounding the plant following an experimental test of a safety feature.

The severity of mass traumatic events also differ greatly in how they impact the survivors psychologically. North (2003) suggests that disaster’s psychological impact on survivors can be ranked from least amount of impact to most severe impact as follows: natural disasters, disasters of human error, and disasters of intentional human acts. While North’s rank ordering of disasters’ impacts on survivors is based on the assumption that it is more disturbing to know a disaster was inflicted with intent than to experience a disaster as occurring outside of human control, it does not take into account the individual’s response to the disaster. For example, an individual who has grown up in Northern Ireland and has been surrounded by acts of terrorism all their life may not feel particularly traumatized by witnessing a car bomb detonate. On the other hand that same individual may have a difficult time experiencing a tornado destroying their home.

What I feel North is trying to describe is that an event like a natural disaster is less likely to challenge one’s assumptions about the world. I disagree with North and feel that there is an assumption in the rank-ordering of significance and impact disasters may have. On the occasion translators were available, I listened to the stories of the people of Batticaloa, Sri Lanka. Many of their stories were filled with anger at “what the sea had done to them.” Nearly all of the stories I heard personified the tsunami as an angry entity. They felt betrayed by the ocean. They were torn between a dependence upon the ocean and loving the treasures it provides them and feeling hatred toward it for stealing their loved ones.
I feel that the reaction that the people of Batticaloa had to the tsunami in 2004 challenges the assumption that North makes but attempting to rank-order the severity of the psychological impact of mass trauma. From my experience with the people of Eastern Sri Lanka, I feel that while they would be distressed by an intentional act of terrorism, they would be impacted more by another “betrayal of the sea,” as it was so often referred to. However, it can be argued in the example I provided that the disaster, while natural in origin, was perceived to be the act of an intentional entity. If we can loosen our understanding of intentional acts to include supernatural or transpersonal entities, I feel that we can gain a better understanding of how the trauma is challenging our client’s assumptions about the world.

In the specific case of the people of Batticaloa, I got a felt sense that their understanding of meaning in the world had been challenged by the tsunami. While they may not have subscribed to Janoff-Bulman’s Just World hypothesis, many of the people I listened to spoke from a place of frustration that the tsunami had attacked those in prayer in mosques and temples. This contributed to their belief that the tsunami was an evil entity that had no respect for others. I feel that the tsunami called into question the belief that the world, specifically the ocean, is a safe place. I imagine that this event sparked an awareness of one’s own mortality as well as the limitations of one’s agency or freedom in the world. While the destruction of the tsunami can be easily tallied by lives lost and buildings destroyed, the existential trauma that occurred on mass scale is less easily accounted for. I believe that by gaining an understanding of the client’s lived experience of
the event, we as clinicians can begin to help the client reconcile their assumptions of the
world in the light of the traumatic event.

In order to begin understanding another person’s lived experience of an event,
Husserl urges phenomenologists to *epoché*, or “bracket” one’s own assumptions about
the event. Husserl describes this process of bracketing as a, “detachment from any point
of view regarding the outside world” (Strumpf, 1975, p. 474). This process allows the
clinician to abstain from attempting to determine an objective truth of a phenomena in
favor of nourishing the subjective, personalized relationship between the client and
phenomena as it is experienced by the client. Merleau-Ponty explains the purpose of
bracketing our assumptions as clinicians by noting, “...in order to see the world and seize
it as a paradox, it is necessary to disrupt our familiarity with it” (1964, p. 85). The goal of
suspending our assumptions of an event is to highlight the assumptions our clients hold
about the same event. By doing this, we can begin to gain an understanding of the client’s
particular experience of any given phenomena.

Another way to conceptualize this way of observing phenomena is by applying
Heidegger’s terms *ontic* and *ontological*. Cooper (2003) explains the concept of the
ontological as universal aspects of being human. An example of this world be the
universal inevitability of death. All living beings must face their own death. The
difference however, is how one chooses to face one’s mortality. This is what Heidegger
called the ontic (Cooper, 2003). Another example of ontic experience is the person who
experiences the car bomb detonation in Northern Ireland. The experience of the explosion
and how one interprets the event is one’s ontic experience, the reminder that we have
limitations and will someday die is the ontological experience of the event. It can be understood that every ontic experience is entwined to one or more ontological experience.

If a clinician is able to bracket their own assumptions of an experience, their own ontic experience of the phenomena, then the clinician can begin to observe and describe the client’s ontic experience of the phenomena. I believe that this approach is absolutely necessary for working with survivors of mass trauma. The very nature of the term “mass trauma” suggests an event that affects each person in the same way. While an agent like a hurricane can certainly be only one physical reality, its effects as it destroys a town incurs a number of subjective realities equal to the number of people directly affected by the trauma. To use Heidegger’s language, the physical reality of a hurricane destroying a particular town is part of one’s lived environment that leads to an ontic experience. The hurricane’s path and presence in the town is an unalterable reality, a universal limitation for those living in that particular town. How one chooses to respond to the hurricane, such as boarding up the windows on one’s house or leaving town entirely, is the ontic reality of the phenomena. The feelings of not being in control of nature, facing one’s mortality, or the limitations of one’s ability to protect against such an event, are ontological experiences.

By using Husserl’s steps to conducting phenomenological research, this dissertation will attempt to incorporate a working understanding of one’s subjective experience of the lived experience of mass trauma. Husserl called this kind of subjective experience of phenomena *lebenswelt*, or life-world (Strumpf, 1975). Husserl asserted that
it was the goal of phenomenological research to reduce the understanding of an event, through bracketing one’s own assumptions, to the client’s ontic reality of the phenomenon. He expands on his concept of Lebenswelt by saying, “The life-world consists of all those experiences—the perception, response, interpretation, and synthesis or organization of the many facets of everyday affairs—in which human beings are typically involved” (Strumpf, 1975, p. 476).

Husserl and others have argued that many other approaches to scientific research have stripped man’s personal experience of an event and reduced the phenomena down only what can be observed and measured by the scientist. Halling (2008) points out the intention of existential phenomenology:

Phenomenology (and existentialism, with which it converged by the middle of the twentieth century) seeks to take us back to phenomena so that we might understand them more fully, not just as an individual experiences but as having common themes or qualities” (p. 145).

By working with the client to understand their subjective experience of an event, the clinician can collaboratively conduct research with clients while still preserving their humanity as well as seeing the client’s struggle with the experiences that are universal to being human. Merleau-Ponty (1964) comments on the role of phenomenology in science:

It does not convert the certitude of the world into certitude of the world as thought, nor does it replace the world by the significance of the world. On the contrary it recognizes my thought as an inalienable fact and it eliminates every type of idealism in discovering me as presence to a world (p. 85).

As Merleau-Ponty suggested, the goal of phenomenology is not to refute observable and measurable phenomena but to utilize a more balanced approach to understanding an event
that incorporates the subjective and objective realities into a more holistic understanding of an event.

Since one’s personal experience of an event can never be removed from the objective reality of the phenomena, as highlighted in the example of a hurricane destroying a town, I feel that this is the most appropriate approach to use for this dissertation. Strumpf (1975) also urged for the use of this approach by insisting that the world is what we understand it to be because of our ontic reality of it, citing Husserl as saying that “the correlate of subjectivity which gives it ontic meaning, through whose validities the world ‘is’ at all” (p.476). Strumpf (1975) then goes on to describe the refreshing quality of including one’s humanity in scientific research: “Through the *epoché*, the life-world emerges as a fresh terrain for the enterprise of description, opening a new way of experiencing, thinking, and even theorizing” (p. 476). By having the client describe their ontic experience of a traumatic event in my program, the clinician can begin to understand the ontological given that has been challenged by the traumatic event.

The Therapy of Being-with

Psychotherapy has a long history of being mystified by those who initially founded it. The original model for psychotherapy was such that a client sought out an extensively trained, and therefore all-knowing, analyst who would then interpret or “make sense” of the client’s behaviors and emotions. In more recent years, psychotherapy has experienced a shift away from these smoked filled rooms with oversized couches
towards something that is more accessible and less intimidating to the general public. Clients are now beginning to seek out clinicians that respect their humanity and present themselves as not as experts but as guides who can help them to explore their experiences. I think that this is at least in part a reaction to the stigma so often associated with one who enters into therapy. By removing the veils and demonstrating that therapists are not magicians or con-men, the field is working to remove the stigma of therapy as well as attempting to make the therapy hour a more inviting space. It cannot be ignored that managed care’s emphasis on empirically supported interventions has also had an effect on de-mystifying the therapy process, for better or worse.

This leads me to ask, “What is therapy?” I’ve mentioned the therapeutic process and concepts like lebenswelt and empathy, but what is therapy? Is it still some elusive process that is akin to sorcery or magic? I believe that while therapy is certainly not a collection of flim-flam spells and incantations, I do feel that much of how therapy is done remains unclear to those seeking clinical services.

This discussion came to an interesting pique during the International Federation of Dasein Analysis’ (IFDA) conference, which I attended in Brussels of this year. IFDA is an organization of existential therapists and other existential practitioners, such as pediatricians and neurologists, who agree to meet every few years to discuss the translation of existential theory and philosophy into therapeutic practice. Since there are few structured guidelines for existential interventions, the group discussion seemed to move towards discussing how to be an existential therapist. One of the therapists in attendance, Dr. Ado Huygens, offered his insights on this topic and explained that he
often feels like he doesn’t know how to tell if he is “being existential” during the therapy hour. Much to the horror of managed care providers, the existential approach to therapy is an ambiguous one, that requires the therapist to be fully present as a human being. As a result, many existential therapists feel like there aren’t “being existential” because there are just “being themselves.” The therapeutic value of this is not to be overlooked. The genuine reactions and feelings of empathy that come from this approach to therapy have tremendous effects for the clients engaged in this type of therapy. Research has demonstrated that the therapeutic relationship is the most important aspect of therapeutic change (Niolon, 1999).

As I have done with the word crisis, I think it is best to return to the origins of the word therapy to see the original intent of the word. The Oxford English Dictionary states that the origin of the word therapy is the Greek word therapeia, which means, “healing” (AskOxford, 2009, “Therapy”). While I feel that this helps to describe the expectation of the therapeutic relationship, the definition of therapy as being a healing process is still too broad for our use in this context, as it does not make a distinction between physical or emotional healing. Despite the current vagueness of what therapy is it is still clear to most people that the role of a therapist in marriage counseling is very different from the role of a therapist that is helping someone relearn how to walk.

While the definition of therapy is still accurate in both of these examples, the therapy that we wish to examine and utilize is that of psychotherapy. If we look at the origins of the word psyche, which is the root of the word psychology, we can see that it comes from the Greek word psukhe, which means, “breath, life, soul” (AskOxford, 2009,
"Psyche"). This allows us to see that the colloquial use of the word therapy, which is the shortened form of psychotherapy, has the meaning of healing of the life or soul. I feel that this definition captures the essence of the therapeutic relationship better than the New American Webster Dictionary (1995a) definition of “treatment of mental disease” which is embedded with negative associations of dysfunction or brokenness (p. 542).

Although the working definition of therapy as “healing of the life or soul” helps to narrow down what the intentions of therapy is, it does not illuminate the process of how this is done. I’ve found that my personal experience corroborates this, in that many people outside of the field of psychology are familiar with what therapy is, often from television or movie depictions, but the process of how therapy is conducted is still a mystery. In fact, my experience during the IFDA conference suggests that the how of therapy may even be something of a mystery to many clinicians. I feel that this is particularly the case for existential therapists. Since much of the foundation of existential psychology was drawn from the philosophical work of Heidegger, there is often a gap between knowledge and application.

Despite the difficulty in describing the how of therapy, most existential therapists agree that the presence of being-with is a large contributor to therapeutic change. Moustakas (1995) describes being-with as “listening and hearing the other’s feelings, thoughts, objectives, but it also means offering my own perceptions and views. There is, in Being-Within, a sense of a joint enterprise- two people fully involved, struggling, searching, exploring, sharing” (p. 84). Being-with is similar to the humanistic technique of being genuine, “[the counselor’s] words match his own internal feeling; and the extent
to which the counselor’s response matches the client’s expression in the intensity of affective expression" (Rogers, 1961, p. 48). The existential therapist validates the client’s experience by being present as a human being and not just a reflective surface, as is often suggested in other psychotherapeutic traditions. Rogers (1961) briefly discusses why both the humanistic and existential approaches to psychotherapy differ from other psychotherapeutic approaches in that they advocate being-with the client: “To withhold one’s self as a person and to deal with the other person as an object does not have a high probability of being helpful” (p. 47).

In addition to being-with, Moustakas (1995) asserts that one can also be-in and be-for in relationship to others. He describes being-in as the experience of being fully immersed in the experience of the other. He goes on to describe being-in as being “totally in the world of the other. My attitude and interest are focused on being aware and understanding the other from her or his frame of reference. I do not select, interpret, advise, or direct” (Moustakas, 1995, p. 82). One can experience what Moustakas means by being-in an experience by recalling a time when they were totally enthralled in the plot of a book. One often does not make interpretations when reading; one is caught up in the experience of being-in that experience, understanding what it means for that particular character and allowing the character’s story naturally unfold before them.

Moustakas (1995) describes being-for as a way of relating to others in which one is with the other and experiencing the other, but also present as themself. This presence is felt in the relationship as a collaboration or collusion. Moustakas (1995) provides an example of being-for by noting:
I am also offering a position, and that position has an element of my being on that person’s side, against all others who would minimize, depreciate, or deny this person’s right to be and grow. I express this position; the other knows where I stand (p. 83).

I think that the experience Moustakas describes as being-for, can be understood as what is commonly called client advocacy. When I am being-for a client in a session I am taking a stand and acting upon what I feel is in their best interests. In other words, I am present with them and listening to their lived experience, but I am also present as myself and acting upon my opinion of what is best for the client. Whether I am suggesting that my client contact their school to set up an individual educational plan or suggesting that they seek consultation from their general practitioner I am advocating and in Moustakas’ terminology, being-for my client.

I feel that Moustakas’ descriptions of ways of being in relationship to clients, particularly the concept of being-with, helps to de-mystify how the existential therapist conducts therapy. Therapy from this perspective is a relationship with the client in which the therapist is “bearing with its vicissitudes, its shifts and turns, and its crises” (Moustakas, 1995, p. 71). I feel that this is quite different from the humanistic concept of “unconditional positive regard” in which the therapist unconditionally supports the client in their endeavors. Rogers (1961) describes unconditional positive:

It means he prizes the client in a total rather than a conditional way. By this I mean that he does not simply accept the client when he is behaving in certain ways, and disapprove of him when he behaves in other ways. It means an outgoing positive feeling without reservations, without evaluations (p. 62).

While I do agree that being-with is similar to unconditional positive regard in that the therapist’s support is not based on conditions in which a client can “earn” the
attention of the therapist, it is my opinion that unconditional positive regard is
contradictory in its own definition. Rogers (1961) describes unconditional positive regard
as an “outgoing positive feeling without reservations, without evaluations” (p. 62) but I
assert that holding a positive attitude toward the client is evaluative in itself. This
difference is not just a semantic one, as the concept of being-with suggests that the
therapist “bear with” the client’s struggles and whose role is to explore the client’s
challenges, whereas unconditional positive regard is more of a reassuring supportive
approach to helping a client through difficult challenges in their lives.

While the existential therapist may also support a client in a session, the focus of
being-with is to validate the client’s experience by attempting to understand the client’s
lived experience of an event. The clinician can achieve this by listening to the client’s
ontic experience, described in their everyday experiences, and working to understand the
connection to the ontological challenge the client is facing. Once the clinician can gain an
understanding of what the client’s lived experience of that ontological struggle is, the
clinician works with the client as a witness to bear with the struggles the client faces. By
being-with, the clinician is able to provide a space where the client’s experiences are
validated unconditionally, which in theory will lead to a client’s loosening of
constrictions.

Constriction, in this context, refers to the self-imposed limitation of choices. The
goal of existential therapy is to help the client find a way to embrace and live into the
possibilities and limitations present in one’s life. Constriction is commonly used to
denote self-imposed limitations in one’s life, whereas thrownness is used to denote the
limitations in one’s life that one has no control over (Cooper, 2003). *Thrownness* was the term that Heidegger coined to highlight how individuals are thrown into particular factual situations, which he likened to a dice roll that one has no ability to create the outcome for (Cooper, 2003). The reservation one has regarding dancing publicly is a common self-imposed limitation that one can work to “loosen,” assuming that this is a constriction that one wishes to focus on.

Despite thrownness representing limitations that cannot be removed, this does not mean that one cannot live into their given situation. This also does not mean that a person is totally devoid of choices within any given thrownness. In the example of a person who wants to dance but has no legs, the possibility of dancing, as they previously conceptualized it with one’s own legs is no longer a choice, but this does not mean that the person does not have choices in regards to their situation. One could decide to learn how to use prosthetic legs or could learn how to dance using a wheelchair. The person in this example could also choose to change their understanding of what dancing is in order to loosen their definition to fit an activity they could engage in considering their physical limitation. I used this example to highlight the distinction between different types of limitations in our lives, but also to show that we still retain choices within those limitations. The role of the existential therapist is to help the client to embrace their limitations as well as their choices within those limitations.

In addition to highlighting the existential concept of *agency* (embracing one’s limitations and choices), the previous example also introduced the concept of *meaning making*. The existential understanding of meaning making is the expression of one’s
agency in relationship to how one interprets what one is experiencing. Simply said, meaning making is the process of choosing how to make sense of one's environment and one's feelings and can either lead to the experiences of distress or happiness in one's life. Frankl (2006) stresses the importance of one's ability to choose how one feels in a given situation by saying that "everything can be taken from a man but one thing: the last of human freedoms- to chose one's attitude in any given set of circumstances" (p. 66).

Jaspers (1971) builds on Frankl's emphasis of choice over how one feels, by highlighting the role of agency and meaning making in the ability to be happy. "Existence wills its own happiness: Truth is the satisfaction of existence resulting from its creative interaction with its environment" (p. 37). The Buddhist monk Matthieu Ricard (2003) also suggests that happiness comes from experiencing life as being meaningful. Frankl (2006) elaborates on the importance of meaning in one's life: "What matters therefore, is not the meaning of life in general but rather the specific meaning of person's life at a given moment" (p. 108).

All of these poignant statements are at the foundation of how existential therapists help their clients by being-with the client's admist their struggles and to help them to make meaning of the challenges to their assumptions about their world and themselves. As Frankl (2006) suggested, the existential therapist works with the client "in the here and now," meaning that the therapist works with the client to explore their feelings as they occur in the moment. Existentialism's focus on the present helps clients to "take up" agency in how they choose to feel as they experience events. Additionally it helps to highlight the client's ability to make meaning of events as they occur as opposed to being
a products of their past, as other therapeutic traditions, such as Psychodynamic and Behaviorism, have suggested.

Alternative Ways of Being-with

Now that some of the mystery of psychotherapy has been dispelled and the goal of existential therapy has been highlighted, I wish to explore alternative ways of being-with clients outside of verbal expression. While, verbal communication is the most common mode of conducting therapy it is not the sole way of “experiencing being experienced” which Goleman (2006) pointed out as being crucial to the therapeutic relationship. I feel that by exploring and critiquing the theories and techniques associated with expressive therapies, which includes expression through art, music, and movement, I can incorporate these techniques into a program that will allow clinicians to be-with clients when words fail to work as an effective form of communication.

I feel that Jaspers (1971) illustratively points out the elusive, yet undeniable connection humans beings have between artistic expression and their ontic expression of reality:

No aesthetic theory can scientifically understand the intrinsic reality of art- that is, the truth that was experienced and created in art. What, for example, objective thinking calls, ‘expression’ and relates to a ‘sense of life’ or character, is really a communication from the origin to a possible origin, and is encompassing reality (p. 23).

As a result of the philosophical nature of art, the humanistic and existential approaches have a long history of focusing on clients’ ability for creativity and healing. Malchiodi (2003) and others have emphasized creativity “as a means of experiencing and
actualizing human potential as a healing agent" (p. 58). I agree with Malchiodi that the act of creating can help clients to experience agency in one’s life that utilizes both the mind and the body. This is one distinct advantage that expressive therapies have over more traditional verbal therapies. McNiff (1981) who points out that “action within therapy and life is rarely limited to a specific mode of expression” (p.viii). The work of Miller and Steinberg (1975) also supports the understanding that human beings are inherently multimodal by asserting that interpersonal connections occur “most frequently when [they] use multiple sensory channels” (p. 168).

The techniques associated with expressive therapies provide clients additional modes of expressing their experiences to themselves or others. Each activity, like drawing, painting, drumming, singing, or creative movement, provide the client with unique ways of being experienced by others (Malchiodi, 2003). Horovitz (1999) provides an excellent explanation of why expressive therapies should be at the foundation of any program that is intended to be used when words fail our clients:

Language is fueled by imagery. While words punctuated on the linear stage of air may occasionally fall flat, they live on in thought and sometimes in deed. From this, ideas are born, enacted, and truths unfold. Cognition assembled through word serves as a springboard into imagination. Artistic imagery becomes the primal pump. It hurls us towards and reminds us of our existence in as primitive a fashion as one can imagine (p. 15).

Although I intend to incorporate a wide range of interventions from various forms of expressive therapies, I feel that it is important to set the parameters of what each expressive therapy is. Since expressive therapies can be conceptualized from any of the many psychotherapeutic approaches, I will provide a general definition of each of the
expressive therapies and then go on to explain how existential therapists conceptualize that particular form of expressive therapy.

The American Art Therapy Association (2004) defines *art therapy* as a therapy that uses “art media, images, and the creative process, and respects the patient/client responses to the created products as reflections of development, abilities, personality, interests, concerns, and conflicts.” Existential art therapists use this definition as a foundation for their work but also place a heavy emphasis on refraining from making interpretations of symbols or colors included in the client’s art. The existential art therapist views the client’s artwork as a way of being able to see the client’s lived experience *through the client’s eyes* (Malchiodi, 2003). Zinker (1977) poignantly emphasizes this point to the clinicians training with him by suggesting that they look at their clients as they would look at a landscape. “Chances are you wouldn’t say, ‘This sunset should be more purple’ or ‘these mountains should be taller in the center.’ You would simply gaze in wonder. So it is with another person” (p. 22). Following this advice allows the client to retain their humanity, which is often a struggle in the aftermath of a traumatic event.

Steele (2003) discusses the usefulness of art therapy when working with clients who have survived trauma:

It does not matter what the trauma victim draws or how he or she draws it, just that the victim draws. Its is the psychomotor activity of drawing that will begin to trigger the sensory memories of the trauma experience (p. 145).

This is supported by our neurological understanding that activities such as drawing stimulate both hemispheres of the brain as the client plans a shape (left brain) and then
physically draws that shape (right brain) (Carlson, 2008). It is assumed that by stimulating the brain in this way, traumatic memories from the client’s left hemisphere are expressed by the movement initiated in the right hemisphere.

It is important to reiterate that from an existential perspective, the focus is on the client’s expression through the art and not the clinician’s interpretation of the art product. If the client is able and willing to verbally describe what is being expressed in the art product, this should be the principle focus of the clinician rather than attempting to interpret the client’s lived experience based on shapes, colors, or use of symbols. Interpretation should also avoided because it shifts the client’s engagement with their feelings or memories from a felt sense of experiencing to a cognitive level of analysis (Steele, 2003).

The American Music Therapy Association (2004) uses a similar definition to set the parameters of music therapy as a therapy that uses “music to effect positive changes in the psychological, cognitive, or social functioning of individuals with healthy or educational problems.” The existential music therapist would use music as a way of helping the client to express themselves in the here and now. I feel that Harris (1991) captures the essence of what existential music therapists emphasis in therapy: “Any individual moment in the music has a had a past and is prelude to a future. Our success as listeners consists in our increasing ability to hear each moment in a wider context” (p. 131).

There has always been a connection between music and good health. The word health comes from the Old English word hal which is a “root word signifying whole,
healing, hale, and inhaling” (Campbell, 1997, p. 10). The word heal comes from Northern Middle English and means “to make sound, to become healthy again” (Campbell, 1997, p. 10). Looking at the roots of these words we can begin to see how music has been entwined into health and how the very word sound has become a synonym for meaning good, whole, or complete. This is a stark contrast from the opinions of the general public that were presented by some of the clinicians at the IFDA conference. It was said that art is often viewed as “a luxury that can be tossed aside when individuals are too busy to engage in the process.” I feel that if more people viewed art, in the broadest sense of the word, as a way of maintaining their health, as the root of the word suggests, rather than something that is injected to correct an imbalance, people would lead more meaningful lives.

Movement therapy is defined by the National Coalition of Creative Arts Therapies Association (2004) as a therapy “based on the assumption that body and mind are interrelated and is defined as the psychotherapeutic use of movement as a process that furthers the emotional, cognitive, and physical integration of the individual.” The existential dance/movement therapist conceptualizes that who we are is how we chose to move through the world. As such, when a client chooses to express themselves through the use of movement or dance, they are also expressing how they feel at that particular moment.

Additionally, the client’s choice of movements serve as a way of expressing to others how the client is currently bodying-through a given situation. Lewis (1996) asserts that using movement therapy can help clients to express aspects of their traumatic experience that are otherwise un-verbalizable citing Winnicott’s (1971) theories: Reclaiming preverbal memories which lie in the body and bodily sensations allow both the client and therapist to reconstruct early trauma.
Winnicott has stated that many memories are ‘preverbal, non-verbal and unverbalizable’ (p. 130) (p. 101).

Loman (2003) considers expression through movement to be utilizing what she calls the “language of movement,” which she asserts is known and understood by all (p. 77). Historically movement, in the form of traditional dance, was used to as a part of many indigenous people’s healing rituals. Dance may have been an innate form of healing that these early cultures recognized as a result of its “action-oriented process that encourages new behaviors and symbolically communicates hidden emotions, releases anxiety, and serves as a vehicle to integrate body, mind, and spirit” (Loman, 2003, p. 68).

Each of these forms of expressive arts have unique benefits in addition to allowing the client to express themselves to others. For example, music often is associated with socialization when collaboratively playing a song with others (Malchiodi, 2003). Similarly, dance tends to help others form connections to others and offers opportunities to deepen existing relationships (Malchiodi, 2003). These benefits likely occur because group dancing and collaborative music require a certain degree of attunement and mirroring which are elements common to building and maintaining rapport (Loman, 2003). Visual art tends to be a more individual practice and can help to provide the client a place to explore their identity (Malchiodi, 2003). However varying the intervention, the element common to all of the expressive therapies is imagination.

Limitations of Expressive Arts Approaches

While utilization of imagination is typically seen as a restorative force in one’s life, therapists are often met with resistance from clients when exploring expressive arts
techniques. Although the reasons are likely to be as varied and unique as the clients themselves, there are some common obstacles when introducing expressive techniques to clients. One of the most common constrictions encountered is the belief that the client does not feel he or she is creative. Sometimes a client may boldly exclaim, “I’m not artistic, I can’t do this!” This self-imposed constriction has roots in how the words creative and artistic are used in reference to one’s self.

Creative is often used synonymously with imaginative or artistic with the embedded connotation that this applies to one who can create admirable finished products. Creativity is thus viewed as an ability one possesses, that is valued by others. The extrinsic valuing of internal abilities is known as commodification. Commodification tells the individual that they are not of value as a being, but rather their value is determined by their ability to produce things of value. The commodification of finished expressive works has led many people to believe they are not creative.

It is my belief that we all have the capability to create art, regardless of its aesthetic value to others. Malchiodi (2003) makes distinguishes creativity from imaginative by noting that “creativity occurs when self-expression is fully formed and achieves a novel and aesthetic value” (p. 11) while imagination is the innovative thought process that leads to self-expression. This distinction is similar to Heidegger’s (2001) belief that we are always expressing ourselves through our actions; we are never not expressing ourselves. I suggest that creativity should be viewed as a process rather than an ability that one either does or does not possess. This process is then the relationship
between the one expressing and the medium through which they have chosen to express
themselves.

If a client is willing to explore the mediums presented to them by the clinician in a
space that is free from the expectation to produce an end product of aesthetic value, the
client may very quickly and easily loosen this constriction and embrace themselves as
being expressive. In this context, expressive can be used synonymously with
communicative, as the client is intending to send a message to others through an
expressive modality, such as painting or dancing. It is important to note again that
refraining from interpreting the client’s art products is essential to loosening the client’s
constriction resulting from commodification. Interpretation, in this context, is nothing
more than the process of determining the object’s value. By refraining from such
processes, clinicians can help to lessen the client’s expectation of “not being good
enough.”

Related to the belief of “not being creative” is the fear of failure resulting from
not completing what one set out to express. This constriction is harder for the clinician to
assist the client in relaxing, as the fear of failure is often a deeply held fear. The clinician
should aptly point out that expressing one’s self is always a risk. We never know if others
will receive our messages as we intended them. Sometimes if the clinician simply
acknowledges the risk that the client is taking by choosing to expressive themself in a
novel or unfamiliar way, the client’s anxiety regarding failure can lessen.

Zinker (1977) offers a great example of how this can be said to clients who are
experiencing this phenomenon:
Creativity is an act of bravery. It states: I am willing to risk ridicule and failure so that I may experience this day with newness and freshness. The person who dares to create, to break boundaries, not only partakes in a miracle, but also comes to realize that in his process of being he is a miracle (p.4).

Rollo May (1975) was perhaps one of the first to formerly acknowledge the risk the client takes exhibits the “courage to create.” May (1975) also was partial to calling the one who creates a rebel as he felt this term best captured the bravery the client exhibits as they “emerge themselves in chaos in order to put it into form” (p. 32).
Campbell (1997) offers an example of what a clinician could say to someone who is intimidated by musical instruments and believes they “are not musical”:

You are already more musically inclined than you think. Everyone is. The world is inherently musical...Music speaks to everyone - and to every species. Birds make it, snakes are charmed by it, and whales and dolphins serenade one another with it (p. 10).

Helping clients move away from the pejorative, commodifying experience of “lacking artistic ability” and allowing them to see themselves as being expressive individuals is just one obstacle that is common to expressive therapy interventions.

Perhaps in some ways related to feeling “uncreative” is the expectation to “be perfect.” In his book Zen Guitar, Philip Sudo (1997) stresses that perfection should not be the primary focus of playing music and that mistakes are an unavoidable part of being human. Sudo’s (1997) encouragement to embrace our limitations while playing an instrument, can be expanded to include our approach to any expressive art. We should abstain from being un-human and perfect and learn to embrace our mistakes as reminders of our limitations in life. Accepting this existential given greatly reduces the anxiety the client experiences when exploring an instrument or other medium.
As provided above, there are a few simple interventions that the clinician can employ to help the client loosen their constriction regarding a desire to be perfect when engaging an expressive medium. As with before, providing a space for the client to explore the medium without feeling evaluated or expected to produce an end product that is of value to others greatly reduces this anxiety. However, the clinician can also participate in the expressive projects when providing such a space is not enough to reduce the client’s anxiety to interact with the medium. The clinician’s participation in expressive projects can serve as an opportunity to display healthy modeling when the clinician “makes mistakes.” The clinician can display confusion at their “mistake” and then model bodying-forth as they adapt to the “mistake” and continue to create. If the clinician so desired, they could invite the client to help them “fix” their “mistake.” I chose to emphasize “mistakes” and “fix” in the previous sentences because I do not believe that we should even allow ourselves to conceptualize that we failed to achieve some aspect of expressing ourselves. As I have mentioned before, we are always expressing ourselves and our limitations are embedded in our expressions to others. With that in mind, are expressions can not be anything other than “flawed” as we live out our limitations and are imperfect by nature. As with creating, expressing ourselves, is a perpetual process and the focus on perfection or an end product is nothing short of unobtainable.

In addition to perfectionism and experiencing oneself as being uncreative, Sudo (1997) points out twelve common obstacles to expressing oneself including, instant gratification, competition, failure to adjust, and overthinking. All of these constrictions
can be loosened with the help of modeling and providing a non-evaluative space for the client to engage the materials. If this is provided, many clients will begin to shift their experiences of themselves and consequently loosen their self-imposed constrictions. Once this has begun, the client is ready to engage the materials in such a way that enables them to be-with others as they express themselves.

Another limitation of the expressive arts is that items may have different meanings in different cultures. As Malchiodi (2003) points out, “Toy animals differ among cultures, so it is important to provide figures that are typical to many different cultures and that have distinctive cultural meanings” (p. 28). This is not to suggest that clinicians should avoid particular toys or musical instruments because of the meanings associated with them in certain cultures. What Malchiodi (2003) suggests is that clinicians be aware of this fact when creating expressive interventions so that they include a variety of choices for clients. This is again another instance where refraining from interpreting the meaning associated with a particular toy is helpful for the clinician. A hypothetical example of this may be that rabbits are seen as being a sign of fertility in European cultures yet may be viewed as a nuisance to many South American cultures. By providing clients with a variety of objects to choose from, the client is able to engage the “nuisance” and incorporate it as such into their interpretive dance or they can choose not to use it.

Perhaps a more pressing concern for expressive therapists is the incorporation of touch into their therapy interventions. This is of particular concern when the therapist uses dance/movement interventions. The clinician should be aware that individuals, for
either cultural or personal reasons, may not like being touched. The clinician should therefore introduce movement interventions by modeling the intervention themselves or with a co-therapist. This allows the client to invite the therapist into their dance if they so desire, which lessens the occurrence of “bad touch” experiences on the client’s behalf (Malchiodi, 2003).

The clinician should also take into consideration the cultural norms of the clients they intend to employ dance/movement interventions so that they can be respectful of the client’s expectations of male and female behavior in regards to dancing. Additionally, the clinician can engage the client in many dance/movement interventions without having to touch client. If the clinician feels uncomfortable touching the client because they are unsure of the client’s receptivity due to their cultural or personal history, it is always advised that the clinician avoid employing touch until the client invites their participation as such into their dance. Additionally, if the clinician feels uncomfortable touching the client during their dance, it is advised that the clinician respectfully decline the client’s invitation. Anytime that touch does occur it is important to take note of who is initiating the touch, why it is occurring, as well as any potential ethical concerns. It’s also important to consider whether touch between participants is allowable and if so under what conditions.

I hope that this review of literature will help to establish a solid foundation from which I can begin to critique existing expressive arts programs. By examining the strengths and weaknesses of the programs in current use, I intend to construct a new program in the context of the terms I have thoroughly examined in this proposal. I feel
that by building a program that conceptualizes trauma in terms challenges to our existential assumptions of the world and addresses these challenges through non-verbal techniques, the clinician will be able to be-with the client in a culturally sensitive manner. The need for such a program is great as the world continues to become more connected as a global community. The inevitability of manmade and natural disasters is a limitation of the human condition that we cannot avoid. We do, however, have the choice to live into our thrownness and work to alleviate our suffering. I hope to establish my program as a means of helping clinicians reach out to those who have survived trauma, regardless of cultural or language differences.
CHAPTER 3: METHODS

The world has been reminded several times in the last few years how devastating natural disasters can be to the people who experience them. With slews of eager clinicians ready to lend their support to those traumatized by earthquakes, floods, and tsunamis, it is imperative that we reevaluate our techniques before intervening in these unique multicultural settings. Since we should always approach therapy with the mindset of beneficence and non-malfeasance, we must understand that we may likely hold a different cultural understanding of “trauma” and “suffering.” This is likely to be most noticeable in how we conceptualize clients and approach treatment.

Like Watters (2007) and others have stated, many of the recent attempts of clinicians to working with international survivors of mass trauma have actually incurred more distress from not being able to work within that culture’s framework of suffering, trauma, and healing. Hobfoll et al. (2007) have examined many of the existing protocols for working with mass trauma and have concluded that “no evidence-based consensus has been reached supporting a clear set of recommendations for intervention during the immediate and mid-term post mass trauma phases” (p. 283).

One reason no consensus has been reached regarding a standardized set of interventions is that trauma rarely, if ever, occurs in a standardized fashion. There are always extenuating variables, such as income levels of survivors, available social and economic resources, and geographic location that contribute to the complex situation that clinicians face when working in the aftermath of mass trauma events. A standardized protocol would greatly limit the flexibility clinicians need to adapt to varying
circumstances in order to be effective. Additionally, Hobfoll et al. (2007) notes that since it would never be ideal to set up a control group when working in mass trauma environments classical experiment designs are impossible and thus empirical studies are not feasible to conduct. However, Hobfoll et al. (2007) suggests that being an informed consumer of literature regarding trauma interventions can lead to an “evidence-informed” protocol that is the best possible alternative within the constraints of working in mass trauma situations (p. 284).

Although Hobfoll et al. (2007) have concluded that a standardized set of interventions would not be in the best interests of clients and clinicians alike, Hobfoll et al. (2007) have identified five intervention principles that are empirically supported for effective therapeutic intervention. Hobfoll et al. (2007) urge clinicians to incorporate the following principles into existing and future protocols: 1) promoting a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope. I will now examine each of Hobfoll et al.’s (2007) principles so that I can use these principles as a guideline for critiquing existing protocols that use expressive arts interventions to work through issues of trauma. I will also use Hobfoll et al.’s (2007) work as a framework as I develop my own protocol.

Similarly to the work of Janoff-Bulman’s “Just World Theory,” Hobfoll et al. (2007) suggest that survivors of mass trauma are often challenged to make sense of a world “in the face of shattered assumptions” (p. 285). It is with this in mind that clinicians must not view the reactions of mass trauma survivors as precursors to a disorder or dysregulation. I am advocating that clinicians approach survivors with an
open mind and allow them the space to express themselves without jumping to conclusions by labeling them with diagnoses. Clinicians should still be aware of and note any unusual symptoms and work to understand them from the client’s perspective before deciding if a diagnosis is necessary. By avoiding these labels and working to understand the client’s experience of the trauma we can work to re-establish a sense of safety.

Hobfoll et al. (2007) suggest that survivors of trauma often “believe that the world is completely dangerous,” which perpetuates the client’s feelings of anxiety, fear, apprehension, and depression (p. 286). Hobfoll et al. (2007) suggest that programs addressing trauma should include exercises that promote safety, such as imagining or listing safe places and people as well as fostering group and community cohesion.

Highlighting that the physical and emotional space where therapy is conducted is safe is also a way of promoting safety. Clinicians can also gently limit the amount of verbal recounting of the traumatic events in groups as a way of fostering safety for groups and preventing over-exposure.

Hyper-arousal is often a common reaction following the experience of a traumatic event. While a certain amount of arousal following a traumatic event, often termed vigilance, is a healthy response, prolonged states of high arousal can lead to interferences sleeping, eating, and other daily life tasks. Hobfoll et al. (2007) stress that it is essential for any program to include calming aspects in order to help clients relax and eventually return to their baseline arousal state. Any program should therefore be presented in a calm fashion (i.e. clinicians have a calming presence) as well as introduce skills that clients can master that promote a sense of relaxation. Hobfoll et al. (2007) suggests
breathing exercises, yoga, and therapeutic grounding as skills that can easily be mastered by clients to help them find a sense of calm beyond the therapeutic context.

Hobfoll et al. (2007) also suggests that survivors of trauma are likely to lose their belief that their actions can exert a positive outcome in their lives. This phenomenon is often expressed as a feeling hopeless or inefficacy. Hobfoll et al. (2007) points out that many previous programs have sought to reverse this “can’t do it” attitude by helping the client to build a new sense of efficacy through general tasks. However, the best evidence shows that fostering feelings of efficacy specific to handling trauma-related events is the most beneficial (Benight & Harper, 2002). Hobfoll et al. (2007) advises clinicians to “keep in mind that most victims were living normal lives prior to the disaster or mass trauma, we can see that the task may be more of reminding them of their efficacy than of building efficacy where there was none” (p. 293). What Hobfoll et al. (2007) is suggesting is that programs should include a focus on resiliency in order to promote a sense of self- and collective efficacy. This can be achieved by encouraging clients to participate in whatever rituals have meaning for them following the traumatic event as well as organizing activities such as re-establishing schools in new locations that provide clients with a sense of accomplishment and efficacy as well as promoting a sense that things are returning to normal. Activities such as these can also instill hope that things can get better. Games and group building activities are examples of smaller scale activities that can promote group efficacy.

Hobfoll et al. (2007) also recognized the tremendous amount of research that highlights the importance of “social support” and “sustained attachments” following a
traumatic event (p. 296). Fostering healthy social connections as soon as possible following a mass traumatic event is viewed as being “critical to recovery” by many mental health professionals who have high levels of experience working on-site with mass trauma survivors (Hobfoll et al., 2007; Litz & Gray, 2002; Ursano, Fullerton, & Norwood, 1995). Situations such as evacuation and destruction of home and neighborhoods greatly impact a community’s sense of connectedness. Hobfoll et al. (2007) urge clinicians to make reestablishing social connections a high priority as the “natural support networks will have disintegrated” (p. 297). Fostering social connection can be as simple as providing groups with a time and space to share information regarding resources and ask questions like, “Is safe water available?” Clinicians can also use group activities to promote a sense of connection. Inviting the local community to participate in an activity, such as dinner or a play put on by clients, are other ways to promote connectedness.

Hobfoll et al.’s (2007) final principle for trauma protocols is the inclusion of hope. The feeling of “all is lost” can typically accompany a shattered worldview following a traumatic event. After all, what point does hope serve if one believes that the world is no longer a safe place? While instilling hope is always a primary goal of any therapeutic approach, Hobfoll et al. (2007) urge clinicians to reconsider how we conceptualize hope. Typically hope has been defined as “positive, action-oriented expectation that a positive future goal or outcome is possible” (Haase, Britt, Coward, & Leidy, 1992, p. 141). Snyder et al. (1991) gives a more existential definition of hope as a process that taps into one’s agency and the awareness to complete goals and overcome
obstacles. Hobfoll et al. (2007), Antonovsky (1979), and others urge that these definitions are decidedly individualistic and Western and may lack applicability in more collective cultures. Hobfoll et al. (2007) uses the example of Hurricane Katrina to highlight how defining hope solely upon internal agency and self-efficacy can be detrimental to survivors of trauma: “Many did not evacuate, not because they lacked internal agency, but because they had no reason to hope for a positive outcome of evacuating due to a lack of external resources” (p. 299).

It is apparent that any program working with mass trauma needs to have a wider understanding of hope that goes beyond one’s internal resources. I believe that Antonovsky’s (1979) work with holocaust survivors has yielded the most flexible and application of hope: “a sense of coherence which is [a] pervasive, enduring, [and] dynamic feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can be reasonably expected” (p. 123). This definition allows for one’s individual agency, as well one’s belief in spirituality, a responsive government, and other idiosyncratic beliefs like superstitions (i.e., “Things usually work out for me because I am a lucky person”).

Encouraging clients to seek resources in order to regain a sense of normality is one intervention that clinicians can use to help promote hope in programs. Decatastrophizing is another intervention that can help preserve and instill hope (Hobfoll et al., 2007). The act of validating and normalizing thoughts associated with the trauma (i.e., “I’m going crazy,” “I can’t handle this,” “Things will never get any better”) can also
promote hope. Participation in spiritual rituals and services is not to be overlooked as a potential source of hope for clients.

Program Evaluations and Critiques

After reviewing the literature on trauma and expressive art techniques, I will now critique several current trauma-focused expressive arts protocols. Both the strengths and limitations of each program will be examined and discussed using Hobfoll et al.'s (2007) guidelines that trauma protocols should include interventions that promote the following five principles: 1) promoting a sense of safety, 2) calming, 3) a sense of self- and community efficacy, 4) connectedness, and 5) hope. I will also critique the theory underlying each program’s set of interventions and techniques.

The first protocol I will examine is a pilot study by Lyshak-Stelzer, Singer, St. John, and Chemtob (2007) titled Art therapy for adolescents with Posttraumatic Stress Disorder symptoms. Lyshak-Stelzer et al. do an excellent job reviewing the literature on creative arts approaches and explain that as of their study, there is no previous research attempting to determine the effectiveness of using creative arts approaches with clients experiencing PTSD symptoms. Lyshak-Stelzer et al. (2007) drew from the creative arts theory that traumatized children “manifest their symptoms in metaphoric modalities such as play, drawing, and story-telling” (p. 163). Lyshak-Stelzer et al. then developed a treatment protocol that provided clients with an opportunity to develop a narrative of their traumatic experiences using a series of collages. This intervention technique can also be associated with the general psychology theory embedded in narrative therapy.
This is not an intervention approach that I am familiar with and unfortunately my critique is limited to noting that Lyshak-Stelzer et al.’s approach appears to be utilizing some of the aspects of narrative therapy.

Lyshak-Stelzer et al. received 142 referral’s from two different hospitals in New York City. The participants were screened using a PTSD symptom checklist and only clients with “high levels of PTSD symptomology” were chosen to be randomly assigned to either the independent or control group (Lyshak-Stelzer et al. 2007, p. 164). The control group received standard inpatient care, which included individual and group therapy as well as medical attention and a limited range of craft exercises such as sewing pillows and beading necklaces. The independent group received creative art therapy in addition to standard inpatient care. The participants in the independent group were required to complete a minimum of 13 collages or drawings over 16 weeks of therapy provided by a registered art therapist with a master’s degree and at least two years of clinical experience. Each group was given the UCLA PTSD Reaction Index for DSM-IV, Child Version upon entering and exiting treatment. The scores from these pre and post-test scores were then analyzed using an ANOVA to determine if the creative arts protocol was effective in reducing trauma symptoms.

By the time the two year study was completed, there were 15 patients who met the criteria to be randomly assigned to the control group and 14 that could be assigned to the independent group. Of the initial 142 who were referred to the study, 56 did not assent to participate in the program or were excluded for clinical reasons as determined by the treatment. Of the remaining 86 participants referred, nine were excluded because they did
not meet the required level of symptomology, 23 were discharged prior to completing the 
16-week protocol, five patients withdrew their assent, and three patients were withdrawn 
for clinical reasons (Lyshak-Stelzer et al., 2007, p. 166). Lyshak-Stelzer et al. (2007) do 
not report why the remaining 14 of the original 86 patients who were referred were not 
included in the study.

There were no additional measures of reliability or validity beyond Lyshak-
Stelzer et al. using the already established ULCS PTSD checklist and registered creative 
arts therapists. The means for the control group were 58.1 (pre) and 55.6 (post) and the 
means for the independent group were 58.1 (pre) and 37.3 (post). The Lyshak-Stelzer et 
al. (2007) study did show that using their creative arts protocol significantly reduced 
clients’ PTSD symptoms which supports their hypothesis.

My first critique of Lyshak-Stelzer et al.’s study is that the number of participants 
in each group was too small to get a significant effect size that would provide a strong 
generalization to larger clinical populations. Also Lyshak-Stelzer et al. (2007) did not 
recognize that such small number of participants can impact statistical significance. 
Additionally, since the independent group received the expressive protocol in addition to 
traditional psychotherapy services the study was not able to isolate the effects of the 
creative arts protocol and the results they received can only reflect the effect of 
implementing a creative arts protocol into a client’s treatment plan consisting of 
individual and group therapy. I also feel that by allowing the control group to participate 
in craft activities Lyshak-Stelzer et al. (2007) were not able to isolate the effects of the 
creative process from their control group.
Overall, the study appeared to validate the effectiveness of Lyshak-Stelzer et al.'s creative arts protocol in reducing symptoms of PTSD in children. The limitation of this report is that the protocol used in the pilot study was not detailed in the report, making it impossible for interested clinicians to attempt to replicate their results. What can be assessed from this study is that current research suggests that adding a creative arts intervention that focuses on creating a narrative of the traumatic event decreases symptoms of PTSD. The protocol did appear to allow the participants the flexibility and freedom to create their collages however the participant desired. The limitations of the Lyshak-Stelzer et al. (2007) protocol, beyond lacking the specific details of each exercise conducted, is that creating collages often requires a large amount of verbal instruction. I believe accurately describing the instructions of selecting images and symbols that represent the trauma narrative, which I assume to be the factual and linear progression of the traumatic event as well as the emotional response to that event, would be prohibitive in a setting where the clinician does not speak the same language as the clients. Since I am developing a program that relies on the use of translators as little as possible, I feel that the Lyshak-Stelzer et al. (2007) protocol is not a good fit for my purposes.

Additionally, the Lyshak-Stelzer et al. (2007) protocol requires clinicians to supply magazines, photographs, scissors, paper, and glue in order to conduct the sessions. While many of these supplies can be used for other expressive arts exercises, carrying enough magazines for a group of clients would be difficult and cumbersome for clinicians travelling internationally to meet with clients after traumatic events.
Furthermore, Lyshak-Stelzer et al.’s (2007) protocol does not appear to meet all of Hobfoll et al.’s (2007) guidelines for effective and competent trauma-focused therapy. While Lyshak-Stelzer et al.’s (2007) program did include interventions that promoted a sense of safety, calm, and self-efficacy, it did not include any interventions that directly supported group efficacy, connectedness, or hope. While this program does demonstrate expressive arts’ effectiveness in relieving symptoms of PTSD, the protocol needs to be adapted to include activities that support group efficacy, connectedness, and hope.

The next study I will critique is Chilcote’s (2007) creative arts program titled Art therapy with child survivors in Sri Lanka. Chilcote’s program is four weeks long and is more loosely structured than Lyshak-Stelzer et al.’s protocol. Chilcote (2007) provided the participants with paper, paint supplies, colored markers, and pencils and encouraged them to draw “what they needed to express” for about an hour each week (p. 157). Chilcote (2007) had 113 female participants who were divided into 11 groups according to age with roughly 10 clients in each group. Clients were recruited from three different organizations including schools and orphanages outside of Colombo, Sri Lanka. No guidelines or screening measures were provided in the report explaining how participants were chosen for the study. Chilcote (2007) broadly states that all the participants “were affected by the tsunami in some way (including the loss of a relative or loved ones, extensive damage to home/community, and or personal witness of the tsunami)” (p. 157).

Chilcote (2007) hired a translator and trained them to assist in completing the creative arts protocol. The translator, a retired school teacher from Sri Lanka, also explained “unique cultural aspects of Sri Lankan life, such as the educational system and
rituals for expressing grief" (Chilcote 2007, p. 157). Chilcote gathered data for the study by digitally photographing each child’s artwork at the end of each session. Chilcote (2007) also approached each child and provided them the opportunity to “verbally share her image with the group” (p. 158).

Chilcote’s protocol required the participants to meet for an hour each week for four consecutive weeks. Each week had a specific topic, but the participants were encouraged to express these topics however they felt was appropriate. The topics in order from the first week to the last week were as follows: my life-myself, the day I will never forget, safe places and memories, and three wishes (Chilcote, 2007). Some of the prompts Chilcote (2007) used were: “What are some of your favorite things?,” “How do you feel about your life?,” “Draw what makes you feel comfortable and not afraid,” “If you would like draw a happy memory of a loved one, or something you did together,” and “What is your greatest dream or ambition?” (p. 158-160).

Chilcote’s protocol appears to be utilizing the theory that children who have experienced trauma need to express their narrative of the traumatic event in order to gain resolution. This is my understanding of the protocol as Chilcote (2007) does not explicitly state if any specific creative arts theory was drawn from to make the protocol. Additionally, it appears that Chilcote’s protocol also incorporates the importance of hope and reestablishing safety after a traumatic event.

No measures of reliability or validity were reported in Chilcote’s study. There is no mention of how participants were screened for inclusion or how the effectiveness of the treatment protocol was measured. Although Chilcote (2007) states “art therapy was
an effective psychologically beneficial, and culturally applicable intervention for children affected by the tsunami in Sri Lanka" there is no data provided to support this claim (p. 161). The only data alluded to in the study is the participants' explanations of their pieces at the end of each week's session.

One of the limitations of this study is that the participants were all female, this makes generalizing any effects to both male and female populations more difficult. Additionally, the since the study was conducted in Sri Lanka the any potential effects of the treatment protocol may be impacted by the cultural differences of Sri Lankan culture. One particular strength of this protocol is that it provides the participants with more freedom to express both their experiences of traumatic events as well as factors that lead to hope and resiliency.

The freedom to answer the "call to create" is, as May (1975), Moon (1997), and Malchiodi (2007) all espouse, imperative to begin the process of clearing space and opening possibilities in the wake of experiencing trauma. The Chilcote (2007) protocol does an excellent job providing structure while still respecting the need to feel free to create. I also feel that the topics of: my life-myself, the day I will never forget, safe places and memories, and three wishes are all excellent ways of engaging the client in such a way that the clinician can begin to understand the client's worldview. I also appreciate that the Chilcote (2007) protocol helps clients begin to work through the trauma they've experienced in gentle way that is less abrasive than asking the client to recount the event in great detail. While establishing a narrative for the trauma may be effective, I feel that it also needlessly evokes a lot of suffering. The Chilcote (2007) protocol helps clients to re-
establish a narrative for self, safety, and hope without having to directly deal with the objective facts of the traumatic event. Additionally, Chilcote (2007) protocol also gives the client the control as to how far the participant chooses to go with a particular image as well as the flexibility to put the image aside and revisit it later at their discretion.

Another limitation of the Chilcote (2007) protocol is the heavy use of a translator. It was unclear how much of the protocol was delivered by the translator. I am concerned that the translator may have worked outside of their field of competency if they began to engage the clients in clinical work without being trained as a counselor or psychologist. While I am working to develop an expressive arts protocol that functions well without the use of words during the sessions, I also have the expectation that a translator will be needed in order to perform certain duties such as, help recruit participants, explain and obtain consent from the participants, and briefly introduce any exercise that cannot be explained through non-verbal communication such as modeling.

Chilcote’s (2007) protocol meets nearly all of Hobfoll et al.’s (2007) guidelines for effective and competent trauma-focused therapy. Interventions such as asking clients to express places where they felt safe and to name things that make them feel comfortable and not afraid are excellent examples of how interventions can be used to promote a sense of safety and calm. Chilcote (2007) also used interventions that tapped into the client’s perceptions of self-efficacy and hope (i.e., “What is your greatest dream or ambition?” “If you had three wishes, what would they be?” and “How do you feel about your life/self?”). Additionally, Chilcote’s (2007) protocol includes interventions that help foster connecting to loved ones and community through activities such as “draw a happy
moment with a loved one” (p. 160). The only adaption clinicians would need to make to Chilcote’s (2007) protocol is an inclusion of group efficacy. This could be remedied by inviting the community (or parents of the clients in Chilcote’s setting) to help locate a space to present the artwork to the community. Further outreach into the community, such as locating art supplies, could also establish a sense of group efficacy.

In 2000 Körlin, Nybäck, and Goldberg conducted a pilot study of an integrated expressive arts protocol in Norway with 58 patients identified as being “markedly impaired” with varying diagnoses but included a history of trauma. Forty of the participants were recruited from an outpatient unit while the remaining 18 came from a nearby inpatient hospital ward. Körlin et al. (2000) included patients if they were assessed to be “finished with the acute phase of their condition and on a steady medication” (p. 334). The program lasted several hours a day throughout the entire week for four weeks.

The protocol included groups focusing on body awareness, receptive music therapy, art therapy, occupational therapy, and verbal group therapy. The body awareness group was held twice a week and focused on attuning to the body’s experience of emotions, relaxation techniques, and grounding exercises. The receptive music group was conducted once a week and followed the Bonny method of Guided Imagery and Music (GIM) where clients listened to classical music in a relaxed state and were asked to follow any images or memories that arose while listening to the music (Körlin et al., 2000). The participants were then asked to draw the images reflecting their GIM
experience. Körlin et al. (2000) then verbally processed the images and experiences with the participants in a structured post-session group.

Art therapy was conducted once a week and participants had the option of free drawing or making a drawing that followed a pre-defined theme. At the end of each session Körlin et al. (2000) asked the participants to write a "short impression of the others' pictures" (p. 334). These notes were then shared and processed with the group.

The occupational groups were held once a week and participants were given a choice of working with textile, leather, wood, ceramics, or computers. Körlin et al. (2000) structured the groups so that participants experiences tasks that were group oriented that focused on building cohesion as well as individual tasks that encouraged creativity and autonomy. Participants also participated in verbal group therapy twice a week where there experiences from previous group activities was explored from a psychodynamic perspective (Körlin et al., 2000). Körlin et al. (2000) also incorporated "linear graphic depictions" of the participants' lives (p. 335). Clients were asked to incorporate their past and future as well as concerns and possibilities on these "life lines." Körlin et al. (2000) also encouraged all of the participants to keep personal diaries that were keep private during the entire duration of the four-week protocol.

Körlin et al.'s (2000) outcome measures consisted of three self-rating forms: Hopkins Symptom Checklist-90 (SCL-90), Inventory of Interpersonal Problems (IIP), and Sense of Coherence Scale (SOC). Each form was administered before and after the 4-week treatment period as well as six months after discharge from the program. The SCL-90 contains 90 items that cover nine clusters of symptoms: somatization, obsession-
compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (Körlin et al., 2000). The IIP contains eight sub-scales: autocratic, competitive, cold, socially avoidant, non-assertive, exploitable, overly nurturant, and overly expressive (Körlin et al., 2000). The SOC contains 29 items and has three sub-scales: comprehension, meaningfulness, and manageability (Körlin et al. 2000).

Körlin et al. (2000) used a t-test to compute the parametric statistics of the independent variables (self-rating scores) for correlations between effects and clinical subgroups since the sample size was adequate and exhibited a normal distribution. Körlin et al. (2000) also used a group of psychotherapy students as control group to establish norms for each of the self-rating forms. The means between the control group and treatment group were all significantly different.

Of the original 58 participants, 51 completed the study. An additional excluded eight from the study because they had begun taking psychotropic medication within three weeks of the beginning of the group (Körlin et al., 2000). Of the remaining 43 participants in the study, all showed statistically significant improvements across all three measures of symptomology and functioning.

The most immediate limitation of Körlin et al.’s (2000) study is that the effectiveness of the GIM and art therapy protocols can not be independently evaluated. The study did however demonstrate that expressive arts programs do contribute to a significant reduction in symptomology. Despite this, Körlin et al.’s (2000) protocol does not lend itself to my purposes since the entire protocol, including the music therapy groups, is heavily dependent upon verbal processing.
Additionally, psychodynamic approach of “uncovering” repressed memories and feelings is anathema to the collaborative nature of existential therapy since the psychodynamic approach espouses that such uncovering can only be done by an experienced psychoanalyst. Körlin et al.’s (2000) decision to have each participant give an interpretation of the group’s art pieces after each session is baffling. Körlin et al. (2000) does not give any rationale as to what the purpose of processing these interpretations serve. Furthermore, interpreting clients’ artwork is generally not advised or practiced by clinicians utilizing art therapy techniques (Horovitz, 1999; McNiff, 1981; Moon, 1997; Malchiodi, 2003). Interpretation can often discourage clients from expressing themselves more freely and lead to frustration with exercises. If the clinician wishes to explore the symbols and metaphors with the client, this is certainly encouraged. The key difference to note is that exploration is a collaborative approach where the clinician holds the belief that the client is the expert of their art. The client’s art is then viewed as an externalization and expression of emotions and personal history. This is drastically different from the psychodynamic approach of interpreting the client’s artwork as “metaphors of psychological issues” (Körlin et al., 2000, p. 334).

The most prominent strength of Körlin et al.’s (2000) study is that it did demonstrate that utilizing expressive arts interventions contributes to the reduction of symptomology associated with trauma. Since the protocol also included other forms of psychotherapy in addition to pharmacological interventions, it is not possible to determine the extent to which the expressive therapies reduced symptomology. However,
Körlin et al.'s (2000) findings do “encourage further applications of dedicated creative therapy programs within general psychiatry” (p. 339).

Körlin et al.'s (2000) protocol meets many of Hobfoll et al.'s (2007) guidelines for effective and competent trauma-focused therapy. Körlin et al.'s (2000) inclusion of occupational group activities was structured in such a way to promote group and self-efficacy as well as connectedness. However, while the clients did establish a sense of efficacy from these activities, the type of efficacy appears to be more general than trauma-related as Hobfoll et al. (2007) recommends. Additionally, the interpretation and discussion of other group members’ artwork in a group format does not appear to promote connectedness or a sense of safety but rather discourages it. Despite some obvious obstacles in meeting Hobfoll et al.’s (2007) guidelines, the body awareness group in Körlin et al.’s (2000) protocol is an excellent example of how to develop a sense a calm through relaxation techniques and grounding exercises.

While Körlin et al.’s (2000) protocol drew from psychoanalytic theories of therapeutic change Tripp (2007) created a protocol for working with survivors of trauma that integrated a modified version of EMDR and expressive arts interventions. EMDR or Eye Movement Desensitization Retraining uses eye movement techniques that stimulate both hemispheres of the participant’s brain in such a fashion that has shown relief of trauma-related symptoms. Tripp (2007) also draws from the work of Steele (2003) and Rothchild (2000) that trauma is difficult for clients to articulate because of neurological changes that occur as a result of experiencing psychological trauma. The field of neurology has demonstrated that the parts of the brain associated with working memory
and memory retrieval reduce in size after experiencing a traumatic event. Rausch et al. (1996) conducted an experiment where positron emission tomography (PET) scan were administered to clients who experienced trauma while being exposed to scripts of their trauma. The results showed that the left frontal cortex, particularly Broca's area (often thought of as the center of speech) appeared to shut down entirely when the clients recalled the events of their trauma (Rausch et al., 1996).

Further research has hypothesized that often times traumatic events are "remembered in the body" in a visceral physical sense rather than in a more intellectualized fashion that most of our other memories are stored (Rothchild, 2000). Tripp (2007) also developed her protocol by incorporating Lusebrink's (2004) theory that "art therapy, utilizes both hemispheres of the brain is uniquely suited to make use of neural pathways to process memory, visual, and kinesthetic information" (p. 176). Lusebrink (2004), Steele (2003), Rothschild (2000), and others have and espoused that the psychomotor activity of expressing oneself through art has the potential to tap into the sensory memories of trauma that are otherwise inaccessible through verbal communication. In addition to Steele's (2003) theory that the process of making art externalizes traumatic events, it is commonly believed that engaging in the process is often relaxing and soothing to client's who have experienced trauma. Malchiodi (2003) also stated that art therapy can invite the client to consider alternative ways to respond to others and events, encourages exploration of feelings, experimentation, and playfulness that all facilitate positive emotional change.
Tripp’s (2007) protocol is greatly informed from the work of Francine Shapiro, who developed EMDR. Tripp (2007) states, “Dual attention stimulation in EMDR originally consisted of the therapist facilitating the client’s bilateral eye movement across a focal plane and was later expanded to include bilateral taps (tactile) and sounds (auditory)” (p. 178). Shapiro (2001) posited that EMDR activates memory networks while attention is focused on the present with the help of external cues.

Tripp’s (2007) EMDR and art therapy protocol required clients to select a disturbing memory or negative self-belief relating to a traumatic event and develop an image for that memory or belief. The client was then asked to begin making drawings while standing up. The client wore a set of headphones that played soothing music and tones that alternated bilaterally between the left and right ears (Tripp, 2007). The clients also wore a small device that was strapped behind each knee which gently vibrated that alternated bilaterally as well. Some of the identified thoughts and beliefs were, “I am unlovable” and “I am helpless” (Tripp, 2007, p. 178).

Some of the most apparent limitations of Tripp’s (2007) protocol is the cost of the EMDR tactile devices. A brief search for the devices on the internet will yield therapy kits including the devices for $300 or more, which makes it cost prohibitive for settings where more than one participant would receive services at a given point in time or in scenarios when the clinicians have limited financial resources. Additionally, utilizing such devices without clinical training in EMDR raises ethical concerns pertaining to competency. Following that line of thought, becoming certified in EMDR practices would pose an even larger cost to clinicians wishing to use Tripp’s (2007), who is a
Certified Level II EMDR clinician, protocol or severely limit the use of techniques to clinicians already well-trained in EMDR. The devices themselves seem to be uncomfortable for clients since they require the client to stand for the entirety of the art making process although Tripp (2007) notes that clients find them “soothing and relaxing” (p. 178). Another limitation of the Tripp (2007) protocol is that EMDR utilizes verbal processing during sessions, which again prohibits this technique from applying in settings where verbal communication is limited due to cultural differences between the clinician and the participant.

While Tripp’s (2007) study provided anecdotal support that an integrative EMDR and expressive arts protocol can reduce symptoms of trauma, the larger limitation of this program is that its underpinnings of neurology do not provide space for the client to make meaning of the traumatic event or address the assumptions challenged by experiencing the trauma. The evidence Tripp (2007) cites in her study supports the understanding that trauma leads to structural changes in the brain, which can then be alleviated or reversed by bilaterally stimulating the brain through tactile sensory input while the client focuses on images associated with the trauma and expressed these images through art. This understanding suggests that symptom reduction is equatable to psychological healing. This approach does not account for the existential search for meaning and loss that often accompanies experiencing a traumatic event since there are not manifested in observable symptoms like hyper-vigilance and loss of sleep. This protocol runs the risk of reducing symptoms that are perhaps arising from a client’s struggle with existential givens, such as losing sleep over not being able to embrace one’s own mortality, without addressing the
underlying cause of those symptoms. In other words, Tripp’s (2007) protocol seeks to remove symptoms rather than seeking to help clients work through their experiences of trauma.

As a result of this constricting and highly individualistic approach to working with trauma, Tripp’s (2007) protocol does not meet many of Hobfoll et al.’s (2007) guidelines for effective and competent trauma-focused therapy. While making art can in itself be found to be calming, Tripp’s (2007) protocol offers little beyond the gentle vibration of the EMDR devices to support this principle of working with trauma. Likewise, the protocol does little to promote safety for clients beyond the sense of safety inherent to the therapeutic space. In fact, the protocol may even cause more distress for clients as it requires clients to focus on negative thoughts and images associated with their experience of trauma. While the supporters of EMDR espouse that re-exposure to traumatic events through visualization while stimulating both hemispheres of the brain can lead to a reduction in symptoms associated with trauma, current research suggests that there is evidence supporting that techniques like psychological debriefing and EMDR are “not effective in preventing subsequent psychological disorder” (McNally et al., 2003).

Additionally, Tripp’s (2007) protocol does not include activities that foster group efficacy or connectedness. This is the result of the protocol being solely focused on the working with clients individually. While, the process of making art may promote self-efficacy on an individual level, the protocol also does not promote self-efficacy associated to being able to handle trauma-related events. The protocol’s requirement to
focus on negative thoughts and images associated with the traumatic event is perhaps the most detrimental limitation. As mentioned above, there is evidence supporting that re-exposure to traumatic events has not shown any efficacy in preventing future distress. More importantly, focusing on such negative experiences does not foster hope. Tripp’s (2007) does not mention any other intervention that instills hope and would balance the negative thoughts required to complete the protocol. For all of the above mentioned reasons, Tripp’s (2007) integrative EMDR and expressive arts protocol will not be considered for inclusion in my protocol.

The last protocol I will examine is the Structured Sensory Intervention for Traumatized Children, Adolescents, and Parents (SITCAP) developed by Steele and Raider (2001). The SITCAP model is the product of eleven years of field testing and research conducted by the National Institute for Trauma and Loss in Children. The protocol was developed to address ten typical trauma reactions: fear, terror, worry, hurt, anger, revenge, accountability, powerlessness, absence of safety, and victim thinking versus survivor thinking (Steele & Raider, 2001). Some of the primary interventions include exposure, cognitive reframing, and developing a trauma narrative. Steele and Raider (2001) use drawing as the primary vehicle for exposure to the traumatic events and safe and controlled manner through the use of trauma-specific questions. Steele and Raider (2001) state that “each intervention is structured for the purpose of creating a sense of safety for the child, adolescent, or parent while re-experiencing, re-telling, and re-framing of major trauma reactions” (p. 2). Steele and Raider (2001) go on to explain that the use of structured sensory activities allows clients to access the memory of the
trauma, which is often a sensory memory, and direct those sensory experiences into a
cognitive framework.

Steele and Raider (2001) based their protocol on the theoretical foundation that,
"trauma is dissociated from the rest of the mind" and that it "needs to be integrated into
consciousness (p. 3). Steele and Raider (2001) also espouse that if these traumatic
memories are not dealt with and are suppressed or repressed the trauma is likely to
influence the individual's thoughts, feelings, behaviors, and personality. Ultimately, the
SITCAP protocol was design to help clinicians "bring the trauma experience into
consciousness and help the patient provide a detailed account of the experience" through
re-exposure to the traumatic events (p. 3). Steele and Raider (2001) cite the 1959 work of
Malleson and the 1961 work of Stampfl pertaining to the use of "implosive therapy" in
"identifying cues and triggering the memories and reactions and then exposing the client
these cues repeatedly resulting in the extinction of trauma reactions" (p.3).

Steele and Raider (2001) also draw from Mower's principle of learning and its
application in exposure therapy. In classical conditioning a neutral stimulus is paired with
unconditioned stimulus. Let's use the example of a car accident to illustrate the lived
experience of classical conditioning. Prior to the accident, the person driving the car
probably did not have any particular response to being behind the wheel. This is an
example of a neutral stimulus. The fear the person experiences during and shortly after
the car accident is a naturally occurring response and is classified as an unconditioned
response since the response was not learned at some point in the person's history. The
learning theory states that it is very likely that the person driving will associate, or pair,
driving (neutral stimulus) with being frightened (unconditioned response) after experiencing the accident. In instances like these, the feeling of being scared or re-experiencing the trauma or fearing that the trauma will re-occur persists after the trauma is over (e.g. worrying about getting into future car accidents when there is no immediate threat of being in a car accident in that moment).

Exposure techniques are therefore seen as interventions designed to “help the trauma victim realize that the conditioned responses are no longer dangerous and avoidance no longer necessary” (Steele & Raider, p. 4, 2001). Steele and Raider (2001) feel that the ability to manage stress and tolerate experiences of fear are crucial to the recovery process. Once the client begins to have less severe stress reactions to the traumatic event, cognitive reframing of the event’s narrative is utilized to help the client further reduce feelings of fear and anxiety.

The Steele and Raider (2001) protocol asks clients to create a drawing that represents the experience of the traumatic event and then to share the drawing with the clinician. The clinician then uses trauma-specific questions to help guide the client into developing a narrative of the trauma. Once the narrative is established, the clinician works to reframe the event with the client to extinguish the fear responses to the event. “Drawing provides a link between dissociated memories and retrieval into consciousness after which the experience can be translated into narrative form and then reordered by the child’s effort to integrate the experience into his life experiences” (Steele & Raider, p.6, 2001). Steele and Raider (2001) go on to state that “The motor (drawing) and verbal (giving the narrative) actions of the drawing helps move the individual from a passive
(internal) powerless involvement with the trauma to an active (external) control of that experience” (p. 6).

Steele and Raider (2001) conducted a study of utilizing an eight-week SITCAP protocol with 100 total children ranging from ages 6-18 who had experienced a recent trauma. Seven of the eight sessions were individual sessions with one session being a joint session with the child’s parents. The study sought to test the efficacy of the SITCAP’s protocol of drawing, telling the story, and reframing that story. The participants were asked to complete the Child and Adolescent Questionnaire (CAQ) prior to treatment, at the conclusion of the protocol, and three months from the conclusion of the protocol. The CAQ consists of 35 Likert questions that has three sub-scales: re-experiencing the traumatic event, avoidance of associated stimuli, and symptoms of increased arousal (Steele & Raider, 2001). Parents of participants were asked to complete a similar questionnaire that was designed to report their observations of trauma-related symptoms in their child both prior to the onset of treatment, at the conclusion of the protocol, and again three months from the conclusion of the protocol.

Steele and Raider’s (2001) analysis of data showed that there was a statistically significant decrease in trauma-related symptoms from intake to discharge at the 0.05 alpha level. For a majority of the children symptoms continued to decrease by the three month follow up, although this difference was not statistically significant from the mean of symptom presence at discharge at the 0.05 alpha level. Steele and Raider (2001) also report that “a small number of children stayed at the same or lost some of the gains made in treatment” referring to a recurrence of trauma-related symptoms by the three month
follow up” (p. 13). Steele and Raider (2001) point out that all of the participants that reported an increase in symptoms at the three-month follow up experienced additional traumas since being discharged and that their CAQ scores we still lower than they were at intake suggesting that “coping skills were learned and the change from victim thinking to survivor thinking lessened the impact of these additional traumas” (p. 14).

My first critique of the Steele and Raider (2001) protocol is that they did not share their inclusion criteria for the participants that were included in their study. It would also be useful to know how much time had elapsed between when the clients experienced their traumatic events and when they entered into the treatment protocol. I also found that Steele and Raider’s (2001) language regarding their participants was confusing and gave mixed impressions of how they conceptualized them. At various points Steele and Raider (2001) refer to their participants as patients and other times as victims. Both of these terms have very strong connotations associated with them; one being of someone in need of medical attention, the other being that of someone who had some unwanted action perpetrated against them.

It is worth considering if Steele and Raider’s (2001) protocol causes unduly distress for participants by utilizing exposure techniques until the participant’s response to the trauma and associated memories are extinguished. While often effective in reducing trauma-related symptoms, exposure interventions raise ethical considerations as outlined by the American Psychological Association’s first principle to do no harm and to provide clients with the best possible treatment (2010). Clinicians considering exposure techniques when working with survivors of trauma should critically weigh the benefits of
the intervention against the possible duress that the intervention may incur as well as consider what the current literature suggests are effective alternatives. Although Steele and Raider (2001) offer support that exposure interventions reduce symptoms of trauma, there is a growing amount of research that early interventions using exposure interventions are not effective in reducing distress or preventing future psychological disorders (Hobfoll et al., 2007; McNally et al., 2003).

Furthermore, if the focus of treatment is to un-pair the conditioning that occurred when the client experienced the traumatic event through re-exposure until the responses are extinguished, what room does that leave for the client to live into their own possibilities as a human? Steele and Raider’s (2001) protocol appears to promote a constricting way of being as it discourages clients from exploring their lives in the aftermath of a traumatic event by reframing clients’ narratives of the events into something the clinician feels is a more “acceptable” and “healthy” way of experiencing the trauma.

Additionally, Steele and Raider’s (2001) protocol does not meet any of Hobfoll et al.’s (2007) guidelines for effective and competent trauma-focused therapy. While it was not expressively stated, it can be safely inferred that Steele and Raider’s (2001) protocol does promote a sense of safety, either through the physical space of where the protocol was conducted or the very presence of the clinicians. However, Steele and Raider’s (2001) biggest short coming is that their extensive use of exposure interventions do not promote a sense of calm, since exposure techniques typically subject the client to large amounts of distress. Furthermore, depending on how intensive the exposure intervention
is, there is a possibility that clients may actually experience the protocol as being an unsafe space. I also feel that Steele and Raider's (2001) use of reframing technique can be experienced as an invalidating experience and actually diminish hope. Additionally, since Steele and Raider (2001) focused solely on individual therapy settings, there was no opportunities for the promotion of group efficacy or connectedness.

After reviewing Steele and Raider's (2001) SITCAP protocol, I have decided not to include any aspects of their protocol in my own program. While there is evidence showing that re-exposure to traumatic events through drawing can be an effective and safe way of helping clients work through their experiences of trauma, Steele and Raider (2001) fail to meet any of the guidelines for effective and competent treatment of trauma that Hobfoll et al. (2007) developed. Additionally, Steele and Raider's (2001) use of reframing does not allow or encourage clinicians to meet clients where they are but rather shape the client's experience into one that does not merit symptomology. I have also considered the time and cost limitations of Steele and Raider's (2001) protocol in my decision to exclude their work from my protocol. The SITCAP protocol seems much better suited for working with individual clients than addressing the needs of survivors of mass trauma.
CHAPTER 4: RESULTS

Before detailing my program which has been designed to be facilitated by a minimum of two clinicians, I'd like to take a moment to mention that my protocol requires a certain type of clinician in order to implement it effectively. Any clinician considering using my program should be open to new experiences, flexible, not easily frustrated, and able to live fully in the moment. Working with groups, especially with art mediums can be frustrating as things do not often go as planned. Although many of the interventions do incorporate art products, it is not necessary for clinicians to be proficient in the mediums beyond a basic understanding of how each medium works. However, the clinician must be sensitive to the materials being used and know how to control them as the participants are likely already struggling with a feeling of lack of control prior to entering the group and not being able to control the mediums could reinforce this perception. Additionally, it is suggested that each medium’s potential to elicit or reduce an emotional experience should be explored by the clinicians who consider using my protocol. For example, painting often has a calming effect due to the slow movements used in brushstrokes whereas drumming can activate emotional experiences quite readily. Clinicians using my protocol should also be able to “go with the flow” if an activity does not go as planned. A healthy sense of humor is also a much needed attribute as many of the interventions are pantomimed in an attempt to reduce reliance on translators and verbal communication. Being able to appreciate the goofy faces and ridiculous gestures that must be made in order to explain certain interventions through body language will greatly enhance your chances of success using my program. Any clinician considering
using my program in international settings should work to cultivate strong self-reflection skills. It is likely that clinicians will come across situations that are uncomfortable because of cultural differences. Do not shy away from this feeling. Explore your discomfort with an open mind. By refraining from placing judgements on yourself or those around you, you may be able to learn a great deal from the experience. Finally, the program is designed to work for children and adults. If you are considering working with both children and adults in your setting, I highly suggest that you run the program as two separate groups in order to allow each group's members to express themselves as fully as possible.

Self-care: Ehipasiko

After conducting an exhaustive review of literature pertaining to working with survivors of mass trauma, the use of expressive arts in therapy with survivors of trauma, and evaluating several existing trauma-focused protocols currently in use, it has come to my attention that all of these sources are lacking in one particularly important area: self-care. While several of the protocols have included ways for clients to learn how to enhance their self-care skills, none have mentioned ways in which clinicians could do the same. Nor have they addressed that there is even a need for clinicians to do so.

Self-care has been a topic of discussion since the beginning of my graduate studies, yet as I scoured my bookshelf I could not find a single book that expressly stated self-care. This leads me to believe that self-care is more of a scenic overlook rather than a destination unto itself on the road to becoming a competent and effective clinician. For
all of these reasons I have decided to include several self-care techniques into the beginning of my protocol. It would be easy enough for me to simply state here in the preface stage of my protocol: “Self-care is important for clinicians and should be practiced when working with such intense scenarios, such as mass trauma therapy work.” But if I did make such a statement and left it at that, I would feel as if I were perpetuating what many others have done before me: pointing out to others how important self-care is for remaining healthy in our field without offering any suggestions on how to care for ourselves.

I titled this section “Self-care: Ehipasiko” to draw attention to the apparent contradiction between our cognitive recognition for the need for self-care and reluctance to do anything other than recognize that need. Ehipasiko is a Pali word which roughly translates as “come and see for yourself” (Seigel, 2010, p. 50). I purposefully used ehipasiko as a means of formally inviting all the clinicians who read and consider using my protocol to stop talking about self-care and its importance and start “seeing for yourself” its benefits. I truly believe that all clinicians should incorporate some form of self-care into their work to avoid burnout, but this is especially true for clinicians who work with survivors of trauma. You can imagine how much stress increases for clinicians who make the commitment to travel far from home to be first responders to a mass traumatic event.

I can speak from my personal experience that I felt like I had reasonably well developed self-care skills prior to entering my graduate training. However, when I travelled to Sri Lanka to work with children affected by the tsunami of 2004, I found that
many of my self-care skills didn't travel with me. All of the things I took for granted like eating my favorite foods, playing with my two cats, and watching television were no longer accessible to me. Fortunately, I rekindled my love for drawing during this time. Through sketching and keeping a journal I was able to cultivate a sense of calm that helped me to decompress from the day’s events. I also am thankful that during my time in Sri Lanka our days began with daily meditations to help us center ourselves before beginning a long day working with survivors of the tsunami.

I hope that by sharing this experience of my own difficulty utilizing self-care skills that I can further highlight the immediate need for any clinician to develop a wide range of self-care skills. I highly suggest that before embarking on any international trips to work with survivors of trauma, take an inventory of what you typically do to decompress. How many of those strategies can travel with you? In the end I think you may find a good many of the ways we deal with stress are quite dependent on external sources like food, friends, television shows, and the like. The answer to this is quite simple, we must add more self-care strategies that rely on internal resources.

The answer to this proposition is simple: utilize the benefits that Tai Chi can offer clinicians. Tai Chi is an excellent fit for my protocol for several reasons. To begin with, it costs nothing to learn. Further in this section I will provide a brief Tai Chi exercise that I learned and use in between sessions with clients to center myself. As I just alluded to, it can easily be adapted to fit into even the busiest of schedules. While one could certainly practice for an hour or several hours each day, one could just as easily practice a fifteen-minute routine and still gain the benefits Tai Chi has to offer. Tai Chi is also well-suited
for my protocol because it requires no materials to practice. This is a very important factor to consider when developing a protocol for clinicians to use as they travel internationally to work with survivors of trauma anywhere across the world.

I am truly grateful for being exposed to the benefits of Tai Chi can offer as a means of self-care through my advanced therapy training site at the Cancer Support Center. I attended a half an hour session once a week that was lead by one of the center’s participants. The participant began learning Tai Chi when she was diagnosed with breast cancer several years ago. She had studied under the certified Tai Chi instructor Laury Hamburg for three years and offers Tai Chi to the Cancer Support Center as a way of giving back to the center and helping clients find ways to reduce anxiety before surgeries and during radiation treatment. Although I have not undergone any treatment for cancer myself, I can attest that the practice of Tai Chi has helped me on many occasions to ground myself and find calm when my life seemed to have none to offer otherwise.

Tai Chi is a practice of creating and maintaining balance of the mind, body and spirit through the use of movement, meditation, and deep breathing (National Center for Complementary and Alternative Medicine, 2010). Research is finally providing evidence that supports what generations of Asian Tai Chi practitioners have been claiming for years, that Tai Chi helps promote healthier living. A recent study of 77 randomized controlled studies that included more than 6,000 participants found strong evidence supporting that Tai Chi improves cardio-respiratory fitness, physical function, balance, and quality of life (HealthDay News, 2010).
Perhaps the most intimidating aspect of Tai Chi for many Westerners is that Tai Chi has often been mystified as an ancient and exotic practice. Tai Chi has become more "fashionable" for young urban professionals to learn and practice in their homes and offices in recent years. Unfortunately is also seems to have cultivated the stereotype of "people who practice Tai Chi" as yoga mat-toting individuals who are health foodies. I wish to demystify Tai Chi and dispel these stereotypes. Tai Chi is practiced by many different types of people around the world and offers the same benefits to all of them irregardless. From my own Tai Chi experiences I can attest that the people I learned with were as different from one another as you can imagine.

Since Tai Chi is a practice of movement, it is difficult to learn by reading an exercise describing the poses. Rosenberg and Ma (2004) accurately point out that Tai Chi is best learned by watching the forms practiced by someone who is well-acquainted with Tai Chi. This certainly is the best way of learning the forms and additional learning sources like DVD's can certainly be purchased by clinicians if so desired. However, what I intend the following Tai Chi exercise to be is a relaxing series of movements that can be conducted by the group of clinicians prior to conducting each day's set of interventions. The focus should be on clearing the mind and focusing on one's body as one moves from pose to pose, not on trying to execute each form perfectly. To supplement the written exercise provided I have included a series of photographs demonstrating the Tai Chi sequence and how to move purposely from one pose to the next in Appendix A: Visual Tai Chi Sequence Guide.
Before beginning to learn the following Tai Chi exercise keep in mind that breathing and balance are key elements of Tai Chi. Slow deliberate movements combined with mindful breathing are essential to maintaining physical balance through the poses as well as cultivating an inner sense of balance. Mindful breathing will be discussed shortly after introducing the Tai Chi exercise.

Tai Chi Exercise: The Five Elements

When I originally learned the Five Elements I was taught only the poses. After several weeks of practicing the poses the leader of the group offered an explanation behind the poses in order to help us retain focus on the purpose of exercise. The overall focus of the Five Elements is to give thanks for what we have in our lives and to refrain from taking anymore than we need. I found that after hearing this explanation I was able to get even more from my Tai Chi practice as I am inviting acceptance into my life for what I have while simultaneously offering thanks. Knowing this has also helped me to give my mind something to focus on days when it seems to want to become tangled in thought. I will do my best to relay the meanings behind each pose as I know them.

The Five Elements consists of a set of movements that begins facing north and moves clockwise through the cardinal directions until returning north at the end of the fourth repeat of movements. This routine takes approximately five minutes and should be repeated four times to help cultivate mindfulness, balance, and a sense of calm for clinicians. When practicing the Five Elements in a group I suggest learning the following script and speaking it aloud initially. After the group becomes more familiar with the
routine it is possible to conduct the exercise in silence. I personally feel that speaking through the script for the first time of every session is ideal for setting the pace for the following silent practices.

Stand in Mountain pose facing north. Take two relaxing breaths. Connect with Mother Earth through the soles of your feet. Connect with Father Sky through the crown of your head. Feet are parallel and hip-width apart. Soften your knees. With your palms facing down move your energy forward and backward three times.

Reach into space: Move your hands upward above your head.

Clear space: Move your right hand down to waist height. Your left hand remains high. Your palms should be facing each other. Imagine you are holding a ball of energy.

Step back on your left foot and lower your left arm.

Roll in the right foot.

Send out fire: Step forward on your right food and move your hands from waist height to shoulder height, palms facing up. (Element I)

Bring back water: Turn your palms to face the ground and slowly return them to waist height. (Element II)

Make a 1/2 turn to the left. (Turn 180° to face South)

Roll in left foot.
Make a 3/4 turn to the right. (Turn 270° to face East) As you turn, move your hands at waist height in a gentle oscillation up and down to represent the wind blowing (Element III).

Gather precious metals: With palms facing up, move your right hand in a half circle motion from your hips to your center at waist height. Your palm should now be facing down. Repeat this motion with your left hand.

With palms facing up, bring your gathered resources up to center at shoulder height. Take only what you need. (Element IV)

Release and fly: Return your hands to waist height and then with palms facing down extend your arms out and above your head, as if you were flapping wings. Bring the backs of your palms together at waist height and move them up your center as you draw the Earth’s energy up through your body and above your head. (Element V) Return your arms to your side by making a wide circle, representing the world.

Embrace Tiger: With palms facing up, bring your hands to your heart, bending your elbows at waist height. Appreciate and honor all that we have and hold dear to us.

Return to Mountain pose.

The group should now be facing east. Repeat the exercise three more times so that you have practiced the routine facing all four cardinal directions and have returned to facing north. The entire routine of honoring each cardinal direction should be repeated four times, which should take approximately 20-25 minutes.
While it is not necessary or even helpful to approach Tai Chi from any sort of perfectionistic mindset, it is beneficial to use the corresponding foot positions. As these positions are too difficult to describe I have included visual references of what a “half turn” are “three-quarters turn” are and how to use them accordingly. Being able to use the appropriate stance with each pose not only promotes better balance, but reduces risks of fall and injury. With that being said, there is a very low risk for injury using the Five Elements, which is why it was selected for cancer survivors, most of whom are over the age of 65.

Directly following the Tai Chi exercise the group should participate in a 5-10 minute mindfulness mediation. The duration can be adjusted to suit the needs of the clinicians, but I suggest starting with five minutes of meditation before attempting longer durations. I have personally found it helpful to demarcate the beginning of meditation with the ringing of a singing bowl. Due the usually high cost of singing bowls I suggest purchasing a small bell or chime. These can easily be found for $10 or less in many craft stores. Additionally, many unique bells and chimes can be found in most Asian markets.

Recent technology has also made meditation timer applications quite accessible for clinicians that have smart phones such as iPhones and BlackBerry’s. A quick search for “meditation timer” yielded multiple applications ranging from $0.99 to $2.99. The use of these applications does provide certain advantages, such as freeing the group leader from having to keep track of how long the group has been meditating. However, the sound produced by many of these applications is far from soothing and do not come close to replacing the resonance of a small bell or chime.
So what exactly is mindfulness? The Buddhist monk Matthieu Riccard (2003) describes mindfulness as “someone enjoying such an experience, such as walking through a serene wilderness, has no particular expectations beyond the simple act of walking. She simply is, here and now, free and open” (p. 20). Similarly, Siegel (2010) defines mindfulness as “a particular attitude towards experience or way of relating to life that holds the promise of both alleviating our suffering and making our lives rich and meaningful” (p. 5). This is possible because mindfulness helps us attune to here and now experiences and give us insight into how our minds create unnecessary suffering. One any given day we may observe ourselves looking at others and thinking things such as, “I wish I was a pretty as her,” or “If I were tall like him I’d be more confident.” These kind of statements foster nothing but suffering and discontent. While learning to accept our limitations as human beings is a difficult and life long task, there are distinct benefits for clinicians to practice mindfulness.

Siegel (2010) explains that mindfulness is a means to help clinicians become less focused on the self and more aware of the present moment. As if improving our ability to be present with our clients is not enough incentive, several studies have been conducted on the positive effects of meditation for habitual practitioners of mindfulness. Dr. Richard Davidson at the Laboratory for Affective Neuroscience at the University of Wisconsin conducted a study that demonstrated that people experiencing distress have more activity in the right prefrontal cortex than in the left prefrontal cortex. However, in subjects that expressed more content in their lives, particularly practitioners of mindfulness, demonstrated more activity in the left prefrontal cortex than in the right. Dr. Davidson
decided to examine this phenomenon more closely and found that subjects that previously demonstrated more activity in the right prefrontal cortex were able to shift a majority of their activity to the left prefrontal cortex after using mindfulness techniques. Additionally, Davidson’s research team found that the subjects who had more left prefrontal activity responded better to an influenza vaccination (Siegel, 2010). So what does all this really mean? Dr. Davidson’s research supports that practicing mindfulness techniques can greatly reduce feelings of distress and may potentially strengthen one’s immune system.

Schure, Christopher, and Christopher (2008) found similar results when they conducted a study of a 15-week mindfulness course given to graduate level clinical psychology students. The course was designed as a recognition of the need to provide concrete self-care to health care workers who are “particularly vulnerable to stress overload because of high demands and unique challenges” (Schure et al., 2008, p. 47). The students learned the mindfulness techniques in the class through participation and practice and then were expected to practice the techniques during the rest of their week. The students were asked to complete four brief questions at the conclusion of the study pertaining to their experience of the course and the impact that mindfulness had/had not made in their lives. Schure et al. (2008) analyzed the responses using NVivo, a qualitative data analysis program. The analysis showed that all of the students experienced positive changes in their bodies, emotions, attitudes, and mental acuity (Schure et al., 2008). Several students also reported getting sick less, which corroborates with the study conducted at University of Wisconsin by Dr. Davidson. Schure et al.
(2008) conclude their study by saying that using mindfulness meditation as a form of self-care has significant potential to “facilitate personal growth or be used defensively to avoid confronting personal issues or psychopathology” (p. 54).

Actually practicing mindfulness is deceptively simple. The easiest way to do this to close your eyes and observe your thoughts while focusing on your breath. The mind has a tendency to become noisier at first, but by acknowledging that you are having a thought or feeling without making judgement you can eventually learn to let these thoughts arise and pass like clouds on a summer day. It is a common reaction for beginning practitioners to feel that they aren’t be mindful enough because they feel like they think more when they meditate. This feeling is normal, but by placing judgments such as, “I’m not doing this right” and “Why does everyone else seem to get this but me?” you only incur more unnecessary suffering and move further from being mindful. Mindfulness is not the emptying of the mind, but rather being aware of what the mind is doing all the time, including being aware that we are “thinking when we’re thinking” (Siegel, 2010, p. 47). Siegel (2010) goes on to point out:

Rather than eliminating thoughts, it brings a certain perspective, an ability to notice that our thoughts are just thoughts, instead of believing they necessarily reflect external ‘reality.’ Mindfulness practice also helps us stop pursuing thoughts that we have come to see are irrational or unhelpful, while at the same time teaching us that deliberately trying to avoid or block out thoughts only makes them return with a vengeance (p. 47).

I suggest that when these thoughts occur simply state to yourself, “I am having a thought” and then return to focusing on your breath. If you find it difficult to return your focus back to breathing it may be helpful to think to yourself, “I am breathing in. I am breathing out” as a means of becoming more attuned to your body and mind. Noticing the
sensation of one’s breath is what is commonly referred to as mindful breathing. As mentioned before, the incorporation of mindful breathing in Tai Chi helps to further promote Tai Chi’s benefits of balance and well-being.

The path to mindfulness can often be difficult and frustrating for people when they begin practicing. I will provide a brief script that can be read during a 5-10 minute meditation. It should be said in a slow and calming manner in the beginning of the session to provide focus for the group as you meditate. The remainder of the session should be silent, except for occasional prompts reminding the group to return to breath. I also suggest *The Mindfulness Solution* by Ronald D. Siegel, PsyD. and *Happiness* by Matthieu Riccard for additional readings on mindfulness. *The Relaxation and Stress Workbook 6th edition* by Martha Davis, PhD. et al. is a fantastic resource for more structured mindfulness meditation exercises. The following meditation exercise is an adaption of an exercise from *The Relaxation and Stress Workbook* (Davis et al., 2008) and from my own mindfulness training.

Mindfulness Meditation Exercise: Clouds

Find a comfortable seated position either in a chair with a back or seated on the floor. If you are in seated in a chair, sit with your feet hip-width apart with your feet flat on the floor and your back upright along the back of the chair. If you are seated on the floor, sit cross-legged with the seat of your buttocks firmly pressing into the floor with your back in an upright position that is comfortable to you.
Close your eyes and take two deep breaths. Feel the sensation of being firmly ground to the world through your feet/buttocks. Shift your attention to your breath. Like the ocean, your breath rises and recedes and is always constant, always there.

If you notice that you are thinking, try to imagine your thoughts as clouds in a blue summer sky. As they take shape allow them to pass by without judgement, then return to breath. Breathe in and out, noticing the sensation in your lungs.

You may find it helpful to repeat the last line of the meditation script, or some variation there of, once or twice during the meditation to help the group maintain focus on breathing. Aside from any additional prompts to focus on breath, the session should be silent as the group practices the exercise. I suggest using a small bell or chime to demarcate when the practice has begun, prior to reading the script, and when it has ended, once 5-10 minutes have elapsed. The mindfulness meditation script can be found in Appendix B for easy reference.

While I have discussed the benefits that Tai Chi and mindfulness can offer clinicians working with trauma, I think it is important to look beyond the potential health benefits. As Hobfoll et al. (2007) point out in their meta-analysis of trauma-focused protocols, it is essential for such programs to promote a sense of safety, calm, self- and group efficacy, connectedness, and hope. While Hobfoll et al. (2007) may have intended this to pertain to how the program is to approach participants, I feel that the clinicians can also benefit from these principles. The practice of group Tai Chi and mindfulness will inevitably lead to a sense of connectedness on the basis that it is a shared activity. The more cohesive the clinicians are prior to conducting the protocol, the better chance they
have to promote therapeutic change for clients. While there may not be any research supporting this hypothesis yet, it is very likely that sharing a group experience, such as daily Tai Chi and mindfulness exercises, may help prevent symptoms of burnout by fostering feelings of connectedness and belonging. Additionally, these self-care exercises also help to establish a sense of safety and calm for clinicians to draw upon when trying to promote these principles for the participants.

In addition to practicing Tai Chi and mindfulness, I think it is important to remind clinicians of the importance of eating a well-balanced diet and getting enough quality sleep on a regular basis. We often forget that how we treat our bodies greatly influences how we are able to perform at our jobs. Fortunately, the journalist and food activist Michael Pollan (2008) is able to eloquently remind us of how to feed ourselves in order to keep ourselves healthy, “Eat food. Not too much. Mostly plants. That, more or less, is the short answer to the supposedly incredibly complicated and confusing question of what we humans should eat in order to be maximally healthy” (p. 1). It sounds simple enough, but yet it typically is difficult to put into practice.

It is also far too easy to work until the early hours of the morning trying to read a chapter in a book or prepare the next day’s lesson plan. But the impact of doing this can quickly be seen in a deterioration in an ability to be-with clients. Since I feel that self-care extends far beyond incorporating Tai Chi and mindfulness practices into one’s daily routine, I have taken the liberty to provide a number of resources that can help promote self-care through healthy eating in Appendix J.
Session One: Introductions

Session One’s program will begin after the clinicians have spent 20-25 minutes practicing the Tai Chi Five Elements exercise and have spent 5-10 minutes meditating. Once the clinicians have completed these exercises, they can begin preparing the work space where the group will meet. This may include setting up tables, locating chairs, or otherwise preparing the physical space for the participants.

Once the space has been prepared the clinicians need to invite the group into the space and introduce themselves as well as the protocol. This is most likely going to be facilitated by a translator, as it is too difficult to pantomime the daily purposes of the group. It is also possible to have the purpose of the group written and translated ahead of time so that a literate group member could read the purpose to the group, which would foster more agency and ownership of the group. Fortunately, it is very unlikely that a group of clinicians would decide to travel to country and provide services if they had no contact within that country to help set up a space and locate participants for a group. Although it is possible to perform the interventions in my protocol non-verbally, it is important to provide participants with an explanation of the purpose of the group, assure them the space is both physically and emotionally safe, and that the clinicians are competent and trustworthy. All of this can be done with the use of translators or by having a member read prepared translated statements.

The clinicians should include in their introduction that the focus of the group is to provide the participants with a safe space to express their emotions (fear, anxiety, sadness, anger, etc.) about the recent traumatic event. Additionally, participants will
likely find comfort in hearing the stories of people who experienced the event similarly to
themselves. The clinicians should also invite the participants to try to be as open as
possible to engaging the activities, as the more they connect with the activity the more
they will feel that activity has helped them in some way. The clinicians should also
address the limits of confidentiality, which will likely vary from setting to setting.

Once the facilitators have introduced themselves and the purpose of the group, the
clinicians will then lead a brief getting to know each other game. This can easily be
pantomimed by one clinician gently throwing a Kimochi, a soft plush toy depicting an
emotion through a facial expression, to another clinician. When the clinician catches the
object he or she is to say their name. They in turn throw the object to another clinician
who says their name. It may be useful to for the clinicians to point to themselves when
saying their own name so that the group understands that they are to speak their name
when they catch the object.

The Kimochi in this game is fulfilling the role of a talking piece. Pranis (2005)
defines a talking piece as “an object passed from person to person in a group that grants
the holder sole permission to speak” which is a large part of Native American cultures (p.
3). The talking piece in the context of this exercise is not to grant sole permission to
speak, but rather to invite the participant as to when they are to speak. As a natural part of
this exercise the group will likely become silent with the exception of the person who has
caught the talking piece. Some consideration should be taken into what object is used as
the “talking piece” that is tossed about the group. It should be small and easily
thrown/caught. It should also be something that is not easily broken or has the potential to
hurt participants if they do not catch the object when it is thrown at them. For this reason small stuffed toys work reasonably well as talking pieces. They are easy to locate, cheap to purchase, easily thrown, and do not break easily or harm participants. Additionally, many people find playing catch with stuffed animals to be inviting as it may likely feel “silly.”

The introduction game should go on for 5-10 minutes or until everyone has introduced themselves at least once.

The next exercise is a necklace making activity. The clinicians will explain that the participants are to use long lengths of yarn, approximately four feet in length, to make decorative necklaces. The participants can use beads, charms, etc to decorate the lengths of yarn. The clinicians should also have a variety of different colored yarn available to choose from. The clinicians should encourage the clients to be as imaginative as possible to make a necklace that represents that participant. All of the clinicians should make a necklace as well.

This activity should take about a half an hour to an hour depending on how long it takes to explain the activity and how much time the group spends decorating their necklaces. The clinicians should plan for extra time managing resources like yarn, scissors, and beads as their will likely not be enough for each participant to have access to all of the materials at one time. Before the necklaces are “closed” (e.g. tied into a circle) the clinicians will ask the participants to tie off the necklaces with a simple knot on each end. This can be done by pantomiming how to tie off the length of yarn. The clinicians will then explain that all of the decorated lengths of yarn will be tied into one
circle, which symbolizes how the group is made up of many individuals but is still all connected.

The clinicians should then re-introduce the Kimochis to the group. Kimochis are small stuffed pillows that have a facial expression on one side and the corresponding emotion on the other. It is not important for the participants to be able to read the emotion on the back as they is copious amounts of research supporting that facial recognition of emotions is possible regardless of culture (Ekman, 2003; Ellsworth, 1994; Goleman, 2006; Hall, 1959; Harrison, 1974; Scherer, 1994). The development team at Kimochis designed their tool to be an interactive way for children and adults to "get in touch" with their emotions by having a representation of each of the basic emotions (Plushy Feely Corp, 2010). The company choose to name their product after the Japanese word for feeling. The Plushy Feely Corp (2010) has recently built a curriculum based on Goleman's 2006 book *Emotional Intelligence*, which uses the kimochis to teach what they have termed "ki-motional intelligence" (p. 11).

I have personally had several correspondences with Kimochi's educational consultant Diann Grimm, M.A., CCC-SLP, Ed.S. and creator/founder Nina Rapport-Rowan discussing the applications of kimochis in therapeutic settings. While the tool was originally designed to help facilitate socio-emotional learning in classroom settings, the Kimochi team is eager to expand the applications of kimochis to additional settings. The kimochi feelings can be purchased in packs of six feelings (one is blank and a marker is included) for $11.99 per pack. I was able to purchase specific emotions from Kimochi by contacting Dianna Grimm and explaining that I intended to use them for developing a
therapy protocol. The company is eager to work with clinicians who want to incorporate their tool into therapy and I suggest any clinician using my protocol to consider contacting the company through their website and establishing a working relationship with Diann via email at kimochime@kimochis.com.

The clinicians can introduce the kimochi exercise to the group by pulling out one of the kimochis and modeling the same facial expression as the kimochi while pointing to themselves. The clinicians can also use a translator, if available, to ask the group to use the kimochis to show how they are feeling right now. A basket containing all of the kimochis should then be passed around the group, allowing each participant to pick the kimochi that best represents how they feel. If possible the clinicians can use a translator to ask the group how each member felt when the traumatic event first occurred. Also, clinicians can record the responses of each participant’s kimochi to establish a baseline of how each participant is feeling prior to treatment.

After the kimochis have been passed around the group, the clinicians should ask the group to stand up and “shake it out.” This entails shaking the arms and legs a few times each as well as stretching and moving about. This can be modelled by the clinicians or explained by a translator. Once the group has moved around for a few minutes the clinicians will introduce the final exercise of the day. The clinicians will present a box large enough to put the decorated yarn circle into. The should be plain as the group’s task is to decorate it. The clinicians should provide markers, crayons, glue, glitter, beads, etc for the group to use during this exercise. Every group member should have the opportunity to contribute to the box’s decorations.
Once the group is finished decorating the box, the clinicians will ask each member to “put their fears and worries” into the box. A translator may be necessary for this but the clinician can pantomime a worried facial expression and then grasping their chest area with their hand and placing an unseen object into the box. The clinicians should then walk from member to member (now standing around the decorated circle) and allow each one to place their fears and worries into the box. Once the clinicians have gone around the entire group the clinicians should place the box in the center of the circle and then return to standing along the decorated circle with the participants and explain that this space is a safe place to hold and keep the group’s fears and emotions. Again, a translator may be necessary for this explanation. The clinicians should then demonstrate to the group that the group is to pick up the decorated circle and head towards the box. As the group meets in the middle of the circle, the clinicians will demonstrate that the decorated circle is to be placed in the box and closed. Once the box is closed the clinicians should announce that the day’s session is finished and that the participants are free to go. I suggest that clinicians should attempt to learn the local language’s word for peace and that they speak this word at the conclusion of the group. The clinicians should not attempt to “break up” the group if they desire to stay after the conclusion of the group and mingle or otherwise get to know each other better. I will from here on refer to this process as the closing ritual. Middleman (1980) suggests in her book, The Non-verbal Method to Working with Groups, that “the best ending activities are those that unite, that help the group end as a group and put a period, so to speak, on the experience” (p. 126). It was with this in mind that the closing ritual be one that literally brings the group
together in such a way that the participants can feel both a physical and emotional connection to the others in the group.

Session Two: Mandalas

The clinicians will begin their day with the Five Elements Tai Chi exercise followed by 5-10 minutes of standing meditation. The exercise for standing meditation is the same as provided for sitting meditation, only the clinicians are standing for the duration of the meditation. Once the clinicians have finished their exercises they should prepare the group space, if necessary.

When the participants enter, the clinicians should have them arrange in a circle and place the box containing the decorated circle in the center of the circle. The clinicians should attempt to learn the local language’s word for hope and speak it as they open the box and invite the group to retrieve the circle from the box. I will from here on refer to this process as the opening ritual.

Once the opening ritual is complete, the clinicians will invite the group to follow them in several yoga poses. Yoga is an ancient practice that developed in India that combines gentle physical postures, softened breathing, and mindfulness meditation to help cultivate a sense of balance and attunement in one’s life (Telles, Singh, Joshi, & Balkrishna, 2010). For many years indigenous peoples of India and Asia have purported that regular yoga practice leads to a more fulfilling life by increasing one’s ability to manage stress.
A recent randomized controlled study conducted by Telles et al. (2010) found evidence supporting that a week’s worth of yoga practice resulted in a statistically significant decrease in symptoms of sadness and anxiety for survivors of a flood in Bihar, India. The Telles et al.’s (2010) results show that those participating in the yoga exercise “showed a significant decrease in self-rated sadness” while the control group expressed an “increase in self-rate anxiety” (p. 6). In a similar study on yoga’s effect on heart rate variability, Sarang and Telles (2006) found that yoga and meditation practices are effective ways of reducing physiological arousal” (p. 473).

Since one of the most common and often most distressing symptom that follows experiencing a traumatic event is hyper-arousal, it stands to reason that providing the skills to reduce the participant’s arousal back to their pre-trauma baseline should be included in any trauma-focused treatment protocol. I have chosen to include yoga exercises in my protocol as a result of the current research supporting yoga’s ability to reduce stress and decrease states of hyper-arousal as well as its ability to be easily practiced in large groups. This allows the clinicians the opportunity to promote a sense of calm and safety in the group’s space, while also teaching the participants techniques that they can use outside of the group to manage their stress.

The clinicians can introduce yoga to the group by asking if any of the participants have heard of yoga or practiced it before. The clinicians can then briefly explain that yoga is a gentle practice of physical poses combined with relaxed breathing. Most likely a translator will be required for this explanation. Once the clinicians have introduced
yoga to the group, the clinicians can invite the participants to spread out from the circle so that each has enough space for the poses.

I’ve found that Guber and Kalish (2005) *Yoga Pretzels* to be particularly useful for this exercise. Guber and Kalish (2005) have designed a set of 5x7 flash cards displaying various yoga poses on each one. On the backs of each one are visual instructions on how to perform each pose. Because of their heavy visual emphasis, *Yoga Pretzels* lend themselves well to non-verbal applications, like my protocol. In addition to basic poses and breathing exercises, Guber and Kalish (2005) have included several yoga games that connecting and moving with a partner or group. In addition to *Yoga Pretzels*, Guber and Kalish (2008) also have a series flash card containing yoga based activities called *Yoga Planet*. I highly recommend purchasing both of these sets, which cost about $10 a piece, as they make yoga accessible to even the most novice practitioner.

I would suggest selecting simple poses like Mountain, Child’s Pose, Downward Facing Dog, and Warrior II before moving on to more difficult poses like Tree, Airplane, or Turtle. The clinicians should use their best judgement and select poses that the entire group can do safely and comfortably. The clinicians should select 5-10 poses from *Yoga Pretzels* or some other yoga resource. Allow the group enough time to experience each pose without feeling “rushed” into the next one. The focus of this exercise is to promote a sense of calm and safety through slow deliberate movements.

After the group has completed the yoga exercise the clinicians should introduce mandala drawings to the group. *Mandala* translates roughly to mean “sacred circle” in Sanskrit (Malchiodi, 2007). Although the word *mandala* has its origins in the East, the
use of drawing images within a circle can be found in Native American indigenous art as well as in many European stained glass windows displayed in churches. Carl Jung was perhaps one of the most influential people in bringing mandala art to the forethought of Western culture. Jung began keeping a daily journal of circle drawings which he felt, "served as an expression of the self" in that moment (Malchiodi, 2007, p. 123). Malchiodi (2007) adds that mandala images may also spontaneously appear when people find themselves experiencing great distress, as the form of a circle often represents wholeness and stability. Mandalas are typically very symmetrical and usually divided into four quadrants, although many variations are also common (Halliday, 2009). Odle (1998) points out that often times drawing a mandala is calming and helps promote a sense of comfort and safety.

Henderson, Rosen, and Mascaro (2007) conducted a randomized controlled study where they instructed participants experiencing high levels of PTSD, as determined by their scores on both the Posttraumatic Stress Disorder Scale (PDS) and Beck Depression Inventory- II (BDI-II) given prior to treatment, to draw mandalas. Henderson et al. (2007) asked the clients to "draw a large circle and then fill the circle with representations of feelings or emotions related to their trauma using symbols, patterns, designs, and colors (but no words) that felt right to them" (p. 150). Henderson et al. ’s (2007) study found evidence supporting that the experimental group experienced statistically significantly fewer symptoms than the control group did at the completion of the study, as evidenced by the groups post-treatment PDS and BDI-II scores. I have chosen to include mandala drawings in my protocol as a result of the current research supporting
mandala’s ability to decrease symptoms of PTSD in addition to being an exercise that can be easily adapted to a group setting that promotes calmness and a sense of being whole.

The clinicians can introduce mandalas as a way of drawing that reflects the self. The clinicians should briefly that each participant should select colors and designs that feel like they represent themselves. For the first mandala exercise the clinicians should provide already drawn mandalas that the participants can color in by using crayons, or colored pencils. I have found that Monique Mandali’s Everyone’s Mandala Coloring Book series to be quite useful in providing a wide arrange pre-made mandalas that participants can use to color in and acquaint themselves with mandala drawings. Each of Mandali’s mandala books are reasonably priced at $10 and lend themselves easily to being photocopied so that the clinicians can reuse the mandala images. I suggest making several copies of each mandala so that the group has options of which mandala “speaks” to them.

I have provided a set of instructions that could be read to introduce the mandala exercise to the group. It is an adaption of instructions used in Everyone’s Mandala Coloring Book (Mandali, 1991) and from my own experience with mandalas. If clinicians wish to use the instructions a translator would be required. The following script can also be found in Appendix D.

Mandala Exercise Instructions

Let your intuition guide you and choose the design that appeals to you the most at that moment. Surround yourself with a rainbow of colored pencils. Pick up the color that
you are drawn to the most and feel what part of the mandala you would like to fill in. Proceed with other colors until you feel done, which means that there may be blank spaces left. You may wish to change or add to the design. Feel free to follow your emotions and listen to what your intuition guides you to do.

The clinicians should then allow the participants to select a pre-made mandala and an arrangement of colored pencils. The clinicians should allow 30 minutes for the group to color the mandalas. It is appropriate if participants wish to color more than one mandala during this time. It is up to the clinicians' best judgement when the group should move on to the next activity.

When the clinicians feel that the group is done coloring mandalas, the clinicians will provide blank pieces of paper to the group and invite them to free draw. The clinicians should invite the participants to draw anything the participants feel they want to draw, not just mandala images. The purpose of this activity is to gradually acclimate the group to spontaneous drawing, which will be the focus of future exercises. Again, 30 minutes is most likely an appropriate time range for this exercise.

I would recommend Prismacolor brand colored pencils for all of the mandala and free drawing exercises because I feel that their colored pencils have a rich color to them and are long-lasting. However, Prismacolor colored pencils are relatively expensive ranging from $40 to $55 for sets of 48 and 72 pencils respectively. Crayola offers a more cost-effective solution in their Trayola set of 54 colored pencils, which was designed for classrooms and other group settings. The Trayola has 6 pencils of 9 different colors and costs $12. Another alternative is Prismacolor's Art Stix, which are woodless colored
pencils. Unlike traditional colored pencils, Art Stix do not require sharpening and last considerably longer since they are entirely made of pigment. Art Stix are also more reasonably priced at $25 and $35 for sets of 24 and 36 respectively. I feel that Art Stix lend themselves to a wider array of intervention uses than traditional colored pencils and provide a vivid array of colors that the Trayola does not offer.

Once the clinicians feel that the group is done free drawing, the clinicians will ask the clients to “shake it out” and return to sitting around the decorated circle. The clinicians will then begin another round of the name game, where a participant throws the talking piece to another participant who must then introduce themselves by name. Once the talking piece has gone around the circle at least once, the clinicians will model the new rules of the name game, which are that the person who catches the talking piece must speak the name of the person who threw the talking piece to them. The activity ends once the piece has been around the circle at least once. At this time the clinicians will pass around the kimochis and invite the participants to share how they feel.

Once every participant has had the opportunity to express themselves with the kimochis, the clinicians will invite the participants to stand up and return to where the group was drawing/coloring earlier. The clinicians will then instruct the participants to draw a mandala of their own that represent themselves. The clinicians should encourage the clients to use any shapes, symbols, colors, and patterns that they feel express who they are as a person. I suggest that the clinicians have pre-made mandala circles made prior to this exercise. This would essentially provide parameters that the participants can fill however they choose. I have provided a simple template that can be used for this
exercise in Appendix C. This exercise should take 30 minutes. Once the clinicians feel all
the participants are done with their self mandalas, the clinicians will invite the group to
stand up and “shake it out” and return to the decorated circle.

Before conducting the closing ritual the clinicians will play a laughing game with
the group. The laughing game is a variation of the name game, only when a person
catches the talking piece them must laugh instead of saying their name. This can be easily
modeled by the clinicians. Once the talking piece has gone around the group at least
twice, the clinicians will invite the group to conclude the group with the closing ritual.

Session Three: Mystery Drawings

The clinicians will begin their day with the Five Elements Tai Chi exercise
followed by 5-10 minutes of walking meditation. The exercise for walking meditation is
the same as provided for sitting meditation, only the clinicians are walking at a slow and
gentle pace for the duration of the meditation. The clinicians should choose a space
where they can walk freely along a set path (e.g. across the room and back) without
obstruction. Similarly to sitting and standing meditation, the focus of walking meditation
is on the breath. The key difference is that during walking meditation the clinicians
should also focus on the sensations of lifting and lowering the feet as they move through
space and make contact with the ground. A script for walking meditation can be found in
Appendix E.

Once the clinicians have finished their exercises they should prepare the group
space, if necessary. When the participants enter, the clinicians should have them arrange
in a circle and conduct the opening ritual. Once the opening ceremony has been
conducted, the clinicians will introduce the participants to working with pastels. The
clinicians should demonstrate how the pastels can be blended using one’s hand, layered
overtop another, and otherwise manipulated in unique ways. The clinicians should invite
the participants to explore the pastels for 30 minutes or until the clinicians feel that the
group has become comfortable working with the medium.

When it comes to selecting pastels to use for this activity clinicians should be
aware that when buying pastels you “often get what you pay for.” Although buying
inexpensive pastels may appeal to clinicians working on small budgets lesser quality
pastels can easily become more frustrating than the savings are worth. Unlike other
materials, like markers or colored pencils, pastels depend more heavily on how they are
made and the quality of the materials used in them. I recommend *Prismacolor* pastels, as
I have had good personal experiences working with them. Unfortunately, *Prismacolor*
pastel sets are relatively expensive and may be cost prohibitive to buy for a group setting.
A set of 36 and 48 *Prismacolor* pastels cost approximately $45 and $60 respectively.
*Faber-Castell’s* half-stick pastels are a more cost-effective alternative pastel option.
*Faber-Castell’s* products are easy to work with and similar in quality to *Prismacolor’s*
pastels. Although *Faber-Castell’s* sets are half-stick sets, which are smaller than
*Prismacolor’s* pastel sets, there are reasonably priced at $26 and $40 for 48 and 72 piece
pastel sets respectively.

It is also worth mentioning that pastels work best on pastel paper. While all-
purpose copier/printer paper can be used for colored pencil drawings and even marker
drawings, pastels can become frustrating to work with on mediums other than pastel paper. Canson makes an excellent 8.5" x 11" natural white pastel paper for $15 per 10 sheet pack. However, because of its cost, pastel paper should be used only for participants’ projects and not for free drawing exercises. A suitable alternative to pastel paper that can be used for free drawing exercises is newsprint paper. Canson offers several newsprint pads available in a variety of sizes. Both the 9" x 12" and 14" x 17" are reasonable sizes that travel well and are large enough for participants without being too intimidating to fill. The 100 page pads of each of these sizes are $5 and $10 respectively. Depending on the anticipated size of the group and budget of the clinicians, newsprint pads can offer a cost-effective substitute to using pastel paper for all pastel exercises. Clinicians may also want to look into purchasing fixative sprays if the participants’ pastel projects are to be kept beyond the duration of the group.

After group has become acquainted with working with pastels, the clinicians will invite the group to sit around the decorated circle. Using the talking piece, the clinicians will initiate a round of the name game, followed by the guessing variation of the name game, and allowing the participants to express their current emotion using a kimochi. Once the kimochis have been passed around the group, the clinicians will divide the group into groups of five.

At this point, the clinicians will introduce the cup game. The clinicians will need to tie five 3-foot lengths of yarn around the circumference of a medium size rubber band. The clinicians will also need to have several empty plastic cups for this exercise. The clinicians will then demonstrate the object of the game, which is to stretch the rubber
band, using the lengths of yarn as a group, large enough to fit over a plastic cup and then stack the cups in a pyramid shape. The clinicians should also pantomime that the exercise is to be done without words. This can be done without the use of a translator.

The game can be played several times, each time applauding the group that finishes first. The clinicians can adapt the cup game in many ways, such as the number of pieces of yarn attached to the rubber band, the lengths of yarn used, and how many cups will be stacked. The game can also be made more challenging by selecting a rubber band that is much smaller than the cups being used, which would require the group to stretch the rubber band more as a group in order to pick up and release the cups.

After the group has played the cup game several times, the clinicians will invite the group to move to an appropriate space to work with the pastels once again. This time the clinicians will invite the participants to make Mystery Drawings. The clinicians might need to use translators to explain to the group that they are to close their eyes and draw whatever shapes and lines they feel compelled to draw. After they feel they are done making shapes, the participant can then open their eyes and look at their drawing to see what is hidden in their drawing. The participants are then invited to pull out what they see in their drawing by adding colors, shapes, or removing lines until they can reveal the mystery that was hidden in their drawing. The participants may find it useful to think of a story that goes along with what they see in their drawing to help them with the process of revealing what is hidden in their drawing. If sufficient translators are available, the participants can choose to share their stories with the group. If the clinicians choose to do this, they should be cautious not to pressure participants into sharing with the group and
they should remind the group that the group space is a safe place to share personal things, like one’s mystery painting story.

I was introduced to Mystery Paintings in 2008 when I travelled to Sri Lanka to work with children affected by the ongoing civil war and 2004 tsunami. Fr. Paul Satkunanayagam and artist Paul Hogan incorporated the Mystery Drawing exercise into their work at the Butterfly Peace Garden. The participants start working to reveal the image(s) hidden in their drawing and then work to tell the story hidden within those images. Fr Paul and the animators at the Butterfly Peace Garden also invite the participants to take the stories of their Mystery Drawings and adapt them into songs, dances, and plays, depending on the participants’ interests. I mention this because the Mystery Drawing exercise is extremely flexible and easily adapted to a variety of associated interventions. Depending on the availability of resources (e.g. translators, musical instruments, physical space and time) the clinicians may want to expand the Mystery Drawing exercises into one or more sessions. Likewise, if the participants do not appear to enjoy the Mystery Drawing exercise, it can be shortened and limited to the one exercise in Day Three of the protocol.

Natalie Rogers describes a similar exercise in her book, Creative Connection, that she calls the “Big Doodle.” Rogers (1993) offers the following description for how to introduce Mystery Drawings to participants:

Start by taking a [pastel] in each hand. Close your eyes. Sing a song and wave your hands in the air. You are first doodling in the air, letting your hands dance to the humming. Open your eyes for a second to find the paper. Using both hands, start doodling on the paper. Experiment with your eyes closed, then with your eyes open. Continue singing your song. Let anything happen. Don’t worry about what your doodle looks like (p. 29).
The above description may be used by a script by clinicians if so desired. I personally suggest omitting the singing instruction as many participants may feel self-conscious about singing or humming aloud in a group. I do appreciate the inclusion of doodling in the air prior to putting pastel to paper as this gives the participants an opportunity to open themselves to moving intuitively for the exercise.

The clinicians should allow 30 minutes for the process of the Mystery Drawings, with the flexibility to extend the exercise if the participants become particularly engaged in the exercise or choose to share their Mystery Painting stories with the group. After the group has made one or more Mystery Drawings and has had time to share the associated stories with the group, the clinicians will initiate the closing ritual. This is the conclusion of Day Three.

Session Four: Drum Circle

The clinicians will begin their day with the Five Elements Tai Chi exercise followed by 5-10 minutes of lying meditation. The exercise for lying meditation is the same as provided for sitting meditation, only the clinicians are lying on the floor for the duration of the meditation. The clinicians should choose a space where they can comfortably lay without obstruction. The clinicians may wish to include mats for this exercise.

Unlike previous day’s sessions, Session Four requires some careful consideration and experimentation prior to conducting the exercise, especially if the clinicians are using the program to travel internationally to work with participants. Today’s exercises
incorporate drumming into several activities. While it would be ideal to purchase enough
djembe or dumbek drums for each member of the group, it would be highly cost-
prohibitive since either drum typically costs $100-150 per drum. Buying enough drums
for a group of 10-15 participants and 2-4 clinicians could easily cost between $1200-
$2500, which is beyond many clinician’s budgets for such a program. If, however, you do
have the resources to purchase enough drums for the group you will be working with, or
already have access to enough drums, there are several things you should take into
consideration.

Perhaps the most important consideration when buying drums is the ease of which
they can be transported. This encompasses not only the drums’ size and weight, but also
the material they are made from. For example, I have a wonderful hand crafter ceramic
dumbek drum from Full Circle Drums which produces a rich and full deep sound as well
as a loud crisp high tone. Although this drum produces an ideal tone for drumming
activities, particularly meditative rhythmic drumming, it has many drawbacks that makes
it not suitable for incorporation in my program in international settings. Most noticeably,
it is large and has a significant weight. Second, since it is made of ceramic, it is more
likely to break or become damaged as I transport it to the group’s location. Finally, its
cost of roughly $100 makes it an overall poor selection for implementing in my protocol.

While wood and polymer drums are available at significantly more cost-effective
prices (e.g. Full Circle Drums’ polymer dumbek drum $60 or Meinl’s Nino African style
rope-tuned 8’ wood djembe $20) the clinicians should consider the possibility of making
drums for the group. Small hand drums can easily be made from a variety of low-cost
household items. The clinicians should experiment beforehand with small containers, like Pringles chip cans, small coffee containers, and hand sanitizer wipe containers. Each of these objects have a cylindrical shape and the ends can easily be removed. Additionally, they are small, light-weight, easy to transport, and inexpensive.

The general process for making a drum out of these materials is to remove the top of the container and stretch a balloon over the top of the container. The size of the balloon will impact the quality of the sound the drum produces, as a tighter fit will make a higher pitch “snap” sound, while a looser fitting balloon will make a deeper “boom” sound. The clinicians may find it necessary to cut off the small end of the balloon in order to more easily stretch the balloon over the chosen container. Additionally, rubber bands can be used to hold the balloon in place.

In addition to choosing the size of the container used for the drums, the clinicians can also experiment with cutting the bottom off of the container. Doing so often results in a louder drum, since the free bottom allows sound to exit the drum. Putting a second balloon over the bottom can also lead to new variations of sound.

Once the clinicians have found a drum material and design (one-ended, two-ended, open-ended, etc) the clinicians can gather the appropriate materials needed for the participants to make the drums during the first activity of the Session Four. The opening ritual will be conducted and then the clinicians will instruct the participants as to how make the drums. Once the drums are made the participants should be encouraged to decorate their drums with colored pencils, glitter, beads, yarn, etc.
Depending on the material used for the drums, the clinicians may wish to make paper sleeves ahead of time so that the participants can decorate the sleeve and then fasten the sleeve to the container once they are done decorating. This may be particularly useful if the clinicians have decided to use a container like a Pringles chip can or metal coffee can. The important thing to note about the drum making activity is that all of the drums should be made in the same way (one-ended, two-ended, open-ended, etc) in order to produce one homogeneous sound during the day’s last exercise.

Once the group as finished decorating their drums, the clinicians should invite the group to sit around the decorated circle. For the next 20-30 minutes the clinicians should encourage the group to explore their drums’ sounds. No particular rhythm should be set, the focus of this exercise is to become comfortable making music as well as getting acquainted with their instruments. Once the group has had time to play with their drums, the clinicians will pass around the kimochis and allow the participants to express an emotion using the kimochis.

After the kimochis have made it around the group at least once, the clinicians will then pantomime the next exercise by selecting a kimochi (angry and sad work really well for this) and drum making a corresponding face to the kimochi selected. The focus of the exercise is to express through one’s drumming the emotion represented on the kimochi. Translators may be needed to clarify this exercise, but the clinicians should be able to model the exercise adequately.

Once the clinicians have modeled the exercise the clinicians will then demonstrate that one participant will begin with both the talking piece and the basket of kimochis.
That participant is to throw the talking piece to another participant and then select a kimochi for that participant to express through drumming. Once the drumming participant is done, the participant that selected the emotion will return the kimochi to the basket and pass the kimochis to the participant that finished drumming. The participant that finished drumming is then to throw the talking piece to another participant and repeat the process. The rules of this exercise can be modeled and explained to the group with the use of 2-3 clinicians.

After all of the participants have had a chance to select an emotion for another group member and drum an emotion, the clinicians will invite the participants to get up and “shake it out.” Once the group has had several minutes to move and stretch, the clinicians will invite the participants to clear the group space for yoga. As with the previous yoga exercise, the clinicians should use either *Yoga Pretzels* or *Yoga Planet* flash cards to facilitate the group. The clinicians should go through the cards beforehand and remove any poses that may be too strenuous or difficult for the entire group.

Once the group is prepared to begin, the clinicians should begin the exercise by drawing a random card from the yoga flash cards, inviting the group into that pose. After the clinician has selected 2-3 more cards, another clinician should go around the room and begin inviting a participant to select the next pose. This allows the group to be more spontaneous and feel more like the group belongs to them. The clinician should go around the room until each participant has had an opportunity to select a pose. The exercise ends once each member has selected at least one pose.
After concluding the yoga exercise, the clinicians will invite the participants to sit around the decorated circle once more. This time the clinicians will invite the participants to take turns expressing a rhythm, to which the rest of the group will attempt to match and follow. The clinicians may find it easier to have a translator explain this and the following exercises as they can become cumbersome to model accurately. Once every member in the group has had a chance set a rhythm for the group, the clinicians will give the talking piece to a participant and ask them to express how they feel since the traumatic event by using the drum. After the participant has had several minutes to express their feelings unaccompanied, the clinicians will invite the rest of the group to either mimic and follow the participant’s rhythm or contribute to it by adding their own rhythm that they feel expresses what the participant with the talking piece was conveying in their rhythm. After several minutes of accompaniment, the participant with the talking piece is to throw the talking piece to another participant. The whole process of independent expression of the traumatic event followed by accompaniment and group expression of the individual’s feelings is repeated until each member has had a chance to express their feelings of the traumatic event.

Once the group has had a chance to express their feelings pertaining to the traumatic event and subsequently been supported by the group in their expression of that feeling, the clinicians will move on to the day’s final exercise. The clinicians will now invite the group to join them in a shamanic or meditative rhythmic drumming exercise. The clinicians can begin by holding the talking piece and creating a rhythm (simple or complex) and inviting the group to mimic and follow their rhythm. The clinicians can
model this by matching each other’s rhythms and encouraging the rest of the group to
follow in suit. After the clinicians have played with several rhythms or polyrhythms, the
clinicians will set a slow and steady rhythm for the group to follow. It may be helpful for
the clinician setting the rhythm to think of a heartbeat or simply count off in their head as
they hit the drum on every third or fourth beat. The purpose of the exercise is to induce a
calm and steady rhythm that can easily be followed by the group that will help promote a
sense of calm and safety. The rhythm is to be kept for 20-30 minutes so that the group
can begin to shift their focus away from drumming and toward their experience of
drumming and emotions that the collective rhythm stirs for them.

After 20-30 of the following the rhythm, the clinicians will invite the participants
to get up and “shake it out” followed by the completion of the closing ritual. This is end
of the day’s activities. Ideally, the group and the clinicians would conclude the first week
of session at the end of Session Four and began with Session Five at the beginning of the
following week. This would allow the participants and clinicians to have some time to
engage in self-care practices and to decompress from the emotions that were experienced
during the week.

Session Five: Watercolor paintings

Day five’s program will begin after the clinicians have spent 20-25 minutes
practicing the Tai Chi Five Elements exercise and have spent 5-10 minutes sit meditating.
Once the clinicians have completed these exercises, they can begin preparing the group
space. Today’s exercises will require watercolor pencils, brushes, cups, water, and watercolor paper.

Painting offers a calmness that is unparalleled by other expressive modalities. It is a wonderful balance of psychomotor movement and emotional expressivity that uses both the left and right hemispheres of the brain. However, painting has many drawbacks, most notably, painting can be very intimidating for first-time painters. Secondly, learning how to control one’s brush strokes and making the color one wants can become frustrating very quickly. Furthermore, paints, even bottles of tempera paint, are not cost-effective and do not travel well into international settings since they are large amounts of liquids.

Watercolor pencils offer an excellent alternative that are less frustrating and easier to transport than traditional paints. Watercolor pencils look and handle like traditional colored pencils. The participant can draw, color, or doodle as they would with a traditional colored pencil to express themselves. When they are ready to “paint” they simply use a wetted brush to go over the areas where they used the watercolor pencils. The result is that what once looked like a colored pencil drawing transforms into a beautiful watercolor painting.

Watercolors pencils therefore have a lot of benefits when considering including them in an international protocol such as mine. First of all, they are easy to transport. Since they weigh very little and can easily be checked or carried on, watercolors have a distinct advantage over traditional paints. Also, watercolor pencils are far less messy than other paints. Since they only require putting a wet brush to a piece of paper the paint brushes being used go through far less wear and tear and require minimal cleaning.
afterwards. I recommend using golden taklon brushes since they hold up well to frequent use and provide excellent control through firm bristles. A set of golden taklon brushes of varying sizes and bristle types can be bought from Princeton Art & Brush Co for $5 from art stores like Blick and Utrecht. Perhaps the most important advantage of watercolor pencils that they are inexpensive when compared to other paint mediums. Prismacolor has fantastic sets of 24 and 36 watercolor pencils for $25 and $45 respectively. I personally have had good experiences with Reeves' watercolor pencils which can be bought in sets of 24, 36, and 144 for $9, $15, and $70 respectively.

While there is a great deal of flexibility in the brand of watercolor pencil used, clinicians must be sure to provide watercolor paper for any exercises using watercolors. Using watercolor pencils on standard printer/copier paper or newsprint paper would result in soggy rips and tears quite readily. Canson makes an excellent 5.5” x 8.5” 12 sheet wire bound watercolor pad for $4. Ideally, one pad would be purchased for each participant. The wire binding makes the pad easy to manipulate and increases its longevity for the participant once the protocol has concluded. Additionally, larger pads such a 15 sheet 11x15 pad can be cut down into 2”x 3” pieces and yield roughly 200 smaller work surfaces for participants. This is perhaps the most cost effective way of approaching watercolors. In addition to reducing costs, using smaller work surfaces reduces the time required to complete the day’s exercises while also limiting any anxiety that may arise from the feeling of having to fill a larger workspace.

After the group has conducted the opening ritual, the clinicians will introduce the watercolor pencils to the group. This can be done by making a doodle with the pencils
and then demonstrating how to use a wetted brush to change the pencil drawing into a painting. Once the clinicians have demonstrated how to use the watercolor pencils the group should be invited to explore the pencils through 30-60 minutes of free drawing/painting.

Once the group has had a chance to become acquainted with the watercolor pencils, the clinicians will introduce the day’s first exercise. The clinicians can use a translator for introducing today’s activities, but since the activities are relatively straightforward the clinicians could have translators prepare the instructions for the day’s activities by writing them on a piece of paper or dry erase board or whatever medium is most readily available that can be easily read by the group. The group will be invited to express themselves through three paintings before taking a break and three paintings after taking a break.

The first painting is adapted from Chilcote’s (2007) protocol and is a painting of how the participants view themselves. The painting can include other objects, elements, and people, but should in some way express how the participants currently experience themselves. The next painting is also adapted from Chilcote’s (2007) protocol and is a painting of places and people where the participant feels safe. Again, the painting can include many elements and can also be abstract like a painting of God’s love, but it should in some way express where and/or with whom the participant feels safe. The final exercise before the break is a painting of what happened (e.g. the traumatic event). This painting exercise was adapted from Malchiodi’s (2001) article on expressive arts interventions when working with clients that have experienced trauma. Each of the
paintings should take approximately 30-60 minutes. The clinicians can choose to move on to the next painting exercise if the groups appears to need less time to complete the exercises. Likewise, if the group appears to need more time, the clinicians can extend the length of each exercise to provide a space where the participants can engage in the activity without feeling rushed. The clinicians should allot 5-10 minutes for each painting to dry before moving on to the next exercise if using a spiral bound pad of watercolor paper.

After the group has completed the first three painting exercises, the clinicians will invite the group to stand up and “shake it out.” Once the group has moved about for several minutes the clinicians will invite the group to sit around the decorated circle and pass the kimochis around the circle, allowing each member to express their emotion(s) from the basket of kimochis. If a translator is available, the clinicians may chose to pass the kimochis around a second time, this time asking the group how it felt to complete the “what happened” painting.

Once every participant has had a chance to express themselves using the kimochis, the clinicians will invite the group to stand up while the clinicians split the group into two smaller groups. The next activity will be a game that Middleman (1980) calls steal the bacon. I was introduced to this game during my work in Sri Lanka and I can personally attest that it is a fun game for all ages. The rules are the game are quite simple. The clinicians split the group into two teams. Each member of both teams are given a number from 1-X, where X is the total number of people on each team. The talking piece is then placed in between the two teams. The clinicians will call one number
at a time (at first) which will call forth the person on each team who was given that number. Each person wants to grab the talking piece and return to their team's side without being tagged by the other team's player. If a player is able to bring the talking piece back to their team without being touched, that team gets a point. The game is over when one team gets 5 points (this number can be altered accordingly). It is likely that using an outdoor space would be the best way to safely accommodate the group during a game of steal the bacon.

Some considerations to take into account before playing this game with the group would be physical limitations. If more than a few members would not be able to engage in running activities, then the clinicians should consider choosing another game to play. If the clinicians feel that steal the bacon is too strenuous of a game for the group to play, Alana Jones has an excellent book of *104 Activities That Build: Self-esteem, Teamwork, Communication, Anger Management, Self-discovery, and Coping Skills*, that includes many games that could be substituted for steal the bacon.

After a few rounds of steal the bacon, or other game is played, the clinicians will invite the participants to return to the space where the participants were working on their watercolor paintings. Assuming each painting is dry, the clinicians will introduce the first of the next three painting exercises. The clinicians will invite the participants to express what they fear most. This could be anything from people, to events, to abstract things like being forgotten. Next, the clinicians will invite the participants to express how they feel that they have changed as a result of experiencing the traumatic event that occurred. The clinicians should be open to participants expressing both welcome and unwelcome
changes that have occurred. Depending on how the group wishes to engage this activity, it would be appropriate to break the exercise into two smaller paintings of both wanted and unwanted changes that have occurred since the traumatic event. The final exercise is adapted from Chilcote’s (2007) protocol and is a painting of a recent happy moment shared with friends or family. Again, each of these exercises should take approximately 30-60 minutes to complete, but the times allotted for each exercise can be adjusted to meet the pace of the group.

After the group has completed the final painting exercise, the clinicians will invite the group to stand up and “shake it out” before conducting the closing ritual. This concludes the activities for Day 5.

Session Six: Drawing to Music

Day six’s program will begin after the clinicians have spent 20-25 minutes practicing the Tai Chi Five Elements exercise and have spent 5-10 minutes stand meditating. Once the clinicians have completed these exercises, they can begin preparing the group space. Today’s exercises will require colored pencils and a CD player or other music playing device.

After the group has conducted the opening ritual, the clinicians will invite the group to listen to a piece of music while they select colors and shapes to express how they feel while listening to the music. The clinicians should choose a balance of short pieces 3-5 minutes in duration that are calming and exciting. The clinicians may find that loading the selected music onto an iPod/iPhone or similar MP3 device greatly increases
the ease of this exercise by reducing costs and increasing portability. However, if clinicians choose to do this, they should remember to buy or bring a set of external speakers that are compatible with their portable music device. External speakers vary widely in price and can be purchased for as little as $5-10 with the limit being whatever the clinician feels is reasonable for their budget and resources.

After the participants have made several drawing while listening to the selections of music, the clinicians will invite the clients to imagine images of at least one thing that they have lost as a result of the traumatic event. This could be anything from the participant’s home, to a loved one, to a sense of safety. As with the previous day’s exercises, a translator or written explanation of the exercise should prepared ahead of time. Once the group starts to draw the clinicians will play a soothing selection of music. Many relaxation music CD’s are available that range from sounds of nature, like rainfall and ocean noises, to classical compostions and many more contemporary pieces in between. It is up to the clinicians’ discretion to select pieces that are relaxing for the remainder of the day’s exercises.

Once the group has drawn their loss, the clinicians will invite the group to draw how they dealt with that loss. Again, this will likely evoke a wide range of images and responses that express both adaptive and possibly maladaptive coping skills. The last exercise before taking a break will be to draw one thing that brings joy and happiness to their lives. Each exercise should take 30-60 minutes to complete. As with the previous day’s exercises, the clinicians should adjust the time to meet the pace of the group so that
no one is rushed into completing each drawing or left waiting for long periods of time before moving on to the next drawing.

After the group has completed all three drawing exercises, the clinicians will invite the group to stand up and “shake it out” followed by giving each participant an opportunity to express their current emotion by selecting a kimochi. Once each participant has had a chance to express their emotion at least once, the clinicians will invite the group to participate in 30-60 minutes of yoga exercises as completed on Day Two and Four using the *Yoga Planet* and *Yoga Pretzel* flash cards.

After the group has finished the yoga exercise, the clinicians will invite the participants to return to the space where they were working with the colored pencils and begin the day’s final three exercises. The first activity is to draw at least one thing that the participants feel could help them right now in coping with the traumatic event. This could range from anything tangible, like clean water, to intangible things such as emotional support offered by a deceased loved one. The next exercise is to draw what the participants and their families do to heal. Again, this will likely evoke a large range of images that may include religious and spiritual practices, to spending time with family and many other unique self-care practices. The final exercise is for the participants to imagine each of their fears, anxieties, worries, sadness, and hurt as a separate balloon. If the participants are not familiar with balloons, the clinicians can demonstrate placing a fear into a balloon by blowing up an extra balloon from Day Four. Once the group is done drawing their balloons, the clinicians will invite the participants to close their eyes and imagine letting go of all of their balloons and watching them float up into the sky.
Again, if the participants are unfamiliar with balloons, the clinicians can demonstrate tossing or batting away the balloon that was recently blown up.

After the group has completed this visualization of letting go of their anxieties and fears, the clinicians will invite the group to stand up and “shake it out” before conducting the closing ritual. This concludes the day’s activities.

Session Seven: Three Wishes

Day Seven’s program will begin after the clinicians have spent 20-25 minutes practicing the Tai Chi Five Elements exercise and have spent 5-10 minutes walking meditating (refer to Day Three for more details). Once the clinicians have completed these exercises, they can begin preparing the group space. Today’s exercises will require colored pencils, crayons, pastels, watercolor pencils, brushes, cups, water, watercolor paper, newsprint paper, and any other arts supplies like scissors, glue, beads, and glitter.

Once the group has conducted the opening ritual, the clinicians will introduce the day’s first set of activities. Each participant is to use one of the mediums used in previous activities to create a series of drawings depicting three wishes they have for others. The first is a wish for the family, the second wish is one they have for their friends, and the last wish is one they have for their community. The clinicians should encourage the participants to use any combination of the mediums they have used thus far. An example of this may be a pastel drawing of a wish for one’s family, a glitter and bead collage of a wish for friends, and a watercolor painting of a wish for one’s community. The
participants can also choose to make all three of their wishes using the same medium, such as making three watercolor paintings.

This activity can take anywhere from an 1 1/2 hours to 3 hours to complete. Since the focus of this exercise is to instill hope, the group may naturally become light, jovial, or even silly. The clinicians should help cultivate this by using body language, making silly faces, and otherwise promoting an atmosphere of play. This will help the group begin to conclude their work together as the protocol nears to an end.

Once the group has had adequate time to express their three wishes for others, the clinicians will invite the group to stand up and “shake it out” for several minutes before returning to the decorated circle. Once seated, the clinicians will pass around the kimochis and invite each member to express how they are feeling using the kimochis. Once each member has had a chance to express at least one emotion, the clinicians will invite the group to play the second variation of the name game (e.g. the one where the person who catches the talking piece must say the name of the person who threw it to them).

After each member has had at least one chance to name and be named, the clinicians will introduce the animal noise game. To introduce this game adequately, several clinicians are needed. One clinician will toss the talking piece to another clinician who will then make an animal noise and toss the piece to another clinician who will make a different animal noise. The animal noise game will continue until each participant has had at least one chance to make and elicit a noise from another member.
Once the clinicians decide to end the animal noise game, the clinicians will invite the participants to stand up and “shake it out” for a few moments before returning to the space where they were working in their drawings. Once the group is ready for the next set of exercises the clinicians will invite the group to make another set of three wishes, this time for themselves. The first drawing is one thing they wish that their present self could tell themselves right after the traumatic event occurred. The next drawing is one wish they have for themselves right now. Finally, the last drawing is a wish they have for their futures.

As with the day’s previous set of drawings, the participants should be encouraged to engage whatever mediums they want to explore and utilize to express their wishes. Again, it is important to provide the appropriate amount of time that matches the group’s pace in making the drawings. This set of exercises should take between 1 1/2 hours to 3 hours to complete. Once the group has finished this exercise, the clinicians should invite the participants to “shake it out” and conduct the closing ritual. The clinicians should remind the group that the next session will the group’s last session.

Session Eight: Return to Mandalas and Saying Goodbye

Day Eight’s program will begin after the clinicians have spent 20-25 minutes practicing the Tai Chi Five Elements exercise and have spent 5-10 minutes meditating while lying down (refer to Day Four for more details). Once the clinicians have completed these exercises, they can begin preparing the group space. Today’s exercises will require pastels, newsprint paper, and one sheet of oversized newsprint paper.
& Riley make a 36” x 50 yards roll of newsprint paper for $10 per roll. It might be too cumbersome to travel with such a roll, but it would provide a large surface for the group’s final activity, which is a large group mandala. Other alternatives might include buying a large duffle bag to carry the roll along with other art supplies, taking only several lengths of the oversized paper abroad, or simply taping several smaller sheets of newsprint together. While this last option does have some obvious advantages, the task of taping several sheets together does provide obstacles when the group begins coloring the mandala. For this reason, a roll (or at least several sheets from a roll) of oversized newsprint paper is suggested.

Once the group has conducted the opening ritual, the clinicians will invite the participants to make a free drawing (not using anything other than the blank mandala template) to make a mandala of how they feel now after going through the group. This activity should take 30-60 minutes. Once the group has completed their follow up mandala, the clinicians will invite the group to make a group mandala using the oversized newsprint paper.

To make the boundaries of the mandala, the clinicians should have a participant stand roughly in the middle of the paper. The clinicians will then hand the participant one end of a length of yarn and attach a bold marker, crayon, colored pencil, etc to the other end of the yarn. The participant should then kneel to the paper and hold their end of the string to firmly to one space on the paper while the clinician extends the length of yarn to its end and moves 360 degrees around the participant and paper pressing the marking to the paper as they walk, thus making the circumference of the mandala.
Once the perimeter of the mandala has been formed, the group is free to express themselves using any color pastels to make shapes, designs, etc. This activity is likely to take at least an hour and could very well stretch into two hours. The clinicians should attempt to monitor the pastels, providing each member with an opportunity and space to decorate the group mandala.

After the group has completed the group mandala, the clinicians will invite the group to stand up and “shake it out.” After several minutes of movement, the clinicians will invite the clients into 30-60 minutes of yoga as done before on previous days using the *Yoga Planet* and *Yoga Pretzels* flashcards. Once the group has finished the yoga exercise the clinicians will invite the group to sit around the decorated circle for the final time. However, before sitting at the circle, the participants will be encouraged to bring their self-mandala from Day Two and their self-mandala from today’s exercise.

Once everyone is seated the clinicians, with the help of a translator, will ask the group to pick a kimochi that expresses how they were feeling when they entered the group (the first self-mandala drawing) and then to select a kimochi to express how they are feeling after going through the treatment protocol (the most recent self-mandala drawing). After the each member of the group has had a chance to express themselves using the kimochis, the clinicians will invite the group to play the goodbye game using the talking piece.

The clinicians will demonstrate the game by tossing the piece to a clinician and either saying “Goodbye,” “Bye,” or some variation thereof or by waving goodbye to one another. It would be incredibly helpful to learn the local language’s words for such
greetings so that the group feels more connected to the process of saying goodbye the the group members, the group space, and the clinicians. The clinicians will stop the game after each member has had multiple opportunities to say “Goodbye” to several different members.

Once each member has had several opportunities to say “Goodbye” the clinicians will invite the group to stand up and “shake it out” before beginning the closing ritual. After the group has brought out the circle’s box, the clinicians will ask each member to walk to the center of the box and place in any of their remaining fears or anxieties while taking out as much hope as they felt they needed for their future. Once each member has done this the clinicians will ask the group to kneel to the decorate circle and instead of bringing to the box as done in previous sessions, the group will untie the knots holding each segment to one another. The participants are to leave the segments lying on the ground until every member has untied the segment closest to them.

After all the segments are untied, the clinicians will invite the participants to find and stand by the segment of the circle they decorated and contributed during the first session. Once each member is standing by their segment of the circle, one of the clinicians or translators will offer the following closing statement:

This group formed as result of happened outside of our control that has hurt us all in some way. We came together as a group out of hurt. For the last two weeks we shared that hurt with one another. Side by side, we worked through our pain. We learned to release the pain we are holding and to embrace the hope we have for one another. Even though this group has come to an end, we hold the hope for you that lessons you have learned during our time together will leave this circle and follow you through the rest of your lives. Take this piece of our circle as a reminder of what we all experienced during our time together. The hurt, the healing, and the hope we have shared.
Once the closing statement has been shared, the clinicians will go around the circle and tie each participant’s segment around their neck. This concludes the group’s protocol.

**Art Viewing: Return to Community**

I wanted to distinguish this piece of programming from the group’s protocol because it is intended to help the group disband more smoothly and to return to the community. Additionally, it may not be possible, due to either time or space constraints, to hold a viewing of the group’s work for the community. I do stress that inviting the community to participate in such a viewing is a wonderful opportunity to help the members of the group connect with their community and to share their experiences of the group healing process and the traumatic events with those around them in their daily lives.

The difficulty in hosting such an event, beyond those already mentioned, is that it is important to inform the community to refrain from interpreting the members’ art and if they are curious to ask the member questions rather than making assumptions.

Additionally, all of the group members should be provided an opportunity to share their artwork with the community, but not made to feel obligated to do so. The clinicians must keep in mind that the group has endured some difficult lived experiences and sharing these experiences can open oneself to an overwhelming feeling of vulnerability. Therefore, group members should only display their art if they feel comfortable doing so. Additionally, such an event would like need several translators to help the clinicians facilitate the gathering.
While there are some rather larger obstacles to hosting a viewing, the benefits far outweigh the stress of collaborating such an event. It is possible to delegate many of the tasks required to host a viewing (providing snacks, setting up the space, inviting the community) to various members of the group or even within the community. Doing so would provide the group and community to incorporate Hobfoll et al.’s (2007) principles of connectedness and group-efficacy. Additionally, the viewing provides the group members with an opportunity to punctuate the group’s end with one final task that is designed to bring the group together once more, but to have them leave with their families and integrate back into the community at its end. Holding a viewing also gives the group members a chance to verbally process their experiences of the group process amongst themselves and with their loved ones and community, which is an element that has not been otherwise possible in the protocol due to the focus on expressing one’s self non-verbally through various art interventions.

Furthermore, holding such a gathering would provide the clinicians with a chance to invite the group to share feedback about the program. This can be done either by using a translator or by using a brief questionnaire. I feel that a questionnaire would be well-suited for this as it can be translated ahead of time into the group’s language and it provides the members with an anonymous way to share their experience of the group with the clinicians without the sensation of speaking in front of a group and “being on the spot.” Additionally, using questionnaires would allow the clinicians to translate the group’s feedback at a later date. This is especially important if translating resources are limited during the protocol.
The following are a few questions that should be considered for a feedback questionnaire:

- Do you feel the group was helpful for you? (1-5)
- What do you feel was the most helpful activity? (List/ fill in the blank)
- What do you feel was the least helpful activity? (List/ fill in the blank)
- If this group were run again, what would you like incorporated? (blank)
- What, if anything, were you able to learn during the group? (blank)
- If you feel you learned something during the group, how helpful do you think it is in dealing with your distress/suffering? (1-5)
CHAPTER 5: IMPLICATIONS

After carefully evaluating and critiquing several current trauma-focused expressive arts protocols using Hobfoll et al.'s (2007) meta-analysis of principles what must be incorporated in successful treatment of mass trauma survivors, I have developed an eight-week protocol that draws on the strengths and bridges the weaknesses that are present in existing trauma-focused protocols. While my protocol greatly limits the need for clinicians to speak the language of those they are providing therapy to by using non-verbal ways of being-with the client, my protocol still requires a minimal level of verbal expression and comprehension, which can easily be accommodated by the use of translators or prepared translated statements. I intentionally built the protocol so that many of the interventions were logical progressions of previous interventions in order to further reduce the need for a translator to introduce each task. My goal was to provide the clinicians with as much flexibility as possible in this aspect, so that they were not dependent upon having to locate translating resources for the entire duration of the protocol, as these may be greatly limited or too costly to provide in the aftermath of a mass-traumatic event. One possible consideration is to have a translator work with the clinicians to write out a brief description of each task so that the clinicians could use a dry erase board to present instructions to the group instead of relying on live translators for each day of the protocol. This would likely greatly reduce any costs incurred by having a translator present for the entire length of the protocol.

Another implication to consider is the possibility of a client de-compensating or “breaking down.” While there are many possible benefits to removing one's emotional
barriers and more fully living into one’s experience, there are also potential risks involved. Since suicidal or homicidal risk may be difficult to impossible to monitor effectively for clinicians who are outside of the culture they are working with, it is important for the group of clinicians to locate a local resource who can either provide a briefing on how suicidal and homicidal behaviors might manifest in the local culture. It would also be in the clients’ best interests to have at least one facilitator who can speak both the language of the clients and the clinicians so that in the scenario that a client does need to verbally process their reactions to the interventions they are able to do so. This facilitator could be a translator or a counseling professional.

I also want to emphasize that while I structured the protocol so that the clinicians could effectively work with participants with whom they do not share a common language, that it is not to be conducted in silence. If the group is effectively executed, the participants should feel comfortable freely talking to one another during most if not all of the interventions, with perhaps the exceptions being the yoga and drumming exercises. Also, the clinicians may want to consider providing journals to the group so that each participant can use language to process their reactions to each of the interventions. This would be particularly useful if translating resources were limited since many of the benefits of organizing and process events can also occur through journaling exercises.

One area for future research could be piloting my protocol within one’s own language and culture. This would help the clinicians to see the areas where the program needs more detailed explanations. Piloting the study in a setting where the clinicians share a common language with the participants would also help the clinicians to see what
potential barriers the protocol has when attempting to adapt it to a more less verbal setting.

One of the strengths of my protocol is that there is a balance between interventions that invite strong emotions, such as recalling the traumatic event, and those that promote safety or a sense of calm. I also structured the protocol so that interventions begin with promoting a sense safety and connection within then group before introducing interventions that are likely to invite strong emotions. I also attempted to end each session so that the last intervention of the day promoted a sense of calm or at the very least did not have a strong likelihood to invite overwhelmingly distressing emotions. Additionally, the protocol is structured so that a majority of the final interventions focus on promoting a sense of hope. While the promotion of hope is woven through out the entire protocol, I felt that it was important to emphasis the focus on hope as the group concluded. A table of how the each intervention addresses Hobfoll et al.’s (2007) principles for effective trauma-focused therapy can be found in Appendix G.

I also structured the protocol so that the participants are introduced to interventions that are the least intimidating and which they have the most familiarity, such as using colored pencils to color in mandala templates. This was done in an attempt to reduce the anxiety of being in a group and being overwhelmed with new activities like painting or working with pastels. Additionally, these familiar modalities also promote self-efficacy through a sense of accomplishment in the early interventions that can be useful when new modalities are eventually introduced. I structured the protocol so that when a new modality is introduced, the group is invited to become acquainted to the
medium through play, specifically in the free draw exercises. With the exception of the final group mandala, I also suggested that clinicians consider using smaller sized papers for many of the exercises in the protocol since there is often an anxiety associated with having to fill large spaces of paper. Using 8.5'' x 11'' or 9'' x 12'' papers are best suitable for drawing or pastel exercises while 5'' x 8.5'' or smaller are better suited for painting exercises due to the time required to complete the paintings as well as the increase in anxiety associated with needing to fill a large area by painting.

The process of selecting interventions for the protocol was one of great consideration and exploration. Once I determined whether an intervention would be included based on its ability to promote at least two of Hobfoll et al.'s principles of effective trauma focused therapy interventions, I then chose to engage the intervention for myself. This was important to me because I did not feel comfortable asking someone who has never painted before to now paint a place they feel safe without attempting to do so myself. With the exception of colored pencils and art markers, I have very limited previous experience working with many of the mediums in my protocol. I feel that the one of my protocol’s biggest strengths is that it is structured so that anyone can playfully engage a new medium and find ways of comfortably expressing themselves through that medium. Additionally, I feel that the sense of mastery that is associated with becoming comfortable with a new medium is closely connected to one’s sense of self-efficacy and hope. Simply put, the sense of accomplishment from becoming comfortable with a new medium is generalizable to one’s life outside of the expressing one’s self through art. I also feel that by introducing many of the interventions through free play, the participants
benefit from not having the expectation to “produce” artwork. Free play has many other benefits such as building group cohesion and alleviating daily stress.

The opportunity to play and explore each of the mediums in my protocol has been the greatest gift during the dissertation process. At times when reviewing existing programs became daunting or tiresome, I would take a break to explore pastels or acrylics. Over the course of several months I introduced myself to mediums with which I had no previous experience and I found most to be quite enjoyable. Furthermore, I continually checked in with myself as I explored each medium. Was I enjoying myself? Was I becoming frustrated with the medium? If so, how could I approach the medium in a way that was less frustrating? Often times I felt a deep sense of relaxation when I was playing with the various mediums. After these play sessions I would check in with myself to try to determine if it was the medium itself or the task using the medium that had help induce such a state of calm.

I feel that engaging each of the mediums helped me to gain a lived experience of what it is like to work with and express through each particular medium. It also helped me to eliminate mediums that were particularly hard to control and were frustrating to control. I decided to exclude acrylics from my protocol after exploring the medium for several weeks and coming to the conclusion that it was too timely and difficult to control, cumbersome to transport, and required a lot of effort to clean up after a session. I think that by exploring each of the mediums and choosing to exclude mediums, as I did with acrylics, will ultimately improve the success of my protocol when it is implemented.
After much deliberation, I made the decision to exclude traditional dance/movement and psychodrama interventions from my protocol. I did this for multiple reasons. One of the most important reason for excluding these interventions was my inability to reason through how these interventions could be facilitated by clinicians that did not speak the language of the participants in the group. Another salient factor for excluding these types of interventions is that many clinicians do not feel comfortable facilitating these interventions without previous experience. Unlike becoming acquainted with an art medium, dance/movement interventions require more previous experience and specialized training in order to be facilitated ethically. Since I wanted to build a protocol that was accessible to any clinician that wanted to work with people affected by mass trauma, I felt that incorporating interventions that required specialized training would limit the applicability of my protocol.

For these reasons I chose to include other movement interventions that were more easily accessible to both the clinicians and participants. Drawing upon the benefits that dance/movement therapy can provide in a largely non-verbal group setting, I decided to incorporate interventions such as yoga and catch-style games in my protocol. I also chose to use movement (i.e. standing up and “shaking it out”) after each intervention that was designed to begin working through the traumatic event was a helpful way of setting unique physical boundaries on the event. While I feel that these interventions may not provide the full breadth of what dance/movement therapy has to offer clients, I do feel confident that it helped address the needs of the participants of my group in such a way as to provide an additional means of expression and relief. My hope was that this brief use
of movement would help demarcate the end of the work with the trauma and a transition to a different task. I feel that these interventions provide the benefits associated with movement while also doing so in more structured settings, thus reducing the likelihood of feeling too vulnerable and unsafe during interventions such as expressive dance and psychodrama.

As I previously mentioned, when I began selecting mediums and modalities for the protocol I carefully considered the portability, ability to be used in more than one intervention, required control to use, and cost. I attempted to build a protocol whose interventions were easy to transport, that could be engaged and executed by someone with no previous experience with the medium, and were affordable enough to be efficient for a group of clinicians traveling to another country. This is why I selected mediums like watercolor pencils over traditional watercolors, since watercolor pencils are easier to transport, require less control and training to use, and are generally cheaper than traditional watercolors. I also tried to find ways to reduce the overall cost of the materials needed by selecting cheaper alternatives, such as newsprint paper, which could be used for multiple free drawing exercises across modalities. Any clinician interested in implementing my protocol could also look into enrolling in a preferred member card at their local art supplier. I am well acquainted with Blick and Utrecht art supplies and both offer discounts of 10% for those interested in enrolling in their preferred members program at no additional cost. Additionally, many of the supplies in my protocol, such as rubber bands, coffee cans, and yarn, can be donated to any group of clinicians interested in implementing my protocol.
When I initially began developing my protocol I was required to create an estimated budget for the cost of the materials needed. I put a good deal of thought into what costs I might possibly incur, knowing that I wanted to use a wide range of expressive modalities. This original estimated cost of materials was $1500. I am pleased that my final estimated costs are $400 for needed materials. I feel confident that $500 would be a safe estimate to cover any additional materials (such as pre-printed mandala templates, blank paper, carrying cases, etc) that might be needed to implement the protocol. The following table is a break down of costs based on running the group for 10 participants and using mid to low range quality art supplies. I have broken the costs down to show which areas would increase and by how much if the number of participants were greater than ten.
REFERENCES


Stand in Mountain pose facing North.

Take two relaxing breaths. Connect with Mother Earth through the soles of your feet. Connect with Father Sky through the crown of your head. Your feet are parallel and hip-width apart. Soften your knees. With your palms facing down move your energy forward and backward three times.

Reach into space: Move your hands upward above your head.
Roll in your right foot

Lighter shading represents a foot that is off the ground. For the purpose of demonstrating the following poses the model has adjusted her orientation to the camera.

Send out fire: Step forward on your right foot and move your hands from waist height to shoulder height, palms facing up (Element I)
Bring back water: Turn your palms to face the ground and slowly return them to waist height. (Element II). Make a 1/2 turn to the left. You should now be facing South.

Roll in your left foot.
Make a 3/4 turn to the right. As you turn, move your hands at waist height in a gentle oscillation up and down to represent the wind blowing. (Element III) You should now be facing East.

Gather precious metals: With palms facing up, move your right hand in a half circle motion from your hips to your center at waist height. Your palm should now be facing down. Repeat this motion with your left hand.
With palms facing up, bring your gathered resources up to center at shoulder height. Take only what you need. (Element IV)

Release and fly: Return your hands to waist height and then with palms facing down extend your arms out and above your head, as if you were flapping wings.
Then bring the backs of your palms together at waist height and move them up your center as you draw the Earth's energy up through your body and above your head. (Element V)

Return your arms to your side by making a wide circle, representing the world.

Embrace Tiger: With palms facing up, bring your hands to your heart, bending your elbows at waist height. Appreciate and honor all that we have and hold dear to us.

Return to Mountain pose.

*The group should now be facing east. Repeat the exercise three more times so that you have begun the exercise facing all four cardinal directions and have returned to facing north. The entire exercise should be repeated four times and take approximately 20-25 minutes.*
APPENDIX B: MINDFULNESS MEDITATION SCRIPT

[Ring a bell or chime one time to mark the beginning of the session]

Find a comfortable seated position either in a chair with a back or seated on the floor. If you are in seated in a chair, sit with your feet hip-width apart with your feet flat on the floor and your back upright along the back of the chair. If you are seated on the floor, sit cross-legged with the seat of your buttocks firmly pressing into the floor with your back in an upright position that is comfortable to you.

Close your eyes and take two deep breaths. Feel the sensation of being firmly ground to the world through your feet/buttocks. Shift your attention to your breath. Like the ocean, your breath rises and recedes and is always constant, always there.

If you notice that you are thinking, try to imagine your thoughts as clouds in a blue summer sky. As they take shape allow them to pass by without judgement, then return to breath. Breathe in and out, noticing the sensation in your lungs.

[AFTER 5-10 minutes ring a bell or chime 3 times to mark the end of the session]
APPENDIX C: BLANK MANDALA TEMPLATE
Let your intuition guide you and choose the design that appeals to you the most at that moment. Surround yourself with a rainbow of colored pencils. Pick up the color that you are drawn to the most and feel what part of the mandala you would like to fill in. Proceed with other colors until you feel done, which means that there may be blank spaces left. You may wish to change or add to the design. Feel free to follow your emotions and listen to what your intuition guides you to do.
APPENDIX E: WALKING MEDITATION SCRIPT

[Ring a bell or chime one time to mark the beginning of the session]

Begin by selecting a path to walk on. This path can be both inside or outside. If you feel comfortable, take off your shoes and socks. Stand for a moment observing the sensation in your feet as they are firmly connected to the ground. Close your eyes and take two deep breaths, centering yourself.

As you stand silently in your space, take time to notice the feeling of gravity pulling you down, connecting you to the Earth. Notice the sensation of the air moving around your arms, legs, and head. Take in the sounds of the world around you. As you find yourself becoming aware of the space around you, begin to gently shift your focus to your breath.

When you feel ready, slowly open your eyes. Take in what you see as you did with the sensation of gravity, the air moving around you, and the sounds on the air. Notice the colors, shapes, and textures. Now slowly begin to move by picking up one foot at a time. As you pick up your first step, notice the sensations of disconnecting from the Earth, lifting, moving through space, and eventually reconnecting with the Earth. Focus on your body’s experience of this process as you begin to alternate between moving your left and right feet.

[AFTER 5-10 MINUTES RING A BELL OR CHIME 3 TIMES TO MARK THE END OF THE SESSION]
## APPENDIX F: COMPREHENSIVE PROTOCOL AGENDA

<table>
<thead>
<tr>
<th>Session One</th>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td></td>
<td>8:30 AM</td>
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<tr>
<td></td>
<td>9:00 AM</td>
<td>Name game</td>
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<tr>
<td></td>
<td>9:30 AM</td>
<td>Necklace/Circle making</td>
</tr>
<tr>
<td></td>
<td>10:00 AM</td>
<td>Kimochis</td>
</tr>
<tr>
<td></td>
<td>10:30 AM</td>
<td>Box decorating</td>
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<td>11:00 AM</td>
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<td></td>
<td>9:00 AM</td>
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<tr>
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<td>9:15 AM</td>
<td>Yoga introduction</td>
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<td>Cup Game</td>
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<tr>
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<td>Mystery Drawings</td>
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<tr>
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<td>Watercolor: Change as a result of trauma</td>
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**Session Five**

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<td>Watercolor: Self</td>
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<td>Watercolor: Traumatic event</td>
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<td>8:30 AM</td>
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<td>9:15 AM</td>
<td>Free Drawing to music</td>
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<td>Drawing: Something lost</td>
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<td>Drawing: Dealt with that loss</td>
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<td>Drawing: What brings happiness to their lives</td>
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<td>Yoga</td>
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<tr>
<td>12:30 PM</td>
<td>Drawing: What could help them cope right now</td>
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<td>Drawing: What do they and their family do to heal</td>
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<td>1:30 PM</td>
<td>Drawing: Hurt Balloons</td>
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<table>
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<td>Wish: Friend</td>
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<td>Wish: Community</td>
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<td>Wish: Present Self</td>
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<td>Wish: Future Self</td>
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APPENDIX G: LIST OF INTERVENTIONS AND HOBFOLL ET AL. PRINCIPLES

PROMOTED

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<td>Wishes: Past Self</td>
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<tr>
<td>Wishes: Present Self</td>
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<td>Wishes: Future Self</td>
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APPENDIX H: MATERIALS NEEDED

Session One:
Yarn, beads, other necklace making supplies
Kimochis
Talking Piece
Glue, glitter, scissors, and a box

Session Two:
Yoga Pretzels/Planet cards
Mandala coloring book
Colored pencils
Blank mandala templates
Blank paper
Kimochis

Session Three:
Pastels
Pastel paper
Newsprint paper
Plastic cups/rubber bands/ lengths of yarn
Kimochis
Session Four:

8' djembe drums or handmade drums
(coffee cans/rubber bands/ and balloons needed for handmade drums)
Yoga Pretzel/Planet cards
Kimochis

Session Five:

Watercolor pencils
Watercolor paper
Paint brushes
Kimochis

Session Six:

Mp3 or other music player
Colored pencils
Blank paper
Yoga Pretzel/Planet cards
Kimochis

Session Seven:

All previous art supplies
Kimochis

Session Eight:

Pastels
Newsprint paper
Oversized paper roll
Yoga Pretzels/Planet cards
Kimochis
APPENDIX I: BREAKDOWN OF COSTS BY MATERIALS

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<th>Material</th>
<th>Cost</th>
<th>Quantity</th>
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<td>Necklace making supplies (beads, yarn, charms)</td>
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<td>Talking piece</td>
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<td>Yoga Planet</td>
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<td>Mandala coloring book</td>
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<td>Colored Pencils</td>
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<td>---------</td>
<td>----------</td>
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<tr>
<td>Watercolor pads</td>
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<td>Oversized Paper</td>
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<td><strong>TOTAL COST</strong></td>
<td></td>
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<td><strong>$400</strong></td>
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APPENDIX J: ADDITIONAL RESOURCES

Tai Chi


*Tai Chi Ch'uan 24 Forms for Curious Learners.* Rosenberg, H. & Ma, A. (2004)

Mindfulness Meditation


Self-care Through Nutrition


Mandalas


The Mandala Project. www.mandalaproject.org

Yoga

Yoga Pretzels

Yoga Planet.

Art Suppliers/Stores

Utrecht Art Supplies

Blick Art Supplies

Games/Fun Activities

Some helpful information before running this group

The following program is an eight-week trauma-focused expressive arts group protocol designed for facilitators who wish to work with survivors of mass trauma but with whom they do not share a common language. The protocol is structured so that the facilitators can facilitate the group through modeling, demonstration, and prepared translated instructions so that there is a decreased dependence on locating and maintaining translating resources. The protocol was designed by drawing upon the strengths and bridging the weaknesses of several current trauma-focused expressive arts protocols as well as using Hobfoll et al.'s meta-analysis of the general principles necessary for effective trauma-focused therapy interventions. Ease of use, transportability, and cost of materials were also taken into consideration during the development of this protocol. The result is largely nonverbal, culturally sensitive, protocol that incorporates the promotion of a sense of safety, calmness, community and self-efficacy, connectedness, and hope while working through traumatic events individually.
Session: 1

Purpose: Building group cohesion and introducing H.O.P.E. to the group

Materials: String, yarn, beads, and necklace accessories for loop activity. Shoe box, glue, tissue paper, glitter, etc for group box activity. Kimochi feelings for name game.

Possible Prepared Statement: Welcome to the group’s first meeting. (Introduce facilitators). For the next eight days we are going to work together to begin the healing process. Our time and space together is a safe space where everyone can express themselves through art, movement, and play. Many of the things we do may be new to you, while others you may already know. Please feel free to talk and share with those around you as we work and play together. Our hope for all of you is that you can begin to heal your pain through your art and reclaim the joy the world has to offer.

Facilitator Activities: The facilitators will begin the day with 20 minutes of Tai Chi (see Five Elements protocol Appendix A) and 10 minutes of sitting meditation (see Mindfulness Meditation Script Appendix B). Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet. This may include setting up tables, locating chairs, or otherwise preparing the physical space for the group.

Group Activity: Name Game The group will begin by having a facilitator select a Kimochi or other soft talking piece and say their name as they point to themselves. This should be done once or twice to model the activity that will be known as the Name Game. The facilitator should then pass the Kimochis to the other facilitator and have them repeat the modeling of the Name Game. The facilitators should then pass the talking piece around the group so that each member gets a chance to introduce themselves to the group. Once each member has introduced themselves, the facilitators will then throw the talking piece to the other facilitator and the facilitator who caught the piece will point to themselves and say their own name. This should be modeled several times before inviting the group to play this catching variation of the Name Game.

Group Activity: Making the Circle After all the members have introduced themselves, the facilitators will then ask the group to make an oversized necklace that represents themselves. The facilitators will hand out various color string/yarn as well as beads, etc. The average length of string/yarn used should be 3-4 ft from end to end. After the members have put all their beads on their string the facilitators will then show each member to knot both ends of their necklace and then join it to the person to their left. This is will result in each member’s unique contribution being part of a larger whole. This activity should take about a half an hour to an hour depending on how long it takes to explain the activity and how much time the group spends decorating their necklaces. The facilitators should plan for extra time managing resources like yarn, scissors, and beads as their will likely not be enough for each group to have access to all of the materials at one time. Before the necklaces are “closed” (e.g. tied into a circle) the facilitators will ask the group to tie off the necklaces with a simple knot on each end. This can be done by pantomiming how to tie off the length of yarn. The facilitators will then explain that all of the decorated lengths of yarn will be tied into one circle, which symbolizes how the group is made up of many individuals but is still all connected. This can be done with either a translator or prepared statement that a literate group member can read to the group. Afterwards the Circle should be placed at the members’ feet.
Group Activity: Feeling Check-In After the group has made the group Circle, the facilitators will introduce the group to Kimochis and the Feeling Check-In. The facilitators can introduce the Feeling Check-In to the group by pulling out one of the Kimochis and modeling the same facial expression as the Kimochi while pointing to themselves. The facilitators can also use a translator, if available, to ask the group to use the Kimochis to show how they are feeling right now. A basket containing all of the Kimochis should then be passed around the group, allowing each group to pick the Kimochi that best represents how they feel. If possible the facilitators can use a translator to ask the group how each member felt when the traumatic event first occurred. Also, facilitators can record the responses of each group’s Kimochi to establish a baseline of how each group is feeling prior to treatment.

Group Activity: Shake It Out After the Feeling Check-In, the facilitators should ask the group to stand up and Shake It Out. This entails shaking the arms and legs a few times each as well as stretching and moving about. This can be modeled by the facilitators.

Group Activity: Box Decorating Once the group has moved for a few minutes the facilitators will introduce the final activity of the day. The facilitators will present a box large enough to put the group’s Circle into. The box should be plain as the group’s task is to decorate it. The facilitators should provide markers, crayons, glue, glitter, beads, etc for the group to use during this activity. Every group member should have the opportunity to contribute to the box’s decorations.

Group Activity: Closing Ritual Once the group is finished decorating the box, the facilitators will ask each member to “put their fears and worries” into the box. A translator may be necessary for this but the facilitator can pantomime a worried facial expression and then grasping their chest area with their hand and placing an unseen object into the box. The facilitators should then walk from member to member (now standing around the Circle) and allow each member to place their fears and worries into the box. Once the facilitators have gone around the entire group the facilitators should place the box in the center of the Circle and then return to standing along the decorated circle with the group and explain that this space is a safe place to hold and keep the group’s fears and emotions. Again, a translator or prepared statement may be necessary for this explanation. The facilitators should then demonstrate to the group that the group is to pick up the Circle and head towards the box. As the group meets in the middle of the Circle, the facilitators will demonstrate that the decorated Circle is to be placed in the box and closed.

Once the box is closed the facilitators will announce that the day’s session is finished and that the group are free to go. I suggest that facilitators should attempt to learn the local language’s word for peace and that they speak this word at the conclusion of the group. The facilitators should not attempt to “break up” the group if they desire to stay after the conclusion of the group and mingle or otherwise get to know each other better. This process of ending each day’s session will be known as the Closing Ritual.
Session: 2

Purpose: To promote sense of safety and calm as well as foster group cohesion.

Materials: Mandala templates, blank mandala template, colored pencils, crayons, or Art Stix

Possible Prepared Statement: Today we will focus on making sacred circles, or mandalas. We can use colors and shapes to express our hopes, fears, and feelings into our sacred circle. Think of the circle as representing you as a whole person. You can choose to fill it to match however you feel at this moment.

Facilitator Activities: The facilitators will begin the day with 20 minutes of Tai Chi (see Five Elements protocol Appendix A) and 10 minutes of standing meditation. Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet.

Group Activity: Opening Ritual When the group enters, the facilitators should have them arrange in a circle and place the box containing the group's Circle in the center of the group. The facilitators should attempt to learn the local language's word for hope and speak it as they open the box and invite the group to retrieve their circle from the box. This process will be known as the Opening Ritual.

Group Activity: Yoga Once the Opening Ritual is complete, the facilitators will invite the group to follow them in several yoga poses. I've found that Yoga Pretzels to be particularly useful for this activity. Yoga Pretzels are 5" x 7" flash cards displaying various yoga poses on each one. On the backs of each one are visual instructions on how to perform each pose. The facilitators should select 5-10 poses from Yoga Pretzels or some other yoga resource. Allow the group enough time to experience each pose without feeling “rushed” into the next one. The focus of this activity is to promote a sense of calm and safety through slow deliberate movements.

Group Activity: Mandala Drawing After the group has completed the yoga activity the facilitators should introduce mandala drawings to the group. For the first mandala activity the facilitators should provide mandala templates that the group can color in by using crayons, colored pencils, or Art Stix. The following could be prepared ahead of time and read aloud to the group:

Let your intuition guide you and choose the design that appeals to you the most at that moment. Surround yourself with a rainbow of colors. Pick up the color that you are drawn to the most and feel what part of the mandala you would like to fill in. Continue with other colors until you feel done, which means that there may be blank spaces left. You may wish to change or add to the design. Feel free to follow your emotions and listen to what your intuition guides you to do.

The facilitators should allow 30 minutes for the group to color the mandalas. It is okay if a group member wants to color more than one mandala during this time.
**Group Activity: Free Drawing** When the facilitators feel that the group is done coloring mandalas, the facilitators will provide blank pieces of paper to the group and invite them to free draw. The facilitators should invite the group to draw anything the group feel they want to draw, not just mandala images. The purpose of this activity is to gradually acclimate the group to spontaneous drawing, which will be the focus of future activities. Again, 30 minutes or less is most likely an appropriate time range for this activity.

**Group Activity: Shake It Out & Name Game** Once the facilitators feel the group is done free drawing, they will invite the group to Shake It Out and then transition to the Name Game. Once the talking piece has gone around the circle at least once, the facilitators will model the new rules of the name game, which are that the person who catches the talking piece must speak the name of the person who threw the talking piece to them. The activity ends once the piece has been around the circle at least once. At this time the facilitators will invite the group to participate in the Feeling Check-In.

**Group Activity: Self Mandala** Once every group member has had the opportunity to express themselves with the Kimochis, the facilitators will invite the group to stand up and return to where the group was drawing/coloring earlier. The facilitators will then instruct the group to draw a mandala that represent themselves. The facilitators should encourage the clients to use any shapes, symbols, colors, and patterns that they feel express who they are as a person. I suggest that the facilitators have pre-made mandala circles made prior to this activity. This will provide parameters that the group can fill however they choose. A template that can be used for this activity can be found in Appendix C. This activity should take 30 minutes.

**Group Activity: Shake It Out & Laughing Game** Once the facilitators feel all the group are done with their self mandalas, the facilitators will invite the group to stand up and Shake It Out and return to the Circle. Before conducting the Closing Ritual the facilitators will play the Laughing Game with the group. The Laughing Game is a variation of the Name Game, only when a person catches the talking piece they must laugh instead of saying their name. This can be easily modeled by the facilitators. Once the talking piece has gone around the group at least twice, the facilitators will invite the group to conclude the session with the Closing Ritual.

**Group Activity: Closing Ritual**
Session: 3

**Purpose:** To promote sense of safety and calm as well as help foster self and group efficacy.

**Materials:** Non-oil pastels and pastel or newsprint paper. Kimochis.

**Possible Prepared Statement:** Today we will find the stories hidden in each of us. We will be using Mystery Drawings to help us find our stories. By closing our eyes and allowing our bodies to express themselves on paper we will be able to see our stories come to life.

**Facilitator Activities:** The facilitators will begin the day with 20 minutes of Tai Chi and 10 minutes of walking meditation. Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet.

**Group Activity: Opening Ritual** Once the Opening Ritual has concluded, the facilitators will then introduce the group to working with pastels. The facilitators should demonstrate how the pastels can be blended using one's hand, layered over top one another, and otherwise manipulated in unique ways. The facilitators should invite the group to explore the pastels for 30 minutes or until the facilitators feel that the group has become comfortable working with the medium.

**Group Activity: Name Game & Feeling Check-In** After group has become acquainted with working with pastels, the facilitators will invite the group to sit around their Circle. Using the talking piece, the facilitators will initiate a round of the Name Game, followed by the guessing variation of the Name Game, and a round of Feeling Check-In.

**Group Activity: Cup Game** The facilitators will then divide the group into groups of five and introduce the Cup Game. The facilitators will need to tie five 3-foot lengths of yarn around the circumference of a medium size rubber band. The facilitators will also need to have several empty plastic cups for the game. The facilitators will then demonstrate the object of the game, which is to stretch the rubber band, using the lengths of yarn as a group, large enough to fit over a plastic cup and then stack the cups in a pyramid shape. The facilitators should also pantomime that the activity is to be done without words. This can be done without the use of a translator or by modeling. The game can be played several times, each time applauding the group that finishes first.

**Group Activity: Mystery Drawing** After the group has played the cup game several times, the facilitators will invite the group to return to the pastels. This time the facilitators will invite the group to make Mystery Drawings. The facilitators might need to use translators to explain to the group that they are to close their eyes and draw whatever shapes and lines they feel compelled to draw. After they feel they are done making shapes, the group can then open their eyes and look at their drawing to see what is hidden in their drawing. The group are then invited to pull out what they see in their drawing by adding colors, shapes, or removing lines until they can reveal the mystery that was hidden in their drawing. The group may find it useful to think of a story that goes along with what they see in their drawing to help them with the process of revealing what is hidden in their drawing. If sufficient translators are available, the group can choose to share their stories with the group.
The following could be prepared ahead of time and read aloud to the group:

Start by taking a pastel in each hand. Close your eyes. Wave your hands in the air. Doodle in the air, letting your hands dance in front of you. Open your eyes for a second to find the paper. Close your eyes and start doodling on the paper. Let anything happen. Don’t worry about what your doodle looks like. When you feel you are done, stop doodling.

The facilitators should allow 30 minutes for the process of the Mystery Drawings, with the flexibility to extend the activity if the group become particularly engaged in the activity or choose to share their Mystery Drawing stories with the group.

Group Activity: Closing Ritual
Session: 4

Purpose: To foster self and group efficacy as the group expresses themselves through drumming.

Materials: Various musical instruments. Drums or some form of percussion instrument are required for the drum circle activity. A variety of instruments should be selected for the second activity. Instruments should be selected for the tonal qualities as well as ease of use. Kimochis.

Possible Prepared Statement: Today we will use sound to give voice to our emotions. We will be making and decorating drums that we will use as a group to make rhythms. Sometimes you may be drumming on your own while others times you may be drumming as a group.

Facilitator Activities: The facilitators will begin the day with 20 minutes of Tai Chi and 10 minutes of lying meditation. Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet.

Group Activity: Opening Ritual

Group Activity: Drum Making Small hand drums can easily be made from a variety of low-cost household items. The facilitators should experiment beforehand with small containers, like Pringles chip cans, small coffee containers, and hand sanitizer wipe containers. Each of these objects have a cylindrical shape and the ends can easily be removed. Additionally, they are small, light-weight, easy to transport, easily located, and inexpensive. The process for making a drum out of these materials is to remove the top of the container and stretch a balloon over the top of the container. The size of the balloon will impact the quality of the sound the drum produces, as a tighter fit will make a higher pitch “snap” sound, while a looser fitting balloon will make a deeper “boom” sound. The facilitators may find it necessary to cut off the small end of the balloon in order to more easily stretch the balloon over the chosen container. Rubber bands are then used to hold the balloon in place. Cutting off and attaching a balloon to both ends of the container produces a nice sounding drum quickly.

After the Opening Ritual has been completed and the facilitators will show the group how make the drums. Once the drums are made the group should be encouraged to decorate their drums with colored pencils, glitter, beads, yarn, etc. Depending on the material used for the drums, the facilitators may wish to make paper sleeves ahead of time so that the group can decorate the sleeve and then fasten the sleeve to the container once they are done decorating. This may be particularly useful if the facilitators have decided to use a container like a Pringles chip can or metal coffee can. The important thing to note about the drum making activity is that all of the drums should be made in the same way (one-ended, two-ended, open-ended, etc) in order to produce one homogeneous sound during the day’s last activity.

Group Activity: Free Drumming Once the group as finished decorating their drums (additional time may be needed if the decorated drums need to dry), the facilitators should invite the group to sit around their Circle. For the next 20-30 minutes the facilitators should encourage the group to explore their drums’ sounds. No particular rhythm should be set, the focus of this activity is to become comfortable making music as well as getting acquainted with their instruments.
Group Activity: Feeling Check-in

Group Activity: Drumming Emotions After the Kimochis have made it around the group at least once, the facilitators will then pantomime the next activity by selecting a Kimochi (angry and sad work really well for this) and drum making a corresponding face to the Kimochi selected. The focus of the activity is to express through one's drumming the emotion represented on the Kimochi. Translators may be needed to clarify this activity, but the facilitators should be able to model the activity adequately.

Group Activity: Drumming Other's Emotions The facilitators will demonstrate that one group member will begin with both the talking piece and the basket of Kimochis. That group is to throw the talking piece to another group and then select a Kimochi for that group to express through drumming. Once the drumming group is done, the group that selected the emotion will return the Kimochi to the basket and pass the Kimochis to the group that was drumming. The group that finished drumming now throws the talking piece to another group member and selects a Kimochi for them to drum. The rules of this activity can be modeled and explained to the group with the use of 2-3 facilitators. This activity concludes once every member has had a chance to drum and select an emotion.

Group Activity: Shake It Out & Yoga The facilitators should allow the group to select 5-10 yoga flashcards for this activity.

Group Activity: Follow the Leader After concluding the yoga activity, the facilitators will invite the participants to sit around the Circle. This time the facilitators will invite the group to take turns expressing a rhythm, to which the rest of the group will attempt to match and follow. The facilitators may find it easier to have a prepared statement or translator explain this and the following activities as they can become cumbersome to model accurately.

Group Activity: Drumming Our Pain Once every member in the group has had a chance set a rhythm for the group, the facilitators will give the talking piece to a group and ask them to express how they feel since the traumatic event by using their drum. After the group has had several moments to express their feelings unaccompanied, the facilitators will invite the rest of the group to either mimic and follow the group's rhythm or contribute to it by adding their own rhythm that they feel expresses what the group with the talking piece was conveying in the original rhythm. After several moments of accompaniment, the group with the talking piece is to throw the talking piece to another group. The whole process of independent expression of the traumatic event followed by accompaniment and group expression of the individual's feelings is repeated until each member has had a chance to express their feelings of the traumatic event.
Group Activity: Meditative Drumming Once the group has had a chance to express their feelings pertaining to the traumatic event and subsequently been supported by the group in their expression of that feeling, the facilitators will move on to the day's final activity. The facilitators will now invite the group to join them in a meditative rhythmic drumming activity. The facilitators can begin by holding the talking piece and creating a rhythm (simple or complex) and inviting the group to mimic and follow their rhythm. The facilitators can model this by matching each other’s rhythms and encouraging the rest of the group to follow in suit. After the facilitators have played with several rhythms or polyrhythms, the facilitators will set a slow and steady rhythm for the group to follow. It may be helpful for the clinician setting the rhythm to think of a heartbeat or simply count off in their head as they hit the drum on every third or fourth beat. The purpose of the activity is to produce a calm and steady rhythm that can easily be followed by the group that will help promote a sense of calm and safety. The rhythm is to be kept for 20-30 minutes so that the group can begin to shift their focus away from drumming and towards their experience of drumming and emotions that the collective rhythm stirs for them.

Group Activity: Shake It Out & Closing Ritual
Session: 5

Purpose: To help the group express their lived experience of the traumatic event in a safe and supportive environment. The day’s activities also help promote a sense of calm through the act of painting.

Materials: Watercolor pencils, brushes, cups, water, and watercolor paper cut to 2” x 3” pieces. Kimochis

Possible Prepared Statement: Today we will be making six paintings with watercolor pencils. Watercolor pencils work the same as regular color pencils until you brush them with water. Some of these paintings will likely remind you of happy times in your life while others may remind you of more difficult events that you have lived through. Please remember that this is a safe space and you can always stop and talk to someone around you if you need to take a short break.

Facilitator Activities: The facilitators will begin the day with 20 minutes of Tai Chi and 10 minutes of sitting meditation. Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet. The facilitators will likely need to cut larger pieces of watercolor paper down to smaller, more manageable sizes, like 2” x 3”. Doing this will greatly reduce the time required for each of the 6 paintings for the day’s session as well as limit any potential anxiety related to having to fill a larger sized workspace.

Group Activity: Opening Ritual

Group Activity: Free Drawing with Watercolor Pencils After the group has completed the opening ritual, the facilitators will introduce the watercolor pencils to the group. This can be done be making a doodle with the pencils and then demonstrating how to use a wetted brush to change the pencil drawing into a painting. Once the facilitators have demonstrated how to use the watercolor pencils the group should be invited to explore the pencils through 10-15 minutes of free drawing/painting.

Once the group has had a chance to become acquainted with the watercolor pencils, the facilitators will introduce the day’s first activity. The facilitators should prepare the instructions for the day’s activities ahead of time so a literate group member can read them aloud. The group will be invited to express themselves through three paintings before taking a break and three paintings after taking a break.

Group Activity: View of Self, A Safe Place, & What Happened The first painting is of how the group view themselves. The painting can include other objects, elements, and people, but should in some way express how the group currently experience themselves. The second painting is a painting of places and people where the group member feels safe. Again, the painting can include many elements and can also be abstract like a painting of God’s love, but it should in some way express where and/or with whom the group member feels safe. The final painting before the break is a painting of what happened (e.g. the traumatic event). The set of paintings should take about an hour. The facilitators can choose to move on to the next painting activity if the groups appears to need less time to complete the activities. Likewise, if the group appears to need more time, the facilitators can extend the length of each activity to provide a space where the group can engage in the activity without feeling rushed.
Group Activity: Shake It Out & Feeling Check-In If a translator is available, the facilitators may choose to pass the Kimochis around a second time, this time asking the group how it felt to complete the What Happened painting.

Group Activity: Steal the Bacon Game Once every group member has had a chance to express themselves using the Kimochis, the facilitators will invite the group to stand up while the facilitators split the group into two smaller groups. The rules are the game are quite simple. Each member of both teams are given a number from 1-X, where X is the total number of people on each team. The talking piece is then placed in between the two teams. The facilitators will call one number at a time (at first) which will call forth the player on each team who was given that number. Each player then attempts to grab the talking piece and return to their team's side without being tagged by the other team's player. If a player is able to bring the talking piece back to their team without being touched, that team gets a point. The game is over when one team gets 5 points (this number can be altered accordingly). It is likely that using an outdoor space would be the best way to safely accommodate the group during a game of steal the bacon.

The groups' physical limitations should be taken into consideration before playing the Steal the Bacon Game. If more than a few members would not be able to engage in running or vigorous physical activity, then the facilitators should consider choosing another game to play. Alana Jones has an excellent book of 104 Activities That Build: Self-esteem, Teamwork, Communication, Anger Management, Self-discovery, and Coping Skills, that includes many games that could be substituted for Steal the Bacon.

Group Activity: Biggest Fear, How I've Changed, & Happy Memory After a few rounds of Steal the Bacon or another game, the facilitators will invite the group to return to the space where the group were working on their watercolor paintings and introduce the first of the next three paintings. The facilitators will invite the group to express what they fear most. This could be anything from people, to events, to abstract things like being forgotten. Next, the facilitators will invite the group to express how they feel that they have changed as a result of experiencing the traumatic event that occurred. The facilitators should be open to group expressing both welcome and unwelcome changes that have occurred. Depending on how the group wishes to engage this activity, it would be appropriate to break the activity into two smaller paintings of both wanted and unwanted changes that have occurred since the traumatic event. The final activity is a painting of a recent happy moment shared with friends or family. Again, each of these activities should take approximately about an hour to complete, but the times allotted for each painting can be adjusted to meet the pace of the group.

Group Activity: Shake It Out & Closing Ritual
Session: 6

Purpose: To help the group express their lived experience of the traumatic event in a safe and supportive environment. Today's activities also promote a sense of hope and resiliency by focusing how the group has dealt with loss in the past.

Materials: Colored pencils or Art Stix, paper, and mp3 player or other music device. Kimochis.

Possible Prepared Statement: Today we will use music to help us connect to our emotions. We will play music for you as we invite you to visualize images and memories. We will take our time drawing and honoring these images.

Facilitator Activities: The facilitators will begin the day with 20 minutes of Tai Chi (see Five Elements protocol Appendix A) and 10 minutes of standing meditation. Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet.

Group Activity: Free Drawing to Music After the group has completed the opening ritual, the facilitators will invite the group to listen to a piece of music while they select colors and shapes to express how they feel while listening to the music. The facilitators should choose a balance of short pieces 3-5 minutes in duration that are calming and exciting. The facilitators may find that loading the selected music onto an iPod/iPhone or similar MP3 device greatly increases the ease of this activity by reducing costs and increasing portability. However, if facilitators choose to do this, they should remember to buy or bring a set of external speakers that are compatible with their portable music device.

Group Activity: Something Loss After the group becomes comfortable drawing while listening to music, the facilitators will invite the clients to visualize the image of at least one thing that they have lost as a result of the traumatic event. This could be anything from the group member's home, to a loved one, to a sense of safety. As with the previous day's activities, a translator or prepared statement of the activity should prepared ahead of time. Once the group starts to draw the facilitators will play a soothing selection of music.

Group Activity: How Did You Deal with Your Loss Once the group has drawn their loss, the facilitators will invite the group to draw how they dealt with that loss. Again, this will likely evoke a wide range of images and responses that express both adaptive and possibly maladaptive coping skills.

Group Activity: One Source of Joy The last activity before taking a break will be for the group to draw one thing that brings joy and happiness to their lives. All three of these drawings should take approximately an hour to complete. As with the previous day's activities, the facilitators should adjust the time to meet the pace of the group so that no one is rushed into completing each drawing or left waiting for long periods of time before moving on to the next drawing.
Group Activity: Shake It Out & Feeling Check-In

Group Activity: Yoga The facilitators should allow the group to select 5-10 yoga flashcards for this activity.

Group Activity: Something to Help Me Cope Right Now The facilitators will invite the group to draw at least one thing that the group feel that could help them right now in coping with the traumatic event. This could range from anything tangible, like clean water, to intangible things such as emotional support offered by a deceased loved one. As with the previous three drawings, the facilitators will select soothing music to play while the group is completing the rest of the days activities.

Group Activity: How My Family Heals Next, the facilitators will invite the group to draw what the group and their families do to heal. Again, this will likely evoke a large range of images that may include religious and spiritual practices, to spending time with family and many other unique self-care practices.

Group Activity: My Balloons The facilitators will now introduce the day’s final activity. The facilitators will invite the group to visualize their fears, anxieties, worries, sadness, and hurt as separate balloons. If the group is not familiar with balloons, the facilitators can demonstrate placing a fear into a balloon by blowing up an extra balloon from Session 4’s drum making supplies. Once the group is done drawing their balloons, the facilitators will invite the group to close their eyes and imagine letting go of all of their balloons and watching them float up into the sky. Again, if the group is unfamiliar with balloons, the facilitators can demonstrate tossing or batting away the balloon that was recently blown up.

Group Activity: Shake It Out & Closing Ritual
Session: 7

Purpose: To help the group enumerate the resources they feel would be most helpful to them and their families. This session also fosters hope and connection to the members’ natural support system.

Materials: Colored pencils or Art Stix, crayons, pastels, watercolor pencils, brushes, cups, water, watercolor paper, newsprint paper, and all other art supplies like scissors, glue, beads, and glitter that have been previously used with the group. Kimochis

Possible Prepared Statement: Imagine that you have been granted three wishes today, but one of these wishes each had to be used for your family, friends, and community? What would you wish for? You can use any of the supplies we’ve used so far to express these wishes. (Once the group is done with their first Three Wishes) Because of your love and kindness towards those you love, imagine that you have been granted three more wishes. These wishes are just for you. If you could wish one thing to say or give to yourself before the [event] happened, what would it be? What would you wish for yourself right now? What would you wish for your future?

Facilitator Activities: The facilitators will begin the day with 20 minutes of Tai Chi and 10 minutes of walking meditation. Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet.

Group Activity: Opening Ritual

Group Activity: Three Wishes (For Family, For Friends, For Community) Once the group has completed the Opening Ritual, the facilitators will introduce the day’s activity. The facilitators will invite the group to visualize Three Wishes; one for their family, one for their friends, and one for their community. The groups members are welcome to use any of the previous mediums that they have worked with from the previous sessions. The facilitators should encourage the group to use any combination of the mediums they have used thus far. An example of this may be a pastel drawing of a wish for one’s family, a glitter and bead collage of a wish for friends, and a watercolor painting of a wish for one’s community. The group can also choose to make all three of their wishes using the same medium, such as making three watercolor paintings. It should take approximately an hour to complete all three of these drawings. The facilitators should feel free to adjust the time according to the pace of the group.

Since the focus of this activity is to instill hope, the group may naturally become light, jovial, or even silly. The facilitators should help cultivate this by using body language, making silly faces, and otherwise promoting an atmosphere of play. This will help the group begin to conclude their work together as the protocol nears to an end.

Group Activity: Shake It Out & Feeling Check-In Once each group member has had a chance to express at least one emotion, the facilitators will invite the group to play the second variation of the name game (e.g. the one where the person who catches the talking piece must say the name of the person who threw it to them).
Group Activity: Animal Noise Game After each member has had at least one chance to name and be named, the facilitators will introduce the Animal Noise Game. To introduce this game adequately, at least two facilitators are needed. One clinician will toss the talking piece to the other clinician who will then make an animal noise and toss the piece to another clinician who will make a different animal noise. The animal noise game will continue until each group member has had at least one chance to make and elicit a noise from another member.

Group Activity: Shake It Out

Group Activity: Three Wishes (For Past Self, For Present Self, For Future Self) The facilitators will now introduce the day’s final activity to the group. The facilitators will invite the group to make another set of three wishes, this time for themselves. The first drawing is one thing they wish that their present self could tell or give themselves right after or just before the traumatic event occurred. The next drawing is one wish they have for themselves right now. Finally, the last drawing is a wish they have for their futures.

As with the day’s previous set of drawings, the group should be encouraged to engage whatever mediums they want to explore and utilize to express their wishes. Again, it is important to provide the appropriate amount of time that matches the group’s pace in making the drawings. This set of activities should take approximately an hour to complete.

Group Activity: Shake It Out & Closing Ritual
Session: 8

Purpose: Providing closure and disbanding the group.

Materials: Colored pencils or Art Stix, crayons, pastels, and all other art supplies like scissors, glue, beads, and glitter that have been previously used with the group. Blank mandala templates and one sheet of oversized paper (a roll of 36” or wider would be ideal). Kimochis.

Possible Prepared Statement: Today we end our time together. As we say goodbye today, we ask you to think back to the beginning of the group and how you may have changed and grown since we started working together. We asked you to bring your mandala(s) to today’s group because we will be making new mandalas today and wanted you to see how much you’ve grown for yourself by looking at these two different drawings.

Facilitator Activities: The facilitators will begin the day with 20 minutes of Tai Chi and 10 minutes of lying meditation. Once the facilitators have completed these activities, they will begin preparing the work space where the group will meet.

Group Activity: Opening Ritual

Group Activity: Return to Self Mandala Once the group has completed the opening ritual, the facilitators will invite the group to make another self mandala using the blank mandala template to express how they feel now after completing the group. This activity should take 30 minutes.

Group Activity: Group Mandala Once the group has completed their new self mandalas, the facilitators will invite the group to make a group mandala using the oversized newsprint paper. To make the boundaries of the mandala, the facilitators should have a group member stand roughly in the middle of the paper. The facilitators will then hand the group member one end of a length of yarn and attach a bold marker, crayon, colored pencil, etc to the other end of the yarn. The group member should then kneel to the paper and hold their end of the string to firmly to one space on the paper while the clinician extends the length of yarn to its end and moves 360° around the group member and paper pressing the marking to the paper as they walk, thus making the circumference of the mandala.

Once the perimeter of the mandala has been formed, the group is free to express themselves using any of the art supplies to make shapes, designs, etc. This activity is likely to take at least an hour and could very well stretch in to two hours.

Group Activity: Shake It Out & Yoga The facilitators should allow the group to select 5-10 yoga flashcards for this activity.
**Group Activity: Feeling Check-In** Once the group has finished the yoga activity the facilitators will invite the group to sit around their Circle for the final time. However, before sitting at the Circle, the group will be encouraged to bring their self-mandala from Day Two and their self-mandala from today's activity. If the group is allowed to take their artwork home after each session, prior notice that they will be expected to bring their first mandala to the final group may be necessary.

With the help a translator or prepared statement, the facilitators will ask the group to pick a Kimochi that expresses how they were feeling when they entered the group (the first self mandala drawing) and then to select a Kimochi to express how they are feeling after going through the treatment protocol (the most recent self mandala drawing).

**Group Activity: Goodbye Game** After the each member of the group has had a chance to express themselves using the Kimochis, the facilitators will invite the group to play the goodbye game using the talking piece. The facilitators will demonstrate the game by tossing the piece to a clinician and either saying, “Goodbye,” “Bye,” or some variation thereof or by waving goodbye to one another. It would be beneficial to learn the local language's words for such greetings so that the group feels more connected to the process of saying goodbye the group members, the group space, and the facilitators. The facilitators will stop the game after each member has had multiple opportunities to say, “Goodbye” to several different members.

**Group Activity: Shake It Out & Final Closing Ritual** The facilitators will now invite the group to stand up and “shake it out” before conducting an adjusted final Closing Ritual. After the group has brought out the Circle’s box, the facilitators will ask each member to walk to the center of the box and place in any of their remaining fears or anxieties while taking out as much hope as they felt they needed for their future. A translator or prepared statement may be necessary for this. Once each member has done this the facilitators will ask the group to kneel to the decorate circle and instead of bringing to the box as done in previous sessions, the group will untie the knots holding each segment to one another. The group are to leave the segments lying on the ground until every member has untied the segment closest to them.

After all the segments are untied, the facilitators will invite the group to find and stand by the segment of the circle they decorated and contributed during the first session. Once each member is standing by their segment of the circle, one of the facilitators or translators will offer the following closing statement:

This group formed as result of happened outside of our control that has hurt us all in some way. We came together as a group out of hurt. For the last two weeks we shared that hurt with one another. Side by side, we worked through our pain. We learned to release the pain we are holding and to embrace the hope we have for one another. Even though this group has come to an end, we hold the hope for you that lessons you have learned during our time together will leave this circle and follow you through the rest of your lives. Take this piece of our circle as a reminder of what we all experienced during our time together. The hurt, the healing, and the hope we have shared.

Once the closing statement has been shared, the facilitators will go around the circle and tie each group member’s segment around their neck. This concludes the group protocol.
Session: 9 (optional)

**Purpose:** To help the group reintegrate back into the community as well as to celebrate their accomplishments and hopes with the community.

**Art Viewing: Return to Community** This day of the protocol is not required but suggested if time and resources allow. However, inviting the community to participate in such a viewing is a wonderful opportunity to help the members of the group reconnect with their community and to share their experiences of the group healing process as well as their stories pertaining to the traumatic event with those around them in their daily lives.

It is important to inform the community to refrain from interpreting the members' art and if they are curious to ask the member questions rather than making assumptions. Additionally, all of the group members should be provided an opportunity to share their artwork with the community, but not made to feel obligated to do so. The facilitators must keep in mind that the group has endured some difficult lived experiences and sharing these experiences can open oneself to an overwhelming feeling of vulnerability. Therefore, group members should only display their art if they feel comfortable doing so.

Such an event would likely need several translators to help the facilitators facilitate the gathering. While there are some rather larger obstacles to hosting a viewing, the benefits far outweigh the stress of collaborating such an event. It is possible to delegate many of the tasks required to host a viewing (providing snacks, setting up the space, inviting the community) to various members of the group or even within the community itself. Doing so would provide the group and community to foster a sense of connectedness and group-efficacy.

Additionally, a viewing provides the group members with an opportunity to punctuate the group's end with one final task that is designed to bring the group together once more, but to have them leave with their families and integrate back into the community at its end. Holding a viewing also gives the group members a chance to verbally process their experiences of the group process amongst themselves and with their loved ones and community, which is an element that has not been otherwise possible in the protocol due to the focus on expressing one's self non-verbally through various art interventions.

Furthermore, holding such a gathering would provide the facilitators with a chance to invite the group to share feedback about the program. This can be done either by using a translator or by using a brief questionnaire. I feel that a questionnaire would be well-suited for this as it can be translated ahead of time into the group's language and it provides the members with an anonymous way to share their experience of the group with the facilitators without the sensation of speaking in front of a group and "being on the spot." Additionally, using questionnaires would allow the facilitators to translate the group's feedback at a later date. This is especially important if translating resources are limited during the protocol.
[APPENDIX A: VISUAL TAI CHI SEQUENCE GUIDE]

Stand in Mountain pose facing North.

Take two relaxing breaths. Connect with Mother Earth through the soles of your feet. Connect with Father Sky through the crown of your head. Your feet are parallel and hip-width apart. Soften your knees. With your palms facing down move your energy forward and backward three times.

Reach into space: Move your hands upward above your head.
Roll in your right foot

Lighter shading represents a foot that is off the ground. For the purpose of demonstrating the following poses the model has adjusted her orientation to the camera.

Send out fire: Step forward on your right foot and move your hands from waist height to shoulder height, palms facing up (Element I)
Bring back water: Turn your palms to face the ground and slowly return them to waist height.
(Element II). Make a 1/2 turn to the left. You should now be facing South.

Roll in your left foot.
Make a 3/4 turn to the right. As you turn, move your hands at waist height in a gentle oscillation up and down to represent the wind blowing. (Element III) You should now be facing East.

Gather precious metals: With palms facing up, move your right hand in a half circle motion from your hips to your center at waist height. Your palm should now be facing down. Repeat this motion with your left hand.
With palms facing up, bring your gathered resources up to center at shoulder height. Take only what you need. (Element IV)

Release and fly: Return your hands to waist height and then with palms facing down extend your arms out and above your head, as if you were flapping wings.
Then Bring the backs of your palms together at waist height and move them up your center as you draw the Earth's energy up through your body and above your head. (Element V)

Return your arms to your side by making a wide circle, representing the world.

Embrace Tiger: With palms facing up, bring your hands to your heart, bending your elbows at waist height. Appreciate and honor all that we have and hold dear to us.

Return to Mountain pose.

The group should now be facing east. Repeat the exercise three more times so that you have begun the exercise facing all four cardinal directions and have returned to facing north. The entire exercise of should be repeated four times and take approximately 20-25 minutes.
[APPENDIX B: MINDFULNESS MEDITATION SCRIPT]

[Ring a bell or chime one time to mark the beginning of the session]

Find a comfortable seated position either in a chair with a back or seated on the floor. If you are in seated in a chair, sit with your feet hip-width apart with your feet flat on the floor and your back upright along the back of the chair. If you are seated on the floor, sit cross-legged with the seat of your buttocks firmly pressing into the floor with your back in an upright position that is comfortable to you.

Close your eyes and take two deep breaths. Feel the sensation of being firmly ground to the world through your feet/buttocks. Shift your attention to your breath. Like the ocean, your breath rises and recedes and is always constant, always there.

If you notice that you are thinking, try to imagine your thoughts as clouds in a blue summer sky. As they take shape allow them to pass by without judgement, then return to breath. Breathe in and out, noticing the sensation in your lungs.

[AAfter 5-10 minutes ring a bell or chime 3 times to mark the end of the session]
APPENDIX C: BLANK MANDALA TEMPLATE