

Group Art Therapy and Combat-Related Posttraumatic Stress Disorder:

A Case Study

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Abstract

Group Art Therapy and Combat-Related Posttraumatic Stress Disorder:

A Case Study

Cheryl Miller, M. A. Creative Arts Therapies

Concordia University, 2010

With the high number of soldiers returning from war in Afghanistan and Iraq, and the prevalence of posttraumatic stress disorder (PTSD) with this population, it is necessary to explore creative treatment solutions. The current study looks at the implementation of a group art therapy approach as part of an interdisciplinary inpatient treatment program for Canadian veterans diagnosed with PTSD. The purpose of the study is to assess the applicability of an art therapy intervention with this population. The study presents a review of the existing literature on the use of art therapy in the treatment of PTSD, including studies with a specific focus on war veterans. It also describes the group art therapy process of seven veterans. Group art therapy was offered twice a week and qualitative data was collected over a ten week period. Data collected includes images of the art works created in therapy, therapist observations, and observations by other staff members. The process of art therapy is described and data is looked at in terms how the veterans engaged with the process and the issues and emotions expressed in their art making. Potential benefits are explored.

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Dedication

This paper is dedicated to the remarkable men and women who participated in this research project. Their courage for seeking help and their dedication towards overcoming their injuries are an inspiration. It was an honour to be a part of their journey.

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Group Art Therapy and Combat-Related Posttraumatic Stress Disorder: A Case Study

According to Veterans Affairs Canada (VAC; 2008), 10% of Canadian veterans who have been exposed to war zones will develop chronic posttraumatic stress disorder (PTSD). With the high number of soldiers returning from war in Afghanistan and Iraq, it is necessary to expand current knowledge of PTSD, and explore creative solutions for the treatment of this disorder. This case study explores the art therapy process of a group of active and veteran members of the Canadian Forces who are diagnosed with PTSD. The purpose of the study is to assess the applicability of an art therapy intervention in this setting. It was hypothesized that art therapy would be a modality that would engage the veterans and give them opportunities for self-expression.

The study presents a review of the existing literature on the use of art therapy in the treatment of PTSD, including studies with a specific focus on war veterans. A group art therapy program was implemented as part of an interdisciplinary inpatient treatment program. The structure of the art therapy program is described so that a similar process may be replicated in the future. Group art therapy was offered twice a week and qualitative data was collected over a ten week period. Data collected included images of the art works created in therapy, therapist observations, behaviour ratings, and observations by other staff members. Through an in depth review of the process of group art therapy, I explore the different ways that art therapy engaged the participants and allowed them to visually express and explore their emotions, their current struggles, and their hopes for the future.

Summary of Current Literature

A review of current literature on PTSD was performed in order to create an overview of PTSD, its symptoms and associated problems, combat-related PTSD, and current approaches used in the treatment of PTSD. A review of the art therapy literature was used to create a comprehensive summary of the use of art therapy in the treatment of PTSD including the rationale for the use of art therapy with this population and the various approaches that have been developed and implemented. A specific focus was given to studies involving the use of art therapy with war veterans experiencing PTSD.

Posttraumatic Stress Disorder

PTSD is a psychological reaction to severely traumatic events (Morrison, 2001). Traumatic events involve the *experience* of the trauma, usually involving the threat of death or serious injury, and a *reaction* to the trauma, including feelings of fear, helplessness, and horror (Morrison). Van der Kolk and McFarlane (2007) believe that while the reality of the trauma is the core issue in PTSD, it is the individual's subjective response to the event that makes it traumatic. PTSD is characterized by both psychological and physiological symptoms and is associated with various difficulties (Morrison; VAC, 2008).

Symptoms. Symptoms of PTSD are divided into three categories: intrusive or reexperiencing, avoidance, and arousal symptoms (Cash, 2006; VAC, 2008). Intrusive symptoms can include nightmares, flashbacks, distressing memories of the event, emotional outbursts, and physical symptoms tied to reminders of the event (VAC). When

these reexperiencing symptoms occur, individuals can return to a state of acute stress as if they were reliving the trauma, which can lead to panic or aggressive behaviour (Cash). Intrusive thoughts are natural reactions immediately following a traumatic event and can help people to learn from the experience and eventually come to accept it (van der Kolk & McFarlane, 2007). For individuals who develop PTSD, these thoughts are not adaptive, and lead to sensitization to the trauma and increased distress (van der Kolk & McFarlane).

Avoidance symptoms involve changes in the way individuals respond to their environment, and changes in their levels of engagement with life (Cash, 2006). These symptoms can include avoiding reminders of the event, amnesia for parts of the event, lack of interest in pleasurable activities, flattened or numbed affect, feelings of detachment from the self or others, and a foreshortened sense of the future (VAC, 2008). Emotional numbing is an avoidant symptom of PTSD and is described as the inability to feel any emotions (Feeny, Zoellner, Fitzgibbons, & Foa, 2000). Emotional numbing involves a restricted range of affect, feelings of detachment, and diminished interest in activities, and is associated with a higher comorbidity with major depressive disorder (Feeny et al.; Kashdan, Elhai, & Frueh, 2006).

In contrast to avoidance symptoms, some individuals with PTSD will engage in compulsive reexposure (Cash, 2006). Compulsive reexposure involves constantly seeking out reminders of the trauma or trauma related activities, and may lead to harm to others, self-destructiveness, and revictimization (van der Kolk & McFarlane, 2007).

Arousal symptoms can include difficulty sleeping, irritability, angry outbursts, difficulties with focus and concentration, exaggerated startle response, and hypervigilance (VAC, 2008). Arousal symptoms can become overwhelming, and may lead an individual to feel powerless and out of control (Cash, 2006). Van der Kolk and McFarlane (2007), attribute hyperarousal symptoms to the idea that our autonomic nervous system loses the ability to distinguish between neutral and threatening stimuli. According to this view, everything including our own physical sensations can be perceived as threatening.

Herman (1997) believes that people who have experienced trauma alternate between feelings of numbness and reexperiencing the event, simultaneously deflecting attention from and calling attention to the traumatic event. Herman refers to this phenomenon as the “dialectic of trauma” (p. 47).

Associated problems. PTSD is associated with many comorbid mental health problems and interpersonal difficulties. It is common for individuals diagnosed with PTSD to be diagnosed with comorbid mental health disorders (Foa, Keane, Friedman, & Cohen, 2009). Anxiety, depression, and substance abuse are all common problems associated with PTSD (Foa et al.; VAC, 2008). A report by VAC states that depression is seen in as many as 50% of people suffering from chronic PTSD, and is often linked with feelings of guilt and remorse. The same report suggests that alcohol and drug use problems are common in 50% of men with PTSD and 25% of women, and that these numbers are even higher among veterans. Drug use may be associated with an attempt to control the symptoms of PTSD (VAC). Interpersonal problems are also common in

individuals with PTSD. Problems may lead to impaired work and family functioning, lack of social support and interconnectedness, poor relationship quality, and social withdrawal (Schottenbauer, Glass, Arnkoff, & Gray, 2008; VAC).

A study by Kashdan, Julian, Merritt, and Uswatte (2006) found that Vietnam War veterans with PTSD showed greater social anxiety and less emotional well-being, self-esteem, and positive social activity when compared to veterans without PTSD. Social anxiety leads individuals to avoid social situations, or to act hypervigilant, ruminate about perceived threats, and engage in self-protective behaviours when avoidance is impossible (Kashdan et al.). Avoidance behaviours associated with PTSD and social anxiety result in diminished opportunities for positive emotional experiences (Kashdan et al.).

Combat-related PTSD. According to Morrison (2001) combat-related trauma is the most frequent cause of PTSD. Before the diagnosis of PTSD was developed, similar symptoms in soldiers were labelled as soldier's heart, shell shock, war neurosis, and combat fatigue (Herman, 1997; VAC, 2008). War zones expose individuals to horrendous violence. Experiences that can lead to the development of PTSD include: being in a war zone, engaging in peacekeeping missions under distressing conditions, attacks on self, witnessing the death or wounding of civilians or fellow soldiers, and the act of inflicting death or injury onto an enemy soldier or civilian (Cash, 2006; VAC). A study by Hoge et al. (2004) investigating mental health problems associated with combat in Iraq and Afghanistan, demonstrates that the prevalence of PTSD increases consistently with the number of fire fights a soldier has been involved in. Unfortunately, a fear of

stigmatization stops many soldiers from seeking treatment for their symptoms (Hoge et al.).

Treatment of PTSD

Various treatment principles and models have been developed to help individuals suffering from PTSD. Cash (2006) suggests three principles important in any treatment of PTSD. These three principles include: *processing* traumatic memories, *integrating* experiences into a healthy present- or future-oriented framework, and *deactivating* hyperarousal symptoms. Some guidelines to developing treatment plans suggested by Cash include choosing a treatment modality based on individual needs, discussing an individual's expectations, setting realistic goals, addressing comorbid conditions, and keeping in mind special features of PTSD such as trust issues. Herman (1997) believes that recovery from psychological trauma requires empowerment and creating new connections with others. The inclusion of a psychoeducational component is often seen as a key factor in the treatment of PTSD (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005). It is believed that individuals who experienced abuse as children require long term therapy with a multimodal approach (Foa et al., 2009).

The treatment of PTSD or trauma is often organized into a three phase model (Collie, Backos, Malchiodi, and Spiegel, 2006; Ford et al., 2005; Herman, 1997). Herman recommends treatment based on what she refers to as the three stages of recovery from traumatic disorders, which include safety, remembrance and mourning, and reconnection. Tasks involved in the first stage include naming the problem, restoring control, and establishing a safe environment. The remembrance and mourning stage

involves reconstructing the story, transforming traumatic memory, and mourning traumatic loss. Finally, the reconnection phase involves learning to fight by facing fears, reconciling with oneself, and reconnecting with others (Herman). In a treatment model put forward by Ford et al., the first phase involves engagement, safety, and stabilization, the second phase focuses on the recalling of traumatic memories, and the third phase aims at enhancing daily living.

VAC (2008) outlines a strategy for the treatment of PTSD which involves six stages. The first stage involves stabilization and engagement in treatment, the second stage focuses on psycho education about the effects of PTSD, the third stage covers symptom management including psychopharmacological therapy, the fourth stage involves trauma-focused therapy, the fifth stage includes cognitive behavioural therapy, and the final stage focuses on relapse prevention and support.

Cognitive behavioural therapy (CBT), psychodynamic psychotherapy, psychopharmacological therapy, eye movement desensitization and reprocessing (EMDR), hypnosis, and the creative arts therapies are treatment modalities commonly associated with PTSD (Foa et al, 2009).

Cognitive behavioural therapy. One common type of CBT intervention used in the treatment of PTSD is exposure therapy. For individuals with PTSD, exposure therapy can be used to confront distressing traumatic memories (VAC, 2008). Exposure therapy can involve actual exposure to traumatic stimuli, or imagined exposure (Cash, 2006). The rationale of exposure therapy is that if an individual can repeatedly confront a feared situation or memory without any negative consequences, the anxiety associated with

these situations will be reduced (VAC). Exposure therapy involving trauma memories emphasizes that memories are in the past, and aims to show individuals that remembering the trauma is not the same as reliving it (van der Kolk, 2002).

Cognitive restructuring is another form of CBT, which attempts to identify and alter an individual's negative interpretations about the trauma and about themselves, such as self-blame (VAC, 2008). Other types of maladaptive beliefs that can be challenged by cognitive restructuring include over-generalizing, over-focusing on negatives, and incorrect beliefs about cause and effect (VAC). Cognitive restructuring confronts these maladaptive views, and attempts to challenge them and replace them with more realistic thought patterns.

Psychodynamic psychotherapy. Psychodynamic psychotherapy explores the dynamic processes involved in the formulation of symptoms (Kudler, Krupnick, Blank, Herman, & Horowitz, 2009). According to Kudler et al., "From the psychodynamic perspective, a posttraumatic symptom is not a simple defect: It is an adaptive attempt to manage the trauma" (p. 348). Psychodynamic psychotherapy addresses several issues that often play a role in the lives of individuals with PTSD including: developmental issues, defence mechanisms, and interpersonal issues (Schottenbauer et al., 2008). Psychodynamic psychotherapy deals with issues of development by exploring early traumas (Schottenbauer et al.). Early traumas can predispose an individual to react more strongly to traumatic experiences later on (VAC, 2008). Insight into early traumas can lead to an awareness of defensive functions, an improved ability to cope with stress in the

present and future, and freedom from excessive feelings of guilt (Schottenbauer et al.; VAC).

The development of PTSD is shown to be correlated with the use of immature defences such as reality-distorting and reality-escaping defences, including dissociation (Schottenbauer et al., 2008). Schottenbauer et al. suggest that exposure to trauma may weaken an individual's ability to use more mature defences, and that psychotherapy can address this by bringing awareness to defensive actions. Psychodynamic psychotherapy raises awareness of interpersonal issues by focusing on the relationship between the therapist and the client or the therapeutic transference (Kudler et al., 2009; Schottenbauer et al.). Exploring transference in the therapeutic relationship can lead to a better understanding of issues and improved interpersonal interactions with others (Kudler et al.; Schottenbauer et al.). Psychodynamic psychotherapy helps individuals with PTSD to integrate the traumatic experience into their view of their life as a whole (VAC, 2008).

Psychopharmacological therapy. PTSD is associated with psychobiological abnormalities involving neurotransmitter, neurohormonal, and neuroendocrine systems (Friedman, Davidson, & Stein, 2009). Certain drugs are considered to be effective in treating PTSD including antidepressants such as selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and atypical antipsychotics (Friedman et al.). Pharmacological treatments ameliorate symptoms by altering neurochemical processes, and are often used to treat acute symptoms, or as a maintenance treatment to prevent relapse (Cash, 2006). Goals of pharmacological treatments of PTSD include: reducing symptoms, increasing quality of life while

decreasing degree of disability, improving resilience, and treating comorbid mental health disorders (Cash; Friedman et al.). Medication should be combined with other forms of treatment aimed to address underlying issues (VAC, 2008).

Treatment implications for combat-related PTSD. A study by Hoge et al. (2004) showed that only 23% to 40% of American soldiers who met criteria for a mental disorder actually sought treatment for their problems. The study showed that a fear of stigmatization was a leading cause of not seeking help. Hoge et al. suggest that educational and outreach approaches are necessary to combat the stigma associated with seeking help with this population.

Cash (2006) believes that combat-related PTSD is harder to treat than other forms of PTSD because soldiers wait longer to seek treatment and because the cases are often more complex, including higher levels of dysfunction and comorbidity. Cash also advises that veterans with PTSD may have higher levels of anger because military training teaches them to use anger as a way to manage fears. Cash points out that a high level of anger may interfere with an individual's ability to recognize and accept fears, and work through them in therapy.

Art Therapy and PTSD

Art therapy offers something unique to the treatment of PTSD because it provides an alternative to verbal expression. The benefits of using drawing, painting, sculpting, and other creative activities as a means to explore issues related to trauma and PTSD

have been explored by various art therapists and researchers, as will be demonstrated below.

Therapeutic mechanisms. A survey of current practices in the use of art therapy as a treatment for PTSD performed by Collie et al. (2006) revealed seven main functions that art therapy provides in the treatment of PTSD; these functions include: progressive symbolic exposure, externalization, reduction of arousal, reactivation of positive emotion, enhancement of emotional self-efficacy, improved self-esteem, and reconsolidation of memories.

Expressing distressing images and emotions through art making may be less threatening than verbally expressing similar material because the material becomes transformed symbolically (Collie et al., 2006). Art therapy therefore allows for progressive exposure to difficult emotions and stimuli through symbolic form (Collie et al.). As Pifalo (2007) puts it, “A drawing of a feeling is a feeling once removed” (p. 172). Art therapy allows for difficult material to be externalized and contained in images or art objects, which helps to separate the issue from the individual (Collie et al.). In other words, art therapy offers a safer means to explore traumatic memories because the artwork is separate from the maker (Johnson, 1987). Art therapy may be particularly helpful in reducing avoidant tendencies because it allows for traumatic material to be concretized (Johnson, Lahad, & Gray, 2009).

Johnson et al. (2009) believe that many of the therapeutic mechanisms that make the creative art therapies effective are also elements of CBT. These elements include imaginal exposure, stress management skills, enhancement of resiliency, and cognitive

restructuring. Johnson et al. suggest that reexperiencing and avoidance symptoms of PTSD are addressed by the exposure-based mechanisms of the creative arts therapies, whereas hyperarousal symptoms are dealt with by relaxation and distraction-based mechanisms.

Engaging in art making can be both relaxing and pleasurable at times. Art therapy is considered a mind-body intervention that can influence physiological symptoms (Malchiodi, 2003). Art therapy can therefore help to change an individual's level of arousal, which addresses symptoms of hyperarousal in individuals with PTSD (Collie et al., 2006). Van der Kolk (2002) believes that the physical experience of more action based therapies, like the creative arts therapies, can also work to contradict feelings of helplessness associated with traumatic events. The pleasurable experience of expressing oneself creatively can reawaken positive emotions and therefore address symptoms of emotional numbing in individuals with PTSD (Collie et al.). Art therapy can be combined with relaxation techniques further manage stress and hyperarousal (Johnson et al., 2009).

Expressing emotions and difficult thoughts through art making within the context of a supportive group can lead to an increase in emotional self-efficacy and self-esteem (Collie et al., 2006). Expressing emotions through art making can give individuals a sense of control over what is being expressed and can show them that they have the ability to share these emotions without overwhelming themselves or the people around them (Collie et al.). Furthermore, when emotions are shared within a supportive group and are received non-judgmentally, self-esteem can grow (Collie et al.). Johnson et al.

(2009) believe that the creative arts therapies can also help reduce feelings of guilt and shame, and increase resilience.

Art therapy can help reconsolidate and integrate traumatic memories through the creation of a coherent visual trauma narrative (Collie et al., 2006; Gantt & Tinnin, 2009). Cognitive reprocessing, reframing, and the identification of distorted cognitions are also achieved through exploration of the visual trauma narrative (Johnson et al., 2009). According to Collie et al., “only when traumatic material is seen as something that is owned by the person yet external to that person, can it be transformed from something that is distressingly active in the present to something passive that is part of the person’s history” (p. 160). Art therapy can also help to reconnect implicit and declarative memories (Collie et al; Malchiodi, 2003; Spring, 2004). An understanding of the nature of trauma and traumatic memories is essential in comprehending why the visual processing involved in art therapy facilitates integration of the trauma.

The non-verbal nature of trauma. Johnson (1987) proposes that because of the visual nature of traumatic memories, art therapy can play a unique role in the treatment of psychological trauma. Johnson explains that traumatic images which emerge as nightmares or flashbacks are like exact photographic replicas of the trauma. Van der Kolk (1999) believes that the intensity of emotions experienced during a trauma can cause conscious memories of the trauma to become dissociated, and as a result the trauma is stored simply as visual images or physiological sensations. The way traumatic memories are stored results in the reexperiencing of emotions, sensations, and images related to the traumatic event when the event is recalled (van der Kolk, 2002).

This view is supported by the frequent occurrence of flashbacks, nightmares, and arousal symptoms in individuals with PTSD.

Van der Kolk (1999) explains that due to the nature of the traumatic event, an individual's ability to use words and symbols to capture the event is inhibited. Neuroimaging studies show that when traumatic memories are relived, there is decreased activity in the Broca's area, which is an area of the brain involved in producing language (van der Kolk, 2002). Alexithymia, or the inability to verbalize feelings, is common in individuals with PTSD and suggests the need for non-verbal treatment methods (Gantt & Tinnin, 2009; Johnson, Lahad, & Gray, 2009).

Gantt and Tinnin (2009) put forward a neurological view of trauma which supports the notion of trauma as a largely nonverbal issue and describe the instinctual trauma response (ITR) in order to sustain their theory. The ITR is an evolutionary survival strategy found in animals and humans (Gantt & Tinnin). It includes a startle response, a thwarted intention or fight and flight response, a freeze or altered state of consciousness, and self-repair (Gantt & Tinnin). The authors believe that verbal consciousness fails during this process and the experience is captured in nonverbal memory as "fragmentary states of experience without temporal order" (p. 150). These states are not integrated into the verbal mind and may resurface, causing psychological symptoms (Gantt & Tinnin). Gantt and Tinnin believe that if trauma is a non-verbal problem, then a non-verbal resolution of the problem is necessary. They suggest that art therapy provides access to traumatic memories through communication with the non-verbal mind.

Research and approaches. The use of art therapy in the treatment of PTSD has been approached in a variety of ways by different art therapists. Art therapy interventions have been developed for use with various age groups and different types of trauma. The five studies or approaches described below were those which were most influential in the development of the art therapy program used in this study. Other art therapy approaches to the treatment of PTSD exist in the literature but are not described in this text, which incorporate techniques EMDR, bilateral stimulation, and hypnosis (Talwar, 2007; Tripp; 2007; Gantt & Tinnin, 2007).

Chapman, Morabito, Ladakakos, Schreier, and Knudson (2001) describe an art therapy intervention called the Chapman Art Therapy Treatment Intervention (CATTI), which was developed to reduce symptoms of PTSD in paediatric trauma patients. This intervention includes a graphic kinaesthetic activity followed by directions to produce a series of pictures. The kinaesthetic activity is used to promote relaxation and the release of tension and the drawing directives are used to produce a coherent narrative of the event. Both activities were used to activate emotional and perceptual processes. Using a randomized cohort design, Chapman et al. researched the effectiveness of the CATTI with children between the ages of seven and seventeen, who were hospitalized after sustaining traumatic injuries and who were displaying PTSD symptoms. Results indicated no significant differences in overall reduction of symptoms when compared to a control group that did not receive the intervention. However, results did indicate that the intervention produced a reduction in avoidance symptoms at one week and one month follow ups.

Pifalo (2006; 2007) developed an approach to treating symptoms of PTSD with children and adolescents who have been sexually abused, which combines elements of art therapy and CBT. In this approach, art therapy interventions are used to accomplish goals of trauma focused CBT. Art therapy is used to identify and process emotions, facilitate coping skills, map the trauma narrative, and highlight support (Pifalo, 2007). An outcome study of this approach was performed, in which the treatment was delivered once a week over an eight week period (Pifalo, 2006). The study involved 41 participants between the ages of 8 and 16 years old. Pre and post test measures indicated a significant reduction in symptoms of PTSD.

Lyshak-Stelzer, Singer, St. John, and Chemtob (2007) describe an art therapy approach to treating inpatient adolescents with PTSD. This approach involves the creation of drawings and collages based on 13 different trauma focused themes. The art works are used to create a life narrative and are bound together in a book format at the end. This treatment is meant for a group format, which involves sharing among participants. When compared to a control condition consisting of arts and crafts activities, this treatment was shown to produce a greater reduction in symptoms of PTSD.

Henderson, Rosen, and Mascaro (2007) studied the effects of creating mandalas as a way of processing traumatic events. The study involved 36 undergraduate students who demonstrated moderate levels of PTSD symptom severity. Participants were divided into an experimental group and a control group. The participants in the experimental group were instructed to draw a large circle and fill it with images, colors, and symbols relating to feelings or emotions associated to their traumas. Participants in

the control condition were asked to draw an object. Both conditions consisted of three 20 minute sessions over a period of three days. Pre and post test measures indicated that the mandala condition produced a greater reduction in PTSD symptom severity than did the control condition.

Rankin and Taucher (2003) describe a task-oriented approach to treating PTSD with art therapy. Their approach is comprised of six tasks, which include: safety planning, self-management, telling the trauma story, grieving losses, self-concept and worldview revision, and self and relational development. The tasks are meant to be followed sequentially, but the authors emphasize that there will be overlap and revisiting of the various stages during treatment. The authors give examples of some specific art interventions that can be used for each task. This approach utilizes a mix of activities, which promote: expression of emotions, narration of events, exploration of meaning, management of symptoms, and integration of traumatic and nontraumatic material. Rankin and Taucher suggest that this approach can be used with individuals or groups, and can be modified to fit different program lengths.

Art Therapy and War Veterans

Despite the benefits of art therapy as a treatment for PTSD and the prevalence of PTSD with war veterans, only a few studies have explored the use of art therapy with this specific population. No art therapy studies were found involving veterans of the recent wars in Afghanistan and Iraq.

A study by Johnson, Lubin, James, & Hale (1997) explored the effects of 15 different treatment components in an inpatient treatment program for Vietnam War veterans with PTSD. The treatment modalities being studied included art and drama therapy, interpersonally oriented group therapy, relaxation, groups on specific topics such as managing anger and family issues, community service, and others. Single session effects were assessed using a self-report instrument that was given to the veterans before and after each group. Veterans also rated the effectiveness of each treatment component at discharge. The results of this study showed that art therapy was the treatment that was the most successful with the veterans with the most severe symptoms of PTSD. All other modalities were more successful with veterans with less severe symptoms. The study showed that most groups that were high in war-related content were less successful. However, the creative arts therapies were successful even though they contained war-related content. Johnson et al. believe that the creative arts therapies have the dual advantage of being action oriented, while also incorporating psychological content.

Morgan and Johnson (1995) studied the effect of art therapy on a specific intrusive symptom of combat-related PTSD: nightmares. Their study, which involved two Vietnam veterans, compared the effect of drawing immediately after awakening from a nightmare with a similar writing condition. Their results showed that the drawing condition resulted in a reduction in the number and intensity of nightmares in both subjects. The authors attribute the success of the art condition to the distancing, reality testing, and concretizing characteristics of art making, as well as the sense of mastery achieved by the creation of the art work. The authors report that the subjects experienced frustration during the writing condition, and highlight the difficulty of expressing intense

emotions through words. Another result of this study was that the veterans reported feeling more detached from their dreams after the drawing task. They were more aware that they were dreaming and began viewing scenes in their dreams from an aerial perspective.

Golub (1985) studied art work produced by veterans of the Vietnam War in art therapy 15 years after their experiences of combat. Golub noticed symbolic trends representing dualities or opposites in the veterans' self-representations. The types of opposites represented symbolically were: representations of the self before and after Vietnam, as living and dead, as victim and agent, and as soldier and civilian. The veterans also demonstrated a need to express emotions paired with anxiety about being overwhelmed (Golub). Golub believes these opposites may be the result of a splitting in the veterans' views of the self. She suggests that this would be particularly likely with this population because the veterans, who were late adolescents at the time of the war, would have been at a vulnerable stage in self-development. Golub suggests that through art therapy, the veterans were able to work towards self-integration and mastery of the trauma.

Coulter (2008) described the long-term art therapy treatment of an Australian Vietnam War veteran with PTSD. Coulter uses this case study in order to demonstrate how art therapy can facilitate the safe exploration of feelings of anger and resentment and can provide an expressive outlet for self-harming behaviour. Coulter suggests that engaging in art therapy "provided a channel for internalized and repressed anger,

disillusionment and alienation to be externalized and explored in therapeutic safety” (p. 242).

As mentioned above, Collie et al. (2006) established a theoretical rationale for the research and practice of art therapy with individuals with combat-related PTSD. Collie et al. suggest following a three-phase art therapy approach to the treatment of combat-related PTSD. The first stage of this treatment involves developing a sense of safety, reducing arousal symptoms, engaging with positive emotions, and developing emotional self efficacy. The second phase deals with the recall, expression, and consolidation of traumatic memories and the emotions associated with them. The third stage focuses on using new insights and understandings to enhance daily living (Collie et al.). Collie et al. recommend group art therapy for the treatment of combat-related PTSD because combat operations and military training are group experiences and traumas in this milieu are typically undergone and managed in groups.

Methodology

An exploratory case study method was used to explore the art therapy process of a group of seven veterans with PTSD. Group art therapy took place in an inpatient unit for veterans experiencing mental health issues related to their service. Art therapy was offered twice a week and the structure of the art therapy program is described so that the process may be replicated at other sites. Data was collected for a period of ten weeks. Ethical considerations and the limitations of this study are discussed.

Exploratory Case Study

According to Creswell (1998), the case study is an exploration “over time through detailed, in-depth data collection involving multiple sources of information rich in context” (p.61). Case studies provide an in depth exploration of programs, processes, or individuals, within their physical, social, economic, and historical settings (Creswell, 1998; 2003). The case study method was chosen in order to gather as much information as possible on the focus of the research. Case studies can capture subtle information that may be overlooked by other approaches, such as patterns, nuances and latent elements (Berg, 2004). Berg suggests that exploratory case studies are useful as pilot projects or preludes to further investigation. The exploratory case study design was preferred because of the newness of the group art therapy program being researched. An exploratory design allowed for the gathering of information to be used as an initial step in researching the use of art therapy with this population.

Site

The art therapy group took place as part of an inpatient treatment program for individuals experiencing operational stress injuries (OSI). OSI is a term used to refer to mental health issues related to service in the Canadian Forces or Royal Canadian Mounted Police (RCMP). Most individuals referred to the inpatient program are diagnosed with PTSD, other anxiety disorders, or depression. The inpatient program is divided into two different treatment programs: a stabilization program and a residential program. The stabilization program is designed for individuals needing adjustments to their medications. The residential program is designed for individuals who are considered stable but are still experiencing difficulties with daily functioning because of their conditions. The inpatient treatment program has an interdisciplinary approach, which offers a variety of treatment interventions. Art therapy is one of few programs that individuals from both the stabilization and residential programs participate in together.

Participants

This case study explores the process of seven veterans diagnosed with PTSD. All of the participants are clients who I worked with in a practicum setting as a component of my Master's in Art Therapy. Participation in both the art therapy group and the research project were voluntary. All clients admitted to the inpatient program were approached for consent following their admission. Eight participants participated in the art therapy group and consented to being a part of the research project. However, one participant did not have a diagnosis of PTSD and data regarding this client was therefore excluded from the study. Five participants were from the stabilization program, one participant was

from the residential program, and one participant began in the stabilization program and was later transferred to the residential program. The group began with two participants but by the second week there were four participants in the group. For the remainder of the group there was between three and five participants taking part in each session.

All participants had served in the Canadian Forces, where they experienced various types of trauma. Years of service and amount of combat experience varied greatly among the participants. Two of the participants also disclosed experiencing physical and mental abuse as children and one participant disclosed a history of sexual assault and domestic violence. Six of the participants are men and one is a woman. The participants ranged in age from 28 years old to 56 years old. Two of the group participants were married and five were separated or divorced. Most participants were diagnosed with a comorbid disorder, which included other anxiety disorders, major depression, and bipolar disorder. Presenting problems included insomnia, nightmares, anxiety, hypervigilance, dissociation, depression, suicidal ideation, isolation, avoidance, chronic pain, and interpersonal problems. All participants had good awareness of their presenting problems and were motivated to work towards overcoming their symptoms. Of the six participants, two had some previous experience with art therapy.

Participants of the residential and stabilization programs are admitted and discharged on an ongoing basis and therefore participants joined the art therapy group and terminated at different times throughout the process. The size of the group therefore fluctuated from session to session. The number of group art therapy sessions that each participant took part in ranged from four sessions to all twenty sessions.

Group Art Therapy

Schedule. Group art therapy was offered twice a week to all participants in the residential and stabilization programs. These sessions took place during the week for two hours in the evening. A third weekly art therapy session was offered on Saturday afternoons. The Saturday afternoon sessions had smaller attendance due to the fact that most participants were able to go home on the weekends. These sessions often ended up being individual sessions and are not included in this study. Additional individual art therapy sessions were offered on occasion when needed, such as in the event that a participant experienced distress that was not sufficiently addressed within the group. Data from these sessions was not included in this study in order to focus solely on the results of group art therapy sessions.

Set-up and materials. Art therapy sessions took place in several different rooms because of changes going on at the hospital and fluctuations in the size of the group. All art therapy sessions took place with participants sitting around one common table. During most sessions, a variety of art materials were placed in the centre of the table. During sessions where space was more limited, materials were placed on a separate table. Materials which were always available to participants included: acrylic paint, watercolour paint, chalk pastels, oil pastels, markers, pencil crayons, drawing pencils, charcoal, clay, plasticine, and a large variety of images for collage. Participants were also provided with scissors, glue, rulers, paint brushes, water containers, Styrofoam trays, erasers, sharpeners, aprons, and clay modeling tools. During art making a variety of relaxing music was played.

Structure. All art therapy sessions were led by the researcher as a part of a practicum in art therapy. All art therapy sessions began with a check-in period, during which participants were given the opportunity to talk about their current state, their progress, or any issues of concern. Check-in was followed by a description of the session's theme or activity. Some sessions were self-directed, some had a suggested theme, and others involved specific activities. The participants were then given time for art making, which usually lasted around one hour or until all participants had finished their projects. The session ended with a discussion period. During the discussion period, participants were given the opportunity to show their art work and discuss what they had made. Participants were encouraged to interact and respond to each other's art making during this time. At the end of the session all participants helped to put away the materials. Most sessions involved the presence of a mental-health nurse in an observation role for safety reasons.

Themes and activities. Group art therapy sessions involved a combination of themes, specific directives, and free art making. Often, the themes addressed in art therapy corresponded to themes that were being addressed in the other treatment groups that the participants of the residential program were involved in. When themes were given, the participants were encouraged to approach them in any way they felt comfortable. For example, if the theme was anger vs. tolerance and patience, participants were given the choice of exploring anger, tolerance and patience, or the relationship between the two. The group was often consulted to determine how they wanted to approach certain sessions or themes and participants were always given the choice to ignore the session's theme or directive if they did not feel comfortable exploring that

particular theme. At times, specific activities were suggested in order to encourage participants to experiment with different media and ways of working.

Goals. The aim of this group art therapy program is to give participants the opportunity to express the emotions and difficulties that they are experiencing in the present and explore hopes and goals for the future. The focus of treatment in this setting is not on processing past traumas. The therapist's goals of providing art therapy to this group of participants include: decreasing avoidance, increasing self-esteem and self-awareness, reactivating positive emotions, reducing arousal, and exploring feelings and emotions related to present experiences.

Data and Data Collection

Data collected for this study included all art works produced during the art therapy sessions, written observations of the sessions, behaviour ratings, and staff comments. All art works were photographed after each session. Written observations were completed for each participant after each session and included notes on the participant's process of art making, level of involvement in the process, significant interactions with each other and with the therapist, associations to their images, demonstrations of affect, etc. A behaviour observation form (Appendix A) was completed for each participant following each group art therapy session in order to assess their level of involvement with the art therapy process. Whenever possible, the behaviour observation forms were filled out by a mental health nurse observing the group. In cases when no nurse was present, the rating forms were filled out by the therapist. Staff members who came in contact with the art therapy program were asked open ended

questions about their impressions of the art therapy process and its place within the larger context of the treatment program. All clinical staff members of the treatment program received an email before the last week of the program and were asked to respond to the following questions: How did art therapy fit into the overall treatment program? How did clients react to the art therapy program? What was your overall impression about the implementation of group art therapy in this context? Some staff members had observed the art therapy process directly, while others observed the process indirectly by hearing about art therapy and seeing art works in supervision or team meetings, or by speaking with the participants about their experiences of art therapy.

The images selected to be included in this paper were chosen by the therapist because they exemplified the most effective or therapeutic use of the proposed themes or directives of each session. Attention was given to ensure that art making by all participants was portrayed equally and so that a variety of mediums were also represented. The therapist's subjectivity is recognised in the choice of art works represented.

Data Analysis

Data was analyzed on an ongoing basis throughout the process of art therapy. Art images and observations of the art therapy process were looked at in terms of each participant's individual process and progress and in terms of the process and progress of the group as a whole. The participants' own associations to their images were used in terms of analyzing what was expressed in the art works. Behaviour observation forms were looked at in terms of assessing general level of engagement with the process for

each participant and in order to assess whether the level of overall engagement of the group was affected by certain themes or art directives. Staff observations were analyzed in terms of exploring how the art therapy program fit into the larger treatment program.

Ethical Considerations

Procedures were followed in order to obtain permission to do research with human participants. Permission was granted by both the Faculty Research and Ethics Advisory Committee of the Department of Creative Art Therapies at Concordia University and the onsite research committee. All participants were approached for consent prior to joining the art therapy group. The participants were presented with an information letter (Appendix B) and a consent to research form (Appendix C). A participant's willingness to participate in the research project had no effect on his or her involvement in the art therapy group.

Individuals who have experienced trauma are a vulnerable population and this was taken into account in the planning of this research. The art therapy process was planned and implemented with sensitivity to participants' unique difficulties. Art therapy did not focus on processing trauma; its focus was on current experiences of issues and emotions. Participants were not encouraged to explore or progress at a level beyond their comfort. Strict measures were taken to ensure the confidentiality of all research participants. All data collected was filed according to a number system and was not identified with participants' names. Signatures on art works were covered before they were photographed.

Choosing to do case study research with participants that I was treating as a part of my internship in art therapy required that I balance the roles of researcher and therapist. My goal as a researcher is to increase knowledge in providing art therapy services to individuals with PTSD, which is congruent with my goal as a therapist working with this population. As a therapist as well a researcher, I was genuinely involved with my participants throughout the therapy process. I believe that my involvement as a therapist in this research has added to the richness and complexity of my case study. Throughout the process of providing this art therapy group I received clinical supervision by a faculty supervisor from Concordia University and an onsite supervisor.

Limitations

Successful case studies can provide information about the specific case studied and about similar groups or individuals (Berg, 2004). Using information collected in this study, I am able to come up with some tentative assumptions about how similar participants may respond to group art therapy. However, given this method of research and a small sample size, the results of this study may be atypical and may not generalize to other similar populations. Furthermore, the case study design does not allow for inferences of cause and effect. This study is limited by the fact that any potential effects witnessed during the process of art therapy treatment will be confounded with the effects of other treatment modalities simultaneously offered to participants.

Findings

Description of Sessions

A total of more than 115 art works were collected from the seven participants over the ten week period. A description of each participant's art making over the course of the research project would be beyond the scope of this paper and, therefore, the process of one or two participants is highlighted in the description of each session.

Week 1 – Personal folders and elaborations. During the first session, participants were asked to design a personal folder as a way of introducing themselves to me and to the other group members. The participants were each given a large sheet of white paper, which was folded in half, and a variety of painting, drawing, and collage materials were placed in the middle of the table. One participant decided to work in collage and covered both sides of his folder with magazine images (Figures 1 & 2). The participant also incorporated drawn elements in order to integrate the different images and to provide emphasis. He used this activity to explore aspects of the experience of his deployment to Afghanistan and his subsequent return. On the front of his folder (Figure 1) the participant depicted the home and family that he left behind and the friends waiting for him to return at the end of his journey. The participant described a small image of a sculpture of a head with no body as symbolizing the physical effects of war and how he returned home changed. On the opposite side of his folder (Figure 2) he chose images relating to his traumatic experiences, which included explosions and the death of several close friends. The participant also chose a picture to represent being at home. He used arrows to show how his experience of trauma had followed him home and was a constant

presence. Through the use of his folder, the participant was able to demonstrate very succinctly the event that led to his being in treatment.

During the second session participants were asked to create an artwork focusing on one aspect of what they had represented on their folders. Once again a variety of materials were spread out on the table and this time a variety of different colors and sizes of paper were available for the participants to choose from. The participant described above chose to focus on the idea of his journey, which he had represented on the front of his folder (Figure 1) with an image of a winding river. The participant once again decided to work by incorporating collage and drawing (Figure 3). The participant is represented by the image of a boy and his journey lies before him. The participant talked about the importance of learning to move forward with the baggage he has because we can never completely leave our baggage behind us. He also talked about the need to keep looking ahead despite obstacles along the way and despite falling down. He has represented people cheering him on and his motivating thoughts about better things to come. This was a positive image for this client and demonstrated his feelings of determination to overcome his PTSD.

Another participant, who had used his folder to describe his life from birth until the present, chose to focus in on his current feelings and struggles. The participant created five different collages this session, all on the same theme. One of these collages (Figure 4) represents the participant's feelings of disorientation. The participant used landscape images to symbolize a lack of a sense of orientation. On the image the participant wrote: "Need to make a plan! Where am I going now? Which road? Which bearing? Where is my compass? I'm lost! Never, ever happened before". In the same



Figure 1

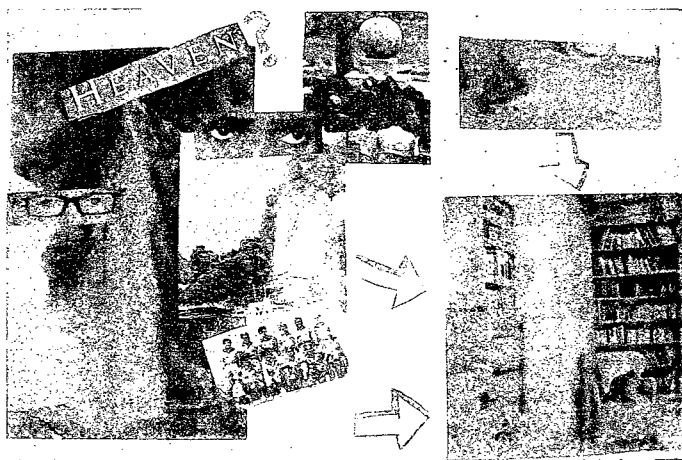


Figure 2



Figure 3

image the participant refers to the difficulties he has been through in the past and uses mountains as a metaphor for obstacles he has overcome.

Week 2 – Safe places and self-directed art making. During the second week of treatment, the participants were asked to imagine a safe place and to recreate this safe place through art making. Some of the objectives of this activity were reducing arousal and increasing feelings of safety. One participant used pastels to draw a deserted tropical island (Figure 5). The participant has depicted himself fishing and there is a hammock and a small boat on the island. The sun is shining, and there are birds flying over head. The participant drew himself alone on the island but when discussing his art work he said that he would like to have included his son on the island as well. This gave the participant the opportunity to talk about how important his son was in terms of inspiring him to get better. His choice of representing a deserted island may also have been linked to feelings of isolation due to his PTSD and his dismissal from the military.

A second participant approached the task quite differently. This participant drew a tropical island as had the other participant, but he drew his safe place inside of an actual safe (Figure 6). He drew himself standing next to the safe holding the key. When talking about his art work, the participant described his inability to feel safe anywhere after having experienced his trauma. As a group, the participants talked about the hypervigilance they all experience as a result of their time in combat. One of the other participants in the group pointed out that the shadow of the figure in the picture did not have the key to the safe. The participant who created the drawing said that there are times, after experiencing trauma, when you feel you cannot even trust yourself. The

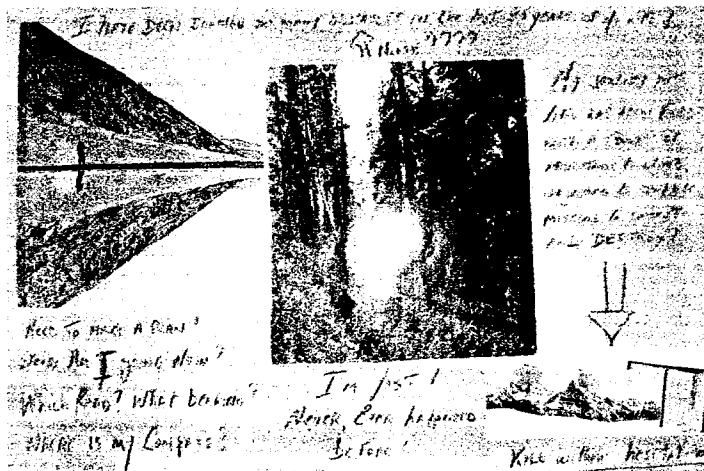


Figure 4



Figure 5

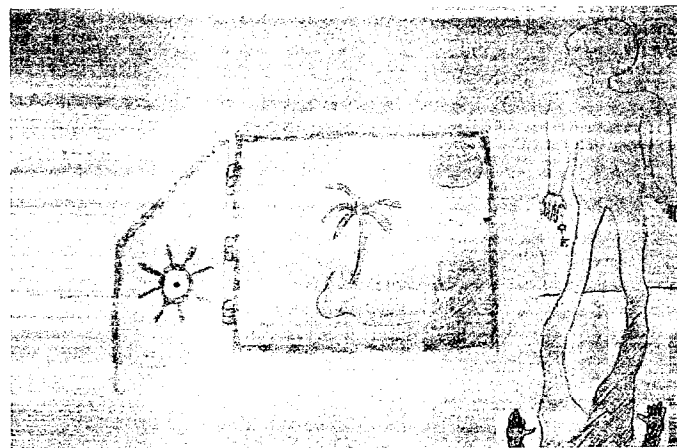


Figure 6

shadow therefore symbolized the side of the participant that he did not trust with the key to his “safe” place.

The second session of week two was left open for the participants to explore the topic and medium of their choice. Reasons for having a non-directive session at this point included: seeing if the participant were able to work in a self-directed way, encouraging the participants to take initiative, and showing the participants that I had confidence in their abilities to make their own choices. One participant chose to try painting for the first time in the group and created a powerful image of resilience (Figure 7). In his image a small new growth is flourishing despite being surrounded by large trees, which partially block out the sun. The participant was very invested in this art work. He continued work on it in the following session in order to finish up the painting and add the phrase “*La vie triomphe toujours!*” or “Life always triumphs!”

Another participant also tried paint this session and combined it with collage to create a mountain scene (Figure 8). The participant used the mountain as a metaphor for the obstacles he has faced in the past. Each mountain peak represents a different year and a different obstacle the participant had surmounted. When the participant described this art work he talked about the feeling of free falling that he had felt when his symptoms of PTSD became out of control. By reaching out and accepting help, the client described no longer feeling like he was falling. In the top right corner of the page a mountain labelled with the current year reaches higher than the top edge of the paper, suggesting that the participant sees his struggle with PTSD to be the highest mountain that he will tackle.



La Vie Triomphe Toujours!

Figure 7



Figure 8

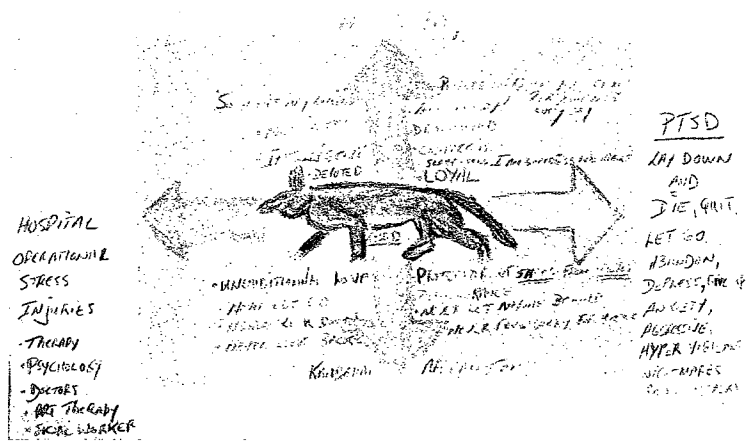


Figure 9

Week 3 – Animals and fear. During the third week of treatment participants were asked to create an art work of an animal as a metaphor for the self. Reasons for this directive included introducing the participants to the use of metaphor, increasing self-awareness and identifying personal strengths. One participant chose to depict a German shepherd dog (Figure 9). The participant had worked closely with these types of dogs in the past and listed the many positive qualities he associated with these dogs including intelligent, loyal, protective, and loving. The participant also used this art work to explore the choices he had faced when he decided to seek treatment. He used different coloured arrows to point to the different choices. Two red arrows point to the choice of returning to Afghanistan or Iraq, a yellow arrow points to the choice of “lay down and die”, and a green arrow points forward to the choice of entering the treatment program. The participant has incorporated a lot of writing into this art work, which may reflect his need to represent his reality in concrete terms.

The focus of the second session of this week was on fear. The objectives of this session were to externalise and contain fearful images, and normalize feelings of fear by sharing them in a supportive peer context. The group participants were asked to explore a fear they had if they felt comfortable doing so. One participant used collage, drawing, and writing to represent his feeling of safety being in the hospital and his fear of being alone (Figure 10). In the same image he also represented his hope to meet someone who would love and understand him, as well as his desire to spend more time with his son. The participant was anxious during the session and ended up leaving the group before the discussion period. It may have been too soon for the participant to feel comfortable addressing the theme of fear in the group. An individual session was scheduled with the

participant in order to find out if something about the group session had felt unsafe to him and to give him the opportunity to talk about how he had been feeling and describe his art work.

Another participant decided to use plasticine and created an explosive device (Figure 11). He placed an eyeball on top of the explosives. He also created a detonator and used construction paper to create the illusion of an explosion. When the participant discussed his art work, he talked about the sense of security one feels when the power is on their side and how quickly security can turn to fear when there is a shift and suddenly the power is on the other side. The participant also talked about the need for balance in power because having too much power can be as dangerous as having too little.

Week 4 – Avoidance vs. connection. The theme for the fourth week was avoidance vs. connection. The purpose of this theme was to reduce avoidant symptoms such as emotional numbing. The objective of the first session was exploring avoidant strategies. In the first session, one participant used drawing to symbolically represent the way she avoids her emotions (Figure 12). She drew a jail cell inside which she represented all the emotions she keeps locked up: anger, sadness, happiness, shame, hope, anxiety, fear, pain, and frustration. Beside the cell the participant drew a representation of herself, pushing her emotions and memories away. The participant also included another representation of herself, this one wearing balls and chains to demonstrate how she has become a prisoner of her avoidance. In the top left corner of the page an image that reminded the participant of her difficult experiences in Haiti serves as a reminder of the things she is trying to avoid. The participant also drew a “to do list” in order to show how she uses activities and routine in order to avoid addressing her emotions. In the

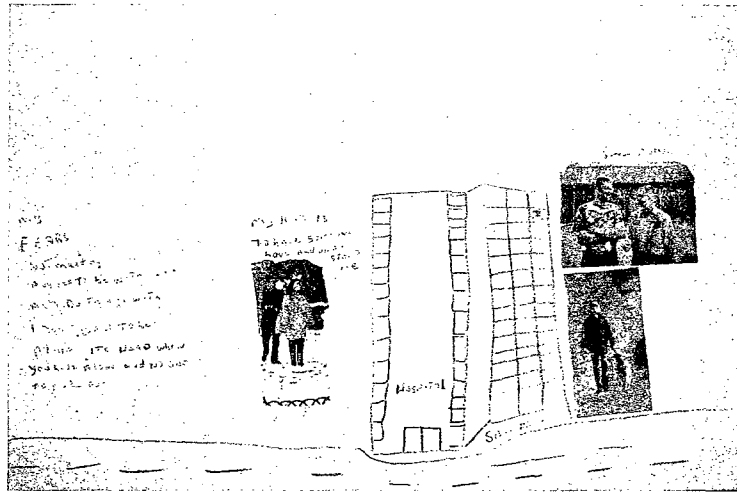


Figure 10

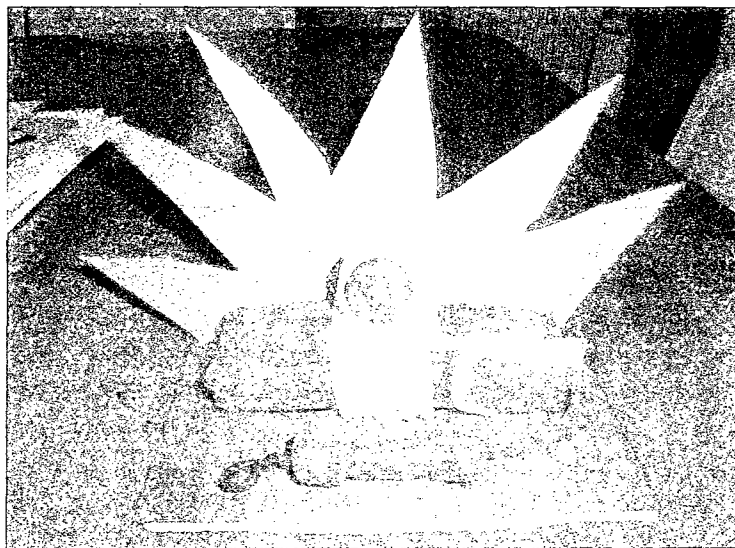


Figure 11

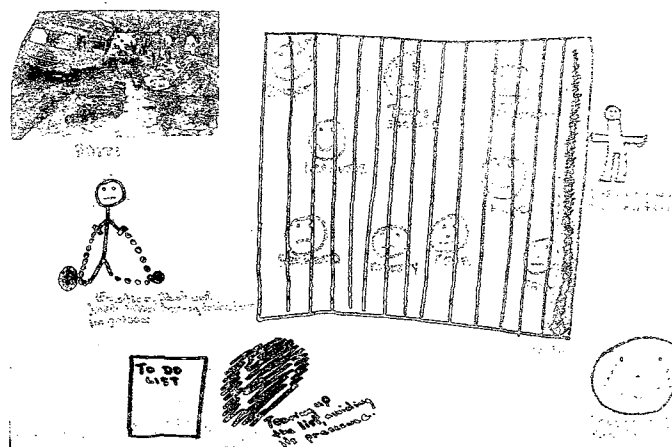


Figure 12

bottom right corner of the art work an image of a face, which is smiling and crying at the same time, represents the participant's desire to be able to accept her emotions.

Another participant, who was participating in the group for the first time this week made a drawing of a clown (Figure 13). The clown has a large red smile but under the smile, less noticeable, is a frown. The participant described the way he uses humour to avoid his emotions. The participant used humour throughout the session, joking constantly with the other group members. The participant appeared to be quite aware of his strategy of avoidance, but was not yet ready to let it go. The fact that this was the participants first session in the art therapy group may have increased his level of discomfort and therefore also increased his need to use humour.

In the second session of the fourth week, participants were asked to think about one emotion, to connect with that emotion, and to explore that emotion using art making. One participant chose to explore the fear he felt in relation to a trauma he had experienced (Figure 14). The participant is represented by a figure in the middle of the page and is surrounded by questions and thoughts that accompanied his fear. Translated, some of these thoughts included "Where am I? Where are the others? I can't get out. I told my wife I would return". In the four corners of the page, the participant wrote four words, which he associated with his fear: fire, death, blood, and black. The experience the participant was referring to involved an explosion while the participant was on a deployment, which resulted in physical injuries and the death of several fellow soldiers. This was a very powerful image for the participant. Talking about his traumatic experience through his image appeared to make the disclosure of his feelings of fear more

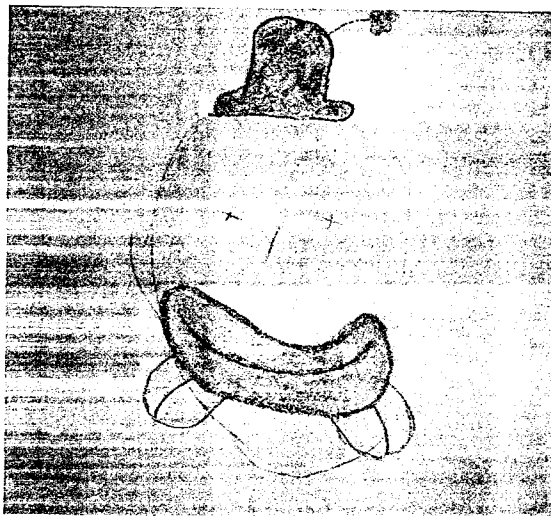


Figure 13

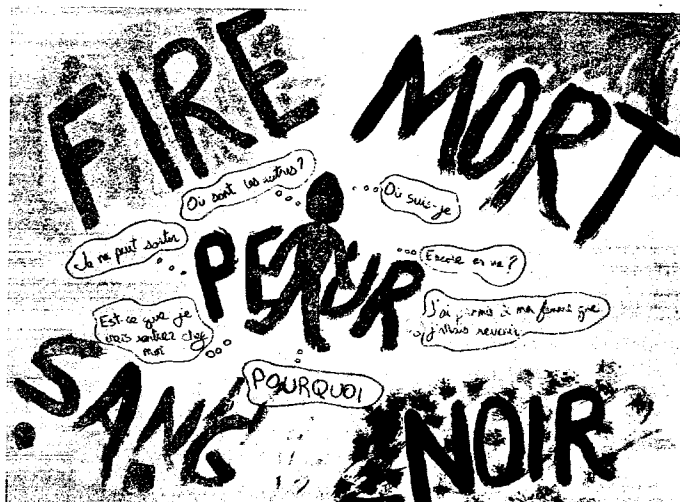


Figure 14

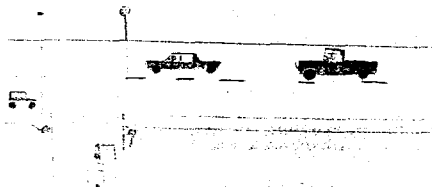


Figure 15

tolerable. The participant was supported by the non-judgemental witnessing of the other group members.

Another participant decided to focus on his anxiety (Figure 15). The participant used pencil crayon to draw a three way intersection with cars approaching from each direction. The participant described the hypervigilance he constantly feels, and how it causes him extreme anxiety when he comes across an intersection while walking. Both fear and anxiety were emotions that the whole group could connect with. The participants were able to support one another and discuss their emotions freely.

Week 5 – Shame vs. self-worth. The theme for the fifth week was shame vs. self-worth. The first session of the week focused on shame and the second session focused on self-worth. The objectives of this week included externalizing and exploring feelings of shame and increasing self-worth. During the first session one participant chose to work with collage to explore some of the shame he felt in relation to his experience of physical and mental abuse as a child (Figure 16). The top left image represents the participant as a child who is being abused and the image next to it represents his father walking away from him and his family. The image in the top right corner of the page represents the effects of the participant's shame eating away at him. On the lower half of the page, from left to right, are images representing the way the participant hid his shame behind a uniform, the "perfect storm" raging in the participant's head, and his feelings of shame finally spilling out.

During this session the participants were asked to share their art making with one other group member and then it was that other group member who presented the art work

and the description of the art work to the group. The participants agreed that discussing the art work with only one other person had made sharing their thoughts on this difficult topic more tolerable. Another reason for doing the sharing in this way was so that the participant who had made the art work would hear someone else telling his or her story, demonstrating to that person that they had really been heard. The participant described above had paired with another group member who had also experienced abuse in childhood, making such a difficult disclosure more tolerable and normalizing his feelings of shame.

Another participant decided to focus his art making on the shame or stigma that is associated with seeking help for mental health issues for this particular population (Figure 17). The participant described the stairs that led to the mental health services at one location where he was stationed. According to the participant, these stairs were nicknamed by soldiers as “the stairs of shame”. At the bottom of the stairs is a soldier who is saying “I am strong” but is also on his knees, possibly symbolising the participant’s ambivalent feelings about his need for treatment. The participant also included the figure of a child in his drawing; he included the image of the child because he felt that shame was not an emotion that comes naturally to children. Shame, he felt, is an emotion that we are taught to feel by others.

In the second half of the week the focus shifted to self-worth and I presented the group with a specific activity. Participants were asked to think about their personal strengths and characteristics of self-worth and invited to create a shield or a crest with symbols of these characteristics. I then showed them how to use printmaking techniques to create a stamp of their crest. One participant designed a crest with images of a cross, a



Figure 16

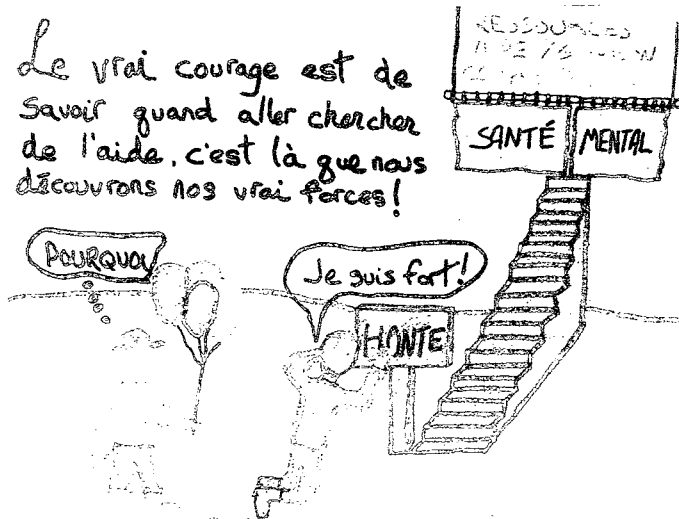


Figure 17

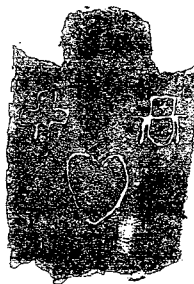


Figure 18

heart, and a nurse (Figure 18). The participant described these three images as symbolizing the strengths of being compassionate, loving, and caring. According to the participant, these are the three strengths that she truly believes she possesses.

One participant had a harder time completing this activity. This participant took almost 45 minutes before beginning to draw a small crest on a scrap of cardboard he took from a donut box (Figure 19). The participant's extreme difficulty getting started with this theme, combined with his use of a scrap of cardboard upon which to design his crest, suggests that his sense of self-worth was quite low at this point. However, the participant was able to identify four of his strengths, which included loyalty, vision, strength, and determination. The participant was also able to identify how these strengths had helped him to overcome obstacles in the past. The format of exploring self-worth through the creation of a crest or shield may have made this activity easier for some and more difficult for others due to the associations to military or family.

This session was the last session for one of the participants who had been in the group since week one. Termination of treatment for the participants of the stabilization program often happens with very short notice. I introduced a ritual for commemorating the departure of a group member. Each other member of the group and I created a postcard with an inspirational image or message for the participant to take with him when he left, and the departing participant made a postcard to be given to the next member of the group who leaves. The participant who was leaving the group appeared touched by the kind offerings of the other group members.

Week 6 – Hope. The theme of week six was hope. The objectives of exploring this theme included reawakening positive emotions, setting goals for the future, and encouraging resilience. During the first session of the week participants were asked to explore the theme of hope in any way. One participant, who was terminating treatment following this session, created a collage based on his hopes for the future (Figure 20). With this image the participant was able to express his desire to be a better father and spend more time with his children. He was also able to express hope for meeting a woman and engaging in pleasurable activities such as fishing and golfing. The participant included an image of a person being congratulated, which depicted the participant's desire to be acknowledged and congratulated by his friends and family for having completed his treatment program.

Another participant used collage to map the journey of moving from his difficulties in the past to his hopes for the future (Figure 21). The participant used arrows between the images to show the process of leaving the past, which is represented by an image of a person peering through a window, and heading towards a future filled with hope and freedom, represented by images of a horse and travel. The participant made use of an image of a turtle to symbolize moving through the slow process of recovery.

During the second session of this week, I suggested that participants use clay to create a symbol of hope. The specific use of clay was suggested in order to encourage the participants to explore different media. I gave each participant a square slab of clay, which they used as a base for creating a clay sculpture. One participant used his clay to create a sculpture of a hand (Figure 22). Onto his hand he carved the phrase “all you

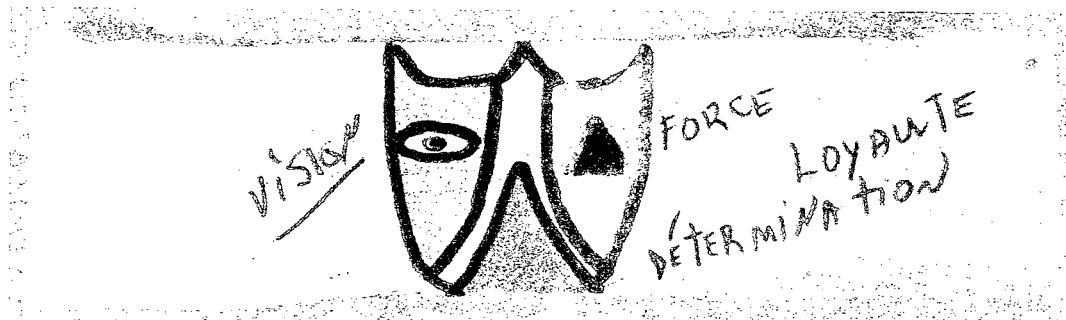


Figure 19



Figure 20

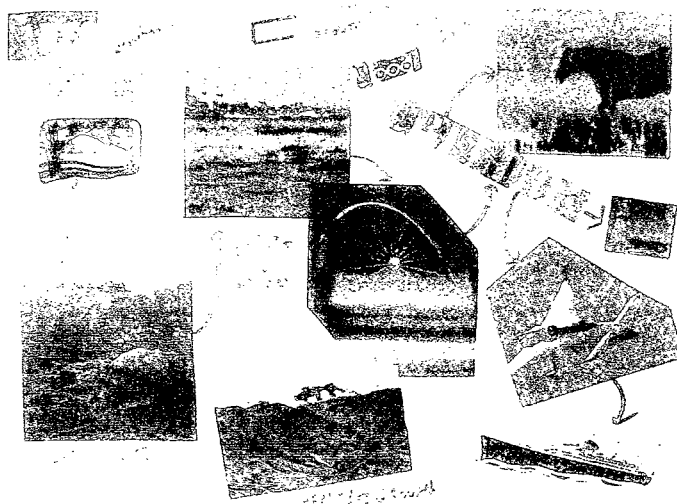


Figure 21

need is love". In discussing his art making, the participant described his sculpture as both the hand that reaches out for help and the hand that offers the help. The participant talked about the help he was receiving in the treatment program. This sculpture opened up a dialogue between group members on the importance of being able to both give and receive help and the courage it takes to ask for help. Another participant used her clay to create a sculpture of a candle (Figure 23). The participant discussed how light is a strong symbol of hope in her life.

Week 7 – Anger vs. tolerance and patience. The theme of this week was anger vs. tolerance and patience. This theme was introduced in order to give participants the opportunity to externalise and explore feelings of anger through art making. The participants were given the choice of how they wanted to explore this theme; they could explore anger, they could explore tolerance and patience, they could explore both or they could explore none. All participants decided to explore both aspects of the theme and all participants chose to work with collage.

One participant used different collage images to represent aspects of his anger, such as its impact, its unpredictability, and its effects on others (Figure 24). He included an image of a stop sign sticking out of a cliff horizontally and described this image in terms of the need to stop his feelings of anger from escalating too high. His collage ends with a positive image of open woods, which symbolized the patience and tolerance aspects of the theme.



Figure 22

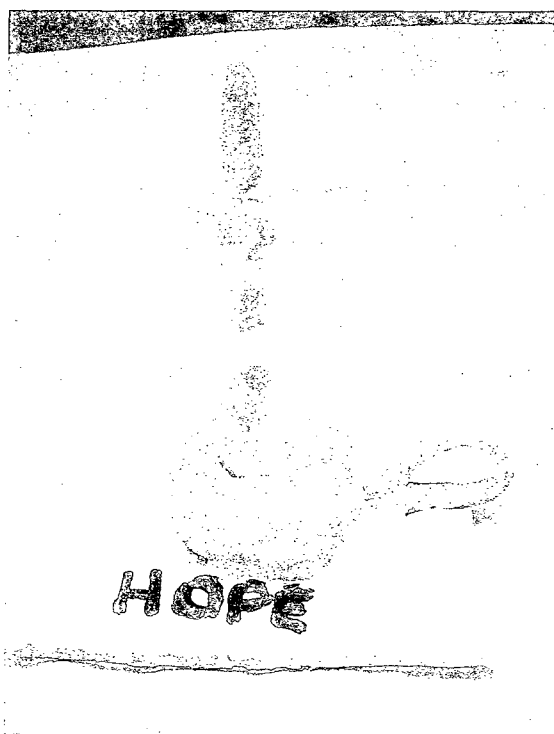


Figure 23

Another participant, after having already created a collage on the weekly theme, created a second collage (Figure 25). The participant was immediately drawn to an image of a half sheared sheep. She described it as representing how exposed and vulnerable she feels now that she is finally learning to express the emotions she has held inside for so long. Next to the cut out images she included faces and names of the emotions she is getting in touch with, including guilt, shame, anger, pain, sadness, and love.

I asked the group how they would like to use their second session this week and all participants agreed that they would like to continue to look at the continuum between anger and tolerance and patience. The participants expressed wanting to work on including more “positive” and less “negative” images in their next art works. This may have been partially due to shame about expressing their feelings of anger. A participant, whose art work in the previous session had focused mainly on anger, created a collage that began with images of anger but was mainly composed of more “positive” images (Figure 26). In this image the participant used only one third of the page to depict anger and the remaining two thirds of the collage were reserved for images relating to his treatment, his hopes for the future, and his self-acceptance.

I had placed the participants’ clay sculptures on the table before they arrived for this session because they were dry and ready to be painted. One participant, who had experienced a bad day, was uplifted when she saw her sculpture of a candle (Figure 23). The participant discussed how she had been focused on negative thoughts all day and



Figure 24

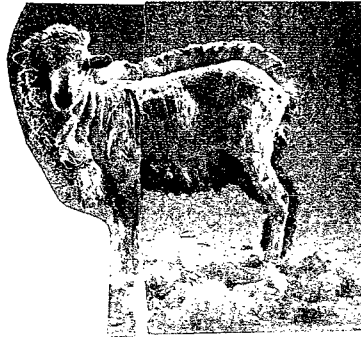


Figure 25

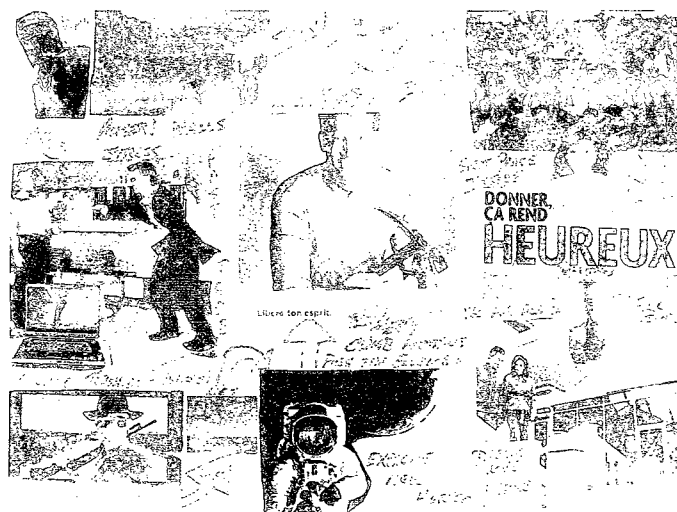


Figure 26

how seeing her sculpture was a sign for her to focus on the positive. The participant painted her sculpture and, when discussing the art work, once again expressed how seeing it had turned her day around. At the end of the session I allowed her to take her sculpture with her and she placed it in her room so that she could be reminded of hope whenever she saw it.

Week 8 – Feeling vs. numbing and running. During the first session of this week I proposed mask making as a way of addressing the theme of feeling vs. numbing and running. Mask making was introduced as a way to externalise and concretize avoidant strategies. As a group, we discussed masking emotions through anger and denial. Participants were given the option of creating a mask or working on the weekly theme in another way. The technique of using plaster strips on prefabricated mask moulds, which could be altered by adding plasticine, was demonstrated. I suggested to the participants that they could use the mask to represent aspects of themselves or a hero. Two of the four participants chose to create masks and used the two sessions this week to construct their masks. Two participants choose to explore the idea of the mask using other media.

One participant decided to work with the idea of the mask by creating a drawing in which he traced the shape of a mask repeatedly (Figure 27). The participant drew a mask-like face representing himself at different stages of life. He began in the bottom left corner by representing himself as a young infant. The participant had disclosed a history of childhood abuse in a previous session. The participant incorporated writing to describe the difficulties he faced at each stage of life. Color is used symbolically in this

drawing. Black represented negative influences penetrating and slowly taking over him. Red appears on the participant's forehead and spreads, representing different thoughts that the participant was struggling with at the various stages. Identity, shame, and needing to keep secrets come up in relation to his childhood and adolescence. After young adulthood the faces all begin to meld together and represent the chaos the participant has experienced. Red is predominant in this section of the image, and blue is used to represent the uniforms the participant wore. The participant talked about trying to make something of life in order to prove wrong a father who told him he would never amount to anything. The participant also described working excessively, feeling shame, stress, and a loss of ideals. In the upper right corner, the participant used the colors green and yellow to represent hope for the future. This art work took two sessions to complete.

Another participant worked in a similar way during the second session of the week. During the first session she had not been ready to deal with the idea of the mask. However, during the second session, the participant felt more comfortable exploring the "masks" she wears to hide her feelings. She was inspired by the work of another participant, and used a mask mould to trace ovals on a piece of paper (Figure 28). The participant painted each mask a different color to symbolize her emotions. From left to right, the different faces symbolized happiness, fear, anger, faith, hopelessness, sadness, trust, and hope. Only happiness is given a face because it is the emotion the participant uses to mask the other emotions that are more difficult for her to express.



Figure 27



Figure 28

Week 9 – Self vs. others. During this week the participants were asked to focus on the theme of self vs. others. The goals of this theme were increasing self awareness and self-esteem, and exploring perceptions of self and others. One participant worked with collage and represented different aspects of himself (Figure 29). On the left side of the page, the participant included images related to his military identity. On the right side of the image, the participant included images related to his civilian identity, which included his desire to travel, find romance, and engage in pleasurable activities. In the middle of the image, the participant has placed an image of a life preserver to symbolize the help he is getting in the treatment program.

Another participant decided to explore aspects of himself as well as aspects of how he believes to be perceived by others (Figure 30). On the left side of his image, the participant used an image of a crumbling tower to represent his present state of mind. The tower represents the walls the participant has built in the past and how they are starting to decay as he progresses through treatment. The participant expressed being ready to move on and leave this tower behind him. In the middle of his page, the participant has placed images related to how he believes others see him. The top image shows two penguins looking at a rabbit as it runs away, the middle image shows a man smoking and represents the participant's belief that others see him as someone who is on drugs, the lower image is of an owl twisting its head to the side and represents looking peculiar to others.

During the second session of this week, one participant who had been working on a mask project for the last two weeks decided to do a performance with his masks (Figure 31). The participant asked all of the other group members to help him to do his



Figure 29

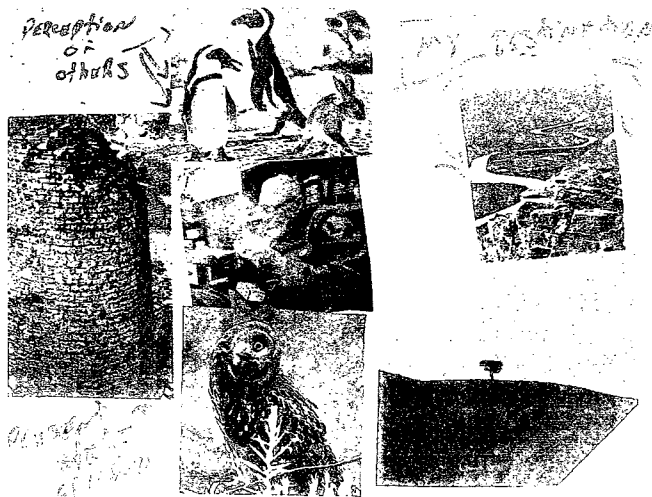


Figure 30



Figure 31

performance piece and the other group members agreed. Using a rather complex system of tubes, boxes, an air pump, his two masks, and the help of the other group members, the participant demonstrated how the pressure of the last few years became too much for him to bear. The participant placed the masks one on top of another. Air being pumped into a ball raised the masks and represented the negative events the participant had experienced. The participant held the masks down to symbolise the efforts he made to not let the experiences affect him. At one point the participant showed how he had no longer been able to stop these negative events from affecting him. Another participant helped him to hold the mask down and then eventually the participant removed the outer mask to reveal the inner mask representing his emotions such as anger and sadness. The participant expressed many emotions during his performance and it appeared to be a powerful experience for him and for the other group members as well.

Another participant painted his plaster mask this week (Figure 32). The participant painted the mask green with yellow and brown stripes. The eyes were also painted brown. While discussing his art making the participant said that the green background symbolised the army, the brown stripes symbolised the negative events of his past that are always with him, and the yellow stripes symbolised positivity and hope. The participant has painted the yellow and brown lines in equal width on his mask but he mentioned that some days the negative overwhelms the positive and vice versa. The eyes of the mask are painted brown as well, which may relate to the visual nature of the participant's traumatic memories. The participant noticed how the painting gave the mask a camouflage look and related this to some of the defences he has developed

following his difficult experiences. The green shows how the participant still sees the military as a large part of his identity.

This was the last session for one of the participants and he decided to create a special art work for each member of the group and for me. The art works were collages and contained some common elements as well as some images chosen specifically for each person. The art works show the high level of peer support and bonds that developed among the participants. One art work, presented as a gift to me included images relating to the way the participant saw art therapy to be beneficial (Figure 33). A statue of Terry Fox symbolised how each participant came to the group with an injury similar to missing a limb. Pieces of a map represented how art therapy had helped the participant to find his direction. The participant loves motorcycles and he included motorcycle images symbolising the journey ahead, making choices, and seeing the light at the end of the tunnel.

Week 10 – Grief and loss vs. new beginnings. This was the last week of art therapy sessions and the proposed theme of the week was grief and loss vs. new beginnings. In light of the fact that the group was ending this week, new beginnings were emphasised over grief and loss. Focussing on new beginnings aimed at addressing the termination of the art therapy group. It should be noted that the end of the art therapy group coincided with the end of one participant's stay in the treatment program; however, three other participants would continue treatment following the end of the group. The reason for termination of the group at this time was the end of the therapist's internship in art therapy.



Figure 32

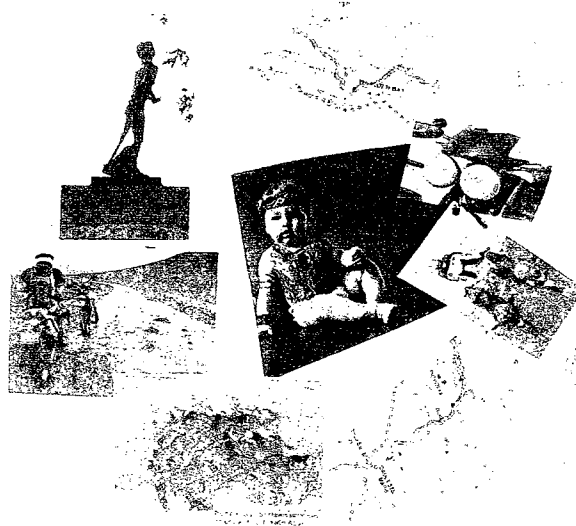


Figure 33



Figure 34

During the first session of the week one participant, who was relatively new to the group, made a painting of a traumatic scene he had witnessed while on a deployment (Figure 34). The participant had begun painting trees and his painting turned into a powerful scene of exploding bodies and birds flying down to eat the corpses. The participant had appeared ashamed of what he had drawn and offered to rip up the drawing. The participant and I decided that we should discuss his art making one-on-one. The participant described the scene, which was an image that intruded his thoughts at times. The participant said that he had not meant to paint it but that it had just come out. I reassured him that there was nothing wrong with what he had done and explained to him some of the benefits of externalising this type of imagery. I asked him how it felt to have made this image and he said that it had felt good to put the image on paper.

Another participant chose to explore his difficult past and his hopes for a new beginning by incorporating collage and writing (Figure 35). Three quarters of the collage images related to the participant's various traumatic military experiences. The final quarter of the collage images represented hope for a new beginning. In this section, images represented his desire to spend more time with his children, engage in pleasurable activities, and find romance.

During the final art therapy session, participants continued with the theme of new beginnings. One participant created a collage focusing on his desire to start a new career as an instructor (Figure 36). The participant expressed a desire to return to the military as someone who could use his years of knowledge and experience to teach young soldiers how to survive in a war zone. With this art work the participant shows how he has been able to transform his traumatic history into a strength that he can use to help others.

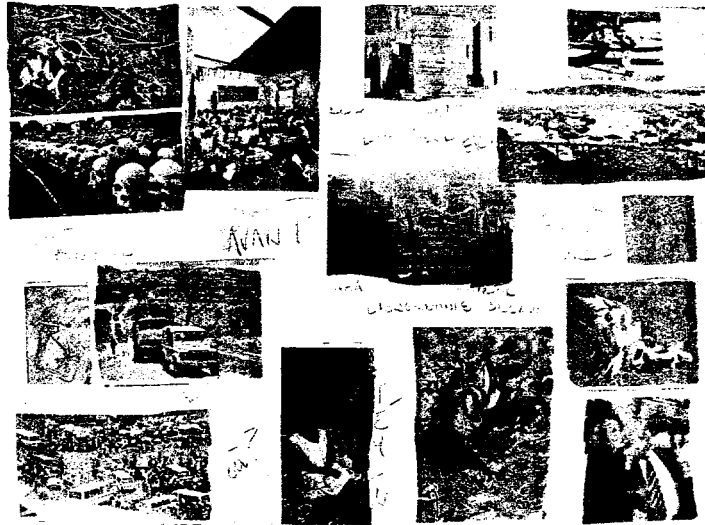


Figure 35



Figure 36

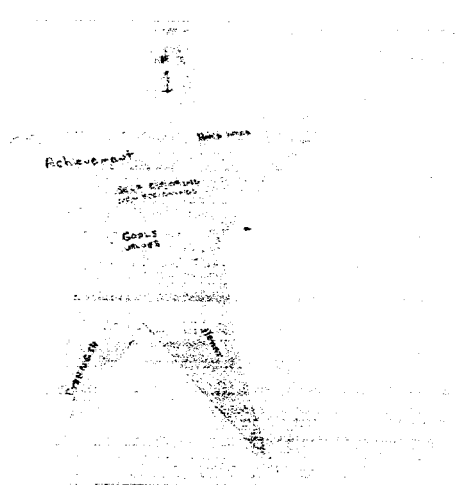


Figure 37

Another participant decided to draw a large star to symbolise her achievement of completing the treatment program (Figure 37). On the five peaks of the star the participant wrote the symbol #1 and the words “achievement”, “hard work”, “strength”, and “heart”. In the middle of the star the participant wrote the words “self exploring”, “new beginnings”, “goals”, and “values”. This art work demonstrates the participant’s increased sense of self-esteem and self-worth. It also demonstrates her understanding of her strengths and how they helped her to achieve her treatment goals.

During this session all of the participants and I made inspirational cards for each other. Through their cards to each other the participants were able to wish each other hope and success and express their gratitude for the support they had given each other over the course of the group. Through their cards to me they expressed appreciation for being given the opportunity to participate in the group and explore their issues and emotions in a new way. With my cards to the participants, I was able to describe the gains I had seen each participant make and I was able to express my profound gratitude for having the privilege of accompanying them on their journeys.

Behaviour Observation Forms

A behaviour rating form was filled out for each participant following each session resulting in 76 sets of ratings. Of these 76 ratings, 35 were filled out by the therapist and 41 were filled out by three different mental health nurses. The scores on the rating form were compiled in a spreadsheet. They range from 1 being the lowest to 5 being the highest. For each participant, an average score on each question was calculated. An average overall score for each session was compiled by taking the average of all scores

for all participants who took part in that session. These averages were used to evaluate if any participant was having trouble in a certain area or if a specific session or theme had been less engaging than others. Average scores were also examined to see if there were differences in the ratings given by the therapist versus ratings given by other raters. Average scores for each session ranged from 3.88 to 5. Table 1 shows the average score on each measure for each participant. It also shows the average overall scores for each participant and the average score for all participants for each measure.

Table 1

Average Behaviour Ratings

Behaviours	Participant							Average
	1	2	3	4	5	6	7	
Seemed interested in the group	4.7	4.2	4.8	4.6	4.5	4.5	3.5	4.5
Engaged in art making	4.6	4.9	4.2	4.9	4.4	4.5	3.5	4.5
Understood activity / theme	4.7	5.0	4.7	4.8	4.8	4.3	3.0	4.6
Participated in discussion	4.8	4.4	4.7	4.6	4.7	4.2	2.5	4.5
Shared emotions	4.4	4.2	4.9	4.7	4.3	4.2	2.8	4.4
Listened to others / showed empathy	4.8	4.4	4.1	4.7	4.3	4.0	3.8	4.4
Initiated positive interactions	4.8	4.2	4.0	4.5	4.3	4.5	3.0	4.4
Appeared to benefit from the session	4.4	4.1	4.1	4.8	4.1	4.2	3.3	4.3
Average overall score	4.6	4.4	4.4	4.7	4.4	4.3	3.2	

The results of these ratings are quite high and show that art therapy was a modality that engaged the participants. High scores may also be related to the subjectivity of the raters who were involved in the process and were not “neutral” observers. It should be noted that participant seven, who received the lowest scores, took part in only four sessions because he joined the group in the last two weeks. His scores increased with each session indicating that if he had been able to participate in more sessions his average

rating would probably have increased. It should also be noted that even though participation in the art therapy group was voluntary, attendance for sessions was 100%. All participants of both programs consented to participate in the group and all participants attended every session that was offered while they were present at the hospital. The only exception to this was one participant who left a session 20 minutes early due to anxiety.

Staff Comments

Four staff members responded to the request for staff feedback about the art therapy program. Two of the staff members were mental health nurses who had directly observed some of the art therapy sessions and had interacted with the participants immediately before and after the group sessions. Feedback was also provided by a social worker and an addictions counsellor who were providing group and individual interventions with some participants. These staff members had observed the process of art therapy indirectly by hearing about art therapy and seeing art works done by the participants in supervision and interdisciplinary team meetings. They had also learned about the participants' responses to art therapy through hearing participants talk about the art therapy group in their other treatment groups. Staff responses are organized according to the three questions asked. Two staff members answered the three questions specifically, while two others responded in paragraph form to all questions.

Program fit. This section summarizes staff feedback regarding the following question: How did art therapy fit into the overall treatment program? Several staff members commented on how well the art therapy group complemented the other treatment modalities offered. One staff member wrote "The art process can reinforce,

elaborate, and model concepts we try to achieve in other groups... ” and commented specifically on how participants spontaneously made connections between art works produced in art therapy and concepts learned in their mapping group. Another staff member suggested that art therapy provided a bonding experience between the participants of the two different programs.

Client reactions. This section summarizes staff feedback regarding the following question: How did clients react to the art therapy program? Staff members noted how much the participants appeared to enjoy and look forward to the art therapy program. One staff member wrote “I frequently heard clients express great enthusiasm for their art therapy class”. Another staff member noted how some participants were apprehensive about the first art therapy session because of a fear that they would be judged. The staff member noted that this usually changed after the first session as participants realized that it was “more about the therapy than the art”. A staff member who was present during many of the art therapy sessions commented on how respectful the participants were of one another during the sharing process and how they listened to each other without judgment. Two staff members commented that some participants were not ready to deal with certain emotions and had found certain themes difficult to explore. It was noted that some of these participants had difficulty sleeping or concentrating after particularly difficult sessions. It was also suggested that expressing these suppressed emotions sometimes had positive benefits. One staff member commented that some of the participants found the two hour sessions to be too long.

Overall impressions. This section summarizes staff feedback regarding the following question: What was your overall impression about the implementation of group art therapy in this context? All staff members noted the perceived positive impact that art therapy had on the participants. One staff member commented on how art therapy had been constructive and therapeutic and how it had a positive and direct impact on the participants. Another wrote “I had the opportunity to experience firsthand the benefits of art therapy to clients suffering from OSI”. One staff member noted that art therapy provided participants with a more personalized means of expression. Another staff member commented on how art therapy was unique in offering participants a different means to work through their difficulties; “It created an opportunity for clients to get in touch with their emotions and to express them in a concrete way... It should be noted that these clients often have difficulty or are reluctant to verbalize their emotions”. It was also noted that art therapy was a medium that allowed the participants to “reflect their emotions and events in their lives through art”. While writing about the process of art therapy, one staff member noted how the participants came to revelations and changes in their perceptions of self and others during the process of creating art. Finally, one staff member noted how art therapy “created a safe and non-judgmental environment for the clients”.

Discussion

All data accumulated, including the review of current literature in the field, was used in order to assess the progress made throughout art therapy, themes that emerged, the use of materials, and the appropriateness and potential benefits of providing group art therapy for veterans with PTSD participating in an interdisciplinary inpatient treatment program.

Overview of Group Progress

With the nature of the group as an open group, where participants joined and left the group at different stages, each participant progressed differently and at their own pace. Four of the seven group participants joined the group during the first three weeks. These first few weeks were a time when trust in both the group and in the process of art therapy was starting to develop. Activities at this time were focused on getting to know each other, introducing different ways of working, encouraging self-reflection and the use of metaphor, and building trust and the therapeutic alliance. Starting with the sixth session, activities began to focus on the weekly themes of the residential program. The participants were asked to reflect on various emotions and issues relating to how they are currently affected by their past traumas. Many of the participants had become comfortable with the process by this point and were developing their own styles and preferred mediums. During the last three weeks, many of the participants were more independent and while the weekly themes were still suggested, participants were given more control over how they wanted to use the sessions. Participants invested a lot in their

art making during these last weeks and the strong bonds that were developing between the group members became apparent when members were discharged and left the group.

Termination of participants in the stabilization program sometimes occurred with little advanced notice. Also, because participants were leaving the group at various intervals, it was important to find some way of addressing these terminations within the group. The ritual of creating inspirational postcards for terminating members of the group was introduced and carried out each time a participant left. The ritual helped both the therapist and the other members of the group in saying goodbye to the participant who was leaving. At the same time, the participant who was leaving was able to take home positive reminders of the group and leave behind his or her own inspirational message for the next participant to leave the group. Following their last session in art therapy, participants were given their art works to take home.

Emergent Themes

Art therapy provided participants with the opportunity to express a variety of symptoms, emotions, and feelings about treatment. Through art making, participants explored some of their current symptoms of PTSD. Symptoms expressed included intrusive thoughts or memories (Figure 2, 32 & 34), avoidance (Figures 12, 13, & 28), and anxiety and hypervigilance (Figures 6 & 15). Art therapy also facilitated the exploration and externalization of difficult emotions such as fear (Figure 11 & 14), shame (Figure 16), and anger (Figures 24 & 26). Art therapy gave participants the opportunity

to create positive images as well. One participant represented resilience (Figure 6), others expressed images of hope (Figures 19 & 20), and one represented her sense of achievement (Figure 37). Through these art works the participants were able express positive emotions, externalize and contain difficult emotions, and gain insight into their symptoms of PTSD.

Issues relating to the treatment process also came up in participants' art making. One participant explored the options he faced when he made the decision to seek treatment (Figure 9), another participant expressed the stigma associated with seeking help for mental health issues in the military (Figure 17), and another participant represented the simple gesture of reaching out a hand to ask for help (Figure 22). The hospital and the inpatient treatment program were represented in participants' images as a safe tower (Figure 10) and a life preserver (Figure 29). Pieces of a map were used to symbolize how art therapy had helped one participant to find his direction (Figure 33). Through art making the participants were able to express their appreciation for the treatment program and were also able to explore their decision to seek help for their PTSD.

Even though treatment in this context was not focused on processing trauma, it was normal that traumatic material arose during the process of art therapy (Figures 2, 14, 16, 27, 34, & 35). It was impossible for the participants to completely focus on their present symptoms and emotions without the traumatic events leading to these to also

arise. It was important to frame the participant's art works so that expressions of past trauma were acknowledged and validated but current issues and emotions were emphasized in verbal discussion. Focusing the discussion of art work on present experiences ensured that participants did not become distressed by hearing recounts of traumatic experiences by the other participants.

The Use of Materials

The participants experimented with painting, drawing, printmaking, sculpture, and mask making; however, magazine collage appeared to be the preferred medium for many of the group members. Collage may have been appealing to the participants because the use of pre-existing images was concrete and somewhat less threatening than creating new images. Using pre-existing images may have seemed less threatening to many of the participants, because art expression in art therapy was a new experience for them. Also, the demands involved in exploring trauma related issues and emotions may have been reduced by using pre-existing images. A variety of magazines and pre-cut images were available to the participants. Collage was used by the participants as a way of planning out their journeys, exploring the continuum or relationship between two extremes such as anger and tolerance, and organizing and reframing their thoughts. Magazine images, along with words and arrows were often used by participants as a way of creating a concrete visual map of their thought processes.

Drawing and painting often resulted in the expression of affective content.

Paintings and drawings were charged with both positive and negative affect and were also used to explore defences and feelings of safety. Sculpture was used rarely but when used produced highly symbolic art works. Printmaking and mask making techniques were introduced to show participants different ways of working and the art works produced with these techniques reflect the themes the participants were working on at the time they were introduced. Mask making naturally encouraged one participant to incorporate elements of performance in his art making.

Program Evaluation

Providing art therapy in a group format in this context had many benefits.

Participants were able to build strong social bonds and learn to rely on each other for support. Creating and sharing art works in the context of a supportive group allowed the participants to express emotions without being judged by others. Participants were also able to witness peers who were expressing emotions and difficulties similar to their own, which served to validate and normalize their own reactions.

Having an open group worked well in some aspects but may have hindered the process in other aspects. Often, participants coming to their first session were sceptical about the art therapy process. Many had not engaged in art making since childhood, and were not yet aware of how doing so might help them with their symptoms of PTSD. However, participants who were sceptical were more at ease with jumping into the process when they could see that their peers had already invested themselves in art

making. Current members of the group would sometimes show the new members of the group the art works they had created in order to show them examples of ways of working. This was not only beneficial for the new members, but also gave the old members a sense of pride and accomplishment, and sometimes provided a new perspective on what they had created. New members of the group often had little time to get comfortable with the group before they were asked to explore themes that may have been difficult for them to approach, which could be seen as a drawback of the open structure of the group. This may have been the case with a participant from the stabilization program who, as described above, left a session focused on fear early due to anxiety.

Providing art therapy to both the participants of the residential and stabilization programs together also had benefits and drawbacks. As noted by one staff member, the art therapy program offered an opportunity for bonding and socialization between the participants of the two programs. Also, because not many participants were admitted to either program, combining both programs resulted in a larger group and more opportunities to give and receive support from peers. The drawback of providing one art therapy group for both programs was the differences in the objectives established by the setting for the two programs. The participants in the stabilization program were admitted for adjustments to medication and stabilization of their symptoms, whereas participants in the residential program were ready to explore their underlying issues and emotions in more depth. Combining the two programs meant that a compromise between these two sets of objectives had to be made.

The focus on the themes of the residential program, during weeks four through ten, once again had benefits and drawbacks. For the participants of the residential program, focusing on the theme of the week meant that they could integrate and elaborate on issues that had come up in their other treatment groups. The themes were relevant to the objectives of the residential program, which included addressing emotions and underlying issues relating to their PTSD. For the participants of the stabilization program, some of the themes which focused on difficult emotions, such as shame, may have been difficult for the participants to explore. Participants in the stabilization program may benefit from a separate art therapy group with themes and activities more congruent with their treatment objectives.

Giving the participants increasing control over how they wanted to use the sessions worked well for several reasons. Giving them control over how to address the weekly themes ensured that no participant felt forced to explore a certain topic or emotion if they did not feel ready. Giving the participants this freedom also demonstrated that I had confidence in their abilities to decide what they were ready or not ready to explore. Including the participants in decisions on how to use the sessions also encouraged them to take more initiative and responsibility in the group; reducing their reliance on the therapist and increasing their reliance on themselves and the support of their peers.

The art therapy program appeared to compliment the other treatments offered in this interdisciplinary setting. Art therapy provided the participants with an alternative to verbal expression. The art therapy group also offered opportunities for peer support and bonding. Through art making the participants were able to integrate and come to a better understanding of the material learned in the other treatment modalities.

Limitations with regard to the therapeutic level of the art therapy program include the short term nature of the program and the focus on present issues rather than trauma processing. Treatment in this setting usually lasts between four and six weeks for participants of the stabilization program and up to eight weeks for participants of the residential program, which is a relatively short amount of time when compared to the chronic course of PTSD experienced by these individuals. However, the program prepares the participants for long term therapy on an outpatient basis, which may involve trauma processing.

Potential Benefits

Of the therapeutic mechanisms used in art therapy described in the literature review of this study, progressive symbolic exposure, externalization, cognitive restructuring, reactivation of positive emotion, and enhancement of emotional self-efficacy and self-esteem appeared to most benefit the group participants.

Progressive symbolic exposure involves addressing difficult material through the transformation of that material into symbolic forms and visual narratives. By means of

this therapeutic mechanism, participants were able to address certain issues and emotions, which may have been distressing to them, in a manner that made them less threatening and easier to tolerate. They were able to choose what they felt comfortable expressing, when, and with what art media, which gave them a sense of control over their lives. As mentioned in the discussion of emergent themes, difficult emotions and traumatic material were often transformed through the art process and media, into images the participants could use as a starting point for discussing these difficult issues in the context of the group.

Externalizing difficult issues and emotions by turning them into images made them more concrete for the participants. The art works served a containing function and helped the participants to distance themselves from difficult material. One way that this was done was by the externalization of avoidant tendencies into a mask or a painting of a mask, which served as a concrete external representation and fostered awareness.

Through art therapy, participants were able to work on cognitive restructuring. Mainly through the use of collage, the participants were able to identify distorted cognitions and explore and reframe their thoughts and their perceptions of self and others. Through the creation of emotionally laden art works, participants who considered themselves incapable of expressing emotions came to new understandings of themselves.

Art therapy appeared to reawaken positive emotions in the participants. Flattened or numbed affect are among the avoidant symptoms of PTSD. Through the creation of

art works, participants were able to express emotions such as hope. Finally, art therapy allowed participants to achieve greater emotional self-efficacy and self-esteem. By expressing emotions non-destructively and in a supportive atmosphere, participants were able to gain confidence in their abilities to communicate their emotions to others. Self-esteem was enhanced by focusing on positive strengths, and through the supporting and witnessing other group members with similar issues.

In the short term, art therapy did not appear to produce a reduction in arousal symptoms, in fact, some staff members noted that participants appeared more anxious after having explored difficult emotions in the group. However, it is possible to infer that exploring difficult topics in the group may lead to reduced arousal in the long term. Similarly, it was difficult to assess if art therapy had any impact on intrusive symptoms. Some participants disclosed having more nightmares after particularly difficult sessions but described an overall reduction in intrusive symptoms over the course of treatment. Overall reduction in intrusive symptoms was likely the result of all the treatment modalities offered to participants including changes in their medications.

The symptom cluster that the art therapy group appeared to have the most impact on was avoidant symptoms. As previously mentioned, avoidant symptoms can include avoidance of reminders of the event, loss of interest in pleasurable activities, flattened or numbed affect, feelings of detachment from the self or others, and a foreshortened sense of the future. Through the selection and inclusion of war-related images in their art

works, participants were able to address reminders of their traumatic events without becoming overwhelmed. In many art works, participants were able to express a desire to engage in pleasurable activities. Furthermore, participants began to look forward to art therapy sessions and expressed enjoyment of the social aspect of the group. Art therapy provided many opportunities for the participants to express and explore emotions visually and verbally. Discussing emotions in terms of what was represented in an art work appeared to make verbalizing emotions easier and more tolerable. By addressing personal material through art making, participants were able to reconnect with aspects of themselves. Through the creation of strong bonds, participants were able to feel connected to their peers. These strong bonds were highlighted in the personal cards the participants made for each other at the end of each participant's treatment.

Conclusions

Through this study, art therapy was shown to be a treatment modality that engaged veterans with PTSD and that the veterans looked forward to taking part in. Participants consistently engaged in art making and discussion, shared emotions, listened actively and showed empathy for one another, and initiated positive interactions during the art therapy group.

Through the process of creating and discussing art within a group of peers, the participants were able to open up and express important thoughts and emotions in an atmosphere of mutual support. The participants used art making to express some of their symptoms of PTSD, externalise difficult emotions, express positive emotions such as hope, and explore issues related to being in treatment. Participants were also able to use art making to organize and reframe thoughts and make plans for the future. The therapeutic mechanisms of progressive symbolic exposure, externalization, reactivation of positive emotion, cognitive restructuring, and enhancement of emotional self-efficacy and self-esteem all appeared to benefit the group participants. Art therapy appeared to be particularly useful in addressing avoidant symptoms of veterans with PTSD.

Group art therapy fit in well with an interdisciplinary approach because it offered an alternative to verbal expression. In the future, it is suggested that art therapy at this site be provided separately to participants of the stabilization and residential programs, which

would allow the art therapy sessions to be focused more specifically on the objectives of each program.

The art therapy literature shows that art therapy is a modality that has been used by many art therapists to treat various types of individuals experiencing PTSD. Although the use of art therapy with this type of population has shown promising results, a lack of empirical evidence stops art therapy from being considered alongside other evidence based treatments for PTSD. This study was limited by its small sample size and by the use of a case study method, which does not allow for inferences of cause and effect. It is hoped, however, that this study will serve as a preliminary study for a larger scale outcome study on the efficacy of group art therapy with war veterans experiencing combat-related PTSD.

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Appendix A

Group Art Therapy Behavior Observations

Participant: _____

Date: _____

Observer: _____

Behavior	Low		Medium		High
Seemed interested in the group	1	2	3	4	5
Engaged in art making	1	2	3	4	5
Understood activity / theme	1	2	3	4	5
Participated in discussion	1	2	3	4	5
Shared emotions	1	2	3	4	5
Listened to others / showed empathy	1	2	3	4	5
Initiated positive interactions	1	2	3	4	5
Appeared to benefit from the session	1	2	3	4	5

Additional Observations: _____

Appendix B

CONSENT INFORMATION LETTER (*Art Therapy and Operational Stress Injuries: A Case Study*)

ART THERAPY STUDENT: Cheryl Miller
Concordia University
1455 De Maisonneuve Blvd. West
Montreal, Quebec, Canada H3G 1M8

RESEARCH SUPERVISOR: Josée Leclerc, PhD
Concordia University

BACKGROUND INFORMATION:

One of the ways art therapy students learn how to be art therapists is to write a research paper that includes case material and art work by clients they have worked with during their practicum. The purpose of doing this is to help them, as well as other students and art therapists who read the research paper, to increase their knowledge and skill in giving art therapy services to a variety of persons with different kinds of problems. The long-term goal is to be better able to help individuals who engage in art therapy in the future.

PERMISSION:

As a student in the Master's program in The Department of Creative Arts Therapies at Concordia University, I am asking you for permission to photograph your art work and include selected images in my research paper. I am also asking you for permission to include observations from our sessions in my research paper. A copy of the research paper will be bound and kept at the Concordia University Library, and another in the Department's Resource Room. This paper may also be presented in educational settings or published for educational purposes in the future. You may also request on the accompanying consent form that a summary of the findings of this research be sent to you.

CONFIDENTIALITY:

Because this information is of a personal nature, it is understood that your confidentiality will be respected in every way possible. Neither your name nor any other identifying information will appear in the research paper or on your art work.

ADVANTAGES AND DISADVANTAGES TO YOUR CONSENT:

To my knowledge, this permission will not cause you any personal inconvenience or advantages. Whether or not you give your consent will have no effect on your involvement in art therapy or any other aspect of your treatment. You may withdraw your consent at any time before the research paper is completed without giving any explanation. To do this, or if you have any questions about this research study, you may contact my research supervisor Josée Leclerc, at (514)848-2424 x4795.

Appendix C

CONSENT TO PARTICIPATE IN RESEARCH

(Art Therapy and Operational Stress Injuries: A Case Study)

This is to state that I have read the accompanying information letter, and I agree to participate in a program of research being conducted by Cheryl Miller of The Department of Creative Arts Therapies of Concordia University (cheryl.miller@vac-acc.gc.ca).

A. PURPOSE

I have been informed that the purpose of this research is to increase the knowledge and skill in providing art therapy services to persons who have experienced operational stress injuries. The long-term goal is to be better able to help individuals who engage in art therapy in the future.

B. PROCEDURES

I understand that group art therapy sessions will be offered twice a week as a part of my treatment. I understand that my art work will be photographed and that selected images and case material will appear in the research paper. I understand that neither my name nor any other identifying information will appear anywhere in the paper.

C. RISKS AND BENEFITS

I understand that to the best of the researcher's knowledge, this permission will not cause me any personal inconvenience or advantages. I understand that whether or not I give my consent will have no effect on my involvement in art therapy or any other aspect of my treatment.

D. CONDITIONS OF PARTICIPATION

- I understand that I am free to withdraw my consent and discontinue my participation at anytime without negative consequences.
- I understand that my participation in this study is CONFIDENTIAL.
- I understand that the data from this study may be published.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

NAME (please print) _____

SIGNATURE _____

I would like a summary of the results of this study to be sent to me at the following address.

If at any time you have questions about the proposed research, please contact the study's Research Supervisor, Josée Leclerc, PhD, The Department of Creative Arts Therapies, Concordia University, at (514)848-2424 x4795 or by email at jleclerc@alcor.concordia.ca

If at any time you have questions about your rights as a research participant, please contact the Research Ethics and Compliance Advisor, Concordia University, Dr. Brigitte Des Rosiers, at (514) 848-2424 x7481 or by email at bdesrosi@alcor.concordia.ca