ST. STEPHEN'S COLLEGE

EMERGING ART THERAPIST INTEGRATING THE PSYCHOPHYSIOLOGICAL PRINCIPLES OF SELF REGULATION THERAPY (SRT):
Integration of mind, body and soul

by

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ABSTRACT

Nearing completion of my studies required for obtaining a Master degree in Psychotherapy and Spirituality with specialization in Art Therapy I enrolled in Self Regulation Therapy (SRT) training. Though personal and professional immersion in both therapeutic processes I developed a curiosity over the possible integration of the theoretical underpinnings of art therapy and SRT. My research methodology included heuristic inquiry (Moustakas, 1990), along with reflexive/narrative autoethnography (Ellis, Adams, and Bochner, 2011). I explored the lived experience of my immersion into the neurobiological approach to healing trauma, as taught in SRT, while also developing my emerging identity as an art therapist. Through self-reflective narrative I sought answers to my questions around how I might integrate overlapping therapeutic principles and practices of SRT with what I have come to value through my aligned identity and commitment to the community of the creative art therapies.

Both approach the client therapist relationship through right-brain-to-right-brain intersubjective attunement, which attempts to reintegrate the mind body and soul of individuals dealing with the experience of trauma and its resulting dysregulating effects. Significant evidence of theoretical and therapeutic overlap was discovered, leading to validation for further research into this possible integration. Further client work and research study is needed to explore the feasibility of developing a protocol that might successfully integrate these two processes.

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I am thankful for my friends and family who believed in my potential to satisfy the requirements of this undertaking, and saw the heart in it all. I am blessed to have my husband and my two children, who constantly offered their encouragement and interest in my quest. It is with great tenderness that I hold the privilege of being a mother, and having explored the experience of my daughter's birth in this research, I am mindful of the impact this telling may have on her.

I am honored by the trust my client has placed in me, to both fulfill the role and hold the space as her therapist, and then to consent to my using this shared experience for my thesis research. This trust was foremost in the intensions I have set and given to my words.

I am grateful to all those who supported me in this thesis writing process. I wish to acknowledge the support of my thesis supervisor, Dr. Lynne Zettl. It is with her guidance and direction that I found my way through the complex and inspirational learning that is foundational to understanding Self Regulation Therapy SRT, and my own nervous system. I appreciate the opportunity and support St. Stephen's College has given me to reach my dream of becoming an art therapist. It is my continued commitment to life-long learning that is essential to holding this title.

I am especially grateful to everyone I met along my journey to completing this research, who pointed the way when I had lost my direction on this road. It is a result of the people I have had the honor to share life stories and insights with that have lead to my growth, an expanded personal and professional intrapersonal, interpersonal and transpersonal integration of my own mind, body and soul.

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Chapter One: Introduction

The Influence Of Self Regulation Therapy Training (SRT) on the Art Therapist

The purpose of this inquiry is to determine how the psychophysiological approach to healing trauma, Self Regulation Therapy (SRT) (Zettl & Josephs 1998) has relevance in my work as an emerging art therapist. As I was nearing completion of my coursework for a Masters of Psychotherapy and Spirituality with a specialization in art therapy, I enrolled in SRT training. This commitment to continual learning was congruent with the essential skill building and self-reflection necessary for me to becoming an effective therapist. I became specifically curious about SRT following my powerful and influential first experience with this therapy as a client. I was inspired to find ways to explore how I might want to include and assimilate the new learning that has come out of my personal experience as a client and as a student of SRT with what I have already gained through my training in art therapy.

As I engaged in my own SRT personal therapy, I began to connect with my beliefs and emerging identity around my own personal and professional development. As well I noted my reservations and apprehensions around opening the door to my own transformation process as I entered into the role of therapist. It was necessary for me to explore SRT training in order to unearth the unresolved energy, the dysregulated affect that still remained in my nervous system as result of past trauma and to gain transformation from this process of therapy. This transformation aided me in becoming a more regulated individual and contributed to my becoming a more resourced, attuned, and confident therapist. "The person who has successfully renegotiated the trauma will experience a much broader range of resiliency, wisdom and vision, a transcendent

transformation" (Josephs & Zettl, 2009 p. 3, Training Manual, SRT Foundation Level I). I discovered that trauma could be transformative. This transformation also included a personal integration, an intrapersonal, interpersonal and transpersonal evolution. As a result I have become conscious of a new identity, that of an art therapist, a SRT practitioner/counselor, and a spiritual psychotherapist.

My educational training at St. Stephens College included research in the field of spiritual care and spirituality. VanKatwyk (2003) described how spiritual care in psychotherapy, "once the domain of theologians, now resides in a rich pluralism of research methods" (p. 151). He added, "the core of spiritual care is established in how the caregiver is present both as a connected self and as a self-defined other" (p.154). I have discovered, that it is the quality in which I am connected and present in my own being and doing, alongside my presence with another that will determine how effective I will be as a therapist. My goal in providing spiritual care is therefore to become consciously aware and connected to my core being: my own mind body and soul. As VanKatwyk (2003) suggested, true learning, which brings about new ways of being and doing, results in following "uniquely personal pathways, authenticating a student's reality and learning style" (p. 153). An embodied learning has resulted from my personal experience, exploration and self-reflection.

This research journey began as a curiosity about SRT and led to the exploration of the feasibility of integrating this process with that of art therapy. I began to see how integrating the psychophysiological language and a greater understanding of the neuroscience that explains the affect of trauma and its treatment would contribute to my development as an art therapist. I discovered that opening myself up to this new learning

resulted in a professional integration of knowledge and experience. As well this learning has promoted a greater personal integration through an intrapersonal, interpersonal and transpersonal transformation.

Through this learning I was challenged to examine how my transformation from art therapy student to art therapist had now been informed by the neuroscience research forming the foundational principles of SRT. I discovered published art therapy research and client studies that explained how art therapy theory has already been expanded to integrate the language and theories of SRT. Although few in numbers these studies explain the power of the creative therapeutic process in neuroscience terms. Only art therapy research and client studies that informed my quest to explore the overlap of theories and principles of SRT and art therapy were included.

The Research Question

What is the lived experienced of an emerging art therapist exploring the therapeutic process of SRT and of integrating neurobiology with the language of the art therapist? As I journeyed from being a client and a student, I had to find a way to focus my research and the data to facilitate and prioritize the essence of this experience more specifically from the perspective of an art therapist on a journey of professional development.

The psychophysiological approach of SRT is to engage the felt sense of the body, and to work with the neurological effects of trauma on one's life. This process bears similarities to the work I experienced through creative art therapies. Both therapeutic processes share a common goal to help people reconnect with themselves, their mind, body and soul, and hopefully this transforms to a renewed connection with their own

lives. Janoff-Bulman (1992) stated that for the victims of trauma, fundamental beliefs and connection to their own core being is shattered as a result of the feeling that their safety in their known universe or world is threatened. This intent of both therapeutic models to facilitate growth and transformation following a traumatic event comes from the shared belief that disturbing experiences interrupt a person's ability to enter into one's *best life*.

Trauma Defined Through Neurobiology and Creative Arts

As regards using creative art therapy methods with trauma survivors, art therapist, Judith Rubin (2006) stated, "Art therapy has roots in the art of the mentally ill, itself a response to the terror of psychosis-a loss of contact with both the self and the world" (p. 9, cited in Carey, 2006). She also noted, that it is well known that trauma often involves and resides in the body. She stated, "Art and expressive arts therapies as helping professions exist, because some events are so devastating that words fail, and the arts become the best way to say what presses for release" (p.9). Speaking to the spiritual benefits of using art therapy, Hansen (2001) described trauma as evident in how the body makes, "subtle responsive adjustments to what is experienced as intolerable and . . . it literally becomes part of the victim's *bodyspirit" (p. 193).*

Janoff-Bulman (1992) described trauma as resulting from "extreme life events that produce psychological difficulties"(p. 50). The experience of trauma and the resulting disembodiment can be described as disconnection from one's own soul. Dealing with trauma through therapy can be transforming as the process of finding oneself again, one's mind, body and spirit, and can result in a new personal reintegration of the whole self (Siegel, 2011).

Prominent art therapists believe that there is a need to promote the integration of neurobiology research with art therapy to further explain and create more attuned creative therapies techniques. These therapists include, Hass-Cohen and Carr, 2008; Kaplan, 2004; Lusebrink, 2010; Malchiodi 2011; & McNamee, 2006. Kaplan (2004) stated, "There is a growing awareness of the need to incorporate the findings of neuroscience in the conduct of our profession" (p. 123). West and Hass-Cohen (2008) co-editors of a book dedicated to research findings on art therapy and neuroscience stated that the experience of trauma organizes a person's "emotional and meaning-making systems" (p. 226). They suggested, "The burgeoning of neuroscience findings has revolutionized clinical psychology, making it necessary to update art therapy perspectives" (15). West and Hass-Cohen (2008) added current art therapy techniques and practices need to be extended to include functional information about the brain and the nervous system.

Further defined from the perspective of SRT, trauma is viewed not as an event but as residual charge that remains present in the body's nervous system as a result of unresolved responses to perceived threat. This remaining energy in the nervous system effects how a person responds to stimuli in the environment. Unresolved responses to past threat can result in neurophysiological changes that alter the way a person lives their life in the world. Josephs & Zettl (2009) described SRT as a non-cathartic gentle psychophysiological, mind/body approach to deal with significant overwhelming traumatic events that result in changes in the nervous system, and as a result negatively impact one's life. The impact that past traumas have on our lives according to developers of SRT therapeutic process Josephs & Zettl (2009) is the establishment of procedural dysfunctional patterns of behaviour. The most recent psychophysiological and

neurobiological research points to non-conscious mind-body processes which act as the driving force in behaviours and coping strategies that contribute to maintaining such dysfunctional patterns.

To help explain procedural dysfunctional pattern of behaviour I have referenced insights discovered in a work of fiction by Bonnie Burnard (1999). In this story a young girl suffers a traumatic fall. She was somewhat able to heal the physical injuries she experienced as a result of this event, but she was unable to resolve the residual charge in her nervous system. In the story the young girl's behaviour, witnessed while sharing in a family celebration, is revealing of how the traumatic fall has changed her. She is startled by the noise of hot chestnuts, which are exploding in a harvest celebration fire. "Daphne jumped and someone else laughed, making light of her fear, which was new to her, and to them all" (p. 32). Her parents noticing the change in her responded, "First we have to get her properly healed . . . 'It is her nerve,' said her mother, "We'll have to help her get her nerve back" (p. 32). The mother in this story also stated, "What matters most is that we get her back to herself somehow . . . I don't want her changed by this. I want her to be exactly the way she was" (p. 32). The goal of therapy is to help people in real life reconnect to themselves, a reconnection of mind body and soul, following the experience of a traumatic event that leaves its residual charge in the autonomic nervous system ANS.

Personal Interest

My personal journey of learning has opened the door to my own reflections around what this exploration means for my emerging new identity as an Art Therapist and an SRT practitioner. Having undergone SRT and creative arts therapy for my own traumatic life events, I have gained an embodied connection to my personal healing and

transformation. My curiosity about psychotherapy and the phenomenon of witnessing others and myself find personal meaning from trauma therapy opened me up to being able to self-reflect on my professional development. This included self-reflection on how I have been influenced by my immersion in both of these therapeutic approaches.

I discovered that I have aligned myself with these two distinct therapeutic processes and their communities. I had created a new professional identity for myself that integrated both views. The research literature which demonstrated how the neuroscience understanding of trauma affect and trauma treatment described through psychophysiological principles of SRT could also be explored by reflecting on existing art therapy process and theory. I also discovered both processes embrace the power of the imagination and need for personal expression. For example, imagery and creativity are used as resources in both. The desire to integrate these two therapeutic processes has grown into a faith that this may be possible.

Therapeutic Processes Defined

The Canadian Art Therapy Association defines art therapy as follows: “Art therapy combines the creative process and psychotherapy, facilitating self-exploration and understanding. Using imagery, colour and shape as part of this creative therapeutic process, thoughts and feelings can be expressed that would otherwise be difficult to articulate.” Retrieved from www.canadianarttherapy.org

In an attempt to distinguish trained art therapists from other health service professionals who use art media in counseling sessions, Hinz (2009) stated that the foundational framework for using art in therapy is a “unique discipline in its own right

with a theoretical framework that can guide the use of art media and experiences (p. 17)". Art therapy is more than a modality of verbal psychotherapy.

According to the American Art Therapy Association, art therapy uses the creative therapeutic process to help those who have survived trauma, as well as people experiencing developmental, medical, educational, and social or psychological impairment and other health disabilities and disorders.

A goal in art therapy is to improve or restore a client's functioning and his or her sense of personal wellbeing. Art therapy practice requires knowledge of visual art (drawing, painting, sculpture, and other art forms) and the creative process, as well as of human development, psychological, and counseling theories and techniques. Art therapy helps people resolve conflicts and achieve personal insight while providing an opportunity to enjoy the life affirming pleasures of art making. Retrieved from www.arttherapy.org/aata-aboutus.html#whatisarttherapy

According to Josephs & Zettl, (2009) of the Canadian Foundation for Trauma Research and Education (CFTRE):

> Self Regulation Therapy (SRT) is a non-cathartic mind/body approach to therapy, aimed at diminishing excess activation in the nervous system. It has its basis in neurobiology and reflects our innate capacity to flexibly respond to novelty or threat. Significant overwhelming events at anytime in one's life can result in changes in the nervous system that negatively impact the way a person feels and relates to others. SRT enables the nervous system to integrate overwhelming events and brings balance to the nervous system. The individual is guided to complete the thwarted responses of fight, flight or freeze. By resourcing the client,

> new neural pathways are developed to flexibly manage daily challenges and stressors. Once the nervous system is balanced, individuals are able to experience joy, closeness in relationships, and an increase in personal vitality and resilience in the body. Retrieved from website www.cftre.com

CFTRE offers two courses teaching the SRT process. The first course, Self Regulation Therapy Practitioner Training, teaches practitioners how to work with shock trauma. The second, *Psychological Anatomy* is a training focused on identifying and correcting developmental dysregulation. Certification as a SRT practitioner requires Foundational (Levels I-IV), and Advanced (Levels I-IV). Advanced level training builds on the psychophysical skills taught in the foundational level.

My Personal Journey: Exploring Trauma From a Psychophysiological Perspective

My personal journey with SRT began with a therapeutic experience I had when I was given the opportunity to work with one of the developers. We worked on the traumatic impact a recent surgery had on my own nervous system. I was guided to bring awareness to subtle psychophysiological communications that were rising from within my body. I was asked to notice physical sensations as I revisited this past memory, to re-member, through explicit and implicit, conscious and unconscious retrieval. Later exploring the trauma of a much older surgery, the emergency caesarean section that I underwent happened 27 years earlier, the SRT experience was more intense and revealing. As I experienced physical sensations I became conscious of the psychophysiological state I was in at the time this event took place. The exploration of my felt sense connected my awareness to the resulting activation still resided in my nervous system. This was caused by the anesthesia I was given.

Sensation is described in the SRT process as a felt sense, such as a tension, or relaxation. According to the SRT manual; Foundational level I, “sensation can be felt as a movement of life force, of life intelligence which can help to mend broken connections to self, and to spirit” (Josephs & Zettl, 2009, p. 4). The release of bound energy stored in the body in the autonomic nervous system (ANS) is described as the excess activation, and is manifested as symptoms such as twitches, jerks, sweating, tears, laughing or shaking (p. 9). This release is called discharge. In my personal therapy these sensations were tingling, tears, heat, and some discomfort in and around my pelvis and jaw.

Dr. Lynne Zettl, co-developer of the SRT process, is also my thesis supervisor. She specializes in the treatment of PTSD symptoms and developmental dysregulation in adults and children from a psychophysiological perspective. Josephs and Zettl (2012) have taught SRT and psychological anatomy throughout North America, Europe, the United Kingdom and Russia. Retrieved from http://www.cftre.com

I was struck by how the SRT process used my imagination as a resource and allowed me to connect with myself deeply, and yet at a pace that was driven from within myself, as the client. The work contributed to my personal development, regulating my own nervous system, so I could become a more grounded therapist. Lum (2002) stated, “If therapists have not resolved these issues, there is a strong possibility that they will have a variety of reactions to clients’ problems, for example, getting stuck, avoiding the issue, skewing the information, or losing focus” (p.182) all of which are undesirable forms of countertransference. Through this experience I gained greater awareness of my own patterns of dysregulation, which were identified to me under SRT supervision. Awareness of my own patterns of dysregulation has led to an increased awareness during

times when I experience states of activation. Becoming conscious of psychophysiological processes and the ability to now ground myself better have helped me become a more attuned therapist. Attuned therapeutic environments have the “capacity for containment and integration of highly charged states” (CFTRE, 2009, SRT manual Foundation Level I). Through this new learning I was also challenged to maintain my belief that the creative art therapies also thoroughly provide a safe container to hold the space. I now have come to accept that this is possible only when held by a grounded therapist, irrespective of the process.

I processed this experience further with Art Therapist, Dr. Hammond-Meiers, during two art therapy sessions in her art therapy studio. Dr. Hammond-Meiers is a Registered Psychologist, Dance/Movement Therapist, and Art Therapist. The art explored was created before and after the birth and surgery trauma work in SRT therapy that took place September 2013. I had worked with Dr. Hammond-Meiers as my supervisor for my practicum to complete my art therapy masters program and so had already developed a therapeutic relationship. The data collected from my personal therapy with Dr. Hammond-Meiers was deemed as secondary data, to be explored as part of this discussion, as it provided insight into my transformation as an emerging art therapist. The insights were limited as the therapy took place early in this research process.

The way the SRT learning and experiential events fell into place, the timing of the discovery of how this traumatic event was held in my nervous system, the professional opportunities that presented themselves to me, and the challenge of writing this thesis, made me wonder if something greater than myself, or some inner knowing within myself was guiding me towards these new discoveries. Through this inquiry of

self-reflection, my identity as a therapist evolved. In the process I integrated this new therapeutic process and knowledge into my evolving sense of myself. It became evident that I needed to experience and learn this knowledge in order to move forward. I was studying SRT in order to become a better art therapist, and this knowing was resonating with me through an embodied, creative and intuitive awakening. As Moustakas (1990) stated, "Although the individual may undergo a long labor awaiting the arrival of the inspiration, ordinarily that actual moment of being inspired emerges suddenly" (p. 70). Only after my SRT experience was I able to begin writing this thesis. I was taught how this experience is described in SRT as being able to move out of a state of fixity, a state of freeze and dissociation into a state of flow. This is also described as the ability to move into desired action. I began to develop a vision of how this research and future application of this learning might look.

Advanced level SRT training was taught over eight three-day seminars initiated in the spring of 2012, and was completed in January 2014. Along with SRT instruction, I fulfilled twenty hours of therapy and twenty hours of individual and group supervision. To complete the SRT Advanced training certification I gathered eight videos of myself as therapist using SRT with one client. As required for SRT certification I explored portions of my work as recorded on these videos through supervision. I then watched myself delivering SRT therapy to a client. I reviewed these videos again through self-reflection and evaluation. I realized then that these video recordings of my efforts working with SRT in my art therapy studio were the data I needed for this research.

I gathered my thesis data by watching these eight videos from the perspective of a researcher, and as the co-research, the subject of inquiry. As the researcher, I reflected on

my responses to watching myself function as an SRT therapist with the client. To best explore how I might be drawn to integrating this new learning into my emerging art therapy practice I aimed my focus by asking myself specific questions as a basis for self-reflection on my own experience. I looked for SRT concepts such as what was happening from a psychophysiological perspective. For example, I observed sensations experienced by the client as evidence of the discharging of unresolved fight and flight reactions of the nervous system. I needed to explore where I felt most comfortable, curious or engaged as a therapist from either the framework of art therapy, SRT or an amalgamation of the both.

I also investigated whether I witnessed any evidence of myself using art therapy processes in the therapeutic context of working and engaging with my client. Where there was no such evidence, I imagined where I might introduce art therapy interventions and gave validation for providing such invitations through consulting art therapy theory resources.

To collect more data for my thesis, I used these same videos, but looked at them from the perspective of how the experience of watching myself through the lens of the therapist in training, not the client nor the client's story or presenting issues, had influenced me. The intention of the viewing was to reflect on my work as the therapist, not to review the work of the client. One discovery that was initially validating was that upon viewing these videos, was that six of the eight videos included art making. I had already found a way to include the creative process as I was initially evaluating my beginner ability to work with clients using the SRT process and as I did so I included art therapy processes even before intending to use these videos for thesis data collection.

Limits In Published Research On Effectiveness of SRT and Art Therapy

When reviewing the challenge of deciding how to approach this research and gather the data, I considered the lack of published research existing on the effectiveness of SRT. The debate over the role of art in therapy and the practice of art therapy is a relatively unexplored area of research. With regards to art therapy research, Kapitan (2010) argued that art therapists are still pioneering a field of research and therapy that has a unique perspective and yet has not established a clearly defined professional identity.

Josephs and Zettl developed SRT following their work in Somatic Experiencing SE therapy. Scaer (2007) responded to SE, the foundational work for SRT theory and stated that through his personal clinical work he found striking improvement in bringing about resolution of dissociative traits and behaviours as well as chronic pain, especially myofascial pain when using SE. He stated however, regarding the safety and efficacy of this therapeutic approach, that SE "needs to be scrutinized through controlled outcome and physiological studies before any conclusion regarding specific aspects of its efficacy can be validated"(p. 188).

Zettl (1998) conducted a study using SE to work with emergency service personnel diagnosed with symptoms of PTSD, and found dramatic relief from these symptoms for all but one of the participants in her doctoral dissertation. In her heuristic inquiry (Moustakas, 1990) research she followed 14 firefighters, police officers, and paramedics to explore the resulting effects of their SE therapy together. The data gathered from a phenomenological approach showed that all but one of the participants in Zettl's (1998) study could no longer be diagnosed with PTSD systems following SE treatment.

Zettl's work with these emergency service personnel included six, ninety-minute therapy sessions. The results also showed that for 80 percent of the participants a noticed improvement in mood and ability to focus, along with a reduction in symptoms of anxiety, amnesia, and flashbacks was reported (Zettl 1998, p. iii). The respondents (Zettl 1998) reported an improved ability in dealing with stress and in being more present in their lives. This included being able to more fully engage in relationship with loved ones.

The resolution of my questions regarding the possible integration of these two theoretical processes becomes partially dependent on my personal experience, as these processes have played a role in my professional identity. This inquiry has been fueled by my curiosity about the overlapping principles and theories. I am curious about the possible benefits integration of these processes might have to enhance my ability to provide an effective therapeutic approach.

This self-reflection of my lived experience in SRT training has called upon my inner knower. As I have entered in these therapies and developed my professional identity as an emerging art therapist with SRT training. I have opened the door to deeper explorations of my inner self. I am exploring the feasibility of integrating these two processes in an attempt to satisfy my hypothesis and also my belief that this integration would be beneficial to my effectiveness in my future professional practice as an art therapist. I have found this research has also opened the doors to a greater integration of myself as a result. This integration includes bringing greater awareness to a personal transformation that has awakened my desire to live a more conscious and joy filled life.

Methodology

My methodology, heuristic inquiry (Moustakas, 1990), included reflexive/narrative autoethnography (Ellis, Adams, and Bochner, 2011; Ellis, 2004, Pillow, 2003, & Wall, 2006). Qualitative research describes an autoethnographic reflexivity methodology as recognition of self and reflexivity of transcendence ((Ellis, Adams, & Bochner, 2011; Ellis & Flaherty, 1992; Pillow, 2003). Wall (2006), stated in *An Autoethnography on Learning About Autoethnography*, that this method, autoethnography, is also presented as heuristic inquiry and a number of authors simply present the method and its product as personal narrative (p. 150). Ellis added, "When researchers write autoethnographies, they seek to produce aesthetic and evocative think descriptions of personal and interpersonal experience" (2011, Ellis et al. p. 4).

Pillow (2003) examined "reflexivity," as defined in qualitative research and challenged the approach towards our subject matter as being something already "familiar" to the writer. Pillow (2003) added, "Reflexivity thus is often understood as involving an ongoing self-awareness during the research process which aids in making visible the practice and construction of knowledge within research in order to produce more accurate analyses of our research" (p. 178). Pillow (2003) argued that there is a need for the researcher to identify her own "truth", and that this "situates the researcher's own need and desire for 'truth' as primary" (p. 186).

I declare this research as both autoethnographic and heuristic. Autoethnography is an approach to qualitative research that seeks to describe and systemically analyze personal experience in order to understand cultural experience (Ellis, Adam & Brochner, 2011). I propose that I have become part of several professional psychotherapy cultures.

Alongside my affiliation with the creative art therapies, belonging to both expressive arts and art therapy training, are the psychotherapy and counselling theories taught during my study for a Master in Psychotherapy and Spirituality with Art Therapy specialization. I am also a student member of World Arts Organization, a member of the International Network of the Expressive Arts Therapies. Expressive arts therapy is grounded not in particular techniques or media but in the capacity of the arts to respond to human suffering (Levine & Levine, 2004, p. 11).

Being a member of these groups and identifying this subjectivity will complicate and enrich my research experience and findings. Corbin and Buckle (2009) discussed the role of membership in qualitative research and suggested that being a researcher alongside being a member in the group complicated data collection and analysis. The researcher must play an intimate and first-hand role.

Heuristic inquiry (Moustakas, 1990) attempts to answer the question the researcher seeks to illuminate. Methodology in autoethnography (Ellis & Flaherty 1992) varies widely, from highly introspective through to the more familiar approaches connected to qualitative research. I have come to identify with the statement by Wall (2006) that the method of autoethnography is more a philosophy, "aimed at restoring and acknowledging the presence of the researcher/author in research, the validity of personal knowing, and the social and scientific value of the pursuit of personal questions" (p. 152). The resulting learning gained by combing these two informed my work and has brought awareness to the influence this learning has had on my emerging identity as an art therapist, a SRT practitioner/counselor, and a spiritual psychotherapist.

Chapter 2 Literature Review

Salient Literature Informing Self Regulation Therapy Theory and Art Therapy

The salient literature reviewed here is drawn from resources that have contributed to neurobiological findings and insights referenced as foundational research for Self Regulation Therapy, (SRT) (Josephs & Zettl, 2009). Alongside these are the literature references that form the foundational and theoretical framework for art therapy as these pertain to the concepts, themes and discoveries made as a result of this inquiry. My intention with this review was to find ways to integrate the foundational research literature for SRT with that of art therapy as it applies to these themes and theoretical principles. I used SRT concepts to frame this literature review and then explored studies and examples of where art therapy may already be applying similar neuroscience principles and theories.

To address my question of how I have attempted to integrate the theories and principles of SRT with those of art therapy, I had to look at research that explained the language of psychophysiology and its application in psychotherapy. I organized this literature research as a systematic overview in order to highlight specific theories and principles I have embraced on my journey exploring the integration of the language of neurobiology with that of art therapy. Presenting this knowledge was essential to describe how I developed an understanding of my new identity as an emerging art therapy/SRT therapist as it has evolved.

As well, I have looked for indication within these two therapeutic processes for complimentary and/or uniquely different therapeutic goals with respect to theory and applications. The review and amalgamation of overlapping theoretical and therapeutic

processes was used to explore a deeper understanding of my personal lived experience and self-reflective narrative. At the conclusion of this chapter I will examine the feasibility of further exploring the prospect of possibly integrating art therapy and SRT based on what I discovered in the literature researched.

A Change in Knowledge Changes the Criteria for Therapy

The acquisition of knowledge contributes to the confidence level for the emerging therapist, as taking a seat in the therapist chair comes with great responsibility and challenge. Continual professional development is required to keep informed and up to date with current research. It can be assumed that new learning is chosen and assimilated into the therapist's skill set, based on a preferred therapeutic approach. The ability to reasonably judge psychotherapeutic processes in regards to similarities and differences in theories and principles comes as a result of an increased ability to discern what knowledge and information is congruent to the therapist and to presenting client issues. This discernment pertains not only to the professional, but also to the personal ethics and values of the practitioner. I have had to evaluate where and how I feel most comfortable and confident with respect to working with either or both of these therapeutic processes.

Self Regulation Therapy

Self Regulation Therapy (SRT) was developed by Dr. Lynne Zettl, and Dr. Edward Josephs (2001) to meet a need for trauma therapy, that addressed dysregulation in the brain, and the nervous system. "SRT was grounded both in theory and practice in the newest developmental, neurobiological, and psychophysiological research"(personal conversation with Zettl, 2014). The main theories that have influenced the development of SRT are: 1) Allan Schore's research on self-regulation, attunement, attachment and

right brain communication; 2) Stephen Porges's (2011) research on the polyvagal nervous system; 3) Robert Post's (1997) work on kindling and quenching: 4) Eugene Gendlin (1981) and Peter Levine's (1996, 2013) therapeutic approaches; and 5) Dr. Zettl's (1998) doctoral research on the efficacy of using a psychophysiological based therapy to treat post-traumatic stress disorder (PTSD) in emergency service personnel. The research literature supports that in order to be effective in healing trauma, therapeutic processes needs to be attuned to how the body, brain and mind are connected.

A Right Brain Approach: Schore

Schore's (2012) work is foundational to SRT process and supportive of art therapy theory and principles. Schore explored psychotherapy from the perspective of attachment, developmental neuroscience trauma, and the developing brain. Schore (2012) stated that understanding the current incorporation of neurobiology into psychoanalytic theory starts with understanding attachment theory. He stated that the attachment theory that Bowlby proposed in 1969 has been expanded upon to support a current and therapeutically relevant model of human development (p. 27). According to Schore (2012) this powerful insight into how and why early social environment experiences influence all later adaptive functions was originally approached through cognitive, narrative and reflective therapeutic processes. He stated that a current transformation of modern attachment theory has evolved as a result of new research that supports a biopsychosocial perspective.

Schore (2012) suggested the work done in clinical social work focused on two core issues, person-in-environment, and of person-in-relationship and that these are congruent with the psychobiological core of the "intersubjective context, the brain-mind-

body environment relational matrix out of which each individual emerges" (p. 28). He explained how psychobiological origins influence the relationship between the infant and the caregiver. These influences include the psychological, biological, and somatic factors along with sociocultural influences. How that relationship was developed within a culture and environment either supports, inhibits or even threatens the infant-caregiver relationship. This is the core of the intersubjective relational context. Schore (2012) expanded the concept of relationship to include the brain, mind, and body of both the infant and caregiver. As these relational origins are developed in an infant's first year of life and earlier, their impact on the individuals development are laid down in the non-verbal unconscious, and these early origins become the drivers behind human emotion, thought and behaviour.

SRT focuses on the development of the intersubjective relationship between client and therapist to include an awareness of and attunement to the client's early development by sensing the non-verbal communications, behaviour, and felt presence. Through the therapist's understanding of the lasting impact of early development and infant caregiver attachment, clients can be viewed through the lens of not only their perceived immediate challenges but through what might have been laid down in their system early in life, and is now behind their unconscious behaviour. The core of SRT training uses this expanded attachment theory to provide insight into clients who present with challenging personality traits and may be perceived as resistant to change. These clients may be reacting to unconscious maladaptive neurological responses spurred by early experiences of unresolved fight, flight or freeze. These responses are now held in the autonomic nervous

system (ANS). Laid down early in the limbic system, these natural survival responses can later become non-conscious maladaptive and fixed responses to perceptions of threat.

Schore (2012) suggested that this interest in and the evolution of attachment theory, has been expanded to explain emotion and emotional regulation. He stated that there is a "paradigm shift occurring; clinical and scientific disciplines are moving away from cognition as the primary cause of affect, to emotional theories of development" (p. 29). He argued that a large number of clinicians now recognize there are limitations to working from left-brain conscious cognitive therapeutic approaches. He stated that resulting paradigm-shifting forces are creating more complex developmental and clinical emotional models. To expand on this, he stated the key mechanism for effective therapy is that the therapist needs to know "how to be with the patient, especially during affectively stressful moments when the patient's implicit core self is disintegrating in real time (right brain focus)" (p. 143).

This right-brain-to-right-brain, intersubjective approach forms the principle theory of the SRT process. According to Josephs & Zettl (2009) the process of helping the client to heal from the psychophysiological effects of trauma is attempted by cultivating a conscious awareness of sensation. They stated sensation "accesses pre-egoic states before the formation of psychological beliefs and before self identity" have been developed (p.40). Attunement to the client's energetic state is essential. It is also imperative that the therapist maintains her/his sense of self-awareness when working with sensation.

Schore (2012) explained how exploration of the impaired regulation, the result of developmental derailment, provides evidence that prefrontal cortical and limbic areas of the right hemisphere are centrally involved in the pathological dissociative response, also

referred to as deficits in mind and body. Schore (2012) illuminated how the client-therapist relationship can work to contain the fight flight responses that are reawakened when a traumatic event is remembered. The relationship can also bring awareness to the freeze or dissociative state, an adaptive response to self-protection when this state is recognized and brought to conscious awareness in the therapeutic context.

According to the SRT manual (Josephs & Zettl, 2009, Foundation Level III), "Dissociation has its roots in the brain's opioid system, which secretes endorphins to blunt strong painful feelings" (p. 13). Schore (2012) concluded that patients dissociate in order to escape from the overwhelming emotions associated with the traumatic memory. He described dissociation as the "sudden implosion or inward collapse of the person into their unconscious self "(p. 127), or the "psychological detachment of themselves, from the environment, and also from awareness of their body, they're actions and their sense of identity"(p. 65). Early exposure to dissociative states lays a neurological pathway that makes a person more susceptible to experiencing dissociative states in later life. This is a scientific explanation of what the therapist witnesses, when someone shows up in therapy, after trauma has caused him or her to disconnect from his or her own soul.

SRT training identified "styles of dissociation," as, being similar to a "dimmer switch," a gradual shading or narrowing of consciousness, witnessed as the light going out slowly (Josephs & Zettl, 2009, Foundation Level III, p. 14). This is described as a blurring of sensory input or may involve dizziness or disorientation likened to "spacing or tuning out" (p.14). The second, dissociative narrowing of consciousness is described as a sensation of being outside the body, in a state of darkness, or even in a world of fantasy and imagery. This state can provide a pleasurable escape from stressful

experience; yet using this escape route also carries the risk of immersion in traumatic images, memories and flashbacks (p. 15). Working with a client who is suffering from dissociation involves restoring awareness and is facilitated gently and slowly by exploring the client's established resources. This slow process can be described as occurring within the person's range of resiliency and uses invitational language that allows the body to dissipate the charge, so it can then reconnect the fragments for reintegration of self. The range and control for dissipating this energy can be provided through the use of images or metaphors such as, dimmer switch, volume control, or pressure cooker valve or stream kettle vent etc. Clients are encouraged to imagine tension or discomfort in the body, and dissipating it one molecule at a time (Josephs & Zettl. 2009). SRT also claims to aid in internal reorganization, as the "dissociated experience is 'dismembered' and with SRT process, will be 'remembered through re-association'" (Foundation Level III p.17).

Schore (2012) added that the optimal therapeutic experience can expand the patients' right brain implicit creative functions, as the right hemisphere is more critical than the left in learning a new task and building on experience. The heightened affective emotion-processing right brain, "the psychobiological substrate of the unconscious," is the site of both the implicit memory base, "the psychobiological source of the non-verbal memory, and is the site from which to correct an emotional experience" (p. 142). Schore (2012) outlined how an "interpersonal resonance within an intersubjective field," (p.101) during a right brain process in psychotherapy triggers an increased "co-creation" of exploration of the arousal state in the client. This is recognized as "relational depth," a profound contact and engagement between the client and the therapist (p. 101). He added,

this intersubjective field generated in a “resonant transference-countertransference context facilitates the intensification of the felt sense in both the therapist and patient” (p. 102). This forms the core principle and process of SRT, and establishes the therapeutic structure from which this therapy is provided. The training begins with the student therapist (myself), exploring her own autonomic nervous system dysregulation. Through more attunement to a right-brain-to-right-brain intersubjective engagement it is possible to witness and resolve past trauma held in implicit and explicit recall.

Schore (2012) described how this right brain connection allows for greater capacity for therapeutic healing when it happens with an empathic and attuned therapist. It is also suggested that the therapist be regulated in her own nervous system to allow for the right-brain-to-right-brain connection to the client. The therapist needs to be conscious of her own felt sense. Art therapy and SRT training both share a common philosophy of how such a right-brain-to-right-brain intense personal experience of therapy and engagement in the therapeutic process needs to precede professional development. SRT training’s essential aim is to develop in students a capacity to become attuned therapists.

Polyvagal Theory: Porges

Stephen Porges’s (2011) work, the polyvagal theory, is foundational to the neuroscience research and theory of SRT. The tenth cranial nerve, the vagus, is part of a complex communication system between brain and body that involves the heart, lungs, throat, and digestive system.

The polyvagal theory describes three stages in the development of the autonomic nervous system ANS: 1) immobilization, feigning death, behavioural shutdown; 2) mobilization, fight or flight behaviours’ dependent on the sympathetic nervous system;

and 3) social communication or social engagement, facial expression, vocalization, and listening (Porges, 2011, p. 16). The autonomic nervous system includes the sympathetic and the parasympathetic nervous systems.

Sympathetic: nervous system. The sympathetic nervous system can be simply described as the general action of the fight or flight response and is primarily a system of mobilization (Porges, 2011) when challenges or a perceived threat occurs that activate sympathetic arousal, vagal activation decreases. Schore (2012) expanded on this by describing the sympathetic nervous system, as the mobilization of energy in the body that is tightly connected to the external environment, and the parasympathetic nervous system as driving disengagement with the external environment. Scaer (2014) stated that the fight/flight response could be triggered by excitement as well as by threat. He added, "what separates the experience of the fight/flight response from anticipatory excitement, of course, is the meaning of the event to the participant" (p. 12).

Parasympathetic: polyvagal system and SRT. Porges (2011) explored the development of the parasympathetic nervous system as two delineated pathways that develop alongside the sympathetic nervous system in the human fetus. Its afferent (sensory) and efferent (motor) fibres allow the brain and points of the body to communicate rapidly to promote homeostatic regulation. Porges emphasized that the vagus, the primary nerve of the parasympathetic nervous system is integral to understanding neural development and behaviour.

Porges (2011) presented the polyvagal theory of emotion to describe how the autonomic nervous system is linked to the "affective experiences of emotional expression, vocal communication and social engagement" (p. 151). The structure and

function of the vagus has evolved uniquely in mammals and can be explained by further describing the three stages of development of the ANS.

The first is associated with how the body responds to threat through immobilization, a most primitive system. This primitive reptilian adaptive function is the result of the dorsal vagal complex, which provides a shutdown of metabolic activity, a freeze or feigned death state. The experience of a dorsal vagal response is one of high activation that results in a dissociative or a freeze state. This parasympathetic pathway in the ANS is present in utero and at birth. It functions as an automatic cut-off switch in the reptilian brain stem when the nervous system is over-activated. It is also known as the "primitive dive response" or the "emergency brake" of the nervous system, increasing the possibility of survival (Zettl & Josephs, 2014, p 3). The polyvagal theory of emotion (Porges 2011) proposed a hierarchical response strategy in the human nervous system with the most recent modifications employed first and the most primitive last.

The second stage is characterized by the spinal sympathetic nervous system and increases metabolic output to mobilize the system to a fight or flight response to threat. This is part of the ANS, which develops and comes online in uturo.

Thirdly, the evolved myelinated vagus in humans controls facial expression, sucking, swallowing, breathing and vocalization. Porges (2011) explained how this vagus system allows for cardiac output to be regulated in such as way as to "foster engagement and disengagement with the environment" (p.151). When challenged, such as during emotionally charged circumstances, vagal activation decreases. Zettl and Josephs (2014) refer to this pathway, which Porges calls the ventral vagal branch, as a means of assessing health in a nervous system and development in a person as a result of

early interaction or lack of, with other human nervous systems. Porges (2011) hypothesized that healthy early attachment relationships are required to build a healthy vagal system. The ventral vagal system allows us to maintain continued engagement by modulating arousal during emotional interpersonal exchanges. The ventral vagal is a more sophisticated braking system that allows humans to engage and disengage without going into fight, flight or freeze. This system develops in connection with the nervous system of the primary caregiver and sets the stage for social interaction in later life.

Porges explored how the three cranial nerves described as the ventral vagal complex provides an organizing principle from which to understand affective expression. For example these cranial nerves regulate the visceromotor processes associated with salivation, tearing, breathing, heart rate, eye movements and tilting of the head. Porges (2011) described how increased heart rate monitored during fetal development provided evidence of the possibility that the sympathetic nervous system was activated before birth. He stated that the impact that early development has on regulating the survival-related processes are indicative of difficulties experienced in later life. The development of cognitive and language skills, appropriate behaviours, and physiological state regulation are related to the ability to regulate our mammalian survival processes of the ANS. A healthy vagal tone develops at around three months when an infant can demonstrate capacity to self-soothe (Cozolino, 2010).

Porges (2011) added that people with healthy ventral vagal functioning are considered to have “high vagal tone”, meaning that their bodies and brains are more resilient under stress, moving more easily from excited to relaxed states. Zettl and Josephs (2014) explained how, “the experience of a ventral vagal response is one of well

being, increased tone in the face and a feeling of connection" (Zettl & Josephs, 2014, p.3). Using the polyvagal theory in a clinical setting, it may be possible to evaluate the vagus to indicate stress and distress vulnerability (Porges, 2011). People with low vagal tone, are more sensitive to stress and disease. They tend to have challenges such as weak digestion, increased heart rate, and difficulty managing emotions. "Ventral vagal regulation allows us to become upset, anxious or angry without withdrawing or becoming physically aggressive" (Cozolino, 2010, p. 234). Healthy vagal tone promotes the ability for an individual to self-regulate, essential for maintaining physical and emotional wellbeing.

Porges's (2011) research is significant to clinical work as an individual can be observed to have healthy ventral vagal tone when they have the ability to calm themselves down without unnecessarily over-reacting to stimulus engaging the fight, flight or freeze responses. As well, a sign of ventral vagal development is a capacity to have social relationships. Understanding the vagus functioning helps to identify personal resilience.

Social engagement system. The SRT (Zettl & Josephs, 2012) process teaches how to apply the work of Porges and the functioning of the ventral vagus when assessing the client. How someone walks into the therapeutic room demonstrates the ability or conversely an inability to engage with the therapist. For example, a lack of eye contact and minimal facial expression may be an indication of a low vagal tone. Social engagement is an integrated system involving several cranial nerves that regulate the expression as well as the detection and subjective experiences of affect and emotion (Porges, 2011). The social engagement system operating through the critical muscles of

the head and neck allows us to demonstrate attunement and engagement with another person by reflecting our interest in another through our facial expressions.

Self-regulation, dysregulation. "Self-Regulation is an innate capacity we share with animals to flexibly respond to novelty or threat and return to homeostasis" (Josephs & Zettl, 2009, CFTRE, Manual I, p. 2). The physiological homeostasis process provides for state regulation, including emotional regulation and expression. Porges (2011) said that the idea of homeostasis, as a construct was never intended to mean a static state, "rather it defined the dynamic feedback and regulation processes necessary for the living organism to maintain internal states within a functional range" (p. 67). Dysregulation is the inability to self-regulate resulting in many disorders (PTSD, anxiety and mood disorder, phobias, psychotic disorders and personality disorders). Physical symptoms of dysregulation can include for some people; insomnia, asthma, allergies, migraines, tinnitus, hyperacousis, neck and back pain, autoimmune diseases, gastrointestinal difficulties, and substance abuse (Josephs & Zettl, 2009).

Returning the client to a state of self-regulation using the SRT process involves helping the client develop his or her physical felt sense, to bring awareness to sensation, tension, relaxation, location, breath, and ANS response. The healing vortex is described as physical, psychological, emotional and spiritual wellbeing, and a sense of empowerment and safety. This can be achieved by interrupting the pattern of dysregulation held in procedural memory which allows shock energy to be deactivated from the nervous system, leading to the development of greater self-regulation (Josephs & Zettl, 2009, CFTRE, Manual I, p. 2). The SRT manual also describes dysregulation as the inability to self-regulate, which occurs when the nervous system becomes over-

activated and the normal activation/deactivation cycle, is disrupted. In reference to the Polyvagal model (Porges 2011), complex behaviors, including social interactions, depend on psychophysiology and how appropriately the nervous system regulates bodily processes.

Damasio (2003) referred to the, “emotion-execution sites” in the brain, namely the hypothalamus, the basal forebrain and some nuclei in the brain stem tegmentum” (p. 62). The hypothalamus is the executor, releasing chemical molecules and hormones that alter the internal function of viscera, and the function of the central nervous system. (Examples of these are peptides, oxytocin and vasopressin). The timely availability of these hormones within the brain structure commands the execution of behaviours, specifically those that are responsible for attachment and nurturing. He added attachment and nurturing are behaviours that occur as a result of the availability of dopamine and serotonin. For example, “the sort of behaviours experienced as rewarding and pleasurable appears to depend on the release of dopamine from one particular area (the ventrotegmental area in the brain stem), and its availability in yet another area (the nucleus accumbens in the basal forebrain)” (p. 63). These areas of the brain also control the movement of the face, tongue, pharynx and larynx, which are executors of many behaviours. These behaviours connect to a range of emotions, those that demonstrate physical attraction, to spanning those that communicate fleeing, to laughing and crying. Damasio (2003) added, “Emotion is all about transition and commotion, sometimes real bodily upheaval” (p.63). These emotions are evident in facial expressions, vocalizations, and body postures and are motivators for specific behaviours.

Kindling and Quenching: Post

In a seminal study on kindling and quenching (Post et al., 1997), kindling is described as being similar to that of fuel for fire, holding energy for future combustion. Kindling is used as a model to explain memory. In the case of human brains affected by traumatic events, " memory takes the form of flashbacks, anger, substance abuse, depression etc., all of which are provoked by specific stimuli" (Post et al., 1997, p. 285). A study was done on rats, which after prolonged exposure to high frequency stimulation (activating stimuli), developed seizures. When these same rats were then exposed to a series of longer low frequency stimuli they no longer experienced seizures. This phenomenon is called quenching (Post et al., 1997). The implication for therapy is that exposure to activating stimuli, the memory and/or sensory stimulation, might best be approached from a very low frequency and more sustained interaction level in order to obtain quenching of kindling in the neurobiological system (Post et al., 1997). This would suggest that therapy would provide clients opportunities to experience activating stimuli at a reduced intensity (titration), for a sustained length of time under the conditions that allow for prolonged and contained psychophysiological responses (quenching). Therefore, rather than exposing people to traumatic event re-enactment, effective therapy would provide a client with the opportunity to engage in gentle slower discharge of the energy that remains in the nervous system as a result of unresolved trauma.

Titration in SRT is done through monitoring that state of arousal and then tracking its resulting physical sensations. The slow releasing of unresolved activation from the body in the present moment is how titration serves to quench the kindled energy in the ANS. The therapist is monitoring arousal and keeping it within a range so that new

pathways can be laid down. In doing so the energy caused by remembering the traumatic event can be discharged.

Both art therapy and SRT use a right-brain-to-right-brain approach and attunement to best assess the quality of the resulting activation and facilitating resource. Resources used for this are found externally and internally, missing or available, trauma-specific or trauma-context free, relational or non-relational (Josephs & Zettl, 2009). Resources for the client include current healthy nurturing relationships, previous safe home environments, and images that are comforting, empowering and soothing. Resources develop in a person a psychophysiological state that accompanies the connection to anything that supports, nurtures, stabilizes, and strengthens the person. This is essential when the work in the therapeutic context is stimulating, for example when generating images and engaging the imagination. The creative process of art making and the created art image serves as a resource. As well, the therapist also serves as resource, sharing the experience of an interpersonal felt sense.

The Felt Sense: Gendlin

The phrase “felt sense” is attributed to Gendlin (1981), who developed a psychotherapeutic approach known as ‘focusing.’ Friedman (2004) researched and reviewed Gendlin’s body based therapeutic method which was developed to emphasize the need to understand an individual’s personal experience in the here and now. He stated this “experiencing,” is bodily felt rather than “thought known” (p. 23). The therapeutic process using the “felt sense” makes direct reference to one’s “felt sense” of the problem, issue, situation or concern explored during therapy. The “felt sense” can also be a present experiencing of a past event. The process of staying with that felt sense and by tracking

physical sensation while generating matching symbols that unfold can result in a “felt shift”(Gendlin 1981).

Malchiodi (2012) in her research on the integration of art therapy and neurobiology referenced how art therapy uses “biomarkers,”(the physical changes such as respiration, and other skin responses), as indicators of stress hormones in the body when assessing which therapeutic art invitations to choose (p. 20). A key element in SRT, is working with physical “felt sense”, which is necessary to quench the kindling. This can be compared to how Malchiodi described biomarkers, and they are constantly referenced when assessing the level of activation in the client.

Somatic Experiencing: Levine

SRT process came out of previous work and research by Josephs and Zettl (2001) in Somatic Experiencing SE, the therapeutic process developed by Peter Levine. Levine (2013) explained how SE was built to treat and explore trauma, and works on the premise that the body can release trauma. His work attempts to reframe how to view trauma, as an injury caused by fright and helplessness. According to Levine trauma can be healed by engaging in our physical sensations, (some extreme), and by cultivating and regulating the capacity for tolerating this connection with our felt sensations, through self-awareness, while supporting self-acceptance (Levine, 2013, CD).

Based on Levine’s work with SE, the process of SRT was developed to help the clients bring their awareness to their physical sensations as they enter a psychological state, associated with a traumatic event. This state is known as activation. Through memory retrieval, the client is invited to bring their awareness and focused attention to resulting felt sensations of the body in the present time. “Memories are more easily

retrieved when the emotional state at the time of memory formation matches the state at the time of retrieval" (LeDoux, 1996, p. 222). While calling on the individual's resources, (personal resiliency, positive memories and sensations) a process of titrating, (slowly releasing the charge this memory holds in the system) begins, and then unresolved energy from thwarted fight or flight in the nervous system can be discharged. The client experiences discharge as felt sensations such as tingling, heat, and even laughter (Josephs & Zettl, 2009). Josephs and Zettl stated, "It is important to remember trauma is in the nervous system and not in the event" (2009, Foundations Manual Level I, p.7).

A foundational principle of SE is SIBAM, sensation, image, behaviour, affects and meaning (Levine 1996). Levine developed SIBAM, a description of aspects of conscious awareness to map the body for therapeutic purposes. "Sensations" (Levine 1996, p.139), speaks to information from the visceral (proprioceptive sensation). This information originates in the body, such as muscle tension, expansion and collapse. "Image" (p. 141) refers to the five senses - sight, smell, hearing, touch, and taste that come from the outside world. "Image" has been expanded in SRT where it is referred to as "Impression" to include all sensory impressions (visual, auditory, aesthetic, olfactory and gustatory) (correspondence with Zettl 2014). "Behaviour" (Levine 1996, p. 143), brings to awareness for the client and therapist, ways of being with and relating to themselves and others through social, emotional and physical expression. These ways can be archetypal, such as hand positions, or dance postures that are universally used and communicated (Levine, 2013). Levine, (2010) described 'affects' as primary emotions, anger, joy, sadness, fear, startle, or disgust (p. 150). Often these emotions such as rage, seen in emotions, are expressed so quickly on the face they may be easy to miss. It is

necessary to note that important affects are also softer feelings and felt sense nuances that help take us through the day. “Meaning” refers to what happens after, when a person survives a traumatic experience (p. 151). When a person moves through a cycle of affects after coming to the realization he or she is a survivor, new meaning and beliefs arise unexpectedly (Levine 2010; Levine 2013). Cognitive beliefs and interpretations can become fixed in the system as a result of the traumatic event. These can be unconscious and dissociated ways of thinking. Through therapy new meaning changes cognition and transforms thinking. The idea that the world is a dangerous place can be transformed into an idea that the world is also safe. For example, life becomes like that of poetry, full of metaphor and sensuality. How SRT has incorporated SIBAM as part of its principle model and process is explored in Chapter Four, on discussion of data.

Zettl: SE and emergency personnel. Zettl (1998) surveyed 14 emergency service personnel diagnosed with PTSD to explore their experience of trauma and Somatic Experiencing Therapy (SE) (Levine) with her. Through heuristic inquiry (Moustakas, 1990) this phenomenological research reviewed the lived experience of Zettl and her participants. Zettl used therapeutic approaches based on psychophysiological principles to work through emotions of terror, rage and grief and observed that gestures and emotions that were frozen in body memories were brought out and explored in conscious awareness. SE therapy with her brought about affect resolution of unresolved arousal energy. Zettl explored psychological patterns of behaviour that included traits of courage, helping, control and protection with the firefighters, police officers and paramedics.

She also identified the archetype of the hero, which provides the energy that spurs emergency service workers to sacrifice themselves in the line of duty with skill, strength

and courage. This role of hero is shattered, when a critical incident “punctures the armour,” and challenges past assumptions of their ability to be effective in their job.

In Zettl’s self-administered questionnaire several development themes emerged. The childhood histories of these individuals diagnosed with PTSD were strikingly traumatic and difficult. As a result these participants were more prone to PTSD diagnosis as a result of pathways laid in their nervous system in childhood due to early trauma and living conditions. Zettl stated, “Working in the emergency services field can be seen as a recapitulation of derailments at mirroring and idealizing in childhood” (p. iii).

Following her therapy work with these participants only one still met the criteria for diagnosis of PTSD. Zettl’s (1998) participants following the treatment of their PTSD were able to renegotiate their shock trauma and described an improved quality of life, which was evidenced in how they related to their families. They were also able to enter more consciously into their lives, and reported that their sleep patterns had improved.

Some participants described an increase in anxiety and nightmares as the work proceeded, and some experienced an increased awareness of physical discomfort, such as in their backs and necks. Zettl (1998) suggested that this might have been caused by an increased awareness of their sympathetic arousal in the body as a result of the therapy sessions. She stated that it was possible that these symptoms did exist before but were cut off from conscious awareness and were held unconsciously in the body. For example, Zettl (1998) explained how anxiety held unconsciously in the body “was split off at the time at the critical incident and was breaking through into consciousness” (p. 233). Some participants described anxiety as having diminished following treatment. It was hypothesized that the sensations of emotions, which were attributed to anxiety, were

coupled with the traumatic events, and had become more manageable because they were dealt with using the process of titration. Zettl stated that after treatment her study participants showed marked improvement in their ability to be more present, less dissociative and more able to be socially engaged with her. Zettl's dissertation and work in SE preceded her work and development of SRT.

Art Therapy: Opportunity to Look for Therapeutic Theory Overlap

Art is also a way to offer sustained contact with a disturbing memory, image, or emotion and can be supported, and softened by using specific art modalities, and materials (Hass-Cohen & Franklin, 2009). Hass-Cohen, (2008) emphasized that therapist knowledge is essential in choosing the materials used, as initially the strain of a novel demand such as art making can be activating for the client. She stated that art making in a non-judgment environment such as the art therapy studio, engages nerves of the somatic nervous system to carry incoming sensory information. Hass-Cohen said that experiences of both pleasure and distress can result, as touching art materials such as clay, "may elicit emotional reactions such as pleasure, discomfort or distaste" (p. 177).

Art therapy can provide relief by pairing fear-arousing emotions with positive new sensory experiences happening in the here and now (Hass-Cohen, 2008). Art therapy can be described as complementary to the SRT process in that it engages activation happening in the here and now, to then express and discharge this energy from the body and the mind, to bring about release.

The Expressive Therapies Continuum, ETC

The foundational framework for using art in therapy, *Expressive Therapies Continuum ETC,* Hinz (2009) is based on the underlying principles of the development of

mental imagery, processing of information, and the integrative power of creativity. Lusebrink (2004) stated, “Art therapy focuses predominantly on visual and somatosensory information; that is, how images and their expression reflect emotional experiences and how the emotional experiences affect thoughts and behaviour”(p. 128).

The theoretical concept of ETC was proposed by Lusebrink and Kagin in 1978 (Lusebrink, 2011) and consists of three levels, Kinesthetic/Sensory, Perceptual/Affective, and Cognitive/Symbolic. Within each level, the concept of “creative” is also present (p. 169). Lusebrink (2011) hypothesized that these three levels of ETC reflected working in such a way as to access different areas of a person’s brain when processing information.

The simplest form of gathering and processing information is through the sensory modalities of the Kinesthetic/ Sensory level of the ETC. Hinz (2009) describes how kinesthetic experiences assist tension release and connection with universal healing rhythms and sensory experiences. These experiences can be meditative and soothing. Lusebrink (2011) suggested using tactile and sensory focused art materials to stimulate the sensory and motor systems of individuals who suffer from organic or traumatic brain damage. These tactile medias used within the Kinesthetic/Sensory component are also likely to stimulate emotional responses.

Progression to the Cognitive/Symbolic component of the ETC (Hinz, 2009) sometimes requires an initial exploration of the impact that trauma has on the body, primarily through the Kinesthetic/Sensory level. When information processing and image formation that occurs at the Perceptual/ Affective level begins to take form, it can become “emotional and raw” (Hinz, 2008, p.140). Working with formal elements of visual expression, such as forms, color and lines represents the perception end of the

Perceptual/Affective component. The affective component of the ETC deals with the expression and channelling of emotions along with the naming and identifying of a mood state such as sad, mad, glad, or frustration. Lusebrink (2011) suggested the inhabitation of emotional expression in artwork as seen in depression may be related to the decreased activity in both left and right hemispheres. This can be evidenced in a decrease in color usage, size of forms, and spatial arrangement.

At the third level, Cognitive/Symbolic, information is processed Healing activities involve complex cognitive operations, using multidimensional symbols that are given intuitive and cognitive meaning (Hinz, 2008, p. 141). Activities for the Cognitive/ Symbolic component include work with realistic or abstract images using spatial and temporal relationships with people, objects or specific occurrences concretely represented. Lusebrink (2011) gave the example of using media such as a collage of cut out shapes representing different aspects of a problem, which can be observed, changed, and reintegrated at a cognitive level (p. 131). From the process of engaging with symbolic representation, meaning making can evolve to bring conscious connection to the self and help the individual find new perspectives from which to view their experience.

Lusebrink (2011) identified how the drawings by individuals with left-hemisphere injury are schematic and repetitive whereas those of individuals with right-hemisphere injuries reflect their inability to perceive and draw complete ideas or themes (gestalts). She highlighted a study in which individuals with right hemisphere injury used spatial perception and reconstruction art activities including clay. Working with clay that emphasized the aesthetic and pleasurable aspects of the experience was used. She cited

that when working with individuals having left brain deficit art invitations that revolved around attention to details and sequences was effective. She stated, creative exploration can occur at any level of the ETC and involves the interaction of both hemispheres.

Hinz (2009) identifies right brain processes as sensory, affective and symbolic. Creative experience can be therapeutic without words, as words are seldom adequate to describe the right-hemisphere-dominant processes (Lusebrink as cited in Hinz, 2009). The counsellor using art in therapy must be confident when working with the non-verbal expression necessary to access implicit memories.

Although Porges (2011) does not focus on the creative art therapies specifically he does suggest music therapy, for those whose deficits in the social engagement system resulting from injury or trauma caused by another person. He added, “music has been used to calm, to enable feelings of safety, to build a sense of community, and to reduce the social distance between people” (p. 246). When a traumatic event is the result of harm done by another human, those who were harmed may experience distress when being around other people. Porges stated that since music contains acoustic properties similar to vocal prosody, music could be an effective therapeutic tool to use to modulate the neural regulation of the middle ear muscles. The use of music in therapy engages the therapist, the client and the music. Porges explored the use of music therapy for its influence of the vagus on the heart through using the breath in phrasing music, especially when singing or playing a wind instrument. He suggested working with the frequency band associated with melodies that duplicate the frequency band of the human voice. Porges refers to the music as “the third (p. 253). The use of the term, “the third” refers to another presence in the therapeutic environment, that of music. In art therapy “the third” is used to reflect all

the art made in the therapeutic context (Hinz, 2009). I also reference the term, the third, to reflect my belief in the mystery of an unexplained spiritual energy that exists, or perhaps is created, when two or more people gather to connect with each other with the intention of inviting healing. This mysterious third represents the integration of the transpersonal with the intrapersonal, and interpersonal right-brain-to-right-brain subjective connection.

Commenting on the use of art and music therapy for trauma, Green (2011) pointed to research that supports art therapy for children and adults to promote problem-solving techniques, teach relaxation and act as a preventative intervention with children who have experienced traumatic events but do not exhibit PTSD symptoms. She stated that drumming, along with the multi-modality approach of expressive arts therapies, could be effective in family therapy where "silence has been a survival tool" (p. 17). Attempts to use non-verbal expression in a safe group environment may help overcome usual censors and defences. Davis (2010) explored using music and expressive arts with children and adolescents to promote self-awareness and self-understanding after experiencing trauma. Malchiodi (2012) promoted a multi-modality approach to art therapy and creative art therapies, and this includes various approaches to using music. Music has been identified as a resource in both processes of SRT and art therapy.

Creating a Safe Environment to Play

The Polyvagal theory (Porges, 2011) explains the need to create a safe environment for the therapeutic context before any effective therapy can take place. He also identified the need to pay closer attention to the therapeutic use of play. Porges (2011) described play that is associated with social contact like that of rough and tumble

sports: it requires face-to-face engagement and transforms aggression to healthy physical play, which is pleasing and calming. This is an example of how people have used play naturally and intuitively.

As taught and experienced in SRT training and art therapy theory; through right-brain-to-right-brain authentic attunement the therapist can provide safety. This safe environment creates a holding container by allowing the arousal, as experienced in the client's nervous system, to interact and connect with the psychobiological affect regulation capacity in the therapist's own nervous system. The effectiveness of this is supported by evidence gathered from research studies that show that people in caring relationships who share and convey emotional experiences create a type of alliance to combat the arousal affects that are activated when remembering a traumatic event.

Such research is found with the work of Schore (2012). He stated that advances in neuroscience research have resulted in the "promotion of relational affectively focused psychotherapy process such as art."(p.11). He said that this intersubjective approach to therapy is more effective with populations (specifically severe personality disorders) that previously benefitted from cognitive and behavioural psychotherapy. Understanding the role of art and the incorporation of right-brain-to-right-brain theory, based on Schore's research, this statement may also be expanded upon to include the use of both SRT and/or art therapy interventions with more populations.

Steven Levine (2005) explained the philosophy of expressive arts therapy and attributed the ability to engage in serious play as being able to develop a sense of one's "true self "(p. 48). The work of Winnicott (1971 as cited in Knill et. al., 2005) is referenced to promote the necessity of creating a "holding environment" (p. 49), which is

an essential physical and psychological space necessary to facilitate the development of the self. The central premise of Winnicott's theory relies on "the transitional object" (as cited in Knill et. al. 2005, p. 49). "Beginning with transitional objects, the child's play-space can extend to toys and, ultimately, as he or she grows into adulthood, to works of art" (Knill et al., p. 40). Art and art therapy studio work can then be attributed to having the capacity to create a container, a safe playground, for the development and expression of the adult and child self, via the art and the creative process. The therapist's assessment that a client's is able to personally immerse him or herself into play can be viewed as an assessment and identify a lack of health. Creating a safe place to explore play serves as a healing tool for promoting resilience and improved vagal tone.

Those who have what expressive arts calls, "a lack of play range present experiences of situation restrictions" (Knill, 2005, in Knill et al., 2005, p. 78). This includes clients who are dealing with situations such as unemployment, illness in a family member, relationship issues, and limiting conditions in work and life opportunities. In these cases there is a prevalent sense of helplessness over the situation. Using play and the imagination to help the clients move through the experience of feeling stuck in their life circumstance can enable them to find ways through the myriad of options. The immersion in play uses and develops creativity.

Art making allows entry into a time-free zone. This experience provides a client with the space to step out of feelings and thoughts and forget them. Even if for a while, engaging in the creative process can be instrumental in strengthening coping pathways and art making can provide distraction from emotional and physical pain (Robin, 2008). In this way art making serves as a powerful resource, as participation in novel

experiences outside the regular routine, calls forth inner resources of ingenuity and problem solving essential for executing creative tasks.

Finding Resource

Resources are drawn from personal experiences and strengths both, internally and externally. Internal resources are those held by the client and external resources are gathered from elements and aspects of the environment, and may also include the therapist herself. SRT recommends the therapist be able to reference resources, internal or external from another time, ground them in the 'felt sense' and go from there (Josephs & Zettl, 2009). External resources are things like; time, nature, people, organizations, objects, rituals, art, books etc., while internal resources are things like imagination, movement, ability to relax, positive memories or experiences, humour, and physical fitness.

The intention of finding resources for the client is to "stabilize/enlarge the healing vortex of the client by having them elaborate on that resource" (Josephs & Zettl, 2009, CFTRE, Manual I, p.7). The healing vortex is described as physical, psychological, emotional and spiritual wellbeing, and a sense of empowerment and safety. Resources for the client include current relationships, previous home environments, (taking a resource from another time), and images. These images are generated when reflecting on dreams, inspirations and fantasies generated through the imagination. Resources are described by SRT process as, the psychophysiological state that accompanies the connection to anything that supports, nurtures, stabilizes, and strengthens the person. People will remember resources from these time periods. When people are not able to

remember the traumatic event, they may be able to connect with the state in their nervous system, and as a result implicit memories may emerge.

Hass-Cohen and Findlay (2009) suggested that having the client in the art therapy invitation intentionally search for active coping resources elicits a perceived experience of control and movement out of a feeling of helplessness. They added that it is possible for pain to be reduced during pleasurable art making if a minimal threshold of arousal is maintained and strong negative emotions are balanced with strong positive emotions to reduce the impact of negativity. They cautioned, “reminders of pain might also induce strong emotions and trigger a fear response” (p. 177). Art therapy works as a therapeutic process and a resource to help a person cope with unremitting and chronic pain. It also helps clients to deal with stress responses and feelings of helplessness.

The use of imagery in both SRT and art therapy is done to offer resource to the client who has entered a state of activation as a result of remembering a traumatic event. Images when used as a resource, helps to titrate the activation. The fight/flight response of the ANS is resolved when working in SRT, by engaging the imagination in such a way that the client does not use gross motor movement. SRT teaches that engaging gross motor responses of movement override the ANS and interferes with quenching.

Imagination - Resource in Both SRT and Art Therapy

Imagining ourselves in a different place physically and psychologically gives hope and lifts us up and out of difficulty when we are stuck. As Matthew Fox (2004) stated, “Imagination is so vast, so large, so free that is grows our souls and allows us to ‘contemplate grandeur’” (p. 64). Holding on to the image that supports us, the art product that engages and nurtures while imagining creative solutions to our problems can be

inspirational and healing. I also believe, as Fox professed, imagination is the life force that runs through all of us and "creativity is a river, running through all things, all relationships, all beings, all corner and centers of the universe" (p. 66).

Integrating Imagination, Art and Neurobiology

An understanding of how art activities engage the brain is evidenced in the array of neuroscience studies that attempt to uncover how knowledge of neurobiology can inform art therapy and its process. Belkofer, & Konopka (201) measured neurobiological activity happening while drawing and painting. They found sufficient evidence to support that "art making may activate the temporal lobes to elicit dormant memories, emotions and sensations"(p. 61). This study measured patterns of electrical activity of a participant's brain following an hour spent painting and drawing. The study used electro-encephalograph (EEG) data to measure high (alpha and beta) frequencies and lower, (delta and theta) frequencies during active painting and drawing, and while engaged with the imagination. Not studied were the results on brain activity when drawing from memory, which may have great significance for art therapy interventions. The results suggested it is too simplistic to identify art making as solely a right brain activity given the complex roles that each hemisphere plays. The results were inconclusive as the study was done with only one participant Study of a larger group with multiple baseline measures over a longer experimental phase is required.

Bilateral integration. Bilateral art attributed to McNamee (2006) explored both left and right hemispheres of the brain as well as multiple sensory systems. Results from the study conducted on bilateral art with clients at a university family therapy centre over an 18-month period were derived from tracking changes in behaviour noticed by the

therapist, and described by participants (McNamee 2006). The process involved creating images using both hands. Drawings made following directives given by the therapist to use alternating hands were given. Conflicting feelings, events, and emotions were explored and evaluated as either positive or negative. All the while the client was asked to identify a focus. A scale of 1-7 was used to evaluate the belief in each of the opposing elements. Revisiting the scale and reflecting on the experience using narrative and/or drawing completed the process. McNamee (2006) showed how bilateral art may serve to integrate a client's cognitive or logical knowing with more emotional 'felt' knowing" (p. 13). The results also called for more controlled studies to further evaluate the effectiveness of the intervention.

Siegel (2012) addressed bilateral integration and stated the key to creating awareness and connection between the two distinct right and left hemispheres, is through engagement in activities that acknowledge equally the important ways of knowing in both. Activities dominant in one hemisphere can upset the balance, causing vulnerability in the other. Opening to the body's sensations and accompanying emotions, a right sided subjective functioning, can create an irrational and often ambiguous experience which can feel fragile to the logic-based and language defined left hemisphere. As well, the experience of being flooded by emotions can be soothed by the left hemisphere's logical approach. The ideal integration is a balanced operation of the two.

Use of language in psychotherapy. Schore (2012) suggested that psychotherapeutic theories that favour the use of language, as it has been previously thought to be dominant in the left hemisphere are no longer tenable. He stated that both positive and negative emotional words activate the right and not the left prefrontal cortex.

Schore said this pertains especially to spontaneous expressions that occur in the therapeutic space held by the regulated and attuned therapist. This research can also be used to support the use of language to express and regulate emotion. The use of language in conjunction with the non-verbal expression in therapy is promoted as, it is now understood that, emotionally charged language is generated and expressed using the multiple facets of communication in the brain and the body.

The use of language in this way during therapy, also described as cognitive and symbolic processing, is seen in both processes of SRT and art therapy. This use of language can lead to a greater state of awareness and a more conscious connection to oneself. Hass-Cohen & Findlay (2009) stated, the use of language and narration in creative art therapies help express and discover new meanings and contributes to affect regulation. When a conscious connection to the body, (our physical sense of existing in the present moment happens) a person can express the realization that he or she survived and are alive. The person who comes out of this state of disconnect from themselves, a result of an increased connection to their felt sense, can start to reconnect to their sense of self and engagement with their body. Then language can be incorporated and personal meaning making can happen.

Riley (2004) examined the rationale for using imagery and related recent findings in neuropsychology to support the practice of using the language of art in therapy. She argued for the effectiveness of art therapy as a process for facilitating “connection to the felt sense in the body, the mind-brain-body synthesis where trauma can be held and trapped” (p.187). In response to inner images, she stated that “unless we offer tools to our clients to enable them to actualize these representations, they will remain

inaccessible" (p. 186). It is this new way of understanding our complexity and the creative powers we possess that gives insight into overlapping theories and principles in these processes. Malchiodi (2003) suggested that by facilitating the creation of a narrative for a client, art expression may help to bridge the implicit and explicit memories of a stressful event through which the person can explore these memories and discover why they are so upsetting. She stated, "art activities, in this sense, may help the traumatized individual to think and feel concurrently, while making meaning of troubling experiences" (p. 21).

Influenced by McNamee's (2006) bilateral art, Talwar (2007) developed an art therapy protocol to access traumatic memory. Talwar suggested, "as a result of neuropsychology research on creativity, neuroimaging research on trauma and current art therapy studies, it is possible to infer that art making involves both of the brain's hemispheres in accessing memories and processing emotions" (p. 26). In this study a sequence of images was created with paint on a long run of paper, while the client was instructed to walk back and forth. This process entailed creating a story by creating a sequence of events and then narrating this story while assigning emotional significance to it. Talwar (2007) suggested that this type of processing allowed the client to observe his/her thoughts and create sensory awareness, which promoted affect and emotional regulation, and therefore resulted in engaging both sides of the brain. There were limitations to determining the effectiveness of this method. Talwar identified this article came out of work from her personal clinical practice and no research study has been undertaken.

Rappaport (2009) developed focus-oriented art therapy (FOAT), which integrated art therapy with the therapeutic approach of *Focusing* (Gendlin, 1981) in relation to a variety of clinical populations. Her hybrid therapeutic approach was developed over a 30 period. Rappaport (2009) developed FOAT to integrate Gendlin's six-step focusing method, with art therapy. Interspersed within a psychotherapy session, the client is directed through these steps in no particular order in accordance with the client's moment-by-moment experiential process.

Stelter (2000) reviewed FOAT process to highlight working therapeutically through the "felt sense" and presented the perspective that working from an internal physical sensation requires a phenomenological approach, which comes not in the form of thoughts or words, but as a bodily feeling. "This way it is possible to enter in to a dialogue with one's inner- knowledge" (Stelter 2000, p. 76). He described how exploring an image or presenting of a specific felt sense leads to change. Like SRT, Rappaport's FOAT works on shifting a felt sense, and when this felt sense changes, you can change and the traumatic event or incident will have less of an effect on your life.

Malchiodi (2008) recommended being cautious when visual images that come from traumatizing memories evoke an activating and negative emotional affect. She repeatedly witnessed how clients can express feelings through art before they can put what they are feeling into words. She added that one of the disadvantages of the non-verbal power of art is that is that it can activate visual images of traumatizing memories, create an emotional overpowering, and reawaken the amygdala fear responses. SRT process could be an effective intervention in such an event, to resolve this activation state caused by the charged memory which surfaces as emotional affect, and release its

psychophysiological hold. Zettl (2014) stated that SRT uses imagination because it accesses the activation in the brain and resources it in the neural circuitry without overwhelming the autonomic nervous system. When one uses imagination, it titrates the activation and allows for discharge because of its action on key areas of the limbic system. Overlapping principles of SRT and art therapy is evidence that both place great value on the power of the imagination.

To further explore the use of imagination as a therapeutic resource in therapy, and a resource state as stated in SRT process, I have referenced an art therapy study done researching imagination and the neural basis for episodic memory (Hassabis, et al., 2007). This study demonstrated that, 'imagining new experiences is a manipulative, and useful experimental tool which may prove fruitful in further advancing our understanding of episodic memory" (p. 14373), used in event recall. This study used functional MRI studies and proved we can construct scenes associated with events, and we can associate our feelings experienced during recall of specific episodic memory to these events.

This finding can be used to help us ascertain how we know that an event has actually happened, and may give insight into how we can renegotiate this memory recall, by using the imagination. The ability to renegotiate a memory in order to release its grip on the nervous system and its disabling effect witnessed in those with trauma (as in PTSD diagnosis) and does not suggest that in therapy we deny what has taken place. Rather we use the imagination to revisit and renegotiate our ability to deal with the experience in present time, to facilitate the natural execution of the fight flight and freeze adaptive functions of our mammalian brain.

The imagination is a powerful resource to explore psychological boundary rupture. To explore our endogenous (using only the mind) connection to peripersonal space (the space around the body), Davoli & Abrams (2009) researched reaction time associated with imagining a movement or imagining holding an object in one's hands. The study outlined how the ability to extend "into the space where the body may soon be, as if to scout out" that space for obstacles or threats, and thus avoid unwanted collisions, is evidence that, "the imagination has the extraordinary capacity to shape reality" (p. 294). Relevant to work with SRT and art therapy is that this study indicated clear advantages to understanding that imagining doing an action, or connecting with an object using visualization of images or symbols can help people connect to their personal space, and their perception of boundaries. This ability to work out engagement with the real world, from an imagined relationship to it, creates a form of personal containment and protection. The use of image, symbols, and engagement with physical action using the imagination in therapeutic interventions integrates SRT and art therapy approaches.

Personal Therapy: Regulation Leads to Attunement

The training requirement for both SRT and art therapy required significant hours of personal therapy. This process is intended to promote maturity by increasing the capacity for self-reflection, self-awareness and professional integrity, essential to filling the job of being a therapist. Rizq and Target (2008) discussed the significance of personal therapy in clinical practice, and stated that a reported growth in reflective capacity made a significant contribution to therapists becoming greater attuned and more empathetic towards their own clients. Being seen and having their story witnessed through successful therapy with another therapist helped participants in this study reflect

on and understand themselves and, in turn, their clients. The study also suggested that all forms of therapy might offer this opportunity for personal growth. Through authentic self-reflection, the unknown or unwanted parts of the self became seen, and when these are given substance and significance by both participant and therapist, a sense of wholeness can be promoted (Ritzq & Target, p. 78). Another name for this phenomenon is a personal integration (Siegel 2011).

Janoff-Bulman (1992) defined schemas as pre-existing theories and specifically at the core of trauma and treatment, is the assumptions that the world is benevolent, the world is meaningful and the self is worthy. She stated when these assumptions are shattered by traumatic events it is "necessary to attempt to effect change in people's fundamental beliefs about themselves and the world"(p. 39). In line with SRT and art therapy theory, a crucial task in successful therapy is to organize the traumatic state memories, and to demonstrate in a concrete way that the event is over.

In support of a neurobiological view of treatment of trauma with implications for art therapy, Gantt, & Tinnin (2009) suggested that using art and drawing interventions during a study with clients demonstrated that it was possible to move a connection, or a sense of trauma out of the present sense into the past tense (p. 151). In this study, a patient was instructed to create a narrative of the trauma story in pictures and then label the pictures with the appropriate survival instinct such as startle, fight/flight, freeze, altered state, submission, or self-repair. The client was instructed to draw himself or herself from the perspective of a detached observer. The therapist, as the audience, then represented back to the client an historical account as depicted by the pictures.

The authors, Gantt and Tinnin (2009) claimed this procedure aided in reducing dissociation and alexithymia (p. 152). Alexithymia is the inability to express or name emotion. The authors described using clay work, speaking, writing or drawing in a process of entering into dialogue. The two entities involved in the dialogue were the part of the self that was frozen during the traumatic event and the part the self that the person identified as being present in the here and now. This process attempted to meet the goal of recruiting and integrating the past self into the person's present life.

The art and science of mirroring and mirror neurons. Schore (2003) stated there is convincing evidence that significant metabolic activity in the body results from "psychological treatment that engages the right orbital cortex, and subcortical regions of the brain" (p. 202). Schore (2003) suggested that the most powerful theoretical and clinical implication of this research is that the adaptive self-regulating process of the right mind occurs at two modes: auto regulation, via the processes of a "one-person psychology," or interactive regulation, under the operations of "two person psychology" (p. 216). Schore (2003) added that the capacity of the unconscious right mind to shift between these two modes supports potential for individuals to attain greater self-regulation through intentional connection to self and to others.

Evidence of a client's capacity to engage with others, specifically the therapist in the therapeutic context, needs to be assessed when deciding how to engage with that client. As Franklin (2010) stated, art therapists are in a unique position, "to build on intersubjective understanding by mindfully utilizing empathetic art to receive, consolidate and offer back expressions of deflected affect to their clients" (p. 166). Franklin (2010) urged caution when engaging in empathic art responses, as it is necessary to take into

account one's own unconscious processes and messages. Clients unaccustomed to this form of empathic exchange may feel it is too intimate too quickly.

Although Siegel's (2012) work on the processes in mirror neurons is not referenced in either SRT or art therapy research literature I found a similarity with these processes. Siegel described how neurons distributed in various regions of the brain with both motor and perceptual functions become activated by the perception of behaviour of others and are then able to create maps of another's intentional state. "The proposed mechanism of mirror neurons is supported by a number of investigations but some scientists feel it is not substantiated yet" (Siegel, 2012, p. A1-52).

Moving out of states of dysregulation such as that of dissociation creates greater ability for awareness, and the capacity to enter into a state of being connected to the conscious self. Both these therapeutic processes attempt to facilitate healing while helping a person find a new connection, a new personal integration to deal with the effects of trauma.

Using the example of portraiture work, having a client bring awareness to their emotions that are evoked when observing their own self-image, engages the Perceptual/ Affective component of the ETC (Hinz 2008). This integrated approach might help the client face their emotions, as they gaze upon their own reflected self. The client is then given the opportunity to deal with the resulting emotions, one at a time, while tracking the felt sense in the body. Creating new meaning can then begin to evolve and allow the ANS to shift the emotional affect and its charge out of the body.

The Therapist's Identity: Watching the Changing Portrait in the Mirror

Being an artist first and then becoming an art therapist, suggests that as creative art therapists typically have a background in the arts, identity develops through interests and personal pursuits influenced by this experience. A great indicator of one's identity is evidenced in the group portrait one poses for. As belonging to that community frames personal and professional connection and suggests a shared network and alliance. Emery (2012) illuminated this experience of being influenced by a community one identifies with and used the example of the development of an art student. He explained that the student's approach to learning reveals the tendency to mistakenly identify with what has already been done. He argued that a student would do better to tolerate ambiguity, and allow the development of style, and interests pursued to accumulate and converge over time. Emery examined how artists bring varying interests together depending on interests or inspiration to then enter into the creative process to generate their own work.

Art therapy students can be described as unique in that they may not view learning or research the same as other counselling or psychotherapy students. Art therapy often draws its students from the world of artists. In a study by Deaver and McAuliffe (2009), which examined visual journaling during art therapy and counselling internships, it was discovered that art therapy interns differed from other counselling interns in how they approached feelings of anxiety and fear when confronted with the challenges of working with clients. Counselling students went to the Internet and the library. Art therapy students spent more time in reflective art making processes, and dialoguing with peers and supervisors. The differences may suggest that art therapy interns have a conviction based upon their personal experience in the creative art making process, that

this process will also facilitate support for their clients. The Deaver & McAuliffe (2009) study also showed that the topic of professional growth in art therapy is one that warrants further study. Literature on the subject is scarce.

Personal and Transpersonal Integration: the Final Domain

Siegel (2012) explored nine domains of neural integration and described how the mind creates a coherent self-assembly of information and energy flow across time and context, even when challenged by impairments in affect regulation such as insecurity, unresolved trauma or loss, and dysfunctional social relationships. He defined the final domain, transpirational integration, as the development of a sense of self that evolves into a sense of belonging to something bigger than the physical self. Siegel (2012) stated that even more than connection to others, transpirational integration defines a sense of self, experienced as a "plural verb"(p. 387).

Malchiodi (2008) added that for true transformation to happen, meaningful and personal expression has the most potential for therapy, if it is not imposed but rather comes from the insight of the traumatized adult or child. Malchiodi (2003) observed from her work in art therapy with children from violent homes that art can be used to tap into the body's relaxation response. She observed that art activity had a soothing, hypnotic influence that these children were naturally attracted to when anxious or suffering from posttraumatic stress. "Someday, through the use of brain scans and other technology, we may have a clearer understanding of how to use art therapy to tap the relaxation response for clients of all ages who have undergone intense stress" (Malchiodi, 2003, p. 21).

The literature suggests that a bridge exists between the theoretical and therapeutic foundations and underpinnings of creative art therapies and the neurobiological-based

and psychophysiological principles of SRT. Malchiodi (2009) also referenced work done to explore integration with neuroscience and art therapy, and described two camps of thought: those building this bridge and those for whom, “the bridge has become more pronounced” (p. 57). Perhaps this statement could also be expanded to suggest that the integrating of art therapy and SRT processes might result in gaining greater access to more neurological resources and more areas of brain functioning, and could prove effective for the therapeutic treatment of trauma. This might be achieved by combining knowledge on how the brain responds to art with what is experienced in the psychophysiological processes of SRT.

I believe that where two or three people are gathered in the name of caring and compassion, energy will exist between them. This is *the third,* as I have referred to it this thesis to reflect how I see my work in the art therapy studio as a spiritual practice. Along with research on what happens within the individual, the intrapersonal, evidence of how critical the role of the right hemisphere is in the processing of social and emotional information also supports the interpersonal model of a right-brain-to-brain interaction. My spiritual belief system must then also include the transpersonal, the presence of a mysterious force, *the third*, as the phenomenal presence.

There have been attempts to integrate similar art and science co-authored processes as noted in this chapter. The most significant implication is that the research that supports both these processes attempts to reconnect the clients, the trauma survivors, to themselves, their minds, brains and bodies, creating an interpersonal connection with others and eventually facilitating the transpersonal, reuniting the injured with their souls.

Chapter 3: Methodology

Watching The Self, Reborn Through a Mirrored Reflection

My research methodology included heuristic inquiry (Moustakas, 1990) along with reflexive/narrative autoethnography (Ellis, Adams, and Bochner, 2011; Kapitan, 2010, and Wall, 2006). This inquiry was an exploration of my lived experience as an emerging art therapist learning the therapeutic process of Self Regulation Therapy (SRT). I reviewed eight video sessions of myself using the SRT process in my art therapy studio with the same client. I then developed and posed questions that would aid this exploration and self-reflection of my experience as I watched myself in the therapist's chair.

My own image in the therapist chair was mirrored back to me, as the video camera had captured my reflection in a bureau in the room. Having an image of myself reflected back to me, created another dimension, another picture of myself to use for self-reflection. New themes and discoveries gave insight into my new identity as an emerging art therapist having undergone SRT training were revealed as I watched myself on the screen in the role of therapist. Watching the eight video sessions of myself using the SRT process with my client, it became evident that I filled the role as both researcher and co-researcher. I was both the subject and the observer, evaluating my performance within this framed image. Reflected back to me was my immersion into this complex role of a therapist attempting to deliver personal therapy to another person. The two research methodologies were used in an attempt to determine the influence SRT has had on my professional development as an art therapist, as they allowed me to script a reflective narrative of this experience.

In addition, I was able to view myself in the role of client in three video recorded sessions of my personal therapy with Art Therapist JoAnn Hammond-Meier. I used the process of art therapy to explore my personal transformation and integration that resulted from the influence of SRT training on my professional identity. It was later established that revelations gained during these art therapy sessions contributed to the data that informed this thesis's themes.

Heuristic Inquiry

I chose heuristic inquiry (Moustakas, 1990) methodology to frame this research around my personal experience in SRT training, as it allowed me to delve deeper into self-reflection on how I was being influenced within the landscape of my emerging art therapist identity. Kapitan (2010) in, *Introduction to Art Therapy Research,* interpreted heuristic inquiry as "the researcher's intense interest and personal experience with the phenomenon" (p. 145). Kapitan (2010) challenged the art therapy researcher to think beyond this and become concerned not only with his or herself but also with the nature of the human experience as represented by the experiences of the researcher (p. 145). This experience of watching my image reflected back to me as I viewed my self in the therapist's chair sparked a curiosity about what was happening in my personal transformation. I hope this investigation into the feasibility of integrating neurobiology (as described in SRT process) with art therapy theoretical frameworks will create dialogue among other creative arts therapists. I am curious whether or not there exists a desire or curiosity about the possible results of doing so, and thus embrace this new learning and knowledge into art therapy practice.

Moustakas (1990) named heuristic inquiry when he was searching for a phrase that would encompass the processes he believed to be essential in investigating human experience. “Heuristic” comes from the Greek word *heuriskein*, meaning “to discover” or “to find”, and is the cousin word of “eureka” (p. 9). Heuristic inquiry refers to a process of internal search through which one discovers the nature and meaning of experience, and develops methods and procedures for further investigation and analysis. The heuristic inquiry process (Moustakas1990) incorporates creative self-processes and self-discoveries.

The heuristic inquiry process challenged me to rely on my own resources and to gather within myself the full scope of my, “observations, thoughts, feelings, senses, and intuitions; to accept as authentic and valid whatever will open new channels for clarifying a topic, question, problem or puzzlement” (p. 13). The self of the researcher is present throughout the process: while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge.

Autoethnography

Autoethnography is an approach to qualitative research that seeks to describe and systemically analyze personal experience in order to understand cultural experience (Ellis, Adam & Bochner, 2011). The term originated with D.M. Hayano, in 1979 (Wall, 2006, Wolff 2009). Well-known autoethnographer Carolyn Ellis (2004), stated that what is novel about reflexive ethnographies is that they document ways a researcher changes as a result of doing fieldwork. Reflexive/narrative ethnographies exist on a continuum ranging from starting research from the ethnographer's biography, to the ethnographer studying her or his

life and also other cultural member's lives. This study expands its view into ethnographic memoirs (Ellis, 2004).

Combining Autoethnography and Heuristic Inquiry

I combined methods to give myself a frame that would be open enough to allow exploration of my personal story of professional development. These methodologies also provided a framework to validate exploring my identity as it pertains to alliances with schools of psychotherapy theory. Because they are open to individuated approach both of these methodologies provide room for self-exploration of unique personal narrative. Sarah Wall *(2006)*, in her article, *An Autoethnography on Learning About Autoethnography*, was critical of both approaches. She criticized both Ellis and Bochner (2011) with regards to autoethnographic inquiry, and Moustakas (1990) on heuristic inquiry. I as well found that both of their discussion methods were, "very philosophical and abstract, and somewhat lacking in concrete information about the method and how someone new to it might proceed" (p. 151). Therefore, Wall (2006) suggested incorporating autoethnography alongside other well-known qualitative research methods. I am including reflexive/narrative autoethnography as a methodology alongside heuristic inquiry. I see my commitment to the therapeutic process of art therapy as also being part of a culture, a group in society with a specific and unique identity. I identified with how Ellis, Adams & Bochner (2011) described this approach. They said researchers who do autoethnography write about epiphanies that stem from personal retrospection and they are selected based on affiliation with a culture and its cultural identity. I propose that I am part of both cultures being researched as I study SRT processes as well as art therapy theory and practice.

The Artist, Community and Therapeutic Theories

The artist in me entered into various communities of therapeutic theories, and gravitated towards what was congruent with my interest and energy. It have also gained from accumulative experience and literature explored in coursework completed to satisfy the St. Stephen's College Master of Psychotherapy and Spirituality, Art Therapy Specialization Degree. Involvement with these communities is how I believe a connection to culture has developed as it pertained to an alliance with specific and respective philosophies and therapeutic theories.

Choosing Data

Moustakas (1990) distinguished heuristic inquiry from traditional quantitative and natural science methodology, recognizing that qualitative design and approach is necessary to study human experiences, to focus on the question and problems that reflect the interest, involvement and personal commitment of the researcher. For this research, the search for answers on how my future work as an art therapist has been influenced by my lived experience in SRT training, presented the challenge of choosing relevant data. I faced several challenges in the search for answers about how my lived experienced in SRT had affected my future work. One of the biggest challenges was that of choosing relevant data. In the end my work with my chosen client, and the eight videos that captured our work together, myself as the SRT and art therapist, served as the main source of my data. I included artwork done during art therapy and creative art therapy experiences as I deemed them relevant sources for secondary data collection. (See Appendices A and B)

Moustakas (1994) also identified heuristic methodology as having regard for the data and experience of the researcher, which is imperative to the understanding of human behavior as evidence for scientific investigations. He suggested this experience and behavior represent an integrated and inseparable relationship between subject and object. Heuristic inquiry generally includes an interview process with subjects and/or clients. I chose to modify this methodology and view myself as the subject of inquiry as my research on my experience in SRT training excluded any other art therapists. The questions posed were posed to me as I watched the eight video sessions and witnessed the quality in which I engaged in therapeutic work with a client. I referenced and reflected psychophysiological aspects of SRT therapy to critique my effectiveness, my challenges and successes as a therapist, not to explore the client's story.

This research process that placed me as researcher and co-researcher included dialogue with supervisors in SRT training and an art therapist supervisor. I worked with Dr. Art Therapist JoAnn Hammond-Meiers for three sessions to process my SRT training experience. This was explored to gather insight and obtain feedback regarding my interest in bringing conscious awareness to how I was transforming myself as I was striving to become a psychotherapist. It also helped to keep me rooted in the search to answer my research question from a heuristic inquiry perspective. This form of dialogue is identified as essential in heuristic methodology and inquiry (Moustakas, 1990) and the conversations and influences of each were gathered organically as insights and epiphanies (Ellis, Adams & Bochner, 2011).

From a heuristic inquiry point of view, the bridge that forms between what is known explicitly (with conscious awareness) to what is known implicitly (what is not

consciously known) falls into the phenomenon of intuition. The exploration of my own intuitions, conscious and unconscious reasons for engaging in psychotherapy training, took place in part, in the art therapy studio during this personal therapy. Examining this phenomenon included exploring resulting symbols and meaning making that came from the art made before, and during the art therapy session. This "enhanced meaning and deepened and extended knowledge" (Moustakas, 1990.p 24). Although my art therapy with Dr. Hammond-Meiers complemented the research criteria for self-reflection in this inquiry, I did not expand the analysis of this data as it was deemed as secondary to the data collected by using the eight videos.

Heuristic and Autoethnographic Inquiry, Asking Five Questions Eight Times

Method outline. Moustakas (1990) discussed seven different stages of heuristic research: initial engagement, immersion, incubation, illumination, explication, and creative synthesis. He also described the necessary qualities and processes as - tacit knowing, intuition, focusing, indwelling, and an internal frame of reference. Using Moustakas' (1990) seven stages of heuristic research inquiry method contributed to the examination of how I have changed as a result of this thesis research. Personal inquiry acts as a framework to explore the development of; "discernment" in the individual and this transformation is a result of the research process (Hiles, 2001, p.4). Reflecting on my experience as the researcher and co-researcher brought about an understanding of how I have transformed my views on becoming a therapist. Becoming more conscious of my personal presence in the therapeutic environment has transformed my definition of professional integrity.

Initial engagement: first phase of heuristic inquiry. My initial engagement with my research question began as an invitation by a peer to attend SRT *Psychological Anatomy* training. It was during that weeklong training experience which took place in the spring of 2012, where I first experienced SRT therapy and conceived of the idea that I could use this new learning in my work as a creative arts therapist. My immersion in SRT training continued alongside my continued art therapy and expressive arts therapy training. I was gathering data from these experiences as I attempted to explore my own process through self-reflection and to research the newest literature on psychotherapy and trauma treatment.

To further this inquiry I explored several modalities to engage in art making along with opportunities to advance my education in neuroscience and trauma treatment. This included attending workshops on using art to map the body, using collage to explore the soul, attending a conference on neuroscience and learning, and continued to engage in personal art making in my studio. I later decided that these experiences did not qualify as data to investigate how training in SRT was influencing my professional development. It can be argued however, that in the spirit of heuristic and reflexive/narrative autoethnography inquiry these experiences contributed to my personal and professional development. They enhanced the newly acquired knowledge I was assimilating. This new explicit and tacit knowledge may have surfaced with my responses to the questions I was asking. I brought my entire background and experience I have had thus far to this research. I feel that what Moustakas (1990) stated in response to living and breathing the questions we ask ourselves requires that we embark in this self-inquiry with heart and soul.

> It becomes a kind of song into which the researcher breathes life not only because the question leads to an answer, but also because the question itself is infused in the researcher's being. It creates a thirst to discover, to clarify, and to understand crucial dimensions of knowledge and experience (Moustakas, 1990, p. 43).

Allowing questions to develop. Prior to developing the questions I would pose for self-reflection and critical inquiry as I was watching myself as the therapist in the videos, I sought further reference regarding the nature of heuristic inquiry methodology. In, *Phenomenological Research Methods,* Moustakas (1994) stated that qualitative research models, including the heuristic research model, "hold certain common features that distinguish them from the traditional, natural science, quantitative research theories and methodologies" (p. 21). I reflected on these features of heuristic inquiry when I developed my questions which are as follows:

1. "Recognizing the value of qualitative designs and methodologies, studies of human experiences that are not approachable through quantitative approaches" (Moustakas, 1994, p. 21), I needed to gain a sense of the over-all affect and effect of my therapeutic engagement with this client over several months of therapy. The objective was to make note of what was working and not working from an SRT psychophysiological perspective. As these videos were gathered while in SRT training I also became aware that I was curious about whether or no I was applying what I knew from art therapy application.
2. "Focusin*g* on the wholeness of experience rather than solely on its objects or parts" (p. 21), I was observing myself in SRT therapy and I was also looking to see whether or not I was able to observe myself as an art therapist. If I was not

witnessing myself in the role of art therapist was I able to imagine art therapy theory applications being applied in another session?

3. "Searching for meanings and essences of experience rather than measurements and explanations" (p. 21). I was looking to discern whether or not the spirit of art and the natural energy I know as congruent to my sense of myself as an art therapist student was evident in all or any of the sessions. This exploration was possible only after self- reflection. It challenged me to question whether I perceived the presence of art as essential.
4. "Obtaining description of experience through first-person accounts in informal and formal conversations and interviews" (p. 21), was done from the point of view as both researcher and co-researcher. Dialogue was entered into throughout this exploration of my thesis research and included personal therapy and profession training and supervision.
5. "Regarding the data or experience as imperative in understanding human behavior and as evident for scientific investigations" (p. 21), I needed to ascertain whether I had been able to deliver psychophysiological principles of SRT with some level of proficiency, otherwise the question of integrating these processes would be redundant. It was necessary that I saw evidence of being able to provide effective SRT therapy, before I could begin to explore whether or not I wanted to integrate this therapeutic process with that of art therapy.
6. "Formulating questions and problems that reflect the interest, involvement and personal commitment of the researcher" (p. 21), required that I firstly satisfy the

question of whether or not I would be able to and even, "wanted to," integrate the neurobiology of SRT language into that of art therapy.

7. Viewing experience and behavior as an integrated and inseparable relationship of subject and object and of parts of the whole" (p 21), meant seeing myself mirrored back literally, philosophically and pragmatically. The perspective I was offered of myself in the therapist chair was essential to complete the picture. Mirrored back to me in the eight videos and in the physical mirror in my art/art therapy studio was myself, the therapist. I reflected on how I responded to watching myself engaged in this work. I fulfilled two roles; firstly witnessing myself doing the therapist's work, and secondly, asking myself questions that pertained to my lived experienced as the therapist (the co-researcher), and also as the viewer (researcher), examining the phenomena, the experience of watching myself at work. From this subjective place as the audience, as well as the performance, I was challenged to reflect with as much as honesty as is possible upon my current professional efficiency and how the next stage of my emerging identity would play out as result of its influence.

Immersion: second phase of heuristic inquiry. Hiles (2001) stated in *Heuristic Inquiry and Transpersonal Research* that the emphasis of putting the researcher/inquirer at the center, and researching from this perspective is, "intimately linked with the awareness and the experienced world of the researcher "(p. 9), and "this can contribute to the transformation of the researcher's sense of self or identity" (p.10).

At the same time that I was looking for evidence that would illuminate how I was being influenced by SRT training and learning I was gathering eight video sessions of myself with a client. These recordings were required for completion of advanced level

SRT training and professional supervision. This research material helped to focus my research and formed the bridge between what was new learning and what was describable as my inner knowing. This bridging allowed the immersion stage of the heurist process to develop, as I was able to draw on observed SRT psychophysical principles being delivered and connect these with art therapy process. My identity of an emerging art therapist was already an embodied identity.

Incubation: third phase of heurist inquiry. Incubation is a period of retreat. During this period I retreated from the 'intense concentrated focus on the question" (Moustakas 1990 p. 28). I kept to my regular work schedule, I met with clients in my studio and with groups including women's expressive arts groups. I also continued my work as an artist in residence with Alberta Health Services Psychosocial and Spiritual Resources. While doing so I was exploring the questions for self-reflection and critical inquiry I would ask myself as I watched the eight videos. The questions I explored while watching the eight videos were*:*

1. Having viewed the video session, do I get a sense that I am present as solely a SRT practitioner, or do I perceive there was effort to integrate the art therapist and hence the two processes?

2. Having observed the session what did I feel worked and did not work using the concepts of SRT and what happened from a psychophysiological perspective?

3. If art therapy was used in this session do I perceive that engagement with the creative process contributed to the effectiveness of the session? (What happened from a creative art therapy perspective?)

4. If art making was not part of the session did I find myself drawn to imagining how I would initiate art therapy invitations to work with this client? If so, what might I have done from an art therapy perspective?

5. What did I notice in my own physical 'felt-sense,' as I watch the videoed therapy session?

The questions I developed during the incubation stage were ones I hoped would lead to my illumination in the fourth stage of heuristic inquiry

Illumination: fourth phase of heuristic inquiry. The process of illumination may be an awakening to new dimensions of knowledge, and occurs in situations where tacit knowledge uncovers new meanings and/or themes. As I explored how I had immersed myself into the SRT training philosophy I discovered I was also immersed in a culture that identified itself with neuroscience research. While maintaining a connection to the community of art therapists I reflected on this experience from both a personal and a professional perspective, which opened the lens that allows me to view myself as a member of both of these groups and as an individual within each. This is why I believe this research has had two streams of discovery: one is exploration of my identity as it has been revealed by professional alliance through participation in these communities; and the other is the feasibility of integrating the knowledge that I obtained by these distinct processes into one way of working in the therapeutic studio.

Viewing myself as a therapist and critically examining the congruency of that work with my sense of professional comfort was examined within the framework of the five questions. This process meant that I might be able to integrate personal experiences that were observable. As well, insights gained from new learning not necessarily visible or identifiable watching the video were also found. This type of knowledge that is not immediately obvious, tangible or visible can also be defined as “tacit” knowing (Moustakas, 1990), and forms part of the heuristic inquiry research concept explaining how the researcher can know more than she can tell.

Moustakas (1990) compared this type of knowledge to the learning one acquires throughout a lifetime. This learning is also acquired in the research process as an understanding and embodied assimilation of information. Moustakas compared tacit knowledge with that of learning to ride a bicycle, reading emotion in another person or learning to find our way through familiar situations in novel circumstances, such as finding our seat in a dark movie theatre. Being led into and through my physical felt sensations, exploring the psychophysiological processes of SRT to work with past and personal traumas illuminated a new way of viewing through the lens of explicit and tacit knowing. I experienced this type of learning by applying what was already embodied through my immersion in art making and creative art therapy experiences as client, student and practitioner, and then finding my way in the dark through the completely novel experience of being a SRT practitioner.

Autoethnography applied. The fact that my reflection was captured in the physical mirror in my studio reinforced the metaphor of "being mirrored back" to myself, as in being captured in a repetitive loop of looking at myself, creating an infinite reflection. This phenomenon, discussed further in Chapter 4, is significant in that it demonstrated the concept and process of heuristic inquiry when discovery of the researcher's identification with the focus of inquiry requires entering into (self-) dialogue with the phenomenon (Moustakas, 1990, p. 15) because, " . . . in self-dialogue, one faces oneself and must be honest with oneself and one's experience relevant to the question or problem" (p. 17).

Explication: the fifth phase of heurist inquiry. This provided me the time to identify key themes and make significant discoveries informing this inquiry. I could then

begin to imagine what this new reality for my future work and chosen therapeutic processes might look like. Core themes and discoveries in this stage included the observed psychophysiological concepts that I observed as I explored myself as a SRT practitioner. They also included the theoretical processes I explored in art therapy, along with my curiosity and comfort level experienced when using one /or both therapeutic processes.

As I observed my performance of this work I was challenged to bring greater conscious awareness to my affect in my own felt sense experienced at the time. Witnessing myself in these videos and reflecting on them, I experienced a neurobiological response that I documented as data. This process of turning inward to seek a deeper, more extended comprehension of the meaning of this experience, "indwelling" (Moustakas 1990, p. 24) was intended by making the reflexive/narrative autoethnography method of research, a conscious and deliberate attempt to find meaning and insight. Using intuition to perceive something through observations again brought me closer to discovering of my own insights, which Moustakas termed "truths."

Creative synthesis: the sixth phase of heuristic inquiry. While engaged in this personal experience research I explored a dream I had. I engaged my personal artist self to explore the felt sense experienced during and following this dream. The resulting piece, *In The Blue,* explored my attempts to reach for this new knowledge, as I had challenged my capacity to become a psychotherapist engaged in integrating these two therapy theories (See Appendix A for image).

The image revealed through the use of chalk pastels with my expressive arts mentor and teacher, Markus Alexander, as I sought the embodied, emotional and

psychological experience; the psychophysical impact the dream had on me. The core theme of this experience can be explained as the belief that if I fail or fall, whatever I find the personal courage to reach for in this work, I will survive. My belief is that there is a transpersonal force greater than myself that will catch me, support me, turn me upright onto my feet, and I will continue on my journey. This dream was also explored in SRT therapy with co-founder Dr. Ed. Josephs to the same resolution. A final piece was explored in my studio, in response to the original, and is the creative synthesis.

Validation: seventh and final phase of heuristic inquiry. The question of validation is one of whether or not the researcher has managed to make meaning from the experience of her heuristic inquiry. Only the primary researcher, who has undergone the inquiry from beginning to the end, can make this judgment (Moustakas, 1990).

Pack (2013) stated in her work on the benefits of practice-based research, that research ideally informs practice and practice informs future directions in research. I agree with Pack (2013) and her perspective regarding on the teaching of psychotherapist that, “bringing research and practice as separate activities together in a focus of critical reflection, is considered to count as knowledge in the therapeutic processes” (p.73). In this research I explored how my personal knowledge and experience has promoted personal and professional development and transformation.

Methods of Organizing and Synthesizing Data

I watched the eight videos, reviewed the questions then I reflected upon them through auto-ethnographic and heuristic inquiry methodologies as I witnessed and experienced myself delivering therapy to a client. I then analyzed the answers to these questions and found reoccurring themes. As a result of further self reflection additional

questions emerged. A coding system was established to identify these main themes as they were gathered through my observations of watching the eight video sessions with my client. The coding system was applied to the notes taken while watching the sessions and these included the observed and described evidence of the psychophysiological concepts of SRT. I observed myself achieving therapeutic success and I also viewed myself making therapy errors from both a SRT and art therapy perspective. I gathered data from the described experience of the client along with data obtained by observing and reflecting upon my self-observations when seeing myself as the therapist. The themes and discoveries became more defined and are:

(1) A change in knowledge changes the criteria for therapy;

(2) Imagination: using images, symbols, and play as resource;

(3) Treatment of trauma through therapy can be restorative and transformative;

(4) The therapist's identity: watching the changing portrait in the mirror.

Evidence of respect for, and exploration of client's spiritual identity and resources were reviewed. Also questions emerged about to how I would do the session differently from an art therapy perspective. These musings led me to consider how I would go about this from more of an art therapy process if I had future sessions with this same client. The process of exploring my emerging identity as an art therapist posed more questions about what it was I was hoping to accomplish by learning how to work with SRT processes.

Ethical Issues

I acknowledge that the mirror is a subjective frame from which to reflect on myself. Seeing myself in the mirror was at first uncomfortable and I do not agree that this narrative falls under what Wolff (2009), stated in regards to the ethical concerns of using

auto/ethnography methodology. He stated that although auto/ethonography has made a major contribution to understanding human actions and concerns it has also, in the worst case created a form of, “narcissism and autoerotic relation” (p.6). Critically reflecting on my abilities would have been less revealing of my personal challenges in becoming an art therapist, if I had explored the client’s experience over my own in this thesis inquiry. Watching myself in the videos revealed further work on my skills is required. While in part, watching myself on the screen provided some validation of my ability. In order to guard against delving in to a narcissistic personal exploration, I hoped to approach this viewing of myself as honestly as possible, alongside my intention to maintain a scholarly approach of using the literature and professional training as data that supports a strong research base approach to gather content for this self-reflective narrative.

De Freitas and Paton (2011) examined the practice of self-reflexivity in autoethnography, and challenged the researcher to acknowledge that we exist as “bundles of selves” (p. 485). They also challenged that as researchers we should write narratives that recognize that we are comprised of many partial identities, and that as researcher, the act of reflection maintains two identities of ‘authentic self and “reflexive self” (2011, p. 485). This illuminates my challenge faced in my desire to do good research, as I play two concurrent roles, both the narrating voice, and the audience.

I recognize the lack of others in my research approach. I hope that this personal exploration will lead to further dialogue within my aligned communities of SRT therapists and creative art therapists regarding the possibility, curiosity and perceived feasibility of the integration of the principles and practices of these two therapeutic theories. It is hoped that this study will result in further inquiry into possible ways of

integrating SRT and art therapy, to create a new process, theory and/or new explanation of the phenomenon of existing therapeutic approaches.

I needed to bring awareness to my subjective experience during this thesis research. I have needed to reflect on how this has influenced me, and then challenged me around removing myself as the researcher from my preconceived views (Cilexiz, 2010; Kapitan, 2010). I need to claim my lack of ability to be completely objective with regards to my already existing connection to art therapy and expressive art therapy training. This connection may have biased me towards that which has already birthed in me. Perhaps, once something is birthed and transformed within, it is difficult to criticize and judge unfavorably that which has already emerged. I have also allowed another birthing, namely this research on how SRT training has transformed me personally and professionally, including my cognitive, emotional, and spiritual growth. As I entered more deeply into reflection on my experience with SRT training I became conscious of my desire to defend my alliance to my communities that have been part of my education process. These include the communities of art therapy, SRT, expressive art therapy, spiritual psychotherapy and artists.

The client's perspective and input in this research is minimal compared to my own self-reflection on my role as her therapist. I needed to gain additional consent from my client to use the videos of our work done together for thesis research. She granted initial consent to me to use the videos in SRT training and supervision. Later, she granted her permission for me to use these videos showing our work together as research data for this thesis (See Appendix D). It was crucial that her identity be protected. Viewing of the videos for this research was done from the perspective of my lived experience in SRT

training and my self-reflections following witnessing myself as an emerging art therapist in this new theoretical process. The focus was on my curiosity and effectiveness in this role rather than with analyzing or evaluating the client's story.

Chapter 4: Discussion of the Data

Self-Reflection on My Own Images in the Therapist's Mirror

In analyzing the data, I have categorized key elements of Self Regulation Therapy (SRT) theory to explain how I evaluated the outcomes of these sessions, critiquing my delivery of the SRT process. Key themes in this process were explored through psychophysiological principles as I observed myself in the eight videos working with my client. I initially evaluated my ability to delivery therapy from SRT theoretical principle and theory. Then I included what I observed in respect to the art therapy initiatives that were used. Where there were none, I imagined using specific art therapy invitations and I gave my justification for suggesting these. To reiterate, the purpose of this thesis inquiry, my research was to explore how the psychophysiological approach to healing trauma, Self Regulation Therapy (SRT) is relevant to my work as an emerging art therapist.

Themes and discoveries that surfaced from exploring the data were used to organize the resulting revelations and epiphanies that surfaced. The themes are:

(1) A change in knowledge changes the criteria for therapy

(2) Imagination: using images, symbols, and play as resource;

(3) Treatment of trauma through therapy can be restorative and transformative.

(4) The therapist's identity: watching the changing portrait in the mirror.

Self-reflective narrative is the method that I used to gather the bulk of the data about my lived experience as an art therapist in SRT training. I gathered the data through observing myself as the researcher exploring my work with a client while using SRT in my art therapy studio. I also fulfilled the role of the co-researcher as the subject being observed. I was both the observer and the observed. The data was gained through a self-

reflective narrative on that lived experience. These observations – viewing myself in eight video sessions were my source for self-reflection. The self-reflective narrative was intended to reveal my experience over that of my client's. The client's issues and challenges were explored only to the depth that was necessary to examine my role in providing SRT as her therapist. Although what I observed was a result of a co-created experience, the research in this thesis examines my story and experience more so than my client's. I evaluated myself in this role of providing SRT therapy and I reflected on how I might foresee using this experience to integrate this new learning into my future work as I continue my professional development of becoming an art therapist.

I have experienced phenomenal events and sensations of energy when working with another person using SRT and creative arts therapy processes. Each experience has increased my belief that this way of being and working through difficulty together connects us to some great mystery. This mystery guides me on my life journey as I seek direction on how to find the work I should do. I have sought ways to pursue learning to strengthen and honor the gifts I have been given. This mystery, *this third*, has steered my continued efforts to learn how to become better able to do this work of psychotherapy. I do not believe it was coincidence that my path was directed towards SRT training opportunities. My inner knower, the inner voice that told me that learning SRT would promote and enhance this desire has given me the courage to find ways to integrate this new learning into my already existing commitment to art therapy process.

For my client, traumatic events included a surgery, motor vehicle accidents, relational trauma, and boundary ruptures. In the eight videos the events and issues my client and I explored initially included the witnessing of a motor vehicle incident, a motor

vehicle event, and a stressful car journey. She recalled a surgery, the recovery from it and the subsequent memories of its healing was worked through. Several sessions were spent exploring relationships. Our final SRT session culminated with an exploration of a dream. These presenting issues were approached from the SRT therapeutic approach, as the videos were initially done to fulfill the training requirement for advanced level training certification. Later while exploring my lived experience as part of the heuristic inquiry (Moustakas, 1990), I saw these as a fitting source for my data.

I watched the videos from the perspective of evaluating myself as a psychotherapist working with the SRT process. I also explored where art products, and art interventions were observed. Where there were none I looked for evidence in the SRT principles and theory to help me imagine and explore the possibility for including art interventions. When the therapy sessions used only SRT process, I imagined opportunities I could have used to bring in art therapy interventions, thus exploring the feasibility of integrating these two therapeutic processes. I also took note where the art and the creative process showed up simultaneously with SRT without my planning for it.

I also included data gathered from my personal therapy with an art therapist as well as therapy required for SRT training. Self-reflective narrative is the method that I used to gather the bulk of the data that explored my lived experience as an art therapist in SRT training. This data served as the source for the discoveries and themes. I organized the analysis and discussion of the data around the themes I discovered.

Theme: A Change in Knowledge Changes the Criteria for Therapy

The process of SRT is to bring people through overwhelming experiences without causing them to relive the experience. This is achieved by interrupting the pattern of dysregulation held in procedural memory, to allow for deactivation of shock energy from the nervous system (Josephs & Zettl, 2009). When the nervous system becomes overwhelmed the normal arousal cycle is disrupted. Self-regulation is the ability to discern between novelty and threat, respond appropriately, and then return to baseline. The goal in therapy is to work with the dysregulated client to help them become more self regulated. As a result often the individual reports a renewed connection to self through this transformation. The ultimate goal is "joy." This joy can also be referred to as being able to step into the fullness of life, and can be explored through sensing in to the movement of life force, the flow. This is in contrast to being dysregulated, which can present as the sense of being stuck in difficulty, referred to as fixity. This joy and flow of life force also describes how I use the word, "soul." Trauma can cause a disconnect from oneself, a disconnect from one's "soul." The goal of healing from the effects of trauma is the reintegration of the self – mind body and soul.

Incorporating the new learning SRT began with resourcing. Resource is described by SRT process as the psychophysiological state that accompanies the connection to anything that supports, nurtures, stabilizes, and strengthens the person. The healing vortex is described as physical, psychological, emotional and spiritual wellbeing, a sense of empowerment and safety.

The first priority when using the SRT process is to discover and establish the internal and external supporting resources for the client. Then these are drawn upon to

titrate activation during the therapeutic process. Before learning the SRT process I did not set a specific intention to do this. This is now my utmost priority when I meet with a client in order to attempt to contain the activation that will result by merely meeting with me. Memories and emotions surface when people come to therapy.

Before SRT training and during my student art therapy practicum practice I had used a comfort image as one way to find a support and resource for a client. This art therapy invitation entailed guiding a person to engage his or her imagination to create a fantasy image of a place that was soothing. The client was invited to use all five senses to explore this imagery. I often invited the client to use art materials to reinforce and express this image. It would be referenced when the client needed to take a break. It was hoped that this comfort image would provide a reprieve from the difficult images and emotions the client experienced during therapy. I also hoped this image would develop as an internal resource and would help this individual after leaving the studio. As a result of SRT training, I would now seek to provide a resource state for the client before initiating even this invitation.

Watching the videos of myself doing SRT therapy with my client I observed myself initially exploring a resourced state with her before entering into any therapeutic interventions. I did so to resource my client by helping her to settle into the environment of my studio, to ground her in present time and establish that she was physically present sitting across from me in my studio. This resourcing was done to titrate her level of arousal right from the beginning of the session. It also established a relationship for us.

Resources for this client included: current relationships, previous home environments, images generated through reflection on her art making, dreams,

inspirations and metaphors generated through the imagination. The SRT process seeks to support a resource state in the client before delving into the content of the event or emotion that has caused difficulty. For the client in my eight videos, powerful images were gathered from her dreams, acknowledgement of relationships, as well as works of art she did in the studio and on her own. She also gained support from other resources she was able to identify to me in therapy. Examples of some resources were; relationships, personal strengths, fantasy images, and connecting with her body- her felt-sense (feeling her body in the chair in present time). The intention of finding resources for the client is to stabilize and enlarge the healing vortex of the client by having them elaborate on their resources (Josephs & Zettl, 2009). These resources were also used to develop personal resiliency. The client possessed and identified resources that were both internal and external, as they were identified as existing within herself, and were gathered from her outside supports (for example, her faith). They were used in the therapeutic context to titrate activation in her nervous system as disturbing events and emotions surfaced and were remembered.

This activation is a result of an unresolved charge that resides in the body as a result of past, unresolved ANS responses to traumatic events. This charge or energy is also referred to as a "state of activation" (Josephs & Zettl, 2009). The goal of SRT when observing the psychophysiological state of 'activation' is to then connect the client with a resource state, titrate the arousal and facilitate discharge. For example reminding the client she has survived and is now here in present time, helps resolve the activation state. Bringing the client's attention to her felt sense in present time supports the release of thwarted ANS charge from the body. This movement is called, "discharge." This

discharge is accomplished through quenching the kindling in the nervous system (Josephs & Zettl, 2009). A state of activation was initially observed in my client when we explored content associated with recalling a stressful motor vehicle incident. She expressed the felt sense of tears building and the emotion of sadness that she described as a "lump in her throat."

Gaining an Understanding of Discharging in SRT Process

Although I worked with obvious beginning skills, I did witness the resolution of the unresolved charge that resided in my client's nervous system as a result of past events. I observed that I was able to facilitate, as a therapist, the psychophysiological principles of SRT, namely discharging.

I was empowered by the realization that I could actually facilitate this healing process as a therapist. In the SRT process a charge of unresolved arousal energy is released through the slow process of working with small amounts of activation or energy within the resilience of the client's nervous system. This is called titration and is based on the theory of kindling versus quenching (Post et al., 1997). The implication for therapy is that exposure to activating stimuli; the memory and/or sensory stimulation should be approached from a low frequency and a more sustained interaction level in order to obtain quenching of the persistent kindling in the neurobiological system. Kindling is held as fuel for the residual charge held in the nervous system. It exists in an individual's nervous system because the natural adaptive survival and defence reaction to a perceived threat was not completed.

There was evidence of discharge throughout the eight sessions. These included heat and flushing observed on her face, relaxation of her body into the chair, and tingling

sensations as described by the client in her hands and down her legs. The activation state that preceded this discharge of physical energy was evidenced in observing the movement of physical sensations. For example, the client described in several sessions, ‘a knot, a holding of tension and tightness’, in her stomach. Through the “tracking” of this sensation along with “resourcing,” this tension moved outwards along her sides, like a “girdle”, until this sensation, as stated by this client in later sessions, was “substantially reduced, and was changed or absent.”

Learning How to Remove the Charge Through Titration

Recalling a traumatic event in chronological order typically results in the client being drawn to the most explosive and highest charged aspects of the experience. This is always overwhelming to the nervous system. In SRT, titration is implemented to allow for quenching of the kindled parts of the brain that are related to the trauma. One of the ways that titration is achieved is working achronologically*:* the therapist works “post,” after the traumatic event and then before “pre,” staying away from the main event, the area of the most intense activation (Josephs & Zettl, 2009) until there is more resiliency in the ANS.

When working with my client’s memory of a motor vehicle incident, a long journey, and a surgery, I worked initially with the memories that were gathered post, after the event, recalling the time after the threat had passed and she had survived and track her sensations. Resources established in the memories after (post) of the event along with those already established in present time in the therapist chair, were used to deal with the activation that ensued. This activated state resulted when it was merely identified that the event had occurred. The goal was to work with memories associated with the event from

a distance that ideally allows for a manageable amount of activation to be worked with using the felt sense, and then through sustained tracking of physical sensation, hopefully discharged.

Art therapy and SRT similarly integrate the neurobiological research that highlights the significance of understanding the theory of kindling and quenching. Art therapy allows the art to direct the intensity of the stimulation as the client is given control over the content. With skillful direction in the materials provided, the therapist can contain the intensity of the engagement in the art marking.

Only once the intensity of activation that results in the recall of the event has dissipated does the therapist attempt to explore the memories attached to the traumatic experience – the main event. Only then can it be worked through. It is possible at times to work through this event and renegotiate it. The choice to stay with the charge in the nervous system and engaging the felt self (titration) can result in discharge. This occurs while recalling pre and post memories of a traumatic event. This requires a dance with the process of titration, and an attuned therapist to find a right-brain-to-right-brain intersubjective connection.

Learning What It Means to Be More Attuned

As in SRT and in creative art therapies, the onus is on the therapist to become open and attuned to what is happening within that client. What is happening with my client, in a time of difficulty that touches me is that which resonates between us. As I was beginning to become more attuned to the physical sensations of others during the interpersonal therapeutic connection I experienced sensations in my body that made me wonder if she was experiencing something similar as well. Feeling the challenge of

trauma and injury and its resonating sensations in the client's "felt sense" complements the philosophy of Gendlin (1981). He described how empathetic resonating is living the experience of the, "felt sense". In this way the therapist working as a professional in a therapeutic context also becomes a companion, experiencing and holding the empathetic space for the client to explore her own unique journey.

It is with this understanding that I have come to appreciate that great awareness of my own degree of regulation is essential if I am going to be able to step into this role of therapist. As the neurobiology research has shown, as the therapist I need a regulated nervous system if I am going to be able to hold the space for another's process. If I am not regulated myself I will be unable to lead the client on a safe path, through an attuned connection. I have come to appreciate how, when I am not grounded I can be drawn into the energy of the activated state existing in another person's nervous system. I have discovered that it is essential to join my clients in their experience without being drawn into that experience myself. Identifying my own nervous system as separate from theirs, and discovery of my dysregulation, I can better recognize what is the client's experience and what is mine.

The client came to me to deal with what she described as overwhelming emotions. She specifically named sadness. As therapy progressed, anger and frustration were identified. Her emotional over-load was witnessed in the activated tears, feelings of frustration and the demonstrated thwarted fight response that was repeatedly observed.

The client described these overwhelming emotions that interfered with her ability to fully enjoy her life. The emotions were confusing and the distress amplified by the inability to understand its source, or purpose. She expressed the desire to live an

unencumbered rich life with all the abundance she perceived such a life to offer. She sought skills to help her to contain emotional "over pouring." She said she wanted to step into her life with more enthusiasm and positive energy.

I developed a more comprehensive understanding of SRT theories and principles through ongoing self-reflection and supervision as a result of observing myself working with this client. I began to further understand the significance of being able to work from a right-brain-to-right-brain sensitivity. Through my self-reflections I recognized examples where I observed my own tendency to enter into my left hemisphere, thinking about what to do and say, in order to deal with challenging circumstances. This shift to my own internal world proved to distract from my ability to hold the space, to create the therapeutic alliance with the client. This was also a result of my own tendency to dissociate.

I have come to accept with compassion that this is natural tendency to enter into a dissociated state is based on the dysregulation in my own nervous system. I discovered this tendency to withdraw into this dissociated state was a result of my past injuries. As well, this may be an indication of how my education has valued thinking over feeling. I have recognized my tendency to lean towards a left-brain connection, to think my way through challenging circumstances. I have also noted a shift in my awareness and desire to connect alternatively through my right brain as a result of my work and therapy experiences and my journey in the creative arts.

In one session while we explored the anger and frustration my client experienced as a result of how the work of artists is perceived in the world, my countertransference was witnessed in my verbal and non-verbal connection to our shared insights. Schore

(2012) suggested that a greater intersubjective client therapist healing would have been accomplished through more transference, and countertransference. An example of transference was that the client might have seen me as a companion in her struggle to find support and validation in being an artist. I could have shared her challenges with being an artist who has not made money or a name through my work. I also identified with being a woman and in my 50's having capitulated to roles defined by societal sexist norms. I could have shared that I have come from an imperfect family environment, and the acknowledgement that I have shame around this, would have perhaps normalized our experiences, placing us as humans in a human and imperfect world.

An image from the client's dream was used to access a resource state, and engaging with the imagery of this dream was used to deal with the state of activation. My client described this state of activation as a felt sense of having "heavy weights holding down her ankles." The dream image and the imagined quality of movement of "Jake the Horse," resulted in the client experiencing discharge, a sensation of tingling in her legs and hands, flushing in her cheeks, smiling, and laughter. I witnessed myself mirroring back "expressive vocabulary," and fighting postures that the client had also resourced through this same image. She was then able to express and respond to feelings of anger and frustration as she was beginning to find some meaning and possibly some of the source of her thwarted fight.

We continued to engage in exploring the metaphors and playing with the image. I experienced this SRT session as a truly creative therapeutic approach. I also imagined how I might have been able to spend more time with art materials and movement to further work through these feelings of frustration and anger. I wonder if by using the

creative arts therapy approach of physical expressive movement, engaging and reflecting back to the client the quality and the essence of the emotion explored, whether I might have been able to further facilitate a release of her thwarted fight response. These are the sorts of question that convinces me that it is feasible to continue exploring the integration of these two processes.

Unfortunately, as this session progressed and just as my client was experiencing another discharge of seeing colours of light, I observed myself in the video looking for my phone. Through self-reflection and my memory of this session I suspect I was observing myself shifting into my left-brain focus and as I started worrying about my cell phone. Fearful perhaps of being unable to hold the space, I become protective of her and the experience. I observed myself digging in my purse to find my phone. The client then felt unsafe and not held and the discharge we worked for was aborted. Watching this made me feel shame for my actions, and I wished I could access a time capsule and re-do that moment in time. I had entered into my left-brain, possibly to deal with my insecurity as a result of my lack of confidence in this moment.

However, where this session was successful was that there was still release of good amount of thwarted fight. Some of this discharge was accomplished as a result of finding a powerful resource of imagery to deal with this unresolved desire to fight back, (Jake the horse kicking off his ankle weights) to run free and release some of the energy that had been created and held in this state of activation. When a person's natural response to threat (fight or flight) is thwarted, they are apt to feel anxious, hypervigilant and irritable, and his or her mood may vacillate between anxiety, fatigue, excitement and depression (Josephs & Zettl, 2009, CFTRE, Manual II, p. 5).

Being Stuck in Procedural Behaviors

I witnessed the client repeatedly focus on her right index finger, which was named, “the list maker”, and pointed out all the, “should haves” that were required to get “tasks” done. This always-on-the-go finger would become active as soon as the client started to explore resources, and positive feelings associated with an idea or desired activity. Identified in several sessions was the client’s difficulty in taking in positive affect. Guilt associated with a ‘highly critical work ethic,’ interfered with her ability to enjoy rewards, such as taking in the goodness, the spiritual and “the magic” of life. The client described herself as suffering from the constant weight and pressure of responsibility. She often referred to lists of jobs to complete. She described a sense of being stuck in this pattern of thinking. The job of therapy is to bring conscious awareness to these emotions and through their release allow the flow through of positive energy that puts the client back into the “joy,” of her life. I feel that the emotions of frustration, shame, and sadness were hypercoupled in this behavior and needed to be uncoupled so that the emotions could move through with less charge. If I had had more time, I would have worked with these emotions, tracking the felt sense that each directed. I would have like to work directly with the experience of shame.

Schore (2012) explored shame, as it exists in the dyad between client and therapist. He explained that shame results when we have a desire to hide aspects of ourselves that we don’t want to look at or have anyone else witness either. He stated that shame shows up in dissociation, which is a pathway laid down in early childhood. It can be the “most powerful affect a person in unable to regulate or modulate” (p.98). Dissociation can be described as both a sudden implosion, an inward collapse of the

person into their unconscious self, as well as the detachment from awareness of his or her self and the environment (Scaer, 2014). Schore (2012) outlined how shame can result in the client dissociating, and going within him or herself. For example he added this could happen as a result of the anticipation of a scornful gaze, causing mortification. People dissociate in order to escape from the overwhelming emotions associated with the memory. Schore (2012) added that this going within and avoidance behavior can be witnessed in gaze aversion. He pointed to the most difficult challenge for the therapist at this point is to watch for signs of dissociated shame in both herself and the patient.

The content my client was exploring touched experiences in my own life. I did refrain from sharing my story with my client, which I told myself was part of my professionalism but after greater reflection, it may have been a result of my own shame that resonated with hers. Schore (2012), stated, that shame has gone underground in our world today, and patients are presenting with unconscious, dissociated shame, wherein sometimes shame and not anxiety is the keystone affect (p. 99). The act of writing this alone, is powerfully emotional, and the "felt sense" in my throat, my shoulders and 'gut,' resonates with what my client also may have felt during our sessions together.

Clients sometime experience guilt that is hypercoupled with other aspects of consciousness, namely, sensation, image, behavior, affects and meaning (SIBAM), and this keeps them from self-regulating (Levine, 1996; Josephs & Zettl, 2009). Guilt is not a pure emotion, and is hypercoupled (over-associated) with remorse and judgment, and the feelings usually revolve around a feeling of "should" (p. 9). It is recommended in the SRT process that the client be helped to uncouple the affect. I saw myself in the videos attempting to remove the feeling of remorse, from the judgment (meaning), by

identifying the, “should statement” for my client. For example, identifying the jobs on the client’s job list needing to be completed, and then tracking the felt sense, the physical sensations she had associated with this focus on overwhelming tasks. One sensation that was identified was the behavior of her right index finger (wanting to engage).

When working with an event involving a motor vehicle incident, my client identified two emotions: over-whelming sadness and guilt. The aim was to also uncouple these two emotions. SRT therapy works with one emotion at a time and asks the client to notice the physical sensations and track them. For example, when exploring the emotion of sadness the client was asked to track her sensation of tears and notice where the sensation to cry began. Through repeated sessions working on this particular emotion of sadness, and through the continual call to awareness of this felt sense, the client was then more able to contain the overwhelming emotion, and began uncoupling the sadness from the guilt and shame associated with the “should” statements.

The implication for therapy in understanding these hypercoupled elements of experience can also be explained by exploring another emotion my client often experienced, that of rage. I often felt the client’s anger as she expressed her frustration when relating her experience in particular relationships. I also experienced her anger on occasions directed towards myself.

The client’s experience of the world as being critical and demanding put her on the defensive in certain circumstances. This was evidenced in facial expressions that communicated a fight response when specific activating memories were recalled. As she became aware of her body language in later sessions, she began to realize her body was tensing, preparing for flight. Her hands gripped the arms of the chair she raised her

eyebrows, bared her teeth, and tensed her feet and legs, in anticipation for fight and/or flight. As the sessions progressed she became much more attuned to her body's communications as she was exploring the physical sensations that she had learned to track. She began to compare the intensity and degree to which the sensation was uncomfortable or merely observable as her felt sense began to resource a state out of fixity and into flow.

She was able to then integrate her felt sense associated with her state of activation with already identified resources, and thus began to interrupt the pattern of dysregulation, and allow for the shock energy to be deactivated from her nervous system. She began to allow the sensations of sadness, frustration and anger to surface in small manageable doses. I observed her move from a fixed state in overwhelming emotional activation, to being able to experience emotion, while maintaining compassionate understanding for herself and her circumstances.

Connecting to the communication of our own body, the felt sense, allows us as humans to tap into the gift we possess to heal. I have experienced and witnessed what Levine (1997) referred to as the strength in shamanic approaches to healing. Through the help of another we find ways to retrieve our own souls. The similarities between shamanism and working from an art therapy and/or and SRT process is that with the support of another, we gain a powerful resource for healing. Levine (1997) stated healing is initiated when we re-integrate lost or fragmented portions of our essential self. I agree with Levine that we need a strong desire to become whole again, and this desire is the call to our soul, a pledge to reconnect with our body. SRT teaches that we need another nervous system in order for healing to occur.

My client was able to reflect and make meaning from her experiences, and integrate the emotions with what she was beginning to comprehend as their source. Unraveling the events in our lives means, confronting what has happened to us and also what has been missing. As mentioned earlier, time is often the missing resource, and when offered to the client in therapy, it can provide a safe place in to which to relax, and catch one's breath. Time in therapy also enables the client to change states, and possibly connect with her ability to regulate, connecting to ventral vagal tone. I helped my client bring a greater conscious awareness to her breath and the present moment. Doing this enabled her to relax. The change in her breathing allowed for greater self-regulation.

During our sessions together I worked with my client's thwarted fight response as she drew attention to sensations in her jaw. I was able to identify with the client, recalling SRT therapy I had undergone in which my jaw muscles communicated my own thwarted fight. This tension had become procedural in my body. Often, I would find myself clenching my jaw, and I have come to understand that unresolved urges to fight to protect myself had been left to reside in my own nervous system. Caught on camera was the client's face, which demonstrated that she was in fact demonstrating a readiness to fight. Signs of aggression were evident in her facial expression. I know I have done the same. I have vivid memories of witnessing this on the faces of others, and I believe those people did not have a conscious awareness of what they were communicating.

Understanding the neurobiology behind the expression of thwarted fight helped me have compassion for her while I admit there was also some countertransference happening at the same time. I watched myself negotiate tentatively with this client and observed myself taking too long to direct the therapeutic process. I believe I responded

unconsciously at the time to past traumatic confrontations I have had. These memories were perhaps still powerfully charged. Having become aware of my thwarted fight responses in my own nervous system has made me consciously sympathetic to the client's experience as well as aware of a tendency to instinctively protect myself. I am aware of my own ability to bite (to take an offensive posture) which is a reflection of my own thwarted fight.

As SRT therapy continued with my client I was able to observe her experiencing emotions of sadness and frustration without becoming overwhelmed by them. I also observed my client focusing more on her body's felt sense more, and needing to talk less about why she was experiencing such feelings and focusing more on her physical sensations instead.

LeDoux (1996) stated that emotional feelings involve many more brain systems than thoughts. He added emotions create a flurry of activity all devoted to something important; perhaps life threatening and all the brains resources are called upon. He stated that thoughts, unless they trigger emotional systems, do not do this (p. 300). As our work together progressed, the client was more able to find these emotions by exploring her felt sense. As a result she was less intent on needing to talk about her insights. This was observable in the videos starting around our fourth session.

In the *Expressive Therapies Continuum* ETC, art therapist Lisa Hinz (2009) identified how blocks to kinesthetic functioning result when a person's connection to the body is not comfortable or when he or she has an aversion to this form of communication. She stated that well-functioning individuals are able to value and process information with all components of personal expression mind and body. I observed my

client's ability to deal with a greater range of emotions and thoughts as they became more uncoupled as a result of our work together. We worked to discover and explore the felt sense each emotion had in the body. We then worked to discharge this energy by titrating its affect one at a time. My client was able to move out of overwhelming sadness, a state of fixity and moved on to a state of greater self-regulation, to a state of flow.

It is essential that the therapist create a safe environment. Porges (2011) stated that the client needs to feel he or she is in a safe place before there can be any hope of therapy. He said that when neuroception tells us than "an environment is safe and that the people in this environment are trustworthy, our mechanisms of defense are disabled" (p. 19). Porges (2011) stated that in creating a place that feels safe, there is chance of recruiting more advanced neural circuits that support the pro-social behaviors of the social engagement system.

Observing the interactions between us, I believe the client and I had developed a personal connection that evolved into a therapeutic relationship. The development of a relationship is essential and important to the therapeutic alliance. Ensuring that the client feels safe in my art therapy studio was foremost. As anyone new to learning a task, for example a dance, the first steps may need to be approached carefully, and slowly. Perhaps, my slower movement into the role of providing therapy was partly due to my apprehension about working with what I picked up in my client's thwarted fight as a sensation of aggression. Perhaps it was about my tenuousness in stepping into the role of therapist due to my inexperience. Perhaps it was a combination of all of the above, in conjunction with my natural inclination to enter slowly into a dance of relationship with another. As an emerging art therapist, I am still developing the knowledge of how to

enter into a dance with my client and gauging how to dance with another in the therapeutic studio, while also confidently taking a lead role.

During a particular session of self-doubt while in this heuristic inquiry (Moustakas, 1990) I revisited my data, the eight video sessions observing myself with my client. I was wondering if I was truly capable of being an attuned, grounded, empathetic and creative therapist. Prepared to find a new occupation and go back to teaching art if this was in fact what I would find, I spent hours watching again, with a new objective for my focus. I was actually surprised: instead of feeling as if I should abandon the idea of becoming an SRT/art therapist, I came away feeling empowered. As a result of self-reflection and reviewing the last three videos specifically, I experienced the felt sense of confidence and pride that resided in my heart. My back and my raised head told me I enjoyed watching myself in this capacity, and I saw that the client and I were resonating in a therapeutic right-brain-to-right-brain intersubjective context. I witnessed myself making mistakes, but I witnessed authentic effort and caring as well, and I believe my client went away feeling the same. While writing this chapter I experienced a physical sensation of tightness in my shoulders. This tightness may be a result of my resistance to writing about our shared experience together, giving our personal and even spiritual experience permanent and concrete form for everyone to view. The act of self-reflection brings forward what is perceived to exist in present time, and this may change and want to become something else in future context. Part of my resistance is that writing about clinical practice requires that I intimately expose both myself, and my client.

Learning About Attunement to Physical Sensation

In the first session the client described activation as a sensation found in a, "tightness and knot in the gut." Sensation in the gut is evidence of activation in the nervous system; and the vagal system is critical to the regulation of digestion and stress can cause shifts in vagal tone (Porges, 2011). My job as the therapist was to educate my client about the relevance of exploring sensation. Although I initially observed some confusion and resistance to this form of therapeutic process, the final session (Video 8, Session 11) revealed the client describing how the process had been helpful. She was more attuned to her body's physical sensations.

The client described this new level of awareness as new knowledge, as a "skill" to call upon for future personal work. The client also became adept at tracking her physical sensations as they moved through her body. This was observed as a huge transformation based on our initial attempts where there was a described lack of connection to her felt sense.

Cornell (1996) stated that you cannot make the felt sense do anything it isn't ready and willing to do . . . "You can't make it tell you anything, and you can't make it change – any more than you can make the shy animal your friend against its will" (p. 22). Initially, my client was resistant to the SRT process. Only after our relationship developed and she began to trust the process, her own body's sensations, and myself was she able to allow herself to use the felt sense to move forward in the therapeutic process.

In one of our last sessions she communicated to me that she understood how SRT worked. She was concerned about how she would be able to access this strategy without having to come to see me. We talked about how, once we bring conscious awareness to

our felt sense we are much more able to regulate and calm ourselves. As Levine (1997) stated, this disconnect between the body and soul is one of the most important effects of trauma. My client and I talked about ways to ground ourselves, focus on our breath and connect to our bodies when we become aware of our inner state of activation. Even though we can do a great deal to find coping resources, externally and internally under such circumstances, SRT theory does suggest that we also need another regulated nervous system to help us self-regulate once we are dysregulated or traumatized.

As the therapist, both watching myself in action and reflecting on my experience at the time of the recording, I was constantly bringing my attention to my own tendency to hold my breath. Through SRT supervision I gained a greater awareness of my procedure behavior and the inclination to hold my breath. This is a sign of my freeze response, a symptom of dysregulation. In the SRT process, the client is asked to observe the breath without trying to change it. This response results from adaptation processes in the vagal nervous system (Porges, 2011), part of the conservation mode (reptilian brainstem organization). When observing this same psychophysiological state in my client it was essential that I brought my conscious awareness to my own breath to ensure that I stayed grounded. This is evidence that there is a constant need to return to reflection on the state of my own regulation and times of dysregulation. This knowledge has helped me realize that in order to be present for another person seeking reconnection to his or her essential self, as the therapist I need to be aware of and responsible for my own state of regulation.

Learning How to Work with Boundary Ruptures

A ruptured boundary is experienced as a result of a violation of personal space caused by a trauma, such as a physical or emotional assault. A person's boundary is sensed as broken or vulnerable when that person is unable to protect him or herself from the direction of the threat. As result of the proprioceptive dysregulation the person can be hypervigilant about the ruptured boundary or dissociated from it (Conversation with Zettl, 2014).

Attempts to work with boundary ruptures came as a result of my client identifying that one side of her body wanted to tilt. She described an experience of "being off center." Observations of my attempts to repair what I perceived to be a boundary rupture revealed that I was unable to bring about any effective insight or results. However, I am curious how with continued SRT supervision and more work with boundary rupture and repair, if more could have been done for this client as a result of this discovery.

The SRT approach to boundary repair is used to discover and heal a boundary rupture, to prevent further injury that can be caused by miscues as this rupture interferes with personal space awareness. The client was unsure what was being asked of her, and I was not comfortable attempting the SRT technique. My exit into my left-brain took me out of the role of attuned therapist and I lost my connection to the client and the therapeutic process.

Still, it is my opinion that the key to working with boundary ruptures is with exploring how healthy boundaries look and feel, which can be experienced using therapeutic invitations that engage the imagination. Relevant to work with SRT and art therapy is the study by Davoli and Abrams, (2009), that examined how imagining doing

an action, or connecting with an object using visualization of images or symbols can help people connect to their personal space, and their perception of boundaries. They showed how using imagination has been proven effective in engaging the mind to exercise one's intuitive sense of "space" to "scout out" obstacles or threats in physical space (p. 294). I would suggest that using imagination could also be useful to strengthen and repair boundary ruptures. Using the imagination to scout out emotional, physical, psychological and spiritual boundaries can help a person to heal and gain a greater conscious sense of this personal space.

Art therapy has explored therapeutic work with boundary rupture and repair using the Kinesthetic/Sensory as well as the Perceptual/Affective component of the ETC. Hinz (2009) suggested using boundary-determined media to help contain the expression and exploration of boundary perception and violation. Mandalas are used to create a sacred space from within which much can be explored about boundaries and ways to find rupture and creatively mend and repair them. Care is needed when working with media with flowing qualities. This flowing out of a container can result in boundaries that were intended to hold emotions instead are broken, and as a result emotions can become overwhelming.

In this same session, I continued exploring a possible boundary rupture with this client. I made an assessment error when the client described challenges with her sense of hearing. She identified her lack of hearing as being connected with her sense of sight. For example, hearing quality was improved when the client was wearing glasses. When the client described a desire to move her head towards the weaker ear, I missed the implications of this disclosure and identified a boundary rupture, where a challenge with

sensory stimulation and/or sensory integration would have served as a more apt therapeutic intervention.

SRT process teaches how to work with auditory anomalies such as hyperacousis, or unpleasant sensations fused with sounds. I might have had some success using SRT process of working with the sense of hearing, and offering a optimal scenario to imagine ways to explore the connection of sound and sight, which the client identified as a dependency on wearing her glasses to hear voices over the phone. Offering her some options to explore desirable sound quality while on the phone might have brought forth a recalled event and/or activated state to work with. Then, tracking the physical sensation in the client's felt sense in response to a state of activation might have brought about insight and/or discharge.

Music and its role. I could have worked with this described hearing and acoustic challenge by using music. Porges (2011) described music as a "dynamic interaction between therapist and client . . . and is intertwined with emotion, affect regulation, interpersonal social behavior and other psychological processes" (p. 246). He suggested music might be uniquely associated with working through interpersonal and intrapersonal challenges. Although the creative art therapies have known from a tacit and explicit sensibility that music has healing qualities, we now have the opportunity to communicate this through the language of neurobiology and neuroscience. Therefore, when we enter into a collaborative effort with other therapeutic professions and theories we enrich both therapeutic processes. As we gain an understanding of how neurobiology and psychophysiology research give us a validation of how powerful role the creative process, which includes music and its role as an effective tool for psychotherapy.

Carey (2006) described one way to use voice in art therapy (free singing, or vocal psychotherapy). Evoking words and expressions emotions as they are mirrored back by the therapist can provide an opportunity for reparation of relationships. Carey (2006) said, "They can return to the 'scene of the crime,' companioned by an empathically attuned other . . . grieve what was and what never will be, make meaning out of false beliefs, and accept and integrate the past so that they can live life more fully in the present" (p. 150). I suspected the greatest boundary rupture for my client, came as a result of challenging relationships. There was evidence of sadness and unresolved grief that I felt we only touched on in our work together that referenced back to childhood.

Music engages not only the auditory, but also the sensorimotor, tactile and visual faculties. It communicates by means of the "imagination modalities such as rhythm and sound, and through words or lyrics that evoke strong visual images" (Knill, 2003, p. 127). Davis (2010) stated that the use of expressive arts techniques, specifically music and movement, "continues to increase in the counseling profession" (p. 125). I have personally experienced music as a resource, and a means for grounding myself, and I believe it also represents the presence of a *third.*

Voice prosody. I have had to bring my awareness to my own voice prosody as I work with clients. Voice prosody needs to be attuned to, and can also influence the client's psychological state. The therapist's tone of voice, facial and bodily expressions can convey a sense of optimism that distress can be alleviated (Josephs & Zettl, 2009). It was brought to my awareness that my voice sometimes became too quiet as I initially worked in SRT. Initially I felt this quiet tone complemented the quiet witnessing of art making I experience when facilitating an art therapy or expressive arts therapy

experience. I have learned that the energy level in my voice has an affective influence on a client's nervous system. I am still getting a feel of where and when to be a quiet companion, and when to be more connected to the ventral vagal tone required for attunement and providing a regulated template for the client. Being in silence is also a way of connecting to the ventral vagal as this is a regulated state.

As a result, I am becoming more conscious of my voice prosody and more able to discern how choosing voice prosody appropriate to specific situations and purposes plays an even bigger role in therapy than I had thought. For example, during SRT work it is crucial that I stay connected to my own awareness of being grounded. I remember during SRT training, when the energy in my voice fell too low, and became monotone and hypnotic like. I was directed to bring my awareness to my own breath and voice quality and consciously ground myself. It had become evident that I was connecting with the client's activation state of dissociation, of dysregulation, not a right-brain-to-right-brain resonance. As a result of dysregulation in my nervous system I was following the client's state, a contradiction to therapeutic goals.

I have become more aware of the psychophysiological pathways already laid down in my system as a result of my past experiences of fight, flight and freeze responses. I also have learned that entering into this state with the client is not only ineffective but possibility harmful. For example, if the client delves too deeply and too quickly into the relaxation state, a resulting equal and opposite boomerang response, into high activation can occur. This is referred to as the "warble"(Josephs & Zettl, 2009). The depth of relaxation when experienced too quickly, especially when one is vulnerable due to the amount of activation in their system, can result in an equal and opposite in intensity

switch into a state of high activation. The nervous system perceives this state of relaxation as a lack of necessary vigilance, and therefore the system feels unguarded, and vulnerable to threat. It is important to titrate both the movement into parasympathetic and sympathetic arousal.

SRT and the creative art therapies share a similar perspective regarding the belief that the therapist has the ability to influence the energy of the therapeutic environment by the essence and energy she brings. Both concur that she conveys empathic attunement through voice quality, facial expression and posture. When the therapist can convey an embodied understanding the client has the opportunity to sense empathy. What is communicated on the therapist's face can influence persuading positive affect, for example lifting the spirits of the client who is feeling low in energy and disposition.

The Therapist's Body: the Non-Verbal Speaks

Art Therapist, Hass-Cohen (2008) added, that perceived auditory and visual speech, along with other non-verbal bodily actions, and perceived communications such as those gained from watching mouth movements, "activate mirror neurons in the 'doer' and the observer" (p. 305). In other words, the therapist can also elicit negative affect in the client as well. For example, responding with repulsion, irritation or disgust will mirror the like. Schore (2012) stated that "disgust" is a central threat emotion, associated with relational trauma (p. 100). In this context, expression of disgust is associated with threats to survival, and the response and resulting affect in the nervous system is often highly coupled with fear, and thus, highly activating.

There are also other physical communications, conscious and unconscious, that reveal the unresolved charge of trauma still present in the client. When an opportunity is

provided for the client to renegotiate a circumstance in which enough time was not available to respond and defend him or herself, the client in the present time can organize the orienting pre-movements that would allow for the option to take action - to defend or to fight. “This is often observed in micro-movements such as a slight turn of the head, twitch of the eyes or nose, an acute awareness of the senses”(Josephs & Zettl, 2009, Foundations Level I, p. 5). Through these gestures and non-verbal expressions a person can fulfil adaptive behavioural movements in the present time that were left unfulfilled at the time of the traumatic event. This was seen in my client’s facial expression that communicated a preparation for fight and self-defence and aggression. This was witnessed in my client as she role-played a conversation in which she had fantasized defending herself. Discharge was then witnessed following this expression.

Both therapeutic processes of SRT and art therapy respect the power that the non-verbal presence of the therapist has. I also believe that joining the client in silence and stillness is a form of holding the space (Knill ET. al., 2005) and creating an empathetic environment. Much of the learning in the SRT process included developing a greater comfort with being in stillness, learning how to be in the quiet still space, while the client tracks sensation. Again, this is done to provide time, which is often the missing resource, and serves as vehicle for accessing the self in mapping the felt sense and tracking sensation. This provides a greater opportunity to connect with oneself. Then time is provided for in a safe space, which allows for regulation of the body’s nervous system. This may be effective in encouraging the unconscious implicit processing of emotion the time it needs essential to engaging in meaning making; soul retrieval.

Once a client is aware of the body's capacity for great communication he or she can realize greater insight and awakening to non-verbal expression. For example, watching the videos I could see the quality of my hand movements client that reflected the gesture of conducting and may have been symbolic of directing the client to bring awareness to her own felt sense. These hand gestures may have been an attempt to sooth and calm my client's activation, as I was responding to it, inviting her to quiet the mind and enter her felt sense in her body. This action may have suggested a desire to settle the energy, a signal that it was time to prepare for something else, and a renewed focusing of attention was now required. In other words, "what do you notice?"

An example of how the body can communicate a strong and effective non-verbal response happened when this client initiated dialogue around an art project. The client showed me her art, weavings and paintings of hearts that represented her spiritual connection to the Virgin Mary. This sharing demonstrated how this art represented resource that she used to developed resilience and gain healing. She was reluctant to speak in detail about the symbolic expression and her religious affiliations. However, we did jointly witness the work in silence and appreciation. She shared these with me, and I recognized I had been silent, as this symbol was also powerful in my journey and family story. One never knows when and how it will happen; that what is shared in connection with the client might touch us, not only as therapists but also as individuals. This session left me speechless and touched personally, which can also translate to being touched and moved through a larger expansive universal connection. Hass-Cohen (2008) reminded therapists how crucial it is that we recognize the healing potential of spiritual-religious guides and how this resource can enhance the relaxation response (p.180).

Becoming attuned to the psychophysiological state of others. As I witnessed myself in the therapist chair in the video, I was reminded to focus on my connection to my physical sensations as I viewed myself. As the co-researcher, I needed to reflect on my experience at the time I was with her, to assess whether I was resonating with the client's experience, and whether I was resonating somatically with the client's nervous system. I got a sense that I could identify with the "gut sensation," while watching the session because it took me back to what I had experienced with the client during the session. To be effective and maintain a balance between connecting with the client and maintaining my own boundaries, I needed to ensure that I could be empathic to the client's experience without being pulled into the client's energy. I needed to check if I was staying grounded in my own conscious awareness of my body. Observing my relaxed posture while recalling and observing the session, I believe I was doing this.

It had been established in SRT therapy that the psychophysiological state, as laid down in my nervous system through my own surgeries and anesthesia, could become activated when I was with another person experiencing that state in her or his body. When working through the client's surgery and anesthesia it was necessary that I brought awareness to the influence of my own neurological pathways of dissociation. While working through my 27-year-old birthing trauma during SRT training and personal therapy requirements, I became aware of the unresolved sympathetic arousal and dissociation in my nervous system. As part of a demonstration during SRT medical/dental trauma weekend training, I volunteered to work on my surgery. As I experienced a dissociated state and anesthesia during the therapeutic engagement, other students described having experienced this state in their nervous systems, as they

watched the demonstration. I was able to observe this dissociated state on their faces and postures. I was surprised at how the activation state experienced in my nervous system could so readily activate a similar state in others in the classroom.

As my client claimed no memory of events around her surgery or recovery, I knew that I needed to ground myself in my chair, and bring conscious awareness to my energy. I needed to prevent my neurological pathways of dissociation from becoming activated, and thus joining along with that of my client's. I recognized the state of dissociation in my client was also felt in the room.

It was necessary to uncouple emotions of anger and frustration that were fixed in my client's nervous system as a result of her surgical event. Her activation was obvious in her breathing patterns. As well she described a sensation in her throat (possibly the intubation tube), head tension, nervous finger and hand activity, which communicated the surgical procedures she recalled and those she had unconsciously experienced. She also described sensations of ankle and leg tension and immobility. Sadness and frustration rose up as coupled emotions. Following SRT process I had the client track sensation, while noticing one emotion at a time. Discharge came in the release of tears, loosening of tension in various parts of her body, tingling and laugher.

When we feel we need to tell our story. In my initial work with this client exploring the felt sense was like that of visiting a foreign territory. I witnessed myself, as the therapist, educating her on how to sense into her body. I was also interrupting her desire to talk. I remember feeling uncomfortable at the time when doing this. I noted while reviewing these videos feeling that my interruptions could be viewed as disrespectful towards my client's perceived need to tell her story. I have come to accept

the therapeutic theory of SRT that talking about one's story can lead, not to the release of intrusive traumatic memories and feelings, but rather can result in reliving the state of activation connected to the trauma. This only serves further kinder the activation on of the ANS. The client will benefit in the telling of the story achronologically (out of sequence) if it needs to be told at all as this will help to titrate the charge and quench the kindling.

The SRT process can be compared to that of a study conducted by art therapist Talwar (2007). This study entailed creating a story by painting its sequence of images and events and then narrating the story while assigning emotional significance to these images and events. SRT process attempts to have the client tell the story, but out of order, moving between memories recalled pre and post the main event. Through the kindling and quenching process ((Post et al., 1997) the story is being told as two conversations. One is the words of the client and the other is the most important conversation, that of the client's nervous system (conversation with Zettl, 2014).

Having a client tell the story will evoke the psychophysiological state they were in at the time of the traumatic event. Rather than healing from the telling, the person is set up to re-experience the shock and injury all over again. LeDoux (1996) described memory as being stored as implicit; unconscious, and explicit; retrievable working memory. LeDoux (1996) said memories experienced as a result of a traumatic event are often "especially vivid, and enduring" (p. 223). I was shocked to discover how easily I was able to enter into the experience of my emergency surgery when I underwent SRT therapy. The memories I unearthed and the states of activation I experienced reinforced how my nervous system had managed to keep this experience alive even though the

surgery ended well, and I have a wonderful daughter as a result. Experiencing the huge amount of activation in my body, particularly in my pelvis, and my jaw, alongside my emotional affect made me even more determined to learn SRT and use it to help others. However, even though I believed that I needed to go slowly through this process and work it through the nervous system first, the desire to tell my entire story was huge. There was a tendency to tell the most highly charged facts first.

To move the story out of an emotionally charged experience in the body I agree that it sometimes needs to be told and witnessed. Damasio (1999) stated that in order for the brain to regulate the organism, it naturally weaves stories about what happens to us in the course of experiencing life. He stated that creating brain maps precedes language, and that this process involves the cerebral cortex and both the left and right hemispheres. Damasio (1999) stated that information gathered from images presented in the form of a nonverbal narrative needs to be subsequently "transplanted into language as the non-verbal narrative alone would not give us access to knowing ourselves" (p. 186).

Learning How To Become More Conscious

Damasio (1999) observed that consciousness happens when we become aware that we are stories within stories, and that these are continuously being altered through life experiences and thoughts and this results in our continual internal adjustments. This awareness and increased consciousness has resulted in an internal adjustment that evolved my transpersonal spiritual understanding. This awakening happened as a result of the events that have happened to me, and the self-reflection I have had to make new meaning of them. My spiritual view may be part of a new understanding that is part of my story, a yet unraveling of my past and a yet unknown formation of my future path.

This shift, a conscious transition of my spiritual life that focuses on my personal growth is my own evolution. My new spiritual knowing and *unknowing* has opened me to possible insights for integrating and embracing some greater design for my future. This new awareness is the result of a personal transformation, and continues to evolve alongside greater personal reflection and life long learning.

Part of this spiritual transformation is my new learning, as I am emerging in a new professional identity as an art therapist informed by SRT process. In the language I have used to explore my life direction and made meaning from my experiences I have brought awareness to my own beliefs. My former Christian beliefs: those that are strengthened and those that were shattered, are still part of my continual formation. These beliefs that I have embraced, and those I have turned from are a reflection of life events and new learning that changed me. Awareness of where I am in this respect is necessary when meeting others on a their own spiritual journeys and as our energies join, in a therapeutic context.

What gets people through difficult times is often an increased awareness of connection, a spiritual belief system, or sense of support, which is disconnected as a result of trauma. This I refer to as a *third* - a mysterious presence. Chopra (2012) explored how science and spirituality engage with respect to understanding spiritual paths. Creating greater awareness within oneself increases consciousness. Chopra (2012) supports my belief that increasing personal consciousness is a spiritual choice and is also spiritual work. He stated that spiritual growth means a person wakes up to embracing God. He added that we do this when we wake up, a process that centers on transcending. We then find a deeper level of inner peace when our spiritual path becomes our own

conscious awakening. Chopra (2012) stated that, “the spiritual experiment is yours to set up as you wish” (p. 266). The presence of the *third* for me is what has directed me towards learning what awakens my conscious self. This awakening has made me mindful of my desire to connect to myself, to others and to something greater. Although powerful, this mystery for me currently remains nameless. This unnamable resource and support is also experienced as a deep knowing and has developed into a constant felt sense. I am conscious that this transcendence has brought about personal and professional choices that have led to change.

Change happens in a profoundly deep inner knowing that includes language, and creativity. Schore (2012) acknowledged that the left-brain and the conscious mind provide an essential contribution to the treatment process. He added that the growth-facilitating environment of the therapeutic relationship promotes the development of the right brain and this maturation process increases the knowledge of the implicit self. Talwar (2007) demonstrated that research has proved that engagement in the creative process, which she described as, “a complex combination of sensory, cognitive and motor activities,” emphasizes the holistic functioning of the brain (p. 25). This research suggests that the active process of art making engages the right, and left hemispheres as well as the prefrontal cortex region of the brain. I believe that art making also connects us to our essential self, our soul.

Based on research from both Talwar and Schore, it is suggested that the most important role of therapy is to work toward integrating the implicit unconscious aspects of the self to counter the disintegration of the self that results from unresolved affects of trauma or injury. This way the understanding of our experiences can come from a deeper

implicit, and intrinsic knowing, that can strengthen and provide resilience. This is a creative process of emotional expression that enables meaning making and processing across complex brain regions.

Using Language to Move Through Trauma: Moving Out of Fixity in to Flow

The use of written language through art therapy approaches has been attributed to positive effects on chronic illness, pain relief, and trauma resolution therapy (Malchiodi, 2003). Malchiodi presented research that supports the claim that, "people who write about traumatic events are healthier during the subsequent year than those who do not engage in self-expression of unpleasant experiences (Pennebaker 1997, as cited in Malchiodi, 2003 p. 115). Malchiodi (2012) also that stated, art activities, "may help the traumatized individual to think and feel concurrently, while making meaning for troubling experiences" (p. 21). This research supports using language to process and make meaning out of trauma or difficulty.

My client used a writing journal for self-directed work following one of our SRT sessions together using a collage. I witnessed on the video that my client had a great amount of discharge from her nervous system in this session. We worked with the images from the collage that were resourcing, and then sensed into the activation these produced. Using titration to move from one image that generated activation to another that provided resource, the kindling witnessed as expression of great sadness in one image was resourced by the comfort found in another. By moving between the two images and tracking the resulting sensations, the original activating image lost its charge, and the charge it held was quenched. Evidence of discharge was witnessed by her smiles, flushed

cheeks, sensations in her legs and hands and tears. The later tears were gentle and I felt they were discharge more so than activation.

Later, the client emailed me to say she had been writing about the metaphor explored in this session, and had made a profound discovery around new insights and meaning for 'magic'. Initially this concept and the image that generated it caused activation and the feelings of overwhelming sadness. After the SRT session and the client's continued processing with her writing the emotional charge seemed to have lessoned, almost diminishing. In SRT, meaning is the last thing to change and when it does following therapy the process is spontaneous and lasting. This is evidenced in how my client did not need help with creating new meaning and insights from her experiences, as she showed an ability to bring about meaningful shifts independently. It might have been beneficial to also provide more opportunities with this client to engage in poetry, using words, metaphors, and other creative arts invitations to working with language to further process this insight and find resource in the emotionally charged words generated in the right brain.

Movement. Malchiodi (2003) stated that both hemispheres of the brain are necessary for art expression. Researchers have also discovered connections between language and certain movements in drawing. Malchiodi (2003) stated that in contrast to working with mental images drawing and movement, "allows an individual to actively try out, experiment with, or rehearse a desired change through a drawing, painting, or collage; a tangible object that can be physically altered" (p. 19). Here is an area where these two therapeutic processes are distinctly different. SRT has the client imagine a movement and invites the client to connect into the recruitment of the body using only

the “felt sense.” When gross motor movement does happen spontaneously, it is tracked and integrated in the therapy. However, unlike art therapy the client in SRT is not invited to explore movement as an expression of emotions; feelings that arise due to difficulty or feelings of release and joy. In SRT, work is done by having the client imagine how he or she might move and recruit his or her body, rather than physically engaging in expressive movement. The creative arts encourage clients and participants to engage their bodies in movement as a form of self-expression and self-discovery. Dance is foundational to creative art therapy work. My experiences in creative movement have served as a healing, as a connection to myself, to others, and to some great “beauty”. For myself, this beauty also describes a personal and universal “soul.” Dance and movement is a spiritual practice for me.

Art therapy explores movement using all media as part of the therapeutic process. Traumatic events can precede language development and when this is the case, art that is a non-verbal expression, can be used to express what might otherwise be inaccessible. The creative art therapist engages the body through movement as a form of personal expression and discovery. This process may also access the unconscious where the ANS holds the charge of past events and traumatic experience

When I observed the client connecting to her felt sense and starting to relax, discharging unresolved energy in her activated nervous system, it was consistently noted that she repeatedly began to move her right finger, the “the list maker.” Repeated finger pointing, as observed with this client, was noted as a curiosity by both of us. It showed up as a main character in her story whenever she settled and relaxed. Her finger especially became active while she tracked sensation. After greater self-reflection of my ability to

deliver SRT as a result of viewing the videos, I know that if given a second opportunity to work with this client I would spend more time tracking the felt sense of this finger. We did spend significant time talking about it, but nothing more came of this exploration.

This missed opportunity to explore the message of the "list maker," may have been a result of my slipping into my left-brain trying to figure out the phenomenon. I interpreted my client's focus on he finger as activation and moved the focus elsewhere, or looked for resource to contain it. However, I am curious about what might have resulted in the therapeutic environment if my client was given the opportunity to engage with more movement of her finger. Perhaps, more insights might have been discovered if the client's finger was invited to express itself. Perhaps, the finger needed to dance.

I wonder if this engagement with moving her finger was the client's way of interrupting the process and avoiding confronting difficult emotions Continuous movement, such as toe tapping, an over involvement with the kinesthetic component, could inhibit involvement in the Perceptual/Affective level of the ETC (Lusebrink 1990). Since traumatic memories are likely stored as images on a preverbal level, clients unable or unwilling to process images and emotions associated with trauma can use motor activity such as repeated foot movements as an outlet for mounting anxiety (Hinz 2009), and therefore this form of physical action can be used to ward off the formation of traumatic images and avoid experiencing painful emotions. SRT teaches that engaging gross motor movement overrides the autonomic nervous system, therefore interfering with the opportunity for quenching.

Shifting painful emotions. When working with a surgical event in my client's past, I observed the emotion of anger. Channeling this powerful emotion may have been a

way to help the client get in touch with her personal power. The SRT process welcomes the expression of anger from the client. Word phrasing such as, "passionate feeling or life force" is recommended for those who avoid feelings of anger or who have judgments about anger (Josephs & Zettl, 2009). For some the expression of anger may be a positive feeling. The expression of anger, when contained and titrated can give great insight into powerful, personal and deep understandings of self and the world. As a highly charged state, anger acts as the kindling fuel and the slow release of it, a quenching of it, can bring about peace. A release of anger can return one to a more regulated calming breath.

The titrated, as opposed to a cathartic releasing of this strong emotion is important to prevent further activation of the ANS. The titrated release of anger makes room in the container of the nervous system so that there can be an alternative focus. There is then a potential and opportunity for quiet reflection, to nurture a sense of inner peace so new meanings about one's life can grow. This spiritual work requires a shift in thinking which is more likely to happen if we become more regulated. Chopra (2012) argued that, "we can't shift in our spiritual direction unless the brain shifts, too, and its our desire that alters the material landscape of the brain" (p. 185). Yet, I propose that desire alone is not sufficient to change how we think and respond to our environment.

I have experienced personally and professionally how the effects of trauma had become trapped in my body and mind. That also included my soul, my connection to the fullness and greatest joy of my life. Without the release of this unresolved charge its negative impact on my life would have continued. The unconscious procedural behaviors, the result of unresolved thwarted attempts to protect myself from traumatic

events interfered with my nervous system's ability to regulate. This residual energy also affects the ability to engage in quiet spiritual reflection and a return to joy in life.

Chopra (2012) related the concept of our mind body connection to the eternal laws of nature. When speaking to the uselessness of distinguishing the mind from the brain, he referred to an alternative view, which he called the "cosmic mind" (p. 262). He suggested that it, "exists in our heart, liver, and gut cells as much as our brain, providing intelligence, organizing power, creativity and everything else" (p. 185). He explored personal growth and increased awareness from the perspective of encouraging natural growth from within. He stated, "This is not a search for peace and quiet; rather, we are transcending the maelstrom of everyday thoughts to find the source of the mind" (p. 263). Spiritual growth and the return to the joy of our lives following trauma and traumatic events first requires a conscious mapping of the body as it reflects the health of our nervous system. Then we can develop a conscious and spiritual awareness of ourselves.

Theme: Images and Symbols are Resources in Both SRT and Art Therapy

Images are used as resources in both SRT and art therapy. In Session Three for example, the client explored an image of a baseball, exploring the tight threading that made up the hardness of the ball. This image emerged for the client during the SRT process when she was looking for a visual description of the tightness in her stomach. Through further exploration of this image, a curiosity surfaced about what would be found theoretically, if the baseball were opened up. Would there be an explosive release of the compressed materials that gave it form?

Our following session together was dedicated to art therapy process, (and therefore was not on video). We entered into an art therapy invitation where an old

baseball was brought into the studio. It was explored using the kinesthetic and symbolic components of ETC (Hinz, 2009). The baseball became a symbol as well as a resource image for later sessions. “Discussion of self symbols reveals ways in which clients reflect the qualities represented in themselves”(Hinz, 2009. p. 149). The symbols may represent both positive and negative traits, and clients are challenged to accept and admit to the negative representations of themselves. Symbols are the natural language of the dream, and the exploration of the conscious and unconscious can be expressed in the form of an image.

In another later session with my client, we worked with imagery as resource, which is part of the SRT process. We initially worked on finding a resourced state to work with the activation state that resulted when remembering a stressful automobile journey. The pleasant and substantiating memories of experiences on either end of this journey were used as resource. (For example, the resource of engaging in the client’s generated image of, ‘drinking the magic elixir (experiences of drinking coffee) in a peaceful state,’ was used as a resourcing image). This is an embodied and actual experience and provided a powerful resource. The emotion that revolved around the experience of this journey was considered a major focus throughout our eight sessions. Repeatedly, the activation experienced while recalling this journey contained emotions of feeling overwhelmed by the weight of obligations, which were coupled with emotions of frustration. We worked on one emotion at a time, while I also sought to discover what her life was like at the time before the journey and now, post event. To deal with the emotion the client described as, “obligation,” and the activation that surfaced as a result of identifying its affect. We used guided imagery to produce a resource state to work with

the arousal state of activation. I observed the client being able to readily connect with her felt sense as she began to understand the process. As a result she experienced a great deal of discharge.

Another resourcing image emerged to provide security, rest and time, which were the missing resources on this challenging trip. After imagining herself at the artist's loom, with guard on duty (a bear), she could let down into this safe environment. Her state of relaxation was witnessed in the psychophysiological evidence of flushed cheeks, her smile, and her laughter. I observed what she described as a "letting go of arms, jaw, and the band around the belly loosened." The client also made note of a deeper more relaxed breathing.

Similar to SRT perhaps, a guided daydream, using a creative arts therapies approach, can be used to take clients on a symbolic journey to face situations, and challenges that reveal inner resources (Hinz, 2009). I felt comfortable with working in collaboration with the client's imagery process. SRT and art therapy theory agree that this engagement with the imagined time, space, and environment creates a powerful resource.

In art therapy the healing function of the symbolic component of ETC (Hinz, 2009) is reinforced through activities that help clients to further their own self-understanding on a personal and/or universal level. Symbols are generally multidimensional, and frequently include kinesthetic, sensory and affective facets that partially determine their formation, expression and resolution (Hinz, 2009). The pressures pent up in the binding of the baseball can represent the widely experienced overwhelming expectations many of us have felt in our lives resulting in emotional over pouring (described by client). Lusebrink (2011) would describe the baseball, which acted as a

container for emotions as “boundary-determined media” with physical properties. Hinz (2009) described how this containment limits the scope of expression and, yet this containment can also stimulate understanding and creation of ideas that come together to describe the stimuli at hand. Working from the Cognitive/Symbolic level of ETC can help the client remain somewhat removed from the creative experience, and thus can help the client find meaning and express resolution from an elevated cultural or universal level (Hinz, 2009). However, using the SRT process with this client involved a felt sense connection to the image and physical baseball. I believe it was that connection to the creative process rather the removal from it that facilitated the discharge that was witnessed. As she described this image to me I could feel the intensity of the tight inner weavings that make up the hard ball. This is why I invited her to bring the ball she wanted to start an art project on, to work in the art therapy studio. In many ways it exemplified the intense felt sense she initially described in her ‘gut.’

In another session the client described holding tension in the lower back area. Through imagining herself in a particular lazy boy recliner (resource), touching into felt sense, and tracking this in her body, there was some letting go experienced (discharge). It was identified that too much reclining created a feeling of over vulnerability (activation). Allowing the client to control the image and the amount of reclining in the chair led to release of some tension. I observed the physical sensations as my client tracked their movement in her stomach as they moved up and outwards along her waist. I saw how the sensation traveled out of her body through the right and left outer abdominals. The baseball image was also used to help relieve the tension in the “gut” associated with coupled feelings of guilt, and overwhelming sadness, and frustration.

Following a fair amount of “discharge”, in a session it was noted that activation that was commonly described as the “list maker,” was again evident with the client becoming aware of her right pointer finger. However, suddenly her right hand took a secondary role to the sensation felt in her left hand. As she tracked the sensation in her left hand she was able to describe it as, “wanting to do something.” I asked the client to get out of the chair and come to the art table, where I invited her to work with paper and pastels on a scribble drawing. I invited her to initially use her non-dominant left hand and then added the right hand to move the drawing material as her hand desired.

Bi-lateral art developed by McNamee (2005) invites art making using both right and left hands, to bring about a change in thoughts and feelings, ultimately influencing behavioral change as the desired outcomes. I have witnessed clients repeatedly make deep meaning and affect change when reflecting on a non-directed scribble-like drawing, especially those done with two hands, as was witnessed with this client. I applied McNamee’s bilateral art approach with this client. The resulting image the “blue bag,” showed up to help the client find personal meaning and deal with feelings of overwhelm and sadness. The image of the blue bag reduced all of her life’s cargo to a small, light and easily carried load. This image was now an internal resource the client could use.

Theme: Trauma Therapy Can Be Restorative and Transformative

The effectiveness of my work with my client could not be evaluated by merely viewing these eight videos. There was no formal client assessment given at the beginning of our working together and I did not do a formal assessment of outcomes to ascertain if goals had been met. Therefore, I can only repeat what the client said in our last session together. She noted that she had learned a new way of being in her body, being able to

check in with her felt sense more easily, and that she intended to use this skill in the future. She also communicated to me that she could deal with her feelings, especially the emotion of sadness, without becoming overwhelmed by them. I also observed this capacity in her - to find a new relationship with the feeling of sadness.

The client had changed in her perspective around her body's ability to communicate. When she first came to see me, she wanted to talk about her insights and was somewhat resistant to exploring her sensations. She also changed the way she perceived her emotions, such as being able to be with the emotion "sadness" and to see its meaning differently. This helped her to deal with the emotion and dissipate some of its intensity, so she could experience sadness without becoming quickly overwhelmed by it.

Much of what has been explored in this thesis research demonstrating the restorative and transformative affects of my trauma therapy as well as that of my client's has been discussed throughout this chapter. My final comments on the transformative power of trauma and the resulting therapy will be a summary of what has already been discussed.

Using my past surgery as an event to explore with SRT was not my suggestion, but came from the insight of my supervisor and therapist, Dr. Lynne Zettl. I thought this birthing experience was resolved and ancient history, and there would be little with which to work. I was surprised by the significant grief, anger, sadness, and fear still connected to the birth that was stored unconsciously, kindled in my ANS, 27 years later. I also unearthed feelings of inadequacy, a lack of ability to perform, a sense of not being successful, and feelings of disappointment. In other words, I discovered the myth of not being able to deliver.

The question over whether I had given birth through cesarean section came from Dr. Zettl. She intuited that there was some connection to my clenching jaw and my pelvis. During a SRT training session working on medical and dental trauma I observed my tongue was constantly fiddling with a particular tooth. Later in SRT therapy I recalled that I had broken this tooth while I was in labor. SRT work revealed a great deal of holding on and tension in my pelvis. I have dealt with chronic pain in that area. I still have pain there, but I am better able to sense in to this area and facilitate an easing off of tension. I am much more conscious of my jaw tension. This therapy experience uncovered an unresolved neurobiological response that resulted from the birth trauma experience I had in 1987.

The awareness and connection to my own body's communication through exploring the felt sense promoted healing and greater self-awareness. My nervous system became overwhelmed during the traumatic labor and birth of my daughter. The normal activation/deactivation cycle of the nervous system was disrupted. By interrupting the pattern of dysregulation held in my procedural memory, and by allowing for deactivation of shock energy, more room was created in the container of my nervous system. I brought greater conscious awareness to my felt sense and certain behaviors that stemmed from this dysregulation. These behaviors included dissociation and defensive personality traits and are the result of my thwarted fight. This desire to defend myself, a natural response for survival, was still unresolved in my ANS and thus resided within me. This happens as a result of trauma, my cesarean surgery.

I recognize some of the symptoms of sympathetic arousal, in what others have described as my 'tightly strung,' hyperactive,' and 'defensiveness' personality traits. I

believe I had already experienced great personal growth as a result of having engaged in expressive arts and art therapy training and therapy. Friends and family members had already commented on the changes in my demeanor before I enrolled in SRT training. I do believe however, SRT has given me an additional opportunity for healing of my nervous system as a result of the therapy experienced in the training and my continual research of the process. This process has fast tracked my healing potential.

I have been working on these challenges and experienced a new grounding and self-discovery through these new opportunities. I have also acknowledged a great deal of personal growth as a result of years of work with creative arts therapies, and most recently with SRT training and therapy. I observed myself in the videos as being relaxed, engaged and attuned to the client, and therefore I am suggesting that I am becoming more self-regulated and also possess the potential to become more attuned to others.

I have a greater awareness of how my body communicates my states of activation. I have noted that since SRT training it is much easier for me to deal with life stressors. As a result of the powerful experience I have had in both processes I am motivated to find ways to explore their integration. I believe both have contributed to my growth. I also have discovered that although there are distinct differences, these processes share fundamental therapeutic goals and theory, as has been explored in this data inquiry.

Although trauma survivors can find healing and possibly return to a state of health as a result of therapy they are changed, and as a result, transformed. Personally, this transformation came in the form of greater awareness of myself. I gained a greater intrapersonal connection to my body, my psychophysiological responses to states of activation that resulted as I remembered a past traumatic event. This transformation also

manifested itself in how I made meaning from this experience and integrated this experience into my understanding of my current life and personal procedural behaviours. Continual learning led to a greater transpersonal connection to the constant mystery of my life's purpose. This transformation also influenced the way in which I see myself in the role of therapist.

Theme: The Therapists Identity: Watching the Changing Portrait in the Mirror

I took the SRT therapy experience and my research question exploring how these latest revelations had influenced my identity as an emerging to Art Therapist, Dr. JoAnn Hammond-Meiers, and entered in to personal therapy. Art works that were explored included doodles I did while in SRT training, art work done on my own, as well as art process work done in Dr. Hammond-Meiers private art therapy studio. The initial image I generated with Dr. Hammond-Meiers was done prior to entering into this thesis research. This image provided a view into a landscape that held a place of peace and stillness in the horizon, and it was surrounded by the storm of the sky and the energy of the earth.

I knew that I wanted to learn more about SRT and explore why I was driven to this research. I wonder if the doubt I was having regarding my ability to become a therapist also included my doubt about whether I wanted to in fact become an art therapist. The session was video recorded and as I was able to watch myself as the client. The image I created using watercolors spoke to my feeling of being one of three identities. I was the storm, I was the passion of uplifting energy and force from the earth, and I was the one seeking a quiet still peace. This place of quiet peace was the mid ground of my painting. I wonder if the storm was my nervous system hanging over my desires to find peace, conscious connection to my life. I also wonder if the energetic

ground, bottom layer in the painting was my passion. This passion provides the energy for me to pursue my best life. I do this by continuing my personal and professional growth (See Appendix A for the image).

I found meaning from work with several images created and explored while in session with Dr. Hammond-Meiers. I believe images of doorknobs symbolized entry into a new room or world. Yellow diamonds being ingested into a body's core represented the acquisition of new knowledge, perhaps jewels of wisdom. Numerous self-portraits with a pronounced right eye possibly referenced my brain development of left hemisphere, and a figure standing on my left side seen in my body map may have referenced greater work being done in my right hemisphere. One of these was a body map developed by Jane Solomon. (Retrieved from www. migrationhealth.ca -mapping). The offering, a third hand, a spiritual aid, also part of the body map, may have represented a passing on of knowledge in the form of an orange circle, which symbolized intention and support. (See Appendix A for image).

Exploring these symbols outlined what Damasio (1999) stated with respect to storytelling and brain functions. It may be the case in this inquiry, that questions that are never posed - do get answered. Insights into my personal and professional development I did not set out to explore were illuminated for me in the images I created. Of particular consequence for this research was the discovery that all images evolved around how the training experience in SRT changed the kind of art therapist I was becoming. This new learning had been assimilated into my being, and it was left up to me to open the next door. Drawings of doors and door handles surfaced during my doodles done in SRT training, and in the artworks done in art therapy work in Dr. Hammond-Meiers.

The purpose of this research was to investigate the feasibility of integrating SRT and art therapy. Also explored was the influence that SRT training had on me the emerging art therapist. Through this self-reflection I gained awareness that it would be possible to explore the potential of integrating SRT and art therapy processes. I based this conclusion on examples of overlapping applications of these respective therapeutic principles as seen in the videos and explored the data discussion.

I realized that my identity as an art therapist has been reinforced and I have found further theoretical and personal validation for this process. When explained from psychophysiological framework I began to see how creative art therapy processes worked to create room in the container of the body's nervous system. I also now see areas where I might be able to work in ways that are congruent to my experience and new learning by integrating SRT with art therapy.

The complexity of the SRT process is such that it has been a challenge to compile the literature and convey an understanding of it, not only to the reader, but also to myself, the researcher. The examination of my lived experience has included a continual, and steep learning curve in order to gain an understanding of SRT's foundational theories. This self-reflective method of inquiry required great internal harvesting through personal and professional self-examination. A great deal of research and critical self-reflection was required to convey how the SRT process worked to help my client and where there were gaps in my competency in its use.

On my journey of exploring how the learning of SRT had transformed me personally as well as professionally, I followed the research methodology of heuristic inquiry (Moustakas, 1990). This journey included an exploration of how my inner

knower was communicating and making sense of my experience through the unconscious world of my dreams. To work through this dream I used art making done during an expressive arts experience with the companionship of my mentor, Markus Alexander (registered expressive arts therapist and founder of World Arts Organization 1985). I took the sensations that still resided in my body days later following the dream and asked my inner knowing to express what wanted to come forward using pastels on paper.

The dream entailed images of myself climbing a very high tree and reaching for something high up it. I fell. During the fall I began to accept that I might die as a result of hitting the ground. I saw my body approaching what might have been my death. Suddenly, a gust of air rose upwards and held me suspended in safety. A soft landing placed me on my feet and I walked on. The sensations of this dream resided in my body for several days. There was a physical sensation of being held, of being suspended above the ground. Natural forces of uplifting and powerful air streams turned me right side up. The art told me that the presence of this mystery – which I have already identified as *the third,* was present to support me and prevent me from a crushing fall. I believe my unconscious, as explored through my dream, was assuring me that as I reached for a goal, or pursuit that was held high I could fall. Falling would not be the end and I would not meet mortal failure. Succeed or fail, regardless I will remain whole. I am held in something greater than myself. The image I created shows a figure accompanied by its shadow and its light. These figures represent to me the integration of aspects of myself. They also may represent the intrapersonal, interpersonal and transpersonal integration of myself that I seek. The connection to the figures may represent my desire to find connection to the mystery that is revealed by the yellow and the orange, “the light”. The

figure is surrounded in blue. Blue is ethereal and needs no more analysis than that it represents the felt sense of the dream as it resided in my body days afterward (See Appendix B for the image).

I was encouraged to discover that art and/or art therapy interventions did present for more than half of the video sessions with my client, and did bring support and a nurturing presence to the work for my client. I don't believe it is a coincidence that the client who to entered into this therapeutic experience with myself, is an artist herself. Perhaps this connection was intended to bring my conscious awareness to my continued commitment to working with the healing and mysterious power of the creative process. The next phase of my development in becoming an art therapist integrating the SRT process will require more exploration of art therapy process application, alongside using SRT principles and theory in my practice.

My emerging new identity can be viewed perhaps as a work of art, a work in progress that sheds light on this phase of my personal journey. Zundel wrote in *The Gospel Within* (1993) about the search to name and identify one's connection to this mystery or light. He stated, "The artist who has made herself the disciple of Beauty knows that she will never express this Beauty in its totality" (Zundel, 1993, p. 29). All immersion into work, therefore, all the art making and personal transformation in becoming an art therapist and/or SRT practitioner is but a step in my discovery of myself, an identity which is perpetually being redefined. This expanding and changing identity is formed and reformed by the pursuit of knowledge and experiences.

Chapter Five: Summary And Conclusion

The process of acquiring knowledge through the research literature being written on neurobiology, psychophysiology, and psychotherapy while in SRT training has informed and challenged my identity as an emerging art therapist. This transformation happened alongside my personal reflections and insights gained through creative arts experiences. As I continued my exploration of the SRT training modules, I began to see evidence in everything I was experiencing in my own life to support the fact that our nervous system communicates through our felt-sense. I became conscious that the body holds the charge of our physical experience of trauma as well as informs us of our human existence. I was initially motivated to learn both processes in order to explore integration of theoretical principles. Gradually, the learning evolved to become a process of personal integration within myself: an intrapersonal, interpersonal and transpersonal awakening. As a result, I gained a greater conscious connection to my own mind, body and soul.

The Door Has Been Opened to Enter Into Future Therapeutic Integration

Initially my focus for this thesis research was intent on exploring the possible congruency of two therapeutic processes, Self Regulation Therapy (SRT) and art therapy. It became evident after watching videos of myself engaged in SRT work with my client that the art, the artist, and the art therapist were also simultaneously present. I became curious about the possible feasibility of integrating this new neurobiological language of psychophysiology with what I had already grown to appreciate about art therapy. I was evaluating my ability to deliver SRT with my client when certain revelations were made evident. After further self-reflection and revisiting the eight video sessions I realized that the art, two artists, and myself, the art therapist, were also present and offering support.

This revelation was evidenced as I watched the interactions between the two of us in my art therapy studio. I saw how the art managed to weave its way into the space and create a bridge for us to connect. I was struck by the realization that communication with this client was enriched through the art, as art was a language that we could share. I was also aware that as I was learning how to engage with the SRT process. I was becoming more comfortable and committed to further exploring working in a way that invited art therapy invitations into SRT sessions.

The pursuit of knowledge can be equated to the desire to become more conscious, more aware. The new identity that evolved as the result of my learning and the resulting new knowledge that I acquired through SRT training occurred alongside my continued work and interest in creative art therapy facilitation and training. The integration of these therapeutic processes and their theory and principles that took place as a result reflects a personal as well as a professional new emerging identity: that of an art therapist, who has been influenced by immersion in SRT learning and experience.

Freke and Gandy (2004) explored knowledge through the philosophy of Gnosticism. They described Gnosticism as a state of knowing, or a state of awakening that arises when you are noticing what you becoming conscious of and are actually "knowing" right now (p. 130). They stated that things that we claim to know are actually just opinions, which we believe. I have come to believe that learning SRT has led to a greater personal and professional integration, which will in turn enhance my ability to be a more attuned art therapist.

Through witnessing the art the client brought to share with me, and the art invitations we engaged in I was reminded that resource and resiliency can be enhanced

through the power of the creative process. This reawakening became an embodied realization, as I was bringing awareness to my own body's felt sense while I was watching myself on the screen. I explored what I was noticing within my own psychophysiological states at the time that I was evaluating my response to seeing myself on the screen, in the capacity as the therapist. I answered the questions, which had been established for the purpose of this inquiry, from my heart. I witnessed the client's current art projects and completed work. She shared her dreams for future creations and I imagined alongside her these new future inspirations. These reveries alongside the art invitations that were engaged in during therapy sessions revealed my natural inclination to follow the call of my own commitment to the creative process.

This connection to my psychophysiological state, a heartfelt connection, and my response to watching myself doing therapy work, engaged my nervous system. My right-brain attunement, complemented by my left-brain thinking, enhanced my ability to know myself consciously a bit better. I believe it is through the mind and the body that we attain greater conscious awareness, and through higher states of consciousness we connect to our soul. The tacit and explicit knowledge that I assimilated as a result of this new learning was necessary for me to emerge as an art therapist informed and transformed by my SRT training experience. This exploration brought conscious awareness to the truths around how I envision my future professional identity. I believe the "soul" strives to bring us to greater conscious awareness by encouraging new learning.

New Knowledge Criteria: Successful Therapy Includes Both SRT and Art Therapy

Both of these processes highly value the essential need for creating a therapeutic environment, a safe container from which to work slowly from thus preventing the client from reliving a disturbing event. As Robbins (2000) pointed out, artwork itself creates a holding space. Through engagement with the art, and slowly with the therapist holding the therapeutic space, the art creates a container. The client gains feedback on her/his own internal pathological state and is given the change to play with and organize unresolved conflict and challenges to find new integration and solutions

As I observed while watching myself and the client establishing our initial therapy session it was noted that the client and I had developed a relationship, a working environment and a therapeutic alliance. In an interview aimed at highlighting the theoretical underpinning of person-centered expressive arts therapy, the ideal environment developed in a therapeutic context such as an art therapy studio was discussed in a conversation with Natalie Rogers (N. Rogers, 2004, as cited in Rogers et al., 2012). The importance of understanding people as "human organisms in the context of environment" (p. 36) was discussed, as it was deemed conducive to the client receiving therapy. Tudor (2012) stated, in reference to the therapeutic environment, there are several considerations to keep in mind. He said there is a great need for awareness of the context of therapy as it pertains to the broader environment that includes, the social, economic, and cultural context. This is in line with research done by Schore (2012), on the impact of early cultural environments, such as the quality of the infant and caregiver relationship. This early context has influence and an impact on an individual's development of the mind-body interrelationship.

Interpersonal: Developing Relationship with Another

Reflecting further on this understanding, what was taking place between the client and myself was that we were initiating and developing an essential respectful relationship. We were meeting as two people from a similar community that included artists and we shared a similar perspective around some of the realities of what it feels like to be an artist in our current world.

Perhaps this may have influenced my self-reflection with regards to this thesis in that we shared an interest in art making and we shared an experience of being artists. As a result I may have unconsciously related more to this client, versus someone who did not identify himself or herself as an artist. The likelihood that this client and I could connect in a similar world reality was strengthened by alliances to the community of artists, and this gave us a greater chance of connecting in the therapeutic art studio as well.

Schaverien (2005) stated that when using art in analytical art psychotherapy, instead of transference being observed in the therapeutic alliance between patient and therapist, "The unconscious emerges not within the relationship but from the pictures" (p 73). Art can act as powerful source and container for images and symbols, serving as a *third,* in therapy. Art making can also be effectively introduced with those who do not call themselves artists or have any experience with art materials.

The acquisition of knowledge is a subject for philosophical discourse. Judging one set of knowledge or theory over another leads to debate, whereas accepting that there are variations in how different communities view reality leads to opportunity for dialogue. Psychotherapist Irvin Yalom (2002) advised therapists to be sensitive about what constitutes the definition of reality, for us and for our clients. He stated that

"reality" is merely the world we encounter as it is processed through our, "neurological and psychological apparatus" (p. 13).

Damasio (2014) spoke to creativity and its potential ability to influence how people develop as social creatures. He advocated for neuroscience to take a closer look at how human civilization has used philosophy, theatre, music and art to inquire about the complicated process of the mind. He called for research that would focus more closely on looking into past and present efforts in the arts and humanities to understand our complexities. Damasio (2014) added that the history of culture and the development of social institutions and constructs are the result of our response to human feelings, positive and negative. He suspected that music and art were developed in early civilization as a means to comfort the pain of others. Art and music were developed as instruments of consolation, a response to help in our human struggle of coping with feelings.

According to expressive arts therapy, the experiences that allow us to play together, engage in dreaming or reverie and create art in order to enter into a relaxed state of being, is merely "the origin of culture" (Knill et.al, 2005, p. 40). Perhaps, the "reality" of therapy is that we sometimes gather in a professional therapeutic environment to work through difficulty in a way that art and connection to community used to do, in a natural and organic way.

I have come to understand how my ability to work as a therapist revolves around not only my proficiency in using therapeutic skills, but also my development as a person. My intrapersonal integration therefore is essential to interpersonal connection. When as people and as therapists we find this internal healing and integration within ourselves, there is a greater capacity within to engage with others. I also hold hope that connection

to a fuller life and purpose that evolves within expands our connection to something universal and greater. Self-regulation allows an individual the opportunity to settle within and discover the capacity for personal inner peace.

Intrapersonal: Relationship With Oneself

I have come to understand that the true goal of therapy is the integration of the self after trauma and conflict that causes a loss of connection to soul. I have experienced an overlap of this objective in both art therapy and SRT as these processes attempt to help the client move the effects of trauma that are trapped in the psychological world of the conscious and the unconscious; out of a state of fixity, and into a state of awareness, a state of flow. When this happens energy that was stuck the body's nervous system, as a result of the unresolved adaptive functioning of the brain, is released. Then a person can move on to find meaning, a sense of completion or understanding where only confusion and difficulty existed before.

The reintegration of self and soul can be accomplished in therapy as a way to move forward following trauma and therapy even when closure cannot be found and events cannot be undone. Pargament (2007) spoke to spiritually integrated psychotherapy, and stated that both science and spiritual meaning grow out of an openness to explore with sensitivity, "the mysteries of the universe, and a desire to make manifest the unmanifest" (p 20). He added we can draw on knowledge from scientific explorations to assist people in their own spiritual journeys. In this way, those who are stuck and fixed in their psychophysiological reaction to past traumatic events and circumstances can move out of a state of dysregulation and move closer in to their best life, into a greater state of self regulation, a state of joyful engagement and spirit.

Thus the acquisition of personal and professional knowledge creates a greater opportunity to become a more attuned and consciously aware therapist. Being a more regulated therapist increased the chances I will become successful in providing effective therapy. Becoming more regulated increased my ability to be more fully present, to hold the therapeutic space mindfully and soulfully, in awareness of the other.

During an art therapy session with Dr. JoAnn Hammond-Meiers I was invited to participate in a dance of knowing alongside a dance of not knowing, as my identity and knowledge as a therapist will most likely be continually evolving and re-emerging in subtle ways. I began to see that my need to learn more was a natural inclination as both an artist and a therapist to look at my work and ask, "what was working and what was not complete?" My transformation took the form of a dance. "The dance between inspiration and reason, logic and symbolic expression, expansive and structured ways of knowing provides a climate of flexibility, which stimulates new possibilities, poignant insight, and spiritual transformation" (Netzer & Rowe, 2011 p. 125). The dance between the symbolic expression - art, and the new learning experienced in the neurobiology research has opened me up to insights and possibilities within myself, as well in my practice as a therapist. Most primary in these insights is my desire and commitment to life long learning.

Exploring these symbols outlined what Damasio (1999) stated in respect to storytelling and brain functions. I may be the case in this inquiry that questions that were never posed, do get answered. He suggested that because we have evolved as storytellers who are convinced that knowledge comes in the form of answering questions it is assumed that we become "knowers" because we have answered our questions.

The new learning I have immersed myself into with SRT training has changed some of my viewpoints and my opinions regarding how I want to work in my art therapy studio. These opinions are still being molded and formed, as I bring awareness to what I am noticing, in my felt sense, as I make meaning of my experiences. Learning from intuitive inquiry by way of creativity and innovation "validates multiple ways of knowing, which include and transcend academic knowledge" (Netzer & Rowe, 2011. P.125).

I am still curious about what drives me to this learning that directs my path to psychotherapy. I wonder how my conscious engagement with this new way of being through my continued self-reflection will cast further light on what may be an unconscious pull to fulfill greater self-discovery and inquiry. Damasio (1999), examined consciousness as it pertains to spirit or to the mystery of what it means to be human. Science can explain a great deal about our minds, and still much is unknown. Damasio stated, "understanding consciousness says little or nothing about the origin of the universe, the meaning of life, or the likely destiny of both"(p. 28).

Transpersonal: The Plural Relationship Includes *The Third*

The pursuit of knowledge and the resulting new identity that has grown in me has resulted in a transpersonal connection that resists being named. My spiritual sense has grown alongside my evolving identity. As a result, alignment with any religious institution or group has been uprooted, and is now identified as an increased awareness of this intrapersonal, interpersonal, and transpersonal connection to that "unknown." I have found that in times of silence together with creative experience in community with others of various faiths and beliefs, the presence of *the third*, which is sometimes the art, has

gifted me with phenomenological presence and mystery. “No one can describe what it is, other than by saying what it is not: by projecting, so to speak, in a pillar of light the dazzling shadow it outlines within ourselves” (Zundel, 1993, p. 29).

I have come to define “shadow,” as the lack of connection with ourselves: our bodies, minds, emotions and our souls. This can be the result of trauma. Trauma causes a disconnection from the soul, and this can rob us of our ability to find hope, as well as of our ability to find connection and beauty in our lives. It is not about being able to get through the day but the quality in which I enter into the day. It is not about being alive and pushing through but rather being fully alive and living my best potential life.

Siegel (2012) stated that emotion “directly influences the functions of the entire brain and body from physiological regulation to abstract reasoning” (p. 158). Sensations can reflect primary emotions such as internal shifts in states of arousal, or can be stimulated by emotions such as anger, fear, sadness, excitement or joy. Siegel described how the middle prefrontal region of the brain registers the state of the body and directly influences the body’s state of activation via regulation of the autonomic nervous system ANS. He stated that this region of the brain serves as “a source of social processing, stimulus appraisal, and body/brainstem/limbic (‘emotional’) arousal”(p 158). Our minds can be bombarded with overwhelming feelings, and we can be more or less conscious of aspects of this emotional processing so that “emotions are what create meaning in our lives, whether we are aware of them or not” (Siegel, 2012, p. 161). Levine (2013) stated, that our thoughts are the emergence of our basic instincts. Engagement in emotions, and thoughts as required in the use of imagery and symbols, is what is unique and contributes to our being human.

The Therapist's Identity: Watching the Changing Portrait in the Mirror

My identity as an artist, the initial impetus in my becoming an art therapist, aligns my way of knowing and learning with a gained embodied awareness of myself through the integration of creative and physical processes. It has been my experience that my sense of self has been strengthened when different aspects of my personality or identity have been integrated and enriched by the ongoing discovery and creative processing of insight and awareness. I was inspired by what I had learned and experienced in SRT training. Now that challenge will be to continually find creative ways to integrate this new learning into my evolving practice as an art therapist.

Blending my inner subjective experiences with SRT course material and personal therapy, has transformed my understanding of learning as it has opened new ways of knowing and being with research. Meaningful and purposeful shifts have developed and integrated new awareness on personal and transpersonal levels, awakening my own inner knowing. Seeing myself as a therapist, working in my art therapy studio using SRT practice, was a phenomenal gift as it mirrored back to me a portrait of my journey of exploring critical and meaningful self-reflection. This self-portrait provided an image from which to view myself as an artist, a therapist, and as a separate individual. This is a process of bringing another view of one's soul into the picture, an important component of therapeutic growth.

In one sense I was reflecting on my image as a therapist and my feelings of apprehension, curiosity and sometimes relief were being reflected back as I watched myself on my computer screen. I was inferring from my non-verbal body language what was happening as I was remembering the session. This required me to travel back in time

to revisit and then to reflect on how I recalled experiencing the session then. Being researcher, and co-researcher simultaneously, was creating a form of self-reflection almost like a reverberation. However, watching myself was relatively calming when I perceived the session going well and painful when I perceived my ability to be wanting. Although challenging this sense of critical self-evaluation, was effective in mirroring how I perceived myself, and my performance. As with my client, physical sensations were noticed in my stomach, my sympathetic response to stress associated with my response to personal discoveries. It would have been helpful to seek SRT therapy at this point. Through sustained tracking of this sensation, and by resourcing and titrating of the activation, I might have discharged the emotional hold on my body, which I interpreted as an unconscious lack of faith in my own ability to deliver.

Images and Symbols are Resources For Both Processes

Both SRT and art therapy allow the story to be told and sometimes transformed, and guide the use of images and exploration through a slow pace of expression and discovery. Art therapy invitations, as outlined in Chapter Four, used sequencing of events in the client's story to build on the cognitive component of the Expressive Therapies Continuum (ETC) (Hinz, 2009). Then the movement of this expression is facilitated through further use of affect, perceptual, sensory, kinesthetic, and symbolic components of ETC.

In a client study of a woman with chronic pain, Hass-Cohen and Franklin (2009) explored early emotional development. These researchers used portraiture drawing to explore relationship trauma, the result of the client's abusive relationship with her mother. A lack of healthy attachment was identified. To reiterate what Schore (2003)

stated, “All current theoretical and clinical models of psychoanalysis and psychotherapy now incorporate models of early emotional development and attachment theory” (p. 217). Although work with my client and myself unearthed developmental themes and gave insight into what may have been attachment issues and challenges from childhood, these principles were not explored here due to the breadth and scope of this research and the limited space in which to explore our entire stories. Having discovered the findings of this study by Hass-Cohen and Franklin (2009), I imagine offering my future clients the opportunity to use portraiture for further self-exploration and to perhaps to explore resources and resiliency.

In the Hass-Cohen and Franklin (2009) study, the woman suffering chronic pain found internal and external resources when she focused on her spiritual guide in the image of a “light,” that she used as a resource, imagining cradling her own heart. As a result the client was able to identify coping strengths through this image, alongside identified mindfulness and meditation practices. She told the therapist that her chronic back pain had lessened following work in art therapy self-portraiture invitations. I am also curious about how including the SRT process and working with the client in the Hass-Cohen & Franklin (2009) might be imagined. I wonder if engaging the client to connect with her felt sense using the therapeutic process of SRT might have also brought about relief from her pain. Pain is kindling in the brain and SRT teaches how to quench the kindling. Zettl’s (1998) work with emergency service personnel using SE therapy described how physical pain had been lessened and even resolved following therapy with her. Zettl’s (1998) study used the Somatic Experiencing (SE) therapeutic principles that

later formed the foundation for SRT process development. I hypothesis, that the two processes of SRT an art therapy woven together could prove to be effective therapy.

I believe art therapy could benefit from the neurobiological language developed in SRT therapy. I was inspired to integrate SRT and art therapy processes after observing several SRT therapy sessions that engaged my imagination as a resource to deal with activation. Both SRT and art therapy processes attempt to use imagination to facilitate a resource state for clients, in order to deal with activation. I have experienced discharge of my nervous system, whether I was aware of it at the time or became conscious of these experiences later, through my therapy in both therapeutic processes.

SRT process calls for the slow release, the titration of activation surrounding the traumatic event, by exploring content pre and post this event, until the charge around this has been dissipated. Eventually however, the main event or story is faced and worked through and the memory that holds the story in the body is renegotiated in order to heal, and release its hold on the ANS. I believe that using SRT principles and the prompts outlined in the therapeutic process can further the capability of art therapy invitations to resolve the charge of trauma out of the body. Studies explored in this thesis research has shown how certain art therapy interventions, do in fact, focus on engaging the felt sense when reviewing disturbing images and memories. Through a conscious intention to work this way, integrating the therapeutic process of SRT alongside those of art therapy, I hypothesize that the charge of traumatic events can be released from the bodies of our clients.

Treatment of Trauma Through Therapy Can be Restorative and Transformative

As my knowledge of SRT therapy grew as a result of my personal and professional immersion in learning this process I began to gain greater confidence in my ability to become an art therapist. This was due to the fact that I was beginning to see SRT's psychophysiological principles, contributed to my understanding of how art therapy interventions could be effective. I was finding explanations for how trauma is held in the body and how therapy can help move its unresolved charge out of a persons' nervous system. Although I found that art therapy and SRT also differed in many ways, including the use of language to describe their respective processes. I discovered there were greater similarities in the their therapeutic goals and creative approaches when working with people who have experienced trauma and traumatic events. Through personal therapy using both processes, I recognized how they worked similarly and distinctively through my personal therapy in both.

I am not consciously aware that my cesarean section birth trauma, as explored in SRT therapy, ever appeared or was expressed in my artwork. Nor can I state for certainty that images resulting from this traumatic event were processed and explored during other expressive art therapies. However, as I look back on the creative arts therapy work I have done over the past five years in my journey towards becoming a therapist I have created many organic, feminine shapes and forms. Many of these were described with sensual metaphors of "birth," "gratitude for physical life," "creation," being "held and holding."

By more closely examining the data pertaining to exploring the influence that SRT has had on my emerging identity, I rediscovered art therapy theory developing in a new way. Initially, the exposure to SRT training and the personal therapy I underwent

during this process so inspired me that for a time I lost my connection to art therapy and its potential. Then, I imagined including and potentially integrating art therapy practice with SRT language of neurobiology and psychophysiology. A door had opened providing a peek into this opportunity in anticipation of engaging in a rich and powerful therapeutic process. If integrated, this process will be informed and influenced as a result of my experience with both. Future research is needed to explore and create a framework from which this might be created. This research could be a phenomenal piece of artwork.

One area of study, inspired by my therapy to resolve the charge that resided in my system as a result of my emergency cesarean, would be to bring these therapeutic approaches together to work with new moms. There is an abundance of research that develops the case for needed therapy in this group. There is great evidence that care of mothers and infants is essential to creating a healthier, happier, and more regulated world. Hogan (2013) used art therapy to provide a space for women to explore their experience and sense of self that changes as a result of pregnancy and birth labor. She promoted a feminist approach using art therapy to help women through childbirth.

Having a reflected view of myself, as observed in the bureau mirror in my art therapy studio, helped me to observe my non-verbal body language. This is an example of where the artist self, attending to the aesthetic of the camera frame, showed up to promote this research in a phenomenal way. This validated my belief in a mysterious spiritual support for my working from an artist sensibility. “Mystical experiences reach beyond personal story to reveal collective patterns that offer a culture or group an opportunity for revisioning essential myths” (Farrelly-Hansen, 2001, p 196). The belief that I was losing my faith in the healing power of the creative process and making art had

been dissolved. This thesis inquiry has strengthened my connection to the community of art therapy. I have gained a greater understanding of why art therapy is such a healing tool. I have also gained an understanding into how this process can be used even more effectively as a result of the insights of neurobiology research findings.

I have experienced the phenomena of being guided by my greater inner knower, and aided by that "energy or mystery," that exists in the studio between the therapist and the client. Together we worked as co-creators on an exploration of insight and hope for some form of healing. Gifts of meaningful imagery, and surprise revelations restore my faith in the ability of the creative process to bring about effective change: to move from being overwhelmed, stuck and despairing, forward into hope and flow. Into state of *Joy*.

This thesis research only scratches the surface of what would be involved and achieved by integrating these two therapeutic processes, and delivering them under one therapeutic umbrella. Still, I have gained a new understanding of where I am in my process of professional development as a result of my being influenced by SRT training. I have a new essence, a new understanding of being in this role of therapist. I am emerging as an art therapist more educated and becoming more regulated. As a result I am becoming a more attuned therapist. This inquiry also illuminated the need to continue this life-long and perpetual learning required to accept the challenging role of being our best. As Moustakas stated (1990), "the heuristic researcher is not only intimately and autobiographically related to the question but learns to love the question . . . it creates a thirst to discover, to clarify and to understand crucial dimensions of knowledge and experience" (p. 43). Exploring both these therapeutic processes in depth through my own

learning and personal therapy has reinforced the belief, that as a therapist, I cannot ask a client to experience a therapeutic process I have not experienced myself.

This portrayal has revealed how I have lived this experience and have benefitted by these similar, overlapping, and still very much distinctive and separate approaches. Although this research inquiry was not intended to create a protocol or formula for integrating SRT into my art therapy practice, I have discovered that I now think as an SRT practitioner when I am engaging with a client in an art therapy invitation. I am also imagining how to use art interventions for clients who are exploring resources to deal with activation as they seek to discharge and find space in their nervous system in order to gain greater self-regulation. My work from now on will be informed by this new way of being in the role of therapist.

Concluding Creative Synthesis: The Integration of a New Birthing

The creative synthesis of this inquiry is my painting, *The Integration of a New Birthing.* It is an image of my daughter and, at the same time, it is also a self-portrait revealing my own image. The image of three diving female figures, seen to be emerging from water, is like that of the womb of the unconscious. The female figures are integrating and surfacing up into the world of the conscious as one head extends opening oneself up to take a breath and receive light. The third figure has greater clarity of features and form, as if having completed the birth process (See Appendix C).

An image created earlier in this research process was initially chosen for the synthesis of this thesis (See Appendix A). It is related to a dream I had. I was climbing a tall tree, and when I reached out for something up high, just beyond my reach - I fell. I recall that while I was still dreaming I was very aware that I was anticipating my death.

Instead I was swept upwards by a huge rush of air from the ground and I was gently put back on my feet, on the earth, and I walked on. The sensations that resulted from that dream left a residual affect in my body for some time. However this image was not used for the thesis synthesis as it was decided that this image was part of my learning process.

I then created another image to explore my personal integration. The resulting image reflected my understanding of my own nervous system's disintegration and my deep desire and quest for resolution and hopefully for my reintegration. This image tells the story of my intrapersonal, interpersonal and transpersonal formation as I have reached new learning. This learning has evolved as a new understanding of my emerging identity as an art therapist and grew out of the new insights I gained through SRT training. This integration is represented with the three images. There is a submersion into the process of learning, a deep suspension and floating in the experience, and a third emerging and surfacing figure. This art piece is a product as well as a process piece, in that it was deliberate in its intent and execution.

This art piece has also proven to be a *third* mysterious presence in my life. The expression and teachings this painting has offered me continue to be discovered and explored beyond this thesis research. I initially did the piece with my daughter's image as the subject matter. Only later did I discover that it was also my image. The traumatic event that served as the impetus in my quest to learn more about trauma therapy, as it pertained to myself personally and then professionally, involved both, my daughter and myself. My gratitude for our lives and the miracle that brought us together is also celebrated in this painting.

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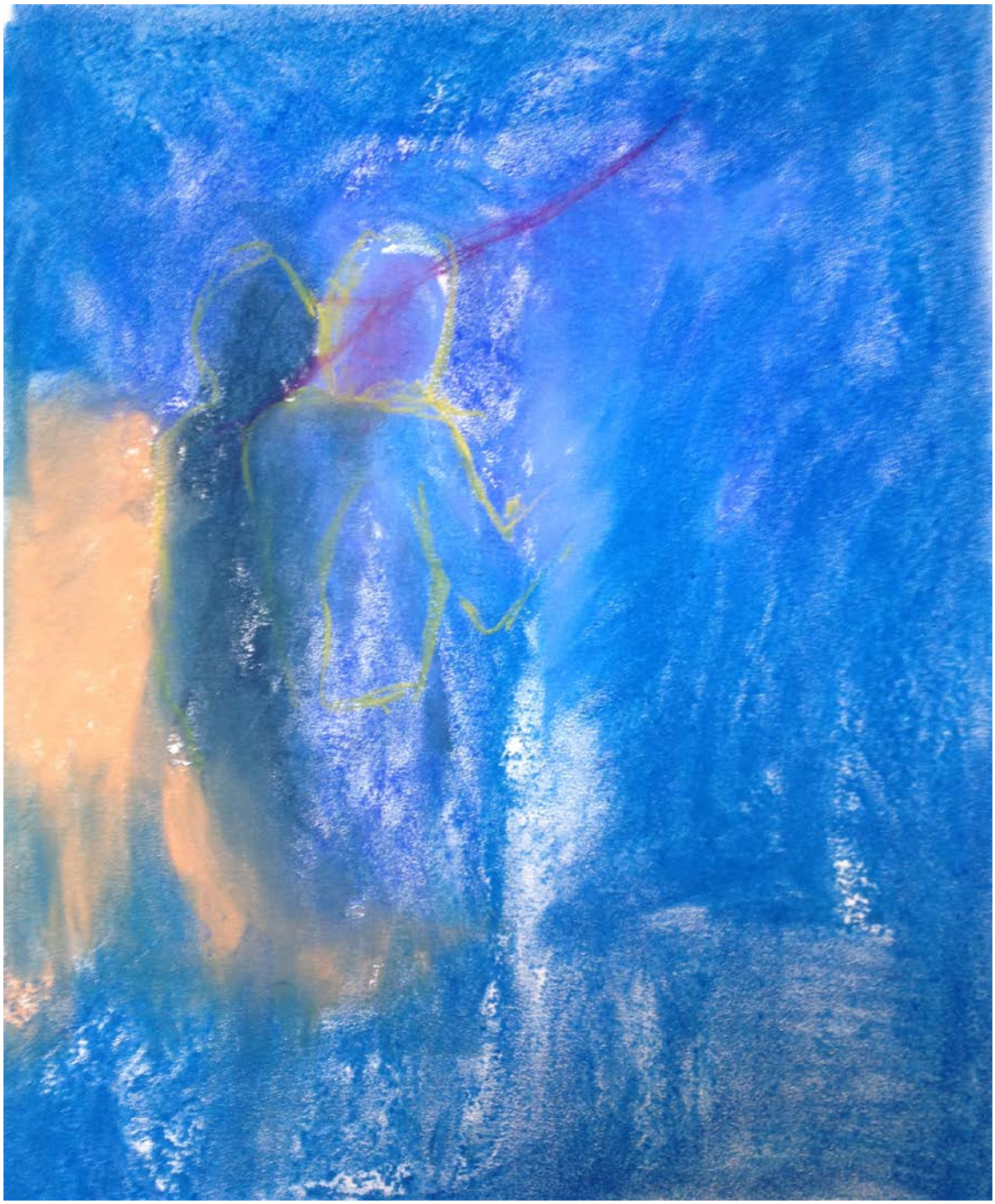
Appendix A

In the Blue
(chalk pastel on paper 24” x 30”)

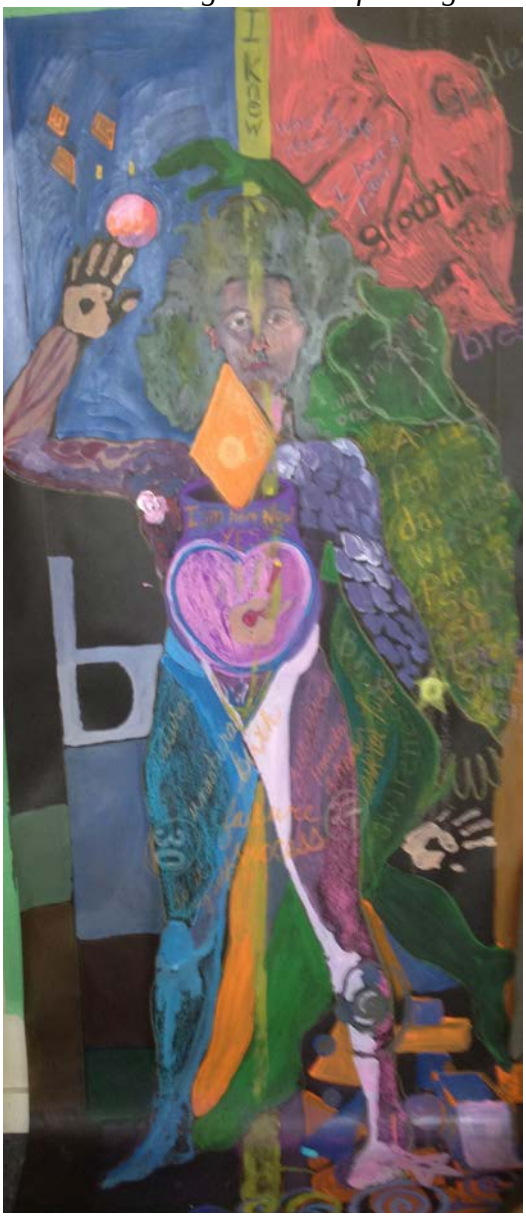


Appendix B: Artwork Done In Art Therapy

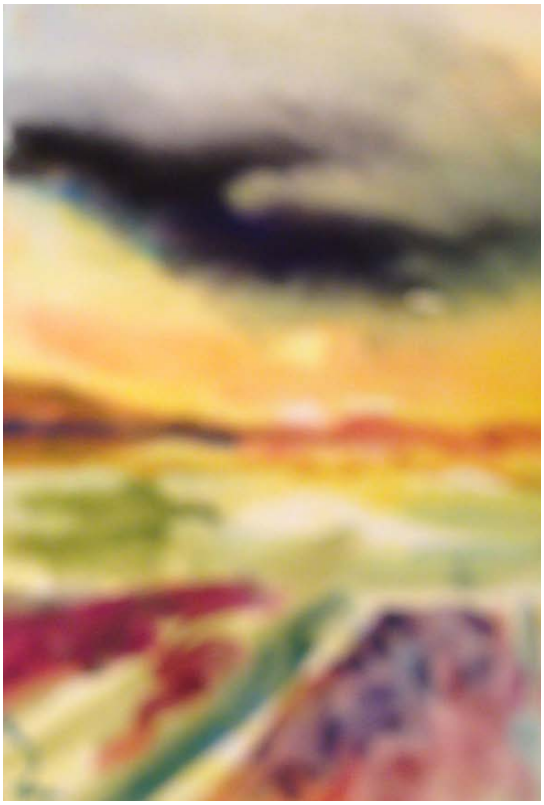
A. *Integrating the New Learning* – Body Mapping (Mixed Media, 6' x 3')
Integrating the new learning, transcending the mind, body and soul.
Body map done during workshop presented by Christine Lummis on
Sept, 21/22, 2013 at St. Stephen's College, Edmonton, Canada.

B. *Seeking a Place in Inner Peace; Quiet Space for Conscious Being*
(watercolor 8"x11" June 2013)
Art done during art therapy with Art Therapist JoAnn Hammond Meiers

A. *Transcending and Transforming*

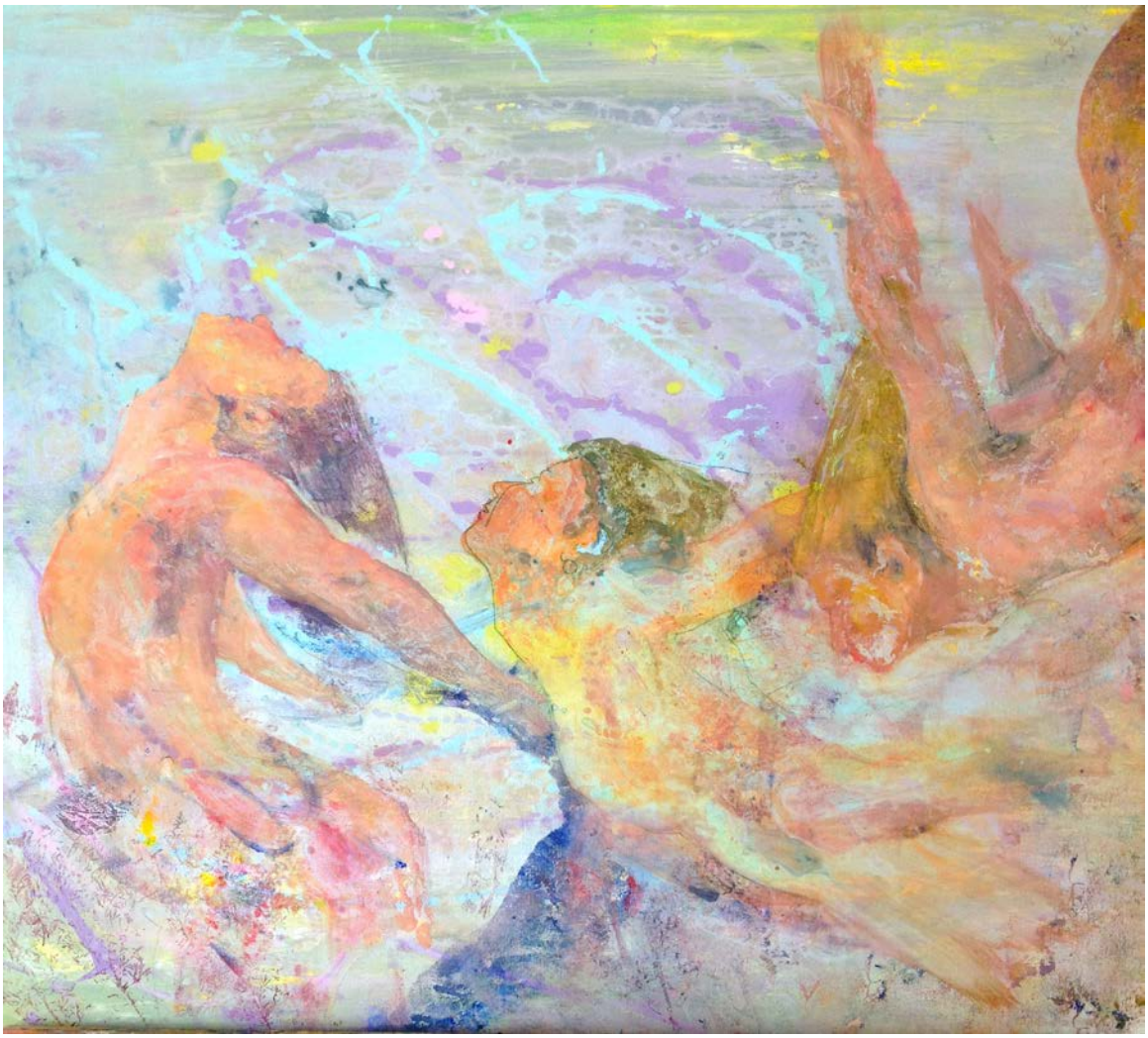


B. *Seeking a Place in Inner Peace*



Appendix C: The Creative Synthesis

The Integration of a New Birthing
(mixed media on canvas – 42” x 36”)
Janet Stalenhoef, April 2014



Dear [redacted]

This email is to ask you for a further consent in my use of eight videos sessions that include you. The consent form you signed previously released information and the videos for use in my being supervised as a Self Regulation Therapy (SRT) student completing SRT Advanced Training Education. The consent I am seeking now is a release of information and videos for inclusion as a reflective resource in my thesis research related to completing the Master of Psychotherapy and Spirituality in Art Therapy (MPS-AT) degree at St. Stephen's College, Edmonton, Alberta.

The question I am researching is: How has Self Regulation Training (SRT) influenced my work as an emerging Art Therapist?

My use of the videos that include you will be solely for the following purposes:

- To reflect on myself, in the therapist's chair, as I am captured in the mirror during our eight video sessions.
- To reflect on my ability – i.e. level of confidence and choice of Art and/or SRT theoretical process applications – during our 8 sessions
- To attend to and explore my own physical felt sense as I watch the videos,
- To consider what worked and did not work with regard to specific SRT applications and Art Therapy applications.
- To consider where I feel most comfortable with regard to the two therapeutic processes of SRT and Art Therapy and, based on this, to envision how I might proceed as a psychotherapist in the future.

As you can see from this summary, it is through the sessions with you that I am asking these questions of myself. The focus of attention is on me. There will be no disclosure of information related to you as my client.

Specifically what I am asking you to give consent to is the following:

- My use of the eight video sessions that include you as a reflective resource for my thesis work, with the understanding that the focus of reflection in my use of the videos is me – i.e. my work as an emerging Art Therapist.

No one will see the videos but me. When not in use, the videos will be stored in a locked file cabinet accessible to me alone. Following completion of my MPS-AT degree the videos will be destroyed.

My commitment to you is to safeguard your privacy by using a pseudonym for your name and making no references to any aspect of your identity that could reveal who you are to those reading my thesis.

Finally, please note that while I am requesting this further consent, there is no obligation for you to do anything more than what you have already done. If you decline consent I will respect your decision and not use the videos in the manner requested here. If you decide to give consent, your typed name as part of replying to this email message will confirm your willingness.

Thank you for your consideration.
Janet Stalenhoef

Statement of Consent: I give my consent for Janet Stalenhoef to use the eight video sessions, for which I gave previous consent in her SRT training, as a reflective resource for her self-reflections in her MPS-AT thesis work. I understand that my identity will be protected and a pseudonym will be used instead of my name. I further understand that Janet Stalenhoef will be the only person viewing the videotapes and when they are not in use they will be stored in a locked file to which only Janet has access. Finally, I understand that the videos will be destroyed after Janet has completed her MPS-AT degree at St. Stephen's College, Edmonton, Alberta.
Signed within the body of this email message [redacted] March 9, 2014

Research Databases and Search Queries

My research used the University of Alberta EBSCO Discovery Service, which searches approximately 100 other databases. I researched the years 2002-2014, and then 1987-2014. I used the key words “art therapy and Self Regulation Therapy” and found nothing. I used key words “art therapy and somatic *” and found numerous entries which I reviewed for applicable relevance to my research. I explored the following further databases: Elsevier, Medline, PsyINFO, SAGE Education, Taylor and Francis, and Wiley Interscience. More research include publications of professional organizations including, *Journal of the American Art Therapy Association, The Canadian Art Therapy Association Journal*, the *Journal of British Columbia Psychological Association*. Books were purchased and sourced by shelf browsing for books with similar call numbers to 489 A72 E94. I used references suggested in SRT training manuals of the Canadian Foundation for Trauma Research and Education CFTRE (Retrieved from www.cftre.com.) I also sourced the National Institute for the Clinical Application of Behavioural Medicine NICABM (Retrieved from http://www.nicabm.com).