

Transmission of Trauma, Ritual, and Art Therapy

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A Research Paper

in

The Department

of

Creative Arts Therapies

Presented in Partial Fulfilment of the Requirements
for the Degree of Master of Arts
Concordia University
Montréal, Québec, Canada

September 2007

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395 Wellington Street
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Your file *Votre référence*
ISBN: 978-0-494-34714-0
Our file *Notre référence*
ISBN: 978-0-494-34714-0

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Abstract

Transmission of Trauma, Ritual, and Art Therapy

Anie Najarian

Using a historical-documentary method, this research aims to explore how art therapy can provide a ritual space in which transmitted trauma and loss can be worked through in a symbolic way. Previous theoretical researchers have suggested that as a result of war, trauma gets transferred to other generations creating a sense of unresolved grief. In war trauma the loss is often ambiguous. As a result, a ritual that may help the grieving process may be absent. Art therapy has been used to help people who have experienced trauma through its unique ability to visually and symbolically communicate difficult emotions. In addition, its ability to create therapeutic rituals can perhaps help those experiencing transmitted trauma.

The connection among these topics needs further exploration. Research exists on the relationship between transmission of trauma and loss, between loss and ritual, and between art therapy and trauma. These relationships will be elaborated in this paper. This research can contribute to how we understand the transmission of trauma and how art therapy can be used to help clients work through it.

Acknowledgements

I would like to express my sincerest gratitude to the many individuals who assisted me during this process. I am thankful to my colleagues and faculty for their interest and faith in my research topic. Our discussions together triggered further reflections about this topic. Notably, I'd like to thank my research advisor, Dr. Suzy Lister, for her helpful suggestions, patience, and whose analogy of the funnel helped bring things into focus. I am also grateful to Ani Koulian for her assistance in the editing of this paper. Her contribution brought further clarity to this research.

I would like to thank my friends and family for their support and understanding throughout this process. Specifically, I extend my deepest appreciation to my parents, Raffi and Marina, and my sister, Adrineh, for their unconditional love, support, and faith. Finally, I am eternally grateful to my loving husband, Shirag, for his patience, active participation, and encouragement. It is easier to see the light at the end of the tunnel when others see it with you.

Dedication

This research is dedicated to the 1.5 million Armenians who perished in the Armenian Genocide of 1915. Although the paper does not directly address the issues surrounding the Genocide, nevertheless the continued effects and denial of the Genocide provided the impetus for my research.

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TRANSMISSION OF TRAUMA, RITUAL, AND ART THERAPY

Introduction

This paper intends to explore how a link can be made between the transmission of trauma, ritual, and art therapy as a tool for healing. Previous theoretical researchers (Boss, 1999; Fogelman, 1989; Hirsch, 2003; Wardi, 1992) have suggested that as a result of war, trauma gets transferred to other generations creating a sense of unresolved grief. Often, when there has been a loss such as death of a loved one, there is a ritual to mark the transition between the time before and the time after the loss, such as a funeral. In war trauma, the loss is often ambiguous, as the fate of missing family members may be unclear. As a result, a ritual that may help the grieving process may be absent. Art therapy has been used to help people who have experienced trauma through its unique ability to symbolically represent traumatic memories (Fitzpatrick, 2002; Golub, 1985; Greenberg & Van der Kolk, 1987; Wertheim-Cahen, Van Dijk, Schouten, Roozen, & Drozdek, 2004). In this way, I suggest that art therapy can provide that ritual space in which trauma and loss can be worked through in a symbolic way. Thus, the research question that guided this historical-documentary investigation is as follows: How can art therapy facilitate the creation of a ritual space in which transmission of trauma can be worked through symbolically?

Statement of Purpose

The aim of this research is to investigate how art therapy can provide a ritual space in which trauma related to political violence and unresolved loss can be worked through in a symbolic way. Literature on the transmission of trauma is limited and predominantly focuses on the existence of the phenomenon, its symptoms, and how it

occurs (Bogaty, 1986; Ganz, 2002; Rowland-Klein & Dunlop, 1997; Steinberg, 1989). Although there is some research on transmitted trauma and unresolved loss (Fogelman, 1989), literature is scarce on how to effectively deal with it. There is also a lack of research in the field of art therapy and ritual. I would like to explore literature on what qualities art therapy has that can facilitate the creation of a ritual space.

The connection among these topics needs further exploration. Research exists on the relationship between transmission of trauma and loss, between loss and ritual, and between art therapy and trauma. These relationships will be elaborated below. However, connections among these three areas have yet to be examined. I will attempt to use the links that already exist between these areas to create a larger link that ties these areas together, in order to propose a new understanding about how art therapy can facilitate the creation of a ritual space to work through transmitted trauma. In this way, I hope to contribute to the body of research available in art therapy. Especially considering these times of political struggle, such as the crisis in Darfur, the wars in Iraq and Afghanistan, this research can contribute to how we understand the transmission of trauma and how we can use art therapy to help our clients work through it.

First, I will outline the methodology of this study. This includes a review of the study design, the method of data collection, as well as delimitations, assumptions, and limitations. Following this will be an examination of the intergenerational transmission of trauma. Within this section, the way in which trauma is transmitted will be investigated. The difference between direct and indirect transmission will also be outlined, as well as the effects of the transmission on the next generation. A review of relevant literature on the use of art therapy with survivors of trauma will follow. A

specific section on art therapy and transmitted trauma is also included. This will aid in making the connection between trauma, transmission of trauma, and art therapy. Next, I will discuss some of the theories on grief and bereavement that are relevant to the study. I will explore how ritual is important in the validation of a loss, the relationship between ritual and therapy, as well as the significance of a witness' presence in ritual and in (art) therapy. At this time, I will attempt to identify the relationship between therapeutic rituals and transmitted trauma. I will also briefly discuss the liminal space between ritual and art. Finally, I will look at ritual and art and outline how art therapy can provide a symbolic ritual to work through unresolved trauma and loss. The paper will conclude with a discussion and suggestions for future exploration.

Methodology

Study Design

The method that I have chosen to use for my research paper is a historical-documentary method. The aim of historical research is “to produce systematic, reliable statements that either increase the available pool of knowledge about a given topic or bring existing knowledge into a more precise focus by means of new interpretive patterns” (Reitzel & Lindemann, 1982, p. 169). I hope to contribute to the existing information about each of my areas (art therapy, transgenerational trauma, and ritual) and propose a new relationship among the three.

In general, historical work requires a point of view and understandably, there is some notion of interpretation required (Tuchman, 1994). As a result, what is presented in the literature is subjective and will further become subjective by my own interpretations in this paper. According to Tuchman, “there is no ‘true,’ ‘objective’ reading of history as

text” (p. 316). Instead, multiple meanings may coexist that are “true.” My interpretation will also not be objective and will be an assemblage of meanings informed by my uniqueness as an individual.

According to Marshall & Rossman (2006), “historical analysis is particularly useful in obtaining knowledge of unexamined areas and in re-examining questions for which answers are not as definite as desired” (p. 119). The authors go on to say that part of the process is also establishing relationships. Considering the relatively unexplored areas I have chosen, the historical-documentary method is most appropriate.

Data Collection

Data collection for my research paper consists solely of researching literature. That is, texts written about my areas of research. No interviews or case vignettes are included. I have used research databases in psychology (PsycINFO), anthropology (AnthroSource), and sociology (Sociological Abstracts). Keywords that I have used in my searches are: “art therapy and trauma,” “art therapy and political violence,” “transmission of trauma,” “transgenerational transmission,” “intergenerational transmission,” “ritual, space and place,” “ritual and liminal space,” “ambiguous loss,” “meaning and trauma,” “unresolved grief,” and “complicated grief.”

Delimitations

Delimitations of this study include researching only the transmission of trauma related to war, genocide, and political violence and not any other kind of trauma. This includes literature on the Holocaust, the former Yugoslavia, and Vietnam veterans. I will also only be focusing on the adult children of trauma survivors and those who were not

present at the time of the conflict. This research is also delimited by studying literature dating from the mid-twentieth century to the present.

How Research Participants are Viewed

As I will not be looking at data provided by participants, I consider my “informants” to be the literature that I read. According to Reitzel & Lindemann (1982), “all knowledge is by definition a product of the human mind” (p. 168). As such, I deem all information that I encounter, including what I produce, to be somewhat subjective.

In reading each of the topic areas, I have also considered how the authors view the participants. In the section on trauma, the majority of authors tended to view the people affected by it as “survivors,” rather than as “victims.” In this research, the terms “intergenerational transmission” and “transgenerational transmission” are used interchangeably. Also, the people affected by trauma, including subsequent generations, are referred to as survivors of trauma and second-generation trauma survivors. However, I have taken note that some participants themselves do not find the term “second-generation trauma survivors” to be appropriate because they consider their experience of “trauma” to be different from that of their parents’ (Weiss and Weiss, 2000).

Assumptions

I am assuming that the transmission of trauma is strong enough between generations for individuals to need treatment. Furthermore, I am approaching this research with my own personal biases related to my cultural history, primarily, the Armenian Genocide of 1915. This includes the assumption that the trauma is transmitted not only to children, but to grandchildren and great-grandchildren. In addition, I assume that the trauma needs to be acknowledged in the form of a ritual and that there needs to

be some form of closure. I am also primarily assuming that aside from being able to provide a ritual, art therapy will have a positive effect on second generation survivors of trauma and it will be a useful method of treatment.

Limitations

As part of this methodology, one is limited by the data that can be found. As Reitzel & Lindemann (1982) suggest, we do not work with an unlimited amount of data. In the case of this study, much of the transmission literature is centred on the Holocaust because this was what was available. I have also not included literature on recent genocides, such as in Rwanda and Darfur, because it is too recent for the effects of transmission to be published. In addition, the questions that can be asked are also limited by what information is available for answering those questions.

The researcher is limited by what information is available, as well as the subjectivity in choosing the material. As much as there may be an awareness of one's personal biases, it will likely affect the research and findings. Moreover, the findings may not be generalizable to other groups of people. As mentioned, much of the literature encountered focuses on the effects of the Holocaust on subsequent generations and so these experiences may not apply to other populations who have experienced war trauma or political violence. Even within a certain group of people, experiences may vary. Additionally, people who identify themselves as second generation survivors of trauma may have different experiences from those who do not identify themselves as such. All of these factors affect the generalizability of the study.

Validity and Reliability

According to Patton (2002), the credibility of qualitative research depends on rigorous methods, the credibility of the researcher, and the belief in the value of qualitative investigation. A strategy in enhancing the rigor of the study entails “discussing one’s predispositions, making biases explicit, to the extent possible, and engaging in mental cleansing processes” (Patton, p. 553). In my research paper, I have outlined in the section on “Assumptions” what my predispositions are. Patton also suggests looking for information that supports alternative explanations. In conducting my research, I have aimed to be open in the cases I’ve presented, including ones that do not fully support my hypothesis.

To establish the credibility of the researcher, Patton (2002) recommends reporting personal and professional information that may have negatively or positively affected the analysis and interpretation of the study. A credible argument is systematic and should let the reader know how researchers came to know what they know (Johnson, 1998). In fact, I have kept a reflexive journal in order to keep record of information about myself, my thoughts, and my method.

Lincoln & Guba (1985) offer a number of ways to increase the credibility (or internal validity) of one’s findings. Applicable to my research is the investment of sufficient time to learn about the context of what I am studying. In my case, I spent 6 months immersed in the literature. Also, throughout my research I have been engaged in peer debriefing in which I consult with my research group and academic advisor about the process of research.

Reitzel & Lindemann (1982) discuss how in this type of research, unlike physical scientific research, studies cannot be replicated. Instead, they offer that the methods used to collect information are what determine its reliability. They also state that “the objectivity of social science is that process of establishing methods of inquiry that will yield knowledge that is reliable in the sense that people of similar training can recognize its worth and use it in their own studies” (Reitzel & Lindemann, p. 168). Since my research is fairly unexplored, I feel it will be able to accomplish this.

What I have outlined above suggests ways of achieving credibility and dependability within my own research. However, I also have to establish credibility and dependability of the sources that I use, especially since literature is my primary source of information. Brettell (1998) suggests that historical anthropologists apply evaluative criteria in order to determine the reliability of documentary evidence. This includes:

an assessment of the social position, intelligence, and linguistic abilities of the observer; of the attitudes that may have influenced the observations; of what is included and what is omitted; of intended audience and the motivation for creating the document; and of narrative style. (p. 517)

Some authors (Marshall & Rossman, 2006; Reitzel & Lindemann, 1982) have cautioned that words and phrases may have different connotations now than they did in the past. Inherent in this is also the context within which the literature was written. These are all elements that I have taken into consideration when reading and using sources. For example, I observed if there was any contradictory information in the literature, if the findings and interpretations were congruent, the year of publication, the place of

publication, and whether any of this may have influenced the author's position.

Moreover, I made attempts at using primary sources as much as possible.

Intergenerational Trauma Transmission

The literature available on the transmission of trauma is predominantly related to the Holocaust. Research centres more on the children of Holocaust survivors and minimally so on the grandchildren of survivors. Nevertheless, Bogaty (1986), in studying the transmission of trauma in Holocaust survivors, asserts that traumatic effects wield an impact upon survivors, their children, and their grandchildren.

Catherall (1998, as cited in Ganz, 2002) describes the concept of "secondary trauma" (p. 5). He speaks about the stress created by living or working with trauma survivors. Family members that are exposed and vulnerable may become secondarily traumatized. This concept demonstrates the long-term impact of trauma, and that it might have a generalized effect on the whole family, instead of simply leading to various symptoms in the traumatized individuals (Ganz).

Evidence shows that the trauma that is passed on to generations does not remain fixed (Bogaty, 1986). Instead, the cross-generational effects of trauma are a dynamic force that affects the interaction between parent and child and impacts the development in each generation (Bogaty). But how does trauma actually get transmitted?

How Transmission Occurs

Research suggests that transmission of trauma can occur through a number of different ways. According to the literature (Schwartz, Dohrenwend, & Levav, 1994; Weiss & Weiss, 2000), nongenetic transmission of trauma can occur either directly or

indirectly. There is also the possibility of a genetic mode of transmission (Yehuda et al., 1998).

Direct Transmission

In direct transmission, it is assumed that the child learns from the parent to think and behave in disordered ways, or in ways that put him or her at risk for disorders (Schwartz et al., 1994). It is directly transmitted because it is learned from the parent. Through socialization and modeling, the parent may pass down to the child maladaptive cognitive styles, coping mechanisms, and reactions to stress that the parent possesses (Schwartz et al.).

According to Chazan (1992) the traumatized parent can instill his or her own emotional insecurity into the offspring. For the child, this results in internalization of parental stress and frightening perceptions of external reality (Chazan). On the other hand, Danieli (1985, as cited in Bauman, 2003) finds that survivor parents try to teach survival to their children in the event that their children might be exposed to more persecution. The parent thereby unconsciously transmits their wartime experiences to their family. Consequently, it is difficult to determine if what is being transmitted is the instability or the survival skills. It seems, nevertheless, that it affects the relationship between the survivor and his or her children.

Using attachment theory, Rowland-Klein and Dunlop (1997) suggest that the process of projective identification may explain the transmission of parental trauma, except in reverse. Originally proposed by Melanie Klein, the process of projective identification is a primitive mechanism the baby uses to communicate to the mother (Rowland-Klein & Dunlop). The baby projects overwhelming anxieties onto the mother,

whereby she must be able to hold and process them and return them to the baby in a more palatable form (Rowland-Klein & Dunlop). However, Rowland-Klein and Dunlop suggest that in the case of children of Holocaust survivors, the children become the containers for their parents' projections. They suggest that the parent splits off the unwanted part of the self, projects this part onto the child, whereby the child internalizes it. Thus, the child begins to think, feel, and act in agreement with the projection (Rowland-Klein & Dunlop).

According to Weiss and Weiss (2000), different factors affect the manifestation of direct transmission within second generation survivors. For example, if the survivor experienced the Holocaust as a child or as an adult, the mode of transmission to their children varied. In particular, if parents lost children in the Holocaust, the probability of direct transmission is higher in the second generation who are born after the war (Weiss & Weiss).

Indirect Transmission

In indirect transmission, the problems that a child has are indirectly due to the disorder found within the parent. In contrast to direct transmission, indirect transmission does not occur through socialization and modeling. The trauma itself is not being transmitted but rather, as a result of having been traumatized, the survivor parent's parenting abilities are reduced (Schwartz et al., 1994). Rowland-Klein and Dunlop (1997) suggest that chronic distortions the traumatized survivor may experience in his or her psychological environment may hinder the ability to form healthy parent-child relationships. As it is not necessarily the trauma that is being transmitted, some speculate

that the term “trauma” may be misleading in describing both the experience of the Holocaust survivor and the second generation’s experience (Weiss and Weiss, 2000).

An example of indirect transmission is described in the study of Weiss and Weiss (2000). The authors presented a clinical account of group therapy with six therapists who are themselves adult children of Holocaust survivors. The goal of the group treatment was to increase their understanding of the meaning of being second generation survivors. At the beginning of the group, each participant shared the parents’ Holocaust experience and the parents’ trauma came up in the group work when relevant to the participant’s story. However, Weiss and Weiss found that the focus of the group throughout treatment was on the members’ subjective experience of their traumatic childhood experiences. The unstructured nature of the group could have allowed for the emergence of this theme. This demonstrated the prevalence of indirect transmission because the focus was not on the survivor parents’ unconscious communication of their own trauma, which is commonly the starting point described in the professional literature (Weiss & Weiss). As a result, the authors propose that transgenerational transmission of trauma is not necessarily the cause of the second generation’s suffering. It may be the result of the difficulties the second generation encountered by being raised by survivors whose suffering interfered with their parental abilities (Weiss & Weiss).

Transmission can also occur through what Albeck (1994, as cited in Bauman, 2003) calls “empathic traumatization.” This is defined as the offspring’s attempts to understand his or her parent’s wartime experience and pain as a way to establish a connection with them. Wardi (1992) explains that survivor parents transmit both conscious and unconscious emotional messages to their children regarding the history

and the fate of relatives who died in the Holocaust. These children are given the role of filling the void that is left in their parents by acting as replacements for family members who have been lost, or by creating a continuation of the family history through having children of their own (Wardi). Because of the significance of their role, Wardi refers to these children as “memorial candles” (p. 30). Fogelman (1989) makes an important point when stating that for the second generation to begin to heal, they must first mourn the loss of those individuals that they have never known. Thus, it seems that second generation survivors are not only grieving for their lost kin, but also taking on the responsibility of compensating for their absence, which can be a difficult, if not impossible, role to fulfill.

In trying to distinguish between direct and indirect transmission, Felsen (1998) indicates a discrepancy in the professional literature between clinical findings and experimental findings. It seems that the former usually finds evidence of direct transmission, whereas the latter, of indirect transmission. Weiss & Weiss (2000) explain this discrepancy by the fact that it is difficult to trace experimental evidence of direct transmission because it is often unconscious. Experimental tools are more easily able to reveal instances of indirect transmission. Clinical publications, however, are usually presented by psychoanalysts for whom explanations of direct transmission are more congruent with classic psychoanalytic thinking.

Weiss and Weiss (2000) stress the importance of differentiating between the two kinds of transmission as a way of assessing the kind of treatment that is needed. Although Schwartz et al. (1994) suggest it is difficult to test the unique effects of these two modes of transmission as they often co-occur, Weiss and Weiss (2000) found

differentiation can be made based on the relative dominance of either mechanism of transmission. They propose that when the dominant mode of transmission is direct, then treatment that is longer and that promotes regression may be favourable. The goal of this treatment would be to expose the lack of differentiation between the individual and the survivor parent in order to begin the process of individuation. When indirect transmission is the dominant mode of transmission, the authors recommend shorter treatment with a goal of enhancing differentiation.

Genetic Transmission

There is some evidence for a possible genetic mode of transmission. In a pilot study consisting of 23 self-selected participants, Yehuda et al. (1998) found children of Holocaust survivors, as a group, have generally lower cortisol levels than children of parents who were not exposed to trauma. Cortisol is considered an “anti-stress” hormone released by the adrenal gland and insufficient production of it in response to stress would have adverse consequences (Yehuda et al.). They found that these lower levels in offspring could be compared to what the researchers had observed in another pilot study, in which Holocaust survivors with PTSD had significantly lower cortisol levels than Holocaust survivors without PTSD (Yehuda et al.). More research is needed to determine the extent to which transmission can be genetic.

Current theory on trauma suggests that its transmission is quite complex. It is described as multi-determined; consisting of intra-psychic, inter-personal, biologic, genetic, and societal components (Hirsch, 2003).

Effects of Transmission

There are many similarities between the symptoms presented by the survivors and their children. Even though the children of survivors did not have first-hand experience of the atrocities of the war, they are nevertheless at an increased risk for many of the same symptoms as their parents (Hirsch, 2003). Steinberg (1989) cites that children of survivors presented symptoms resembling those of their parents, including depression, anxiety, phobias, guilt, separation problems, similar dream imagery and environmental misperception. On the other hand, there are studies (Davidson & Mellor, 2001; Sigal & Weinfeld, 1989) that have found no significant difference between the symptoms exhibited by the survivor parents and their children.

Negative Effects

Bauman (2003) conducted a correlational study to determine the relationship between the survivor's experience of the Holocaust, the second generation's experience of the Holocaust, and the prevalence of PTSD in the second generation. Participants in Bauman's study were collected through a modified network. Out of 300 questionnaires mailed to second generation survivors, 172 individuals responded. However, the current sample contains 166 individuals, as the others were excluded due to missing data. Results show that both the survivor's experience of the Holocaust and that of the second generation are significant predictors of PTSD in the second generation (Bauman). That is, there are certain modes of transmission that are responsible for the transmission of trauma to the second generation. Specifically, Bauman found that second generation survivors who perceived that their parents suffered intense pain as a result of the Holocaust, who witnessed their parents' distress through nightmares and crying spells,

and who felt that their parents' trauma was never resolved experienced increased levels of PTSD symptoms, as well as symptoms of intrusion (that is, re-experiencing of the event), avoidance, and hyperarousal (such as trouble falling or staying asleep, irritable outbursts of anger, and concentration problems). These symptoms were also present when second generation survivors reacted to their parent's Holocaust experiences with feelings of overwhelming guilt and empathy (Bauman). Moreover, second generation survivors who felt their survivor parents to be hypervigilant/socially mistrusting, unrealistic, and lacking empathy, experienced an overall increase in PTSD symptoms, particularly in symptoms of avoidance (Bauman). Second generation survivors who internalized their parent's mistrust of the world and who reacted to it with their own hypervigilance and social mistrust, experienced increased symptoms of PTSD, specifically, in that of hyperarousal. Overall, it seems that the second generation frequently over-identified with their survivor parent's Holocaust experience.

This study differs in that the survivor's Holocaust experience was measured through the perception of the second generation (Bauman, 2003). Thus, the results are based on children's subjective perception of their parent's Holocaust experience and their subsequent reaction to this. It would be interesting to see if children's perceptions of their parent's Holocaust experience are accurate by relating their responses to the survivor parent's responses. This would illuminate what the greater predictor of PTSD is: the survivor parent's actual experience, or the second generation survivor's perception of it.

The mode of communication between survivors and following generations is important in observing the effect of the trauma on offspring. Often there is either an

obsessive re-telling of the traumatic experience or an all-consuming silence (Bauman, 2003). This is a component of indirect transmission because it affects the environment the offspring is raised in. Bauman found that an excessive amount of communication by the survivor parent can play a role in the extensive amount of guilt and empathy found in the offspring. On the other hand, silence can also be dangerous. Steinberg (1989) cited that silence may contribute to a preoccupation with fantasies about the traumatic experience of the parent that may be frightening and pathogenic to the child. Interestingly, the less precise children's knowledge of their parents' Holocaust experience, the more intense was the re-enactment of their parents' fate (Rowland-Klein & Dunlop, 1997). Having only pieces of information, the children would create fantasies based on their own reality (Rowland-Klein & Dunlop). It seems that children's imaginations of what may have occurred to their parents may be worse than hearing what actually happened. Therefore, it seems that open but not excessive communication of the traumatic experiences results in the best psychological outcome for children of survivors (Davidson, 1980, as cited in Bauman, 2003).

Hirsch (2003) conducted a study to establish a relationship between familial coping styles and survivor guilt in second generation Holocaust survivors. The multiple methods of participant recruitment consisted of an ad posting in a Jewish weekly newspaper, the availability of flyers at a conference for survivors and their offspring, and an email solicitation to the United States Holocaust Museum's Second Generation list-serve (Hirsch). The study is based on 66 out of 67 participants who anonymously responded and whose mean scores are compared to the published scores of a non-Jewish population. Results are based on responses on a brief demographic questionnaire, the

Children of Survivor Questionnaire (used to identify family coping style), and the Interpersonal Guilt Questionnaire-67 (IGQ-67) (in order to measure survivor guilt).

Hirsch (2003) found that the offspring of Holocaust survivors have a higher level of interpersonal guilt than their non-Holocaust peers. Also, participants who most strongly characterized the structure of their families as “Numb” or “Victim” were likely to have high scores on subscales of the IGQ-67 that were associated with psychopathology. The offspring of these families showed poor self-esteem, alienation, numbness, and anger. Families that had high scores on the “Victim” scale as their family coping style were described as mistrustful, depressed, worried, and catastrophizing, with a preoccupation on survival and fears of another Holocaust (Hirsch). On the other hand, the families that were characterized as “Those Who Made It” (described as more assimilated and as having a desire to “make it big” to counteract the Holocaust) scored high on the separation guilt scales that were associated with better adjustment (Hirsch).

There was a strong correlation between “Omnipotence guilt” IGQ-67 subscale and all three family structure scales: “Numb,” “Victim,” and “Those Who Made It” (Hirsch, 2003). This suggests that adult children of Holocaust survivors, no matter what type of family structure or degree of family functioning, show a strong tendency to take responsibility for the well-being of others, and to feel guilt if others are not happy (Hirsch). However, the study sample in this report was self-selected. This can present a limitation since the participants identified themselves strongly enough as children of survivors to be affiliated with Second-Generation groups. As a result, children of survivors who do not so identify may have a different profile from the study sample.

No Effects

A number of studies have found no significant differences between children of survivors and other populations who have not experienced secondary trauma. Sigal and Weinfeld (1989), for instance, compared a Montreal-Canadian community sample of 242 children of Holocaust survivors to two control groups; one (N=76) to account for effects of immigration, and the other (N=209) to account for effects of ethnicity. Using the Psychiatric Epidemiology Research Instrument (PERI), no statistical differences were found in experienced anxiety, depression, or suicidal ideation among the three groups. No differences were detected on scales of phobias and psychosomatic complaints. The methodology consisted of a questionnaire of 500 items, partly self-administered and partly administered by an interviewer. As a result, responses could have been affected by participants' unwillingness to reveal negative psychological traits about themselves in a face-to-face interview.

In another study (Davidson & Mellor, 2001) examining the intergenerational transfer of PTSD of Australian Vietnam veterans, there was no significant relationship between the veterans' self-esteem and post traumatic stress scores and that of their offspring's scores. The scores were measured and compared using the Family Assessment Device (FAD), the Rosenberg Self-Esteem Scale, and the Mississippi Scale for PTSD (M-PTSD). Results suggest that instead of transgenerational transmission of posttraumatic stress symptomatology, disrupted family functioning may be the outcome for trauma survivors, mainly those with PTSD. Specifically, the family had difficulty in experiencing appropriate emotional responses and also had trouble in effectively solving problems, both within and outside the home (Davidson & Mellor).

The findings of Davidson and Mellor (2001) are distinct from other American studies, some of which did find that children of Vietnam veterans with PTSD had lower self-esteem (Davidson & Mellor). This could suggest that there may be differences between American and Australian Vietnam veterans, including character differences, differences in the nature of their traumatic war experiences and their readjustment after the war (Davidson & Mellor). Moreover, this study only focused on one child from each family unit (Davidson & Mellor). Results could be different if the study focused on all children. Also, the majority of Vietnam veterans in this study are still married to their first wife. As a result, the stability of the family unit, as well as the roles of the women could be factors influencing these findings.

In spite of the high rate of symptoms among the children of Holocaust survivors, the research shows that, like any other population, they are heterogeneous, ranging from the psychotic to highly resilient (Hirsch, 2003). Evidence shows that there are distinctions in the level of adjustment found in the offspring of survivors of war trauma. In some studies, children are found to be functioning very well, while in others they are found to exhibit significant psychiatric disturbance. Davidson and Mellor (2001) propose that this distinction could be an indicator of the heterogeneity of survivor responses to trauma, ranging from normal adjustment and resilience to psychopathology and maladjustment found in varying studies. Differentiations can also be found within second generation children based on their parent's kind of Holocaust experience. That is, there are distinctions among children of partisan survivors, children of camp survivors, and children whose parents had been in hiding (Weiss & Weiss, 2000). It is probable that there are other elements that affect the cross-generational effects of trauma.

Contemporary research maintains that the processing of trauma appears to be influenced by a combination of environmental, intra-psychic, and biological factors (Yehuda, 1998).

Art Therapy and Trauma

This section outlines the benefits of art therapy for people who have experienced trauma. If art therapy is in fact helpful for survivors, and both survivors and their offspring exhibit similar symptoms (Hirsch, 2003; Steinberg, 1989), then we may propose that art therapy could also be useful for the offspring of trauma survivors.

Art therapy can be useful for refugees and asylum seekers who have experienced trauma. As Kalmanowitz and Lloyd (2005) mention, political violence can result in prolonged periods of helplessness and powerlessness. In contrast, there are choices in art making that may transfer into the lives of the art makers (Kalmanowitz & Lloyd). For example, there are choices in expressing colours and art media (Byers, 1996). Often, art therapy can offer people who seek asylum a temporary distraction from their feelings of hopelessness, and thus help them to cope with their current situations (Wertheim-Cahen et al., 2004). Artistic activity as a crisis intervention modality also has the potential therapeutic benefits of lowering one's defences, releasing tension, providing tangibility and permanence, availability and ease of use, reaching out, and finally, expanding coping resources (Baráth, 2003). The following is a review of literature outlining the beneficial effects of the use of art therapy with people who have experienced various forms of trauma.

Wertheim-Cahen et al. (2004) used art therapy with refugees and asylum seekers to “reduce stress, rebuild trust, and lessen their sense of isolation” (p. 421). They conducted art therapy sessions in the Netherlands in a day treatment setting, a clinical

ward, and a special school for physically limited children. Refugees were from varying countries, including Armenia, Afghanistan, Iran, and Somalia. The authors point out the Dutch mental health system has a longstanding history of using art-making as a therapeutic means.

Wertheim-Cahen et al. (2004) point to the benefit of art therapy in helping individuals gain control over traumatic memories. In a session with a 13-year-old boy from Afghanistan, the art therapists noted that making art made it easier for him to talk about difficulties, grief, and loss (Wertheim-Cahen et al.). The boy had lost both his legs after a rocket attack in his country, which also took the life of his young sister. After fleeing to Holland, yet another sibling died, leaving him with only one younger brother. He was referred to art therapy by the school psychologist because he seemed very troubled after his brother's death and had become restless and preoccupied. In art therapy, he used building bricks to construct a house, giving it small windows but no door. While building, he was able to talk about the grief of losing his brother. Using tiny building bricks with his big hands allowed him to "contain traumatic events at a sensory and tactile level" (Wertheim-Cahen et al., p. 437). Through visually representing their difficulties, clients are able to distance themselves in order to work through and experience the original trauma in a more manageable way. In this way, the safety of the art studio provides a space in which individuals are able to both step away from traumatic memories, and to address them (Wertheim-Cahen et al.).

Fitzpatrick (2002) found that art could be a very valuable tool for people who have experienced significant torture and trauma. The author used a case study design to explore the experiences of two Bosnian women in Perth, Western Australia. Themes and

symbols relating to concepts of home and journey for the women were examined. In describing her work with refugee clients who had experienced trauma, Fitzpatrick stated there are often no words in any language sufficient to describe or contain their experiences. Golub (1985) echoed this notion, when working with Cambodian survivors of war trauma: “Words by their very nature are delimiting and therefore desecrate the pain. Only silence is infinite enough to contain the horror” (p. 7.). It seems at times, the art therapist’s presence and medium provide a unique mode to help clients work through difficult experiences.

Fitzpatrick’s (2002) study is based on a single case study and it is difficult to generalize the experience of one refugee from a particular place to other refugees. It is important, however, in their discussion of developing culturally sensitive art therapy interventions. Fitzpatrick informs the reader that a Western cultural framework cannot be generalized cross-culturally. However, individuals within the same culture can also have varying experiences, so it is important that the term “culturally sensitive” is used with care, and that we not assume that certain values and concepts apply simply because a person is from a particular culture.

Art Therapy as Visual Language

Visual expression can be a valuable tool for individuals who have experienced trauma, as the symptoms often involve disturbing imagery (Fitzpatrick, 2002). The literal and symbolic act of creating something out of nothing is very important in being able to activate and maintain inner change and recovery (Fitzpatrick), and thus can be very empowering for clients. Moreover, in traumatic memories, images come before language and thus can act as links to finding words (Wertheim-Cahen et al., 2004). Wertheim-

Cahen et al. state that by visually expressing traumatic memories, the refugees are able to share them with others when there are, yet, no words. The body and the senses are where traumatic memories are often stored, rather than in language (Wertheim-Cahen et al.), which is why art therapy can be so helpful for people who have experienced trauma.

Greenberg and Van der Kolk (1987) maintain that after a traumatic event, there is often a need to compulsively tell and retell the events that occurred. They argue that the tendency to visually or verbally re-experience is often an attempt at coping with and integrating the trauma into one's life experience. They postulate that in situations of terror, the experience is not yet processed in linguistic forms, but on an iconic level, such as horrific images or visceral sensations. Furthermore, images related to the trauma can be generated in dreams (Greenberg & Van der Kolk) and therefore, perhaps expressing it visually can be helpful. The authors specifically point to work with traumatised children whereby children's underdeveloped verbal capacity has led to the use of play therapy as well as visual cues, such as Rorschach and Thematic Apperception Tests. This provides the means to access and process psychological material that is disturbing (Greenberg & Van der Kolk).

Greenberg and Van der Kolk (1987) provide an example in which a 30-year-old woman was able to access and work through traumatic events in her childhood through painting. Although her experiences are related to psychological, emotional, physical, and sexual trauma and not to war trauma, the article helps to elucidate the empowering nature of art. Through her painting, a previously insecure and withdrawn woman was able to reverse roles and become both artist and critic. As a result, an observing ego eventually emerged (Greenberg & Van der Kolk). Moreover, through visually expressing her

memories, fears, and expectations, the client was able to verbally explore them and also verbally disown them (Greenberg & Van der Kolk).

In this example by Greenberg and Van der Kolk (1987), the content of what was painted was more directed by the therapist than is common in most approaches of art therapy. In his approach, the psychotherapist made suggestions to the client as to what to draw and challenged her to render difficult feelings. In addition, the paintings were not created in the therapeutic space in the presence of a witness. They were created in solitude at home and brought in (either originals or photographs) to the therapist during sessions. Although the authors are not art therapists, they recommend the “painting cure” in the retrieval and integration of traumatic memories. The term “cure” is somewhat problematic because it suggests that there will be no recurrences, but it offers the possibility of healing trauma through art therapy.

Art Therapy and Post Traumatic Stress Disorder (PTSD)

Although this paper is not dealing directly with PTSD, PTSD as a result of war is relevant to the current research because it is one of the manifestations of war trauma.

Golub (1985) describes an art therapy program that she designed as an alternative treatment modality for Vietnam combat veterans, who were dealing with the psychological effects of war 15 years later. The study took place with 25 Vietnam veterans in a PTSD unit of a veteran hospital. All the participants of the art therapy program were diagnosed with PTSD and came either voluntarily or as a result of staff referral. In facilitating individual or open group sessions, Golub found that the creation and transformation of symbols offered a new way for the veterans to integrate their war experiences into their lives and be able to master their trauma. By representing and

objectifying painful events, the veterans could transform them and thus, distance themselves (Golub). They were able to be protected without being overwhelmed or destroyed by the feelings evoked by the images (Golub).

Golub (1985) observed that the veterans became progressively more verbal about their feelings within the art sessions. Perhaps as a result of being able to depict their trauma, they were then able to talk about it. With people who have survived trauma, it is common to have visual imagery that is related to painful memories; through recurring thoughts, dreams, flashbacks, and nightmares (Golub). If trauma is remembered visually, then consequently, expressing it visually can be cathartic.

The veterans seemed to take control in their art, which could translate to their taking control in life. Golub (1985) discussed how the men were able to transform life-threatening situations by what they constructed in their art. Examples of this were through dismantling time bombs or re-attaching severed limbs. Golub found that through the process of art therapy, the veterans were able to link their past traumas with their current difficulties and their inner visions with their outer expressions. They were able to confront their pain without being destroyed by it and as a result, were more able to trust their emotional reactions.

Golub (1985) only briefly mentioned the transmissive quality of PTSD and suggested that there may be similarities between the artwork produced by the partners and children of the veterans. It would have been interesting to compare the art, as there was a support group for female partners of veterans that incorporated art therapy at the same time this group was held.

Art therapy is strongly recommended for combat-related PTSD (Collie, Backos, Malchiodi, & Spiegel, 2006). The authors cite numerous other studies that have found the efficacy of this modality, particularly in the treatment of trauma. For example, Morgan and Johnson (1995, as cited in Collie et al.) found that in the assessment for treatment of combat-related PTSD, those who did a drawing task after awakening from a nightmare had fewer and less intense nightmares than those who did a writing task.

To better understand art therapists' clinical approaches to PTSD, the Research Committee of the American Art Therapy Association (AATA) conducted a survey in 2005 of registered art therapists who treat people with PTSD (Collie et al., 2006). In addition, Collie et al. conducted a review of art therapists' published and unpublished descriptions of their approaches to treating combat-related PTSD. Thirteen art therapists responded to the survey and 10 published or unpublished written descriptions were reviewed. A content analysis was conducted on both the written responses of the survey and the published and unpublished written descriptions, in order to identify topics and concepts that were addressed. Thematic analysis identified two main topics: therapeutic mechanisms and therapy methods. For the purposes of this paper, only the former will be referred to. This is a very small study sample, yet the authors were able to identify 7 primary therapeutic mechanisms. They will be briefly explained here.

1. *Reconsolidation of memories*: Art therapy is found to be a means of integrating traumatic memories and resolving the fragmentation of memory that is an underlying cause of PTSD. Words alone seem insufficient in constructing a coherent trauma narrative and a non-verbal means of communicating through art making seems more suitable. Some of the art therapists explained that only when traumatic material is able to

be owned by the individual yet external to him/her, can it be transformed from something that is active and distressing in the present, to something that is passive and part of the individual's history.

2. *Progressive exposure*: Art therapy seems to be a way of progressively addressing stimuli and the associated emotions that are being avoided. The symbolism of art therapy makes it less threatening to express and reveal traumatic material.

3. *Externalization*: Traumatic material is externalized in the form of images or objects in art therapy and helps the individual with PTSD view the traumatic material with some emotional distance. This is important in the integration of the traumatic material into the individual's self concept and personal history.

4. *Reduction of arousal*: The relaxing and sometimes meditative nature of making art allows an opportunity to change one's level of arousal.

5. *Reactivation of positive emotion*: Making art awakens emotion, thereby directly addressing emotional numbing, including that of positive emotions. The pleasure derived from creating images and the validation received from others contributes to the reactivation of positive emotion.

6. *Enhancement of emotional self-efficacy*: This refers to increasing confidence in an individual's ability to effectively and appropriately express emotions. The "container" an artwork provides for threatening emotional material gives a sense of control and helps to build confidence and manageability in the expression of important emotions.

7. *Improved self-esteem*: In group art therapy, self-esteem can flourish as members are supportive witnesses to the struggles and growth of one another.

The study by Collie et al. (2006) is based on a very small sample. Nevertheless, it highlights the important therapeutic mechanisms in the art therapy treatment of combat-related PTSD.

Helping Those Who Help

In addition to art therapy being provided for individuals with trauma, in some cases, it is also being used to help the mental health professionals who work with them. Canadian art therapist Julia Gentleman Byers (1996) discusses her art therapy interventions in the West Bank and Gaza with the Near East Cultural and Educational Foundation of Canada (NECEF). The aim of NECEF is to “introduce a new approach for reconstruction and rehabilitation in war-ravaged societies by addressing the psychological and emotional trauma of children and their families affected by the combat” (Byers, p. 238). As part of a Canadian mental health team, Byers was invited to participate in a project that worked with children, families, and mental health workers experiencing PTSD.

An interesting part of this project included art therapists giving seminars on techniques and issues in counselling to mental health professionals in the West Bank and Gaza. Mental health workers in this area were understandably displaying symptoms of burn-out and stress (Byers, 1996). The team hoped that through processing their own personal responses to the art workshop experience, the mental health workers would be able to apply theoretical and practical concepts of therapeutic intervention with the children they worked with (Byers). The research needs clarification on two important points: the impact of the therapeutic interventions on the mental health professionals in

order for them to provide continued or additional assistance to the children and second, the amount of cross-cultural training received by the therapists.

Baráth (2003) conducted research on cultural art therapy in the treatment of war trauma in the former Yugoslavia for children, youth, as well as teachers, health professionals and volunteers. In fact, for the latter group, over 30 training seminars with more than 400 art therapy workshops were organized at different locations in Croatia, Bosnia and Herzegovina, and Kosovo since 1992 (Baráth). The primary beneficiaries of these programs have been approximately 100,000 children (Baráth).

The programs designed for children had a study sample of 5,628. Although most workshops were only for children, many sites such as refugee camps also included teachers, parents, and local mental health professionals. To measure the outcome, a repeated measures with pre-test/post-test design was used. Evaluation instruments included standardized tests on cognitive functioning, PTSD screening scales, coping style inventories, and measures of family functioning (Baráth, 2003). In addition, special qualitative measures were developed for recording changes in the quality of participants' art productions (Baráth). Statistical results show that the signs and symbols in the children's artwork had changed throughout the program, reflecting more positive emotions, greater self-empowerment, and an increase in active coping (Baráth). The Slovenian study significantly showed that almost all the invited participants aged 6 to 60 benefited from the program (Baráth).

Baráth (2003) presented a review of art therapy programs done with children, youth, teachers, health professionals and volunteers in the former Yugoslavia. Although the author is in favour of art therapy for use with traumatised individuals, Baráth

discusses a number of studies without clearly providing the sample sizes of each and how the interpretations were made.

The literature on art therapy and trauma shows that art therapy provides a multitude of benefits for people who have experienced trauma. This includes lowering defences, releasing tension, and expanding coping resources (Baráth, 2003). Art therapy is also a way for clients to regain control (Golub, 1985). Some of these benefits can also be applied to second generation survivors of trauma.

Art Therapy and Transmitted Trauma

The literature (Byers, 1996; Collie et al., 2006; Fitzpatrick, 2002; Golub, 1985; Kalmanowitz and Lloyd, 2005; Wertheim-Cahen et al., 2004) shows that art therapy has been found to be helpful for those who have experienced trauma. As the offspring of people who have experienced trauma may share similar symptoms (Hirsch, 2003; Steinberg, 1989), then perhaps art therapy can also be helpful for second generation survivors.

Some therapeutic mechanisms identified by Collie et al. (2006) are also applicable to second generation survivors. For example, art therapy seems to be a way of progressively addressing stimuli and the associated emotions that are being avoided (Collie et al.). Bauman (2003) cites avoidance as one of the PTSD symptoms experienced by second generation survivors who perceived that their parents suffered intense pain as a result of the Holocaust and who felt that their parents' trauma was never resolved. The art therapy space can provide an opportunity for second generation survivors to address those emotions.

Anxiety is a state that can be shared both by survivors and their offspring (Steinberg, 1989). Art therapy has been found to release tension (Baráth, 2003). In fact, the relaxing and sometimes meditative nature of making art allows an opportunity to change one's level of arousal (Collie et al., 2006). Art making in art therapy is also found to reactivate positive emotions (Collie et al.). There is pleasure in creating images and the validation received from others contributes to reactivating positive emotions (Collie et al.). As children of survivors may experience depression (Steinberg, 1989), art therapy can assist in generating positive affects.

In some experiences of trauma, families may be silent about the atrocities that took place (Bauman, 2003). Silence can contribute to a preoccupation with fantasies about the traumatic experience of the parent that may be frightening and pathogenic to the child (Steinberg, 1989). In fact, Steinberg cites similar dream imagery as one of the symptoms shared by children of survivors and their parents. Fitzpatrick (2002) has found that visual expression is a valuable tool for disturbing imagery symptoms. The creation of artwork in art therapy is appropriate in expressing disturbing visual imagery. As a result, art therapy can be helpful for second generation survivors experiencing disturbing imagery.

Silence can also result in families not being able to express the associated emotions of the trauma because they were not being overtly addressed. This includes children who were affected by the family's coping mechanism of denial (Schaverien, 1998). Art therapy increases confidence in an individual's ability to effectively and appropriately express emotions (Collie et al., 2006). The artwork provides a "container"

for threatening emotional material which gives a sense of control and helps to build confidence and manageability in the expression of important emotions (Collie et al.).

Schaverien (1998) presents a relevant article on Jewish identity, transmitted trauma, and art therapy. Through her own childhood experience of finding hidden family photographs of the Holocaust, she came to realize that her personal history was also part of a collective history. She noticed that in her usual warm-ups when she would ask people to make an image of their name and tell the story about it, if there was a Jewish or half-Jewish member, imagery suggestive of the Holocaust appeared. Some carried the names of murdered relatives while others had changed names to accommodate a new identity (Schaverien).

Schaverien (1998) began to offer one and two-day art therapy workshops that focused on inheritance and Jewish identity. The workshops were held in Britain and the Netherlands at first as part of a summer school program, then at various Jewish venues, until finally she was being invited to offer them at other places in Britain. It seems that there was a need for such exploration. The people who voluntarily participated in the workshops ranged in age, but they were always from the second and third generation survivors; there were never any concentration camp survivors. This may be because recalling their experiences may be too painful (Schaverien). Schaverien set up the room so that there was a circle of chairs for talking in the middle of the room and tables against the walls for painting. The process was contained by the circle of the chairs and the wider circle of the entire room.

Schaverien (1998) deliberately left the wording of the workshops open, without mentioning the Holocaust, yet she found that Holocaust imagery usually emerged. For

example, she worded the workshops as “Inheritance: an art therapy workshop on Jewish identity.” Her instructions were worded to allow for as much or as little disclosure as was desired. During the discussion following the art-making, the participants were encouraged to bring their artwork to the centre of the circle, so that even if nothing was said, the commonality of the experience and the images were shared. Schaverien states: “The similarity of history in the group participants seemed to free them from the silence; it broke an unspoken taboo” (p. 163). This was especially important since denial and forgetting seem to be common coping mechanisms that were passed down the generations (Schaverien).

Art therapy offers the opportunity to work at a deep level and integrate the trauma (Schaverien, 1998). The residual effect in the images and even certain remembered incidents can be externalized and therefore, viewed from a distance by the artist/client (Schaverien). Moreover, images are accessed from both the personal and the collective unconscious (Schaverien). As a result of frequent referencing to the collective unconscious, it may be assumed that Schaverien is working from a Jungian perspective. According to Schaverien (1998), before the personal experience can be transformed, the collective history’s outer world reality has to be entirely acknowledged. Research suggests that the group art therapy sessions are able to accomplish this.

Schaverien’s (1998) explicit aim is that this article may be generalizable to other populations who have experienced genocide and trauma, while simultaneously emphasizing the uniqueness of the Holocaust. Schaverien postulates that as therapists, it is important to consider that when individuals of Jewish origin attend therapy, they may not realize that the root of their problem is the fact that they are carrying intergenerational

scars from the Holocaust. Schaverien is hasty in assuming that every person with at least one Jewish parent is affected by the Holocaust. She cautions therapists, however, to keep the possibility in mind.

Loss

Previous theoretical researchers (Boss, 1999; Fogelman, 1989; Hirsch, 2003; Wardi, 1992) have suggested that as a result of war, trauma gets transferred to other generations creating a sense of unresolved grief. This section will look at different approaches to loss and bereavement.

Van der Hart (1978/1983) outlines 7 stages of grief: shock, denial, depression, guilt, fear, aggression, and reintegration. He states that people can experience varying psychological and behavioural difficulties if they become stuck in one of the stages, if they do not complete the process, or if the grief work is pathologically resolved. Thus, when proper farewells to the dead are not made, symptoms can include: psychosomatic disorders, social phobias, depressive reactions, obsessions, and compulsive behaviour (Van der Hart). However, the stage model of grieving assumes that the “normal” reaction is for people to experience all stages and to follow it in a linear fashion, yet this may not be true for everyone. Moreover, it disempowers bereaved people by implying that they must passively go through a series of psychological transitions forced on them by external events (Neimeyer, 2001).

Classic grief theory suggests that individuals will work through the loss, accept it, and then be able to move on to new attachments (Eisenbruch, 1990). Moreover, it suggests that those who are robbed of the chance to mourn properly may experience “arrested grief” or “atypical grief reactions” (Eisenbruch, p. 726). Eisenbruch proposes

survivors of war and genocide may be predisposed to this. The author points to ceremonies in religious gatherings that act as rites of passage to help the mourner complete unfinished responsibilities, express and control anger, as well as to resolve guilt.

Current literature on grief, on the other hand, disagrees that people who continue to be sad or who continue to maintain relatedness to the deceased are suffering from unresolved mourning or pathologic grief (Hagman, 2001). Neimeyer (2001) suggests that it is not clear that a universal and normative pattern of grieving even exists, so it is difficult to judge deviations from it as “pathological.” Instead, Davis (2001) cites several authors who have mentioned that those who are coping with loss and trauma are often compelled to find some meaning or purpose in the event; they frequently have a need to make sense of it. By trying to make sense of it, they are trying to interpret it as being consistent with their worldview or their fundamental beliefs about how and why those events occur (Davis). I suggest that meaning making can be more challenging when the source of loss is as meaningless as war.

A central argument of the new psychoanalytic model of mourning is the need to preserve attachment to the deceased person and have a meaningful relationship which transcends loss (Hagman, 2001). It no longer stresses relinquishing ties with the deceased, but finding healthy ways of keeping symbolic bonds with the loved person and searching for meaning in the loss (Neimeyer, 2001).

A major critique of the classical model of mourning is that it does not convey the important role of others and the social context in facilitating recovery from bereavement (Hagman, 2001). Instead, Hagman proposes that expressions of grief have a

communicative function. According to Bowlby (1961, as cited in Hagman), grief expressions are not only private responses to loss, but the bereaved person's effort to re-establish a connection with the deceased and to obtain comfort from other survivors. Mourning is often not done in isolation and frequently involves the active participation of other mourners and survivors (Hagman). In fact, Hagman suggests that many difficulties arising from bereavement are due to the failure of other survivors to engage with the bereaved person in mourning together. The communicative function of grief as described here can be compared to the communicative function of art, as well as of ritual, which will be discussed further on.

According to Hagman (2001), "what therapists refer to as 'pathological responses' may be unsuccessful strategies to maintain meaning and preserve the attachment to the lost object" (p. 25). That is, mourning is considered as a crisis of meaning (Hagman). Treatment, thus, requires not relinquishing ties with the deceased, but an exploration of the ongoing attachment and a reconstruction of the meaning of the deceased in the context of the survivor's life (Hagman).

Mourning is an ongoing process (Hagman, 2001). This is because old bereavements can be revitalized during times of new loss. Instead of being resolved, the importance of a loss may be elaborated throughout life. Of greater significance is the unconscious meaning attached to bereavement and the internal relationship with the deceased (Hagman). Mourning is intersubjective, meaningful, and concerned with continuity of the tie with the deceased person (Hagman).

Ambiguous Loss

When loss occurs, there often needs to be some kind of an acknowledgment of that loss in order for healing to begin. Boss (1999) discusses how in a loss such as death, an event occurs that officially verifies this loss, such as a funeral ceremony. Boss continues that through everybody's acknowledgment that a permanent loss has occurred, mourning can begin. In war related trauma, losses can become ambiguous. In fact, Schaverien (1998) states that in instances of mass destruction, especially for those who were directly affected by it, it is not possible to mourn for the magnitude of people lost, especially when there are no graves. According to Boss (1999), "an ambiguous loss may never allow people to achieve the detachment that is necessary for normal closure" (p. 10). In the same way that ambiguity complicates loss, the mourning process is also complicated (Boss). In some cases of unresolved loss, as Van der Hart agrees (1978/1983), the need is such that therapeutic funeral and mourning rituals may be appropriate.

Ritual

The topic of "rituals" is studied extensively in social-cultural anthropology. However, as Van der Hart (1978/1983) suggests, it is often focused on the study of tribes and so-called primitive people. Ritual will be discussed here in how it relates to Western society in a spiritual, and not religious sense. By spiritual, I mean that which is sacred.

Schirch (2005) asserts that "ritual uses symbolic actions to communicate a forming or transforming message in a unique social space" (p. 17). This definition can be broken down into different components. Firstly, rituals are symbolic acts that communicate numerous, ambiguous messages to different people (Schirch). Moreover,

rituals often take place in special spaces. Thus, to identify a ritual, one must observe the context in which it takes place. Finally, the definition includes a component of building or changing that takes place in ritual.

Van der Hart (1978/1983) refers to three types of rituals: transition rituals, healing rituals, and telectic and intensification rituals. Transition rituals, or rites of passage, were originally described by Van Gennep (1909/1960) to define all types of rituals that mark a transition experienced by an individual or group, such as birth, marriage, and death. Healing rituals refer to improper or incomplete transitions in the individual or family life cycle. As a result of problems that may arise from this, special ritualistic treatment may be needed (Van der Hart, 1978/1983). Telectic and intensification rituals are reserved for greeting and farewell, and for collective ritualistic activities of a group, respectively. For the purposes of this paper, only the first two types of rituals will be referred to.

According to Schirch (2005), rituals are used to create a sense of community. These rituals can also create a space in which people can express their trauma (Schirch). Schirch maintains that rituals are powerful in being able to make meaning, create relationships, transform and heal identities in a safe space. As mourning is seen as a crisis of meaning (Hagman, 2001), rituals are powerful in being able to make meaning (Schirch, 2005).

As Schirch (2005) mentioned, rituals often use symbols to communicate a transforming message. Firth (1973) discusses the validity of symbols and suggests it depends on how accurately it signifies the intended feelings and experiences of the individual. Van der Hart (1978/1983) concurs that there must be emotional involvement in the ritual, otherwise it is not valid. For many mystics, symbols need to be

communicated in order to be valid (Firth, 1973). However, symbols by their very nature are always changing (Kast, 1992), so assessing their validity can be difficult. Firth (1973) also suggests that the importance of symbols depends, to some extent, on their ability to express experiences and feelings to their audience. This is related to the presence of the witness, which will be more explored later.

One way to enhance the effectiveness of the ritual is to use a special object that symbolizes the new situation (Van der Hart, 1978/1983). A piece of jewellery, for example, that was significant in the previous situation can be exchanged for one that is representative of the current situation. If rituals are effective, they can solve problems by bringing about changes in the social order and the subjective experience (Van der Hart). In the life cycle, the family structure changes and members of the family may assume different positions in relation to one another (Van der Hart). This is particularly true in cases of loss. The children of Holocaust survivors come to mind when in some cases, they are seen to represent lost family members (Wardi, 1992). When family structures are changing in this way, therapeutic rituals help with these transformations (Van der Hart, 1978/1983).

Ritual and Loss

Life is made up of a series of transitions: birth, puberty, partnership, procreation, and death. For each of these events, “there are ceremonies whose essential purpose is to enable the individual to pass from one defined position to another which is equally well defined” (Van Gennep, 1909/1960, p. 3). In fact, mourning through funerals is a transitional period for the survivors, in which they enter through rites of separation and exit through rites of reintegration into society (Van Gennep). Van Gennep characterizes

the living mourners and the deceased as being located between the world of the living and that of the dead. Funerals, then, function as rites of passage that allow for the deceased to be incorporated into the world of the dead, and for the living mourners to be reintegrated into the life of society (Van Gennep). Traditionally, funeral and mourning rituals are able to help relatives resolve their loss and allow them to move on (Van der Hart, 1978/1983). This is because rituals require the expression of different emotional reactions by the bereaved (Van der Hart). Thus, rituals can allow for the expression of emotions that have not been dealt with.

Saying goodbye in separation rituals needs to consist of many symbolic acts and each act must be a further transformation of the utilized symbols (Van der Hart, 1978/1983). In ritual, symbols can be used that represent the relationship to an individual. As the symbols transform in the ritual, the relationship to which they refer also changes, becoming even more detached (Van der Hart). As the meaning of the symbols change, their distressing impact also decreases. That is, the symbols no longer have the painful associations they represent. The idea is not to stop cherishing memories of the individual to whom one is saying goodbye, but to cease the pattern of being stuck in that time (Van der Hart). As current literature on mourning shows, one need not relinquish ties with the deceased, but find healthy ways of keeping symbolic bonds with the loved person and searching for meaning in the loss (Neimeyer, 2001).

Boss (1999) maintains that there is little support for families experiencing ambiguous losses. This is because rituals and community supports are only directed to clear-cut loss (Boss), whereas war-related trauma is unclear. In cases of missing family members, it is unclear whether they are dead or alive (Boss). Thus, they are physically

absent, but psychologically present (Boss). Herman (1993, as cited in Zwart & Nieuwenhuis, 1998) summed it well when she said: “In regular mourning circumstances numerous social rituals help the person concerned through the process. There is, however, no social custom or general ritual to support a mourning process following traumatic life events” (p. 67). In such cases, rituals can be performed in a therapeutic context to receive the necessary closure and to make meaning of the loss.

Ritual and Therapy

When certain rituals are absent, some may have difficulty making a transition safely. In such cases, it is assumed that for traditional rituals, therapy can become a modern substitute (Van der Hart, 1978/1983). However, modern therapeutic rituals are only part of the treatment that helps to initiate a process of change (Van der Hart). Further therapy is often needed. This is because even when therapeutic rituals achieve the desired changes, more therapy may be needed to help integrate the changes into daily life (Van der Hart).

One of the purposes of healing rituals is to solve specific problems (Van der Hart, 1983). Moreover, healing rituals “...provide the opportunity to express anger and other completely or partially suppressed emotions” (Van der Hart, p. 8). Thus, rituals in therapy can help to release some of the emotions that were not able to be experienced, and hopefully, have a cathartic effect.

Therapeutic rituals are aimed at meeting the unique needs of the individual and so, are less standardized than other kinds of rituals (Van der Hart, 1978/1983). Van der Hart suggests that modern therapy is more like traditional transition and healing rituals if the ritual is prescribed by the therapist. However, as Van der Hart suggests, the ritual

must be in consultation with the client and connect with the client's personal experiences and symbols.

Van der Hart (1978/1983) cites examples of therapeutic rituals that involve performing acts with an object that is symbolic of the relationship with the person or situation, or actually creating a ritualistic framework and concluding with a termination ceremony. In one case, he cited a 32-year-old woman who had lost her husband and young child in an accident. She made a painting of each of them, wrote farewell letters, and then buried the paintings and farewell letters, along with a few chosen keepsakes. Although in the end the client was able to be successful in her grief work, making the paintings caused her both emotional and physical pain (Van der Hart). At times, it is a necessary part of grief that difficult emotions must come up and be lived through. In fact, art therapy may have encouraged that kind of depth. However, unlike art therapy, the paintings were made on her own, outside of therapy. Perhaps if they had been created in art therapy sessions, with the presence of the therapist and the containment provided, the process of creating the paintings would have also been beneficial. However, the author did not discuss whether or not that pain served the client. In any case, the client was able to successfully terminate her grief work. This brings us to the significance of having a witness in ritual and therapy.

The Witness in (Art) Therapy

According to Garrick (1994), "psychotherapy is, in a sense, a self-disclosing ritual in which the rituals of witnesses play important roles" (p. 96). In truth, the witness' participation in grief rituals may have a healing effect on the bereaved (Garrick). Garrick points out that when individuals experience loss because of an injustice, they will

frequently need to bear witness to the injustice as an element of self disclosure. By bearing witness, the mourner may feel that a certain degree of justice has been done (Garrick).

According to Van der Hart (1978/1983), the presence of the therapist “during the separation ritual indicates that the therapist functions as a ‘celebrant,’ whose task it is to guide the person through a transition in their life cycle” (p. 126). Whether the guide is the therapist or the client, the witness is important. In fact, the witness plays two crucial roles in grief rituals that foster healing: the mourner is given permission to disclose his or her painful loss; and the mourner’s self-disclosures are validated (Garrick, 1994).

In the first role of the witness, being given permission to grieve requires the individual to feel reassured that it is safe and appropriate to grieve (Garrick, 1994). The therapist can accomplish this task by welcoming the bereaved people into a safe space and by accepting them as they are (Garrick). Furthermore, witnesses assure the mourners that they are committed to helping them “finish” the grief work (Garrick). In a sense, an alliance is built between the bereaved person and the witness, similar to that between therapist and client. Garrick points out that these symbolic rituals in the therapy space can take the place of traditional rituals, if they are lacking. This is most helpful in ambiguous loss when there often is no ritual to mark it.

In the second role of the witness, according to Watzlawick, Beavin, and Johnson (1967 as cited in Garrick, 1994) the experience of receiving validation from others is crucial in the development and stability of mental health. Validating the mourner’s self-disclosure gives him or her a sense that the self-disclosures are authentic (Garrick).

Boss (1999) emphasizes the importance of sharing one's loss with someone who can help to make sense of it. The notion of sharing is important in giving validation in order to work through the grieving process (Boss). This view is also shared by Van der Hart (1978/1983) who states that by having another recognize and validate past suffering, the person is able to let go of grievances. Thus, the therapist can function as the witness who validates the individual's experience and helps him or her move forward with the grieving process.

As a way of validating the ritual, Van der Hart (1978/1983) proposes documenting the ritual that gives witness in some different way. The artwork in art therapy can perhaps be the form of documentation, adding another witness as suggested. Thus, the art therapist can validate the individual, as well as the artwork (Ferrara, 2003), through witnessing the creation of the artwork, in addition to witnessing the individual's experience.

Golub (1985), as mentioned earlier, used art therapy with Vietnam combat veterans. She discovered that the veterans represented painful memories early on in the art therapy sessions. She reflected that the veterans may have been testing her by showing her an emotionally intense event and seeing if she would be able to hold it. This can be compared to the ritual of providing a safe space in which the therapist bears witness and validates the emotions of the traumatized individual (Garrick, 1994).

The witness can take the form of the therapist, the artwork, but also the client/artist. According to Schaverien (1998), art removes the artist from identifying with the experience and places the person into the role of witness. As a person becomes a witness of her own experience, she is able to give its due importance and gain distance

(Schaverien). As a result, art is able to connect the inner and outer experience (Schaverien).

The role of the witness is also important in cases of working through transmitted trauma.

Ritual and Transmission of Trauma

In cases of unresolved loss, trauma can be transmitted to subsequent generations (Boss, 1999; Fogelman, 1989; Hirsch, 2003; Wardi, 1992). Rituals have been shown to be effective in working through unresolved loss (Van Gennep, 1909/1960; Van der Hart, 1978/1983). Although minimal literature exists directly relating the use of ritual in cases of transmitted trauma, it is possible to conclude from the literature mentioned above that rituals may also be effective in such cases.

A pertinent example of the use of creative arts therapies in creating a ritual to work through transmitted trauma is depicted in Canadian drama therapist and dance movement therapist, Yehudit Silverman's (2005) film, *The Story Within*. The film documents six people's journeys of self discovery as they immerse themselves in self-selected and personally meaningful myths or fairy tales. Pandora's Box was the myth chosen by one of the participants to communicate the secrecy in her family of her parents' Holocaust experience. Schirch (2005) asserts that symbols are often used in rituals to communicate a transforming message. The woman in Silverman's (2005) film created a box to represent Pandora's Box and used it in her ritual. Also contributing to the ritual were lit candles representing lost family members.

An important part of ritual is the presence of a witness. Boss (1999) emphasizes the importance of sharing one's loss with someone who can help to make sense of it. The

notion of sharing is important in giving validation in order to work through the grieving process (Boss). In the example cited above, the therapist functioned as a witness who validated the individual's experience and helped her move forward with the grieving process. As a way of validating the ritual, Van der Hart (1978/1983) proposes documenting the ritual that gives witness in some different way. Although documentation can take the form of an artwork, in this case, a video documentation functioned as an added witness. Further research is needed on the use of ritual in the transmission of trauma.

Ritual and Art: The Liminal Space

Cox and Theilgaard (1997, as cited in Kalmanowitz & Lloyd, 2005) state that the metaphor expressed in art acts as a liminal space between the conscious and the unconscious. Liminality, as defined by *Random House Webster's Unabridged Dictionary* (2001) is "the transitional period or phase of a rite of passage" (p. 1115). This is the space in which transformation can occur to merge the separate fields of experience (Cox & Theilgaard in Kalmanowitz & Lloyd).

Mauck (1979) discusses the liminal space between ritual and art. Although she refers to ritual in the religious sense of the word, she makes interesting comparisons about the liminality of art and ritual. She describes liminality as a space and time in which mystery is allowed to unfold, and we give in to the power of symbol. Her main premise is that both ritual and art require the surrendering of the self; of being in a space of ambiguity. From this space, one can emerge with a sense of stability and permanence. However, one must first experience the ritual recalling of the past, making it present, in order to transcend it and move toward the future (Mauck). For the purposes of this paper,

I propose that this may be interpreted as confronting one's traumatic past and being able to move beyond it.

According to Grainger (1974), the artistic nature of ritual allows for an "atmosphere for encounter" in which we discover ourselves. He states: "In ritual, a person comes home, he returns to a primal richness and satisfaction; and because home is *really* home, when he emerges again to continue his wanderings he does so refreshed and renewed, in mind, body, and spirit" (Grainger, p. 167). Thus, the healing effects of ritual and its connection to art make ritual through art therapy particularly suitable.

Art Therapy and Ritual

According to Van der Hart (1978/1983), rituals offer clients the opportunity to express themselves and also to protect them against overwhelming emotional processes. He suggests writing a farewell letter as a mode of detachment; the letter symbolizing the distance the individual experiences. The artwork in art therapy can also serve as a ritual through the safety of the image, by allowing individuals to express their emotions, while allowing some distancing so as not to feel threatened by the powerful emotions elicited. Distancing is achieved by putting the emotions on paper and stepping away, so that the image now holds the emotions. In fact, ritual is sometimes referred to as a "container" (Van der Hart, 1978/1983), as is the artwork in art therapy literature (Collie et al., 2006). The experience of containment is seen in Winnicott's notion of a "holding environment" which becomes a psychological transitional space (Ferrara, 2003). The art therapy space becomes the transitional space where individuals engage in self-reflection and self-transformation and the artwork produced becomes the transitional object (Ferrara).

Accordingly, just as ritual involves transformation, so, too, does the art therapy experience.

Prescribing a ritual to address the client's difficulties implies that the problems will be re-labelled or placed in a different framework (Van der Hart, 1978/1983). Namely, the client will receive a positive labelling in which the difficulties are set in a more favourable context. For example, if a woman is refusing to eat normally and it is revealed that she is fasting as part of the transition to maturity, then fasting is prescribed as part of the transition ritual (Van der Hart). After the ritual is performed, she is then able to eat normally. This re-labelling is compared to traditional healing rituals in which the problem is translated in terms of a particular myth (Van der Hart). The healing aspect involves transforming the disorder in the myth through a ritual (Van der Hart). This is captured in the example of the use of Pandora's Box in Silverman's (2005) film. In this situation the participant constructed and utilized a box to represent Pandora's Box in a ritual. The purpose of this was to communicate and work through the secrecy in her family of her parents' Holocaust experience. The transformation that takes place in the myth through a ritual can further be compared to the function of the artwork in art therapy, in which the difficulties are worked through in the context of the image created. For example, an individual who was not allowed to express her feelings during childhood may draw an image of a child expressing a range of emotions. The use of metaphor in the artwork can have a transformative effect.

Schaverien (1998) compares the artwork in art therapy to a scapegoat that can provide a cleansing ritual. Just as the scapegoat is seen to actually embody the rejected element, the art object may also unconsciously be experienced by its creator as an

embodiment of what it represents; perhaps a feared or repressed memory (Schaverien). As a result, like the scapegoat, the careful disposal of it may have the effect of a cleansing ritual (Schaverien). Disposal of the image may also be a necessary rite of passage to liberate the individual and allow the artist to take control over the previously terrifying content (Schaverien). On the other hand, it may be more important to keep the image as the artist's relation to it may change over time, losing its power, and providing a conscious resolution (Schaverien). Through the viewing and discussion generated by the continued existence of the image, it is also possible to wait as long as is needed to achieve resolution (Schaverien). More importantly, the creation of the image, because it is experienced as "live," has the possibility of offering a psychological shift (Schaverien). That is, like the scapegoat, it may temporarily be experienced as a real physical transference; an actual embodiment of the rejected element, and so offers the possibility of some fundamental change (Schaverien). Thus, just as ritual offers transformation (Van der Hart, 1978/1983), the artwork in art therapy offers the opportunity of facilitating this transformation.

Art therapy is a healing ritual with its own unique principles. As Ferrara (2003) found with her Cree clients, the art therapy space has structure and consistency, which is important in the process of ritualization (Ferrara). Ferrara continues that art therapy has components of ritual through the repetition of elements, structured space, and emotionally-charged symbols. Moreover, there is a sacred aspect, common in rituals and present in art therapy. In the art therapy space, the ritual acts and the objects contained within it, such as the art materials and the artworks created, have unique communicational qualities (Ferrara). Communication is the key. Firth's (1973) position

is that art communicates private symbols into public symbols. Consequently, the communicational quality of art means that it has the ability to externalize and be shared with others. As was mentioned by Garrick (1994), the presence of witness is important in ritual. In art therapy, the artwork that is created acts as another witness, with abilities to communicate the emotions of the creator.

In an article on lamenting and bereavement, art therapist Sirkku Sky Hiltunen (2003) discusses the use of the creative arts in healing from loss. Hiltunen suggests that by using lament as a form of self-expression, clients may be recommended to paint images, write poetry, and make collages that focus on their grief. Hiltunen also recommends a ritual or a ceremony to enhance the bereavement process. She maintains that non-verbal forms of expression often spring from the unconscious and are not inhibited by the rational or critical mind, and so creative channels for expression are encouraged. Garrick (1994) states that although self-disclosure is often verbal, the nonverbal is often of greater significance. Art therapy can then serve as the means of an important visual form of self-disclosure.

Hiltunen (2003) outlines the importance of safety in the therapeutic environment. She suggests that this concept can be enhanced by physically creating a sacred circle and offering the sessions in a ritualistic format. She further suggests that a ritual space can be created by deciding beforehand the format, content, and order of the sessions. Research shows that by maintaining consistency in the art therapy sessions through the art materials, the space, and the therapist, a ritual space can be created that is helpful when dealing with loss.

The Creative Arts Therapies and Ritual

Before concluding, it is important to note how other creative arts therapies have created rituals in order to learn from previous experiences and perhaps incorporate into our own practice. Ritual drama, for example, has been used in individual or group therapy for those with difficulties in unresolved mourning. Aguilar and Wood (as cited in Van der Hart, 1978/1983) give an example in which a group member is chosen to represent the “deceased” member of the family. The “deceased” lies on a blanket placed on the ground, which functions as a coffin. Candles are lit and the client tells the “deceased” everything that was not said at the time of death. When this has been completed, the “casket” is closed by placing a second blanket on the “deceased.” Then a funeral procession is formed and the members walk to the end of the hall where the “funeral” takes place and flowers are laid on the “grave.” During this time, the person who was the “deceased” joins the group. At the end, a coffee break is taken where everyone is allowed to recover from the strong emotions. This is also similar to the time after an actual Western-based funeral when condolences are offered to the bereaved over something to drink and eat. According to Aguilar and Wood (as cited in Van der Hart), ritual drama cannot be used to solve all the client’s problems. However, when unresolved loss is the predominant condition, it has been found that ritual drama has a significant healing effect. Art therapy could have also contributed to this ritual, through the creation of a visual symbol during the ceremony.

Zwart and Nieuwenhuis (1998) cite an example in which a mourning ritual was performed with a traumatised refugee and a team of creative arts therapists. The client was a 20-year-old man from West Africa, whose family had been murdered. After the

slaughter, he was not able to bury his loved ones and to mourn. His symptoms included sleep disorders, nightmares, headaches, and re-experiencing of witnessed atrocities. The purpose of the mourning ceremony was to allow the client to say goodbye to his loved ones. During the ceremony, the therapists and invited clients formed a circle around the client who stood in front of an altar. The candles that were lit on the table each represented a lost member of his family. The client spoke directly to one candle, the one who represented his father. He placed flowers in front of each candle and then blew them out one by one, except the one for his father; he was unable to blow that candle out. Throughout the ceremony, music specifically chosen by the client and music therapist was played. In the second part of the ceremony, a small group of therapists and close friends made their way to the beach to bury a stone which represented his pain. After flowers were placed on top of it, a large wave washed away everything which they experienced as affirmation of the parting. When they returned, the client was now able to blow out the candle for his father. Afterwards, condolences were offered over a communal meal.

In the above case study, the client was in individual art therapy sessions. Prior to the ritual, the art therapist suggested that a tangible solid product be made that could be used in the mourning ceremony (Zwart & Nieuwenhuis, 1998). The client, however, felt his father was too unique to be captured in a representation. The pain he felt and wanted to get rid of was larger than himself. The therapist, inspired by the client, made a drawing instead. She depicted a human figure in pain and symbolically cut out the figure to free him. Although the client was unable to make a drawing before the ritual, he did make a number of them afterwards in art therapy to symbolize his new situation. In fact,

the therapists noticed he showed great improvement. The mourning ritual accelerated his therapeutic process, giving structure over his grief and allowing him to experience new emotions (Zwart & Nieuwenhuis). Also, great importance was placed on the many different sensory aspects of the ritual: "The activation of as many senses as possible furthers the fullness of the perception, the experience. In that way the conscious and unconscious results can be increased" (Zwart & Nieuwenhuis, p. 75). The case depicted here demonstrates well the significance of the sensory aspect of art therapy and its contribution to creating a ritual to work through trauma.

Discussion

Research shows that second generation survivors of trauma exhibit similar symptoms as survivors of trauma (Hirsch, 2003; Steinberg, 1989) and the benefits of art therapy have been documented for people who have experienced trauma (Byers, 1996; Collie et al., 2006; Fitzpatrick, 2002; Golub, 1985; Kalmanowitz and Lloyd, 2005; Wertheim-Cahen et al., 2004). It follows, then, that art therapy can also be beneficial for second generation survivors.

War related trauma can be ambiguous because the fate of missing family members may be unclear (Boss, 1999) and because of the absence of graves (Schaverien, 1998). Literature has been cited (Van Gennep, 1909/1960; Van der Hart, 1978/1983) that shows therapeutic rituals can be helpful in cases of unresolved loss. Art therapy has elements of ritual through its structured space, materials, symbols (Ferrara, 2003) and presence of a witness.

The purpose of this research paper was to demonstrate how art therapy can provide a ritual space in which transmission of trauma can be worked through

symbolically. Efforts were made at demonstrating links between art therapy and trauma, transmission of trauma and loss, loss and ritual, and art therapy and ritual.

There is conflicting information on exactly how the transmission of trauma occurs and how it affects subsequent generations. This shows, however, that transmission is a complex concept that may be affected by many factors. Transmission can occur either directly or indirectly (Schwartz et al., 1994), and some evidence shows the possibility of some genetic influence (Yehuda et al., 1998). It seems, however, that the processing of trauma is influenced by a combination of environmental, intra-psychic, and biological factors (Yehuda, 1998). Regardless of how the transmission of trauma occurs, subsequent generations are affected by it. Symptoms can include depression, anxiety, phobias, guilt, separation problems, similar dream imagery and environmental misperception (Steinberg, 1989).

Although literature is limited as to the benefits of art therapy with individuals experiencing transmitted trauma, it is assumed that the evidence which shows its benefit with those having experienced trauma, will also be relevant to those experiencing transmitted trauma, as they share some of the same symptoms (Hirsch, 2003; Steinberg, 1989).

The literature on art therapy and trauma shows that visual expression can be a valuable tool for individuals who have experienced trauma. As some authors (Greenberg & Van der Kolk, 1987; Wertheim-Cahen et al., 2004) suggest in cases of trauma, experiences are not yet processed verbally and are more likely to be accessed through visual means. Moreover, the distance afforded by visually representing painful events means that individuals are able to engage in transformation and take control (Golub,

1985). The literal and symbolic act of creating something out of nothing is very important in being able to activate and maintain inner change and recovery (Fitzpatrick, 2002), and thus can be very empowering for clients. The symptoms experienced by some second generation survivors, such as avoidance (Bauman, 2003), anxiety (Steinberg, 1989), disturbing visual imagery (Steinberg), and denial (Schaverien, 1998), are able to be worked through in the art therapy space (Collie et al., 2006).

When loss occurs, there often needs to be some kind of an acknowledgment of that loss in order for healing to begin. Mourning that takes place at funerals allows a transitional period for the survivors, in which they enter through rites of separation and exit through rites of reintegration into society (Van Gennep, 1909/1960). In cases of war-related trauma, there may not be such an opportunity. The result is that “an ambiguous loss may never allow people to achieve the detachment that is necessary for normal closure” (Boss, 1999, p. 10). As Van der Hart (1978/1983) suggests, therapy can perhaps be the modern substitute of transitional rituals.

Current literature on grief suggests finding healthy ways of keeping symbolic bonds with the deceased person and searching for meaning in the loss (Neimeyer, 2001). In addition, an exploration is suggested of the on-going attachment and a reconstruction of the meaning of the deceased in the context of the survivor’s life (Hagman, 2001). Thus, “‘pathological responses’ may be unsuccessful strategies to maintain meaning and preserve the attachment to the lost object” (Hagman, p. 25). As mourning is seen as a crisis of meaning, rituals are powerful in being able to make meaning (Schirch, 2005). Hagman (2001) suggests that many difficulties arising from bereavement are also due to the failure of other survivors to engage with the bereaved person in mourning together.

The presence of witness is consequently important, similar to the importance of witness in art therapy. In addition, expressions of grief have a communicative function (Hagman), similar to the communicational qualities of the artwork in art therapy, as well as ritual itself (Ferrara, 2003).

Literature on trauma stresses the need to integrate the trauma into one's life experience to achieve resolution (Collie et al., 2006; Greenberg & Van der Kolk, 1987). A host of authors (Cox & Theilgaard in Kalmanowitz & Lloyd, 2005; Greenberg & Van der Kolk, 1987; Golub, 1985) have pointed to the ability of art therapy to facilitate this. Authors (Van Gennep, 1909/1960; Van der Hart, 1978/1983) suggest that this is also facilitated by ritual.

Art therapy can provide a ritual space for healing from trauma since it possesses components of ritual through the repetition of elements, structured space, and emotionally-charged symbols (Ferrara, 2003). Moreover, there is a sacred aspect, both in ritual and in art therapy. In the art therapy space, the ritual acts and the objects contained within it, such as the art materials and the artworks created, have unique communicational qualities (Ferrara). Consequently, art has the ability to externalize and be shared with others. As was mentioned by Garrick (1994), the presence of witness is important in ritual. In art therapy, the artwork that is created acts as another witness, with abilities to communicate the emotions of the creator.

The aim of this research is not to suggest that all individuals who have parents who have experienced trauma need art therapy. In fact, as a result of their experiences, traumatized parents may foster strengths and coping skills in their children (Rowland-Klein & Dunlop, 1997). However, in some cases, some individuals may be secondarily

traumatized. More research is needed on the specifics of these mechanisms. The connection between art therapy and transmitted trauma, as well as between art therapy and ritual space need further exploration. Future research can also focus on the effects of trauma on third and fourth generation survivors. Research was presented in order to show the relevance of art therapy in providing a ritual space to work through transmitted trauma and loss symbolically.

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