Voicing the Body

Abha Singh

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By: **Abha Singh**

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Signed by the final examining committee:

_____ Chair
Dr. R. Richman Kenneally

_____ External Examiner
Dr. T.J. Measham

_____ External to Program
Mr. L. Peterson

_____ Examiner
Dr. G. Mahrouse

_____ Examiner
Dr. R. Reilly

_____ Thesis Supervisor
Dr. J. Guzder

Approved by _____
Dr. E. Manning, Graduate Program Director

August 14, 2013

_____
Dr. J. Locke, Interim Dean, Faculty of Arts and Science

ABSTRACT

Voicing the Body

Abha Singh, Ph.D.

Concordia University, 2013

This qualitative narrative research explores the in-depth clinical cases of three young Hindu South Asian Indian immigrant women (two Indian Hindu, Punjabi and one Indian Hindu, Gujarati) living in a shelter for domestic violence in Canada, using a culturally modified clinical art therapy modality as part of their therapeutic process. These traumatized women of a different cultural/ethnic background from the host Canadian culture, originate from a society where mental health issues are highly stigmatized. Resistance to seek help outside of the extended family system or outside of the community is often an obstacle to seeking treatment. While the incidence of trauma is high in the South Asian community, modalities of treatment are limited. A clinical art therapy protocol developed for this research uses a 12 week program of individual audio-recorded sessions over a five month period, with a therapist of the same cultural/ethnic background as the women. These women are pre-diagnosed by mental health professionals and exhibit distinct symptoms of harm which manifest in three self-harming categories: superficial self-harm, somatization, and self-defined negative body images. The internalized issues of these women are examined. Furthermore, the use of art therapy as another route to embodiment and changes to the self in a bicultural predicament are also explored. Focus is given to the challenges of culture and traditions in treating this

particular group. Theoretical literature is reviewed, and the personal meanings the women gained from the art process and the images produced from it are examined. A projective drawing test - the draw-a-person assessment tool was used to interpret self-perceptions, and a questionnaire-based interview at the end of the study was utilized and analyzed to address functioning and symptoms to support this research.

The results of this research pilot project indicate that the act of creating art in the context of clinical art therapy helped inform and transform the participant's traumatic experiences and re-engaged their coping strategies. By representing their trauma(s) as symbolic creations in the artwork(s), the women gained awareness of their feelings, thoughts, emotions, and symptoms of suffering. The creative process helped facilitate the emergence of insight into their traumatic experience(s) and healing on both a conscious and unconscious level and through verbal and non-verbal communication. The clinical art therapy modality provided detailed explanations on the women's internalizations and traumas; association between cumulative trauma and embodiment issues; the significance of culture and changes gained through art therapy. This clinical art therapy modality contributes to the trauma treatment of women who are the victims of violence and can be applied across cultural communities.

More specifically, in the description of their experience and response to domestic violence and to the art they have created, an awareness of art as a healing process in their recovery might be elicited.

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Chapter 1. Introduction

This research is unique in that it is a study that helps therapists to understand what facilitates and hinders the recovery process of three abused Hindu South Asian Indian immigrant women. The process of recovery involves more than the treatment of one's traumatic experiences. Although trauma symptoms can be debilitating and persistent, ethnic match of the client/therapist, and the integration of a holistic approach focusing on the participant's culture and traditions, to fully embrace the participant's world views are of importance during treatment. The participants of this research provide a perspective on the role of clinical art therapy treatment within the process of recovery. This study may provide a map for others to follow in the treatment of trauma in cultural communities.

Using a qualitative narrative research method, this study records three young Hindu South Asian Indian immigrant women's stories and follows their perceptions, feelings, and thoughts about their traumas in the context of art therapy within the shelter environment where they reside. More specifically, in the description of their experience and response to domestic violence and to the art they have created, an awareness of art as a healing process in their recovery is elicited. The three women participating in this study have been pre-diagnosed by mental-health professionals with a history of some or all of the following symptoms: engaging in superficial self-harm, somatization, self defined negative body image, and post-traumatic stress disorder.

Although services identifing with the needs of South Asian women in distress are available, they do not use a mental health approach such as the art therapy program in this research. An art therapy program enabling participants to discover if and how the act of creating art in the context of art therapy informs and transforms experience, and

recognize how the body is used to diffuse feelings of discomfort is implemented in this research. In addition to examining the insight gained through art therapy, this research also investigates the ways in which art therapy re-engages a traumatized individual's coping strategies and capacity to symbolize as part of the recovery process (Appleton, 2001; Francis, Kaiser & Deaver, 2003; Malchiodi, 1999; Naumberg, 1966). This research further illustrates the compatibility of ethnic match between the therapist and client in an attempt to facilitate the therapeutic process. Finally, a focus is placed on personal narrative and art therapy as a useful approach to psychosocial support for immigrant women who experience domestic violence and psychological distress expressed through body traumas (Haddon, 1989; Herman, 1992; Lagorio, 1989; Lawson, 2003; Van der Kolk & Van der Hart, 1991; Wadeson, 1980). Psychological distress can be experienced as a result of specific stressors that individuals are unable to cope with, feelings of distress and changes in emotional states (Ridner, 2004).

The benefits of the art therapy project are briefly described as follows:

- The participants are being offered a reflective space for what they are internalizing and to work through the trauma they have experienced.
- Through participation in a 12 week art therapy program, the participants will be given the opportunity to develop their own internal reflective capacity and gain increased perspective on their own challenging situations.
- The participants of this project will be provided with the experience of a creative process involved in artistic self-expression enabling them to resolve conflicts and problems, to develop interpersonal skills, reduce stress, increase self-esteem and self-awareness and to achieve insight. The art therapy tasks can help the

participants visually express emotions and fears that they cannot express through conventional means and can give them some sense of control over these feelings.

- In the context of disseminating these voices that have been silenced, the project may create tremendous opportunities for empathy and giving the participants a voice through there stories. Therefore, the women's narratives may first be brought to South Asian communities and then into the wider community such as women's centers and neighborhood health clinics. Community centers that have an immigrant population base may benefit as part of a program promoting collective accountability for creating equal and healthy relationships and promoting a zero-tolerance response within communities to violence against women.
- The project can help to identify how clinical art therapy as a mental health profession promotes creative processes and the verbal/non-verbal communication process of art making to improve and enhance the mental and emotional well-being of participants who have experienced domestic violence in a shelter setting.

The artwork of immigrant women has been analyzed and interpreted by clinical art therapists (Campanelli, 1991; Dokter, 1998), and the experience of immigrant women with a history of domestic violence has been studied by several researchers (Abraham, 1995; Das Dasgupta, 2000). However, the study of Hindu South Asian Indian immigrant women exhibiting distinct symptoms of self-harming behaviours and art therapy as a treatment modality does not exist in Canada, as the following will demonstrate. In Canada, within the existing research on the prevalence of domestic violence in South Asian communities and mental health, there are no large scale studies (Choksi, Desai,

Adamali, 2010). Existing research mainly focuses on studies originating from the United Kingdom and the United States of America. However, evidence of domestic violence from Canadian women's shelters, organizations and media exposure of abuse within Canada, indicate domestic violence is a concern in the South Asian Indian community (Choksi, Desai, Adamali, 2010). Because of a culture of silencing, there is a paucity of evidence based studies of this. As an adjunct, there has been little development of treatment modalities, such as the work of Jack and Ali (2010), and Davar (1995). Jack and Ali (2010) focus on the "silencing the self theory" that highlights the negative psychological effects that occurs when individuals silence themselves in close relationships and the significance of the social context in precipitating depression, while Davar (1995) analyzes mental illness in Indian women from a gender perspective. Their studies address the specific background and needs of women from this part of the world. A problem cannot be addressed if it is not perceived to exist.

Seeking mental health services poses a problem for some members of the South Asian community. A culture of "silencing" the problems is prevalent. Conflicts and problems are kept within the family; there is a fear that in seeking help, the family is dishonoured (Grewal, Bottorff & Hilton, 2005; Guzder, 2011; Kumar & Nevid, 2010).

Matching an art therapist of the same culture to the Hindu South Asian Indian immigrant participants of this research may perhaps permit a more trusting atmosphere, in a situation where trust is essential to achieve progress in therapy. Additionally, there seems to be a cultural safety when dealing with another person, particularly a woman, of the same culture. Customs and values are given to be understood; there is less fear of judgment of family or religious traditions, as would possibly be perceived to be the case

with a non-South Asian therapist (Inman & Yeh, 2007; Shin, Chow, Camacho-Gonsalves, Levy, Allen, Leff, 2005). The cultural impasse is addressed in the therapeutic space of the art therapy modality, partly because of the background of the therapist (Guzder, 2011; Hussain & Cochrane, 2004) and partly because art therapy offers a less threatening access to the female body and mind (Jacobson, 1994; Rubin, 1987, 1999).

An anecdotal examination of the effects of art therapy on the recovery of three Hindu South Asian Indian immigrant women who are coping with domestic violence and displaying symptoms of embodiment can provide a useful perspective and add to the significant gap in the current literature. It can offer suggestions in treatment approaches for social services and mental health services working with immigrant populations and trauma. By recording the words and perceptions in the context of Hindu South Asian Indian women's cultural beliefs and immigrant experiences using an in-depth multiple case study design, this research can illuminate the role of art therapy in their recovery and cultural resistances.

In order to address my research questions, it is helpful to examine the work of others to demonstrate where my research fits in with the body of work already created around the elements of my own study. The theoretical literature surrounding domestic violence and the South Asian Indian population provides insight and points of discussion that permit the study to probe deeper into these issues as they apply to Hindu South Asian Indian immigrant women who experience domestic violence in their adopted country and to discover a therapeutic approach that is informed by scholarly research (Lagorio, 1989; Malchiodi, 1999, 2003, 2007; Rubin, 1987, 1999, 2005).

This research briefly describes domestic violence and the context of Hindu South Asian Indian immigrant women, and its relevance to this study. Second, it presents art therapy as a mental health approach that utilizes the creative process of making art to improve and enhance the physical, mental and emotional well-being of the participants and describes how the body responds to abusive physical and psychological experiences. This response is manifest in how the Hindu South Asian Indian immigrant women of this research internalize distress and how it is expressed through the phenomena of embodiment. Embodiment is a strategy that seems most appropriate when other methods of communication are restricted or impossible (Lawson, 2003) and this is particularly true for the participants in this study. Embodiment can be classified into three types: superficial self-harming behaviours (Favazza, 1987, 1998; Milia, 2000), somatization (Moore & Jefferson, 1996), and self-defined negative body image (Walker; 1984). Third, a section describing the methodology is provided; next three in-depth descriptive clinical case studies supported by the women's art illustrations and an analysis of the case studies are given. Fourth, the findings are presented, followed by the discussion and conclusion(s) of this study.

For some Hindu South Asian Indian women there are several causes of psychological distress that have been attributed to stressors such as family obligations, cultural responsibilities, and marriage pressures (Das Dasgupta, 2000; Goel, 2005; Inman, 2006; Srinivasin, 2001). Stressful life events may require women to encompass multiple roles with many responsibilities, such as caring for their immediate and extended families, upholding the values and norms of cultural traditions, and the adherence to both familial and societal expectations (Tewary, 2005; World Health

Organization [WHO], 2000). As a result of these pressures and others (socio-cultural factors such as family conflicts and acculturation) there remains a strong impact on mental health (Ahmed, Mohan & Bhurga, 2007). Research has shown that domestic violence also exists and is a concern in the South Asian Indian community. Literature suggests that most South Asian Indian women remain silent about their abuse to maintain the dignity of their families, the structural homeostasis of patriarchy and to preserve their cultural practices (Natarajan, 2002; Raj & Silverman, 2002).

As a result, the family-oriented collectivist values and close-knit family structure ensure homeostasis, but providing stability and security may enable violence against South Asian women and thus cause a barrier to seeking outside help (Gill, 2004). According to Das Dasgupta (2000), when women are faced with domestic violence they are asked by their family/relatives not to leave their abusive husbands in order to maintain family honour. Speaking out or reporting incidents of domestic violence would bring shame on the family by association, which adds another layer of difficulty in coping with the violence that they experience (Bateman, Abesamis, Mendoza & Ho Asjoe, 2009; Bhattacharjee, 1992; Gill, 2004).

Additionally, there is significant under-reporting in this group as there is a cultural stigma associated with mental illness within the South Asian culture (Barnish, 2004; Conrad & Pacquiao, 2005; Kumar & Nevid, 2010). The display of any illness or emotional instability is considered an unfortunate reflection on the individual's family and is hidden from the community as a result of bringing shame to the family (Kumar & Nevid, 2010). These women have been culturally pressured to be accepting and silent in

the face of distressing circumstances (Hussain & Cochrane, 2004; Nestel, 2012; Sarin, 2006).

Many South Asian women who have immigrated to Canada are dealing with a need to observe the cultural norms of their society and bear the stress of migration, acculturation, and adaptation to a new country and different culture including the pressures of conforming to the norms of the host society (Abraham, 1995; Gill, 2004; Inman, 2007; Tewary, 2005). If the immigration experience also includes domestic violence some of these women decide to tolerate the burden for fear of a loss of family and community support (Gill, 2004; Masood, Okazaki & Takeuchi, 2009). However, for others who have attempted to break the silence of abuse and oppression, exposure to support programs may aid in the recovery process. Participating in the proposed clinical art therapy modality may enable these women to rebuild self-confidence and perhaps lead towards the formation of a new identity.

The importance and relevance of this research is highlighted by the deplorable violent act against a young woman in India, and Indian society's attitudes towards women and violence. This incident revealed the shocking prevalence of the community's outrage on brutality against women. The recent expressions of outrage have finally uncovered India's cultural sleep and the country's long history of denial as a strategy. The current protests by Indian men and women, against the culture of a highly gender-segregated society and gender violence in India, may be the beginning of a change to the perceptions and attitudes so deeply woven into the societal fabric, as the public demands an end to violence against women (Dutt, 2013).

Voicing the Body

While residing in Canada there is tension for the participants of this research as the country to which they belong, India, has a deeply rooted entrenched patriarchy and widespread misogyny which restricts women's choices and increases their vulnerability to violence. Women thus continue to be exposed to violence, discrimination, prejudice, and neglect throughout their lives (Bhattacharjee, 1992; Prashad, 2000). As in many countries, the balance of power remains within the control of a male dominated society perpetuating violence against women.

Violence against women across all ethnic groups is a serious concern in Canada. In 2010, it is reported approximately 102,500 victims of intimate partner violence including both spousal and dating. Sinha (2010) states:

> The risk of becoming a victim of police-reported family violence was more than twice as high for girls and women as it was for boys and men (407 per 100,000 versus 180 per 100,000). This heightened risk of family violence among girls and women was true regardless of age, but was most pronounced among those aged 25 to 34 years...The main factor behind females' increased risk of family violence is related to their higher representation as victims of spousal violence. Women aged 15 years and older accounted for 81% of all spousal violence victims. (Sinha, 2010, p. 13)

Ahmad, Driver, McNally and Stewart (2009) investigated South Asian immigrant women's experience of partner abuse. Their results indicated "that 67% of participants who were administered the Wife Abuse Screening Tool demonstrated stress in intimate relationships. Of these, 34.5% suffered emotional abuse, 24% endured physical abuse, and 17% were threatened with hitting by their domestic partners" (Ahmad et al., 2009, p. 614). In addition, Papp (2010) concludes fifteen honour killing incidents since 2002 in Canada. Ayyub (2000) notes that 1 in 4 South Asian women report incidents of domestic

violence within their homes. This suggests that domestic violence may be a common mental health problem faced by South Asian women (Almeida, 1996). A focus on the role of suicide points to South Asian women at higher risks of attempting suicide, "with prevalence ratios 1.6 times that of white women," while "young Asian women (under 30) are 2.5 times more likely to attempt suicide than white women" (Asian Women, Domestic Violence and Mental Health: A Toolkit for Health Professionals, [EACH] 2009, p. 25). Similarly, Ahmed, et al. (2007) found that South Asian Indian women were 2.5 times more likely to attempt suicide than white women as a result of socio-cultural problems.

The severity of physical, sexual, emotional, and financial abuse impact the devastating effects on South Asian women's self-esteem, as well as higher levels of depression and anxiety (Gill, 2004). As a result many South Asian women are at risk for Post-Traumatic Stress disorder. Additionally, a review of 43 studies found PTSD in up to 84% of South Asian women who experienced domestic violence (Jones & Unterstaller, 2001). Such responses are one outcome, but how culture modifies trauma responses within the South Asian Indian society where violence and abuse is rarely unacknowledged and silenced points toward subcontinent young women becoming more prone to suicide (Indian Women's Cultural Association, 2010) and to depression resulting in internalization and embodiment of trauma.

Chapter 2. Context for the Topic

Domestic Violence

Domestic violence occurs when a family member, partner, or ex-partner attempts to psychologically or physically harm or dominate the other partner (Abraham 2000a; Carlson, 1997; Schecter & Edleson, 1999). Similarly, several authors suggest that abuse often includes less noticeable signs and often involves emotional and/or sexual abuse combined with the use of physical violence or a partner physically, emotionally, or psychologically dominating the other person (Hays, Green, Orr, & Flowers 2007; McCoy, 2007; Plummer, 2007; Walker, 1994).

Violence against women is conventionally analyzed through examining the relation of heterosexual women and psychological and physical abuse perpetrated by men against women. The focus is placed on specific factors such as: a constant, systematic pattern of covert to overt abuse, one-sided use of power and control tactics (Abraham, 2000b; Douglas & McGregor, 2000; Loring 1994), and winning accomplished by demeaning, undermining, and changing the woman's perceptions, feelings, values, beliefs, body, and behaviours while establishing control over her movement and choices (Loring 1994; Walker, 1984).

Feminist researchers agree that domestic violence is used by men to exert control over their female partners (Walker, 1994). However, the feminist perspective emphasizes gender as a key factor in determining the experiences of women in society, power inequality, patriarchy and domination in society. They further acknowledge that such factors perpetuate a subordinate role for women (Brown, 2000; Goodman, 2000; Koss, 1990).

Manifestations of domestic violence.

Mental illnesses may develop in women who are witness to or experience traumatic events such as domestic violence. The causes and events of trauma differ in degree, circumstance, and complexity (West, Fernandez, Hillard, Schoof & Parks, 1990). In many such cases post-traumatic stress disorder (PTSD) may develop. Post-Traumatic Stress Syndrome (PTSD) has long term and devastating affects in the lives of women who experience domestic violence, and is the most common diagnosis by mental health professionals (Carlson, 1997; Crowell & Burgess, 1996; Paul, 2004).

According to the Diagnostic and Statistical Manual (APA) of Mental Disorders, 4th edition (DSM-IV), symptoms may include:

- Recurrent re-experiencing: The symptoms may be present immediately or a few days, weeks, months, or years after the trauma is experienced. Individuals may (re)experience disturbing dreams, recollections, or flashbacks of the traumatic event. Symptoms may also manifest as intense responses to either a symbol or an aspect of the event.
- Persistent avoidance: The avoidance symptoms may be directly associated with the event (bypass the place of the event or individual's involved) or forgetting important details of the event. As well, a limited range of emotional distancing, affect, apathy, or a diminished expectation for a normal future life may also occur.
- Increased arousal. The increased arousal may be experienced as sleep disturbances or deprivation, stress illnesses, memory loss, anger, lack of concentration, irritability, hyper vigilance, or a heightened startle response.

Individuals with PTSD may also experience co-morbid depression, substance abuse, or psychosomatic symptoms (American Psychiatric Association, 2005).

However, although the DSM-IV is the most widely used mental disorder diagnostic classification system, feminist critiques and feminist psychological practitioners perceive the DSM-IV as sexist, ethnocentric, and culture-bound (Worell, & Remer, 2002). They argue that certain aspects of the DSM-IV are based on a cultural bias. This critique is clarified by Worell and Remer (2002) in the following three sections:

- Focus on internal pathology: Developed as a medical model, the DSM-IV interprets distress as disease and disorder without considering any external contributing factors to the disorder. It further focuses the clinician on diagnosing internal pathology in individuals as it is limited in locating the cause of a problem to external stressors in diagnostic categories. Thus focusing on individual pathology with either limited or no consideration to a sexist or oppressive environment. As well, priorities regarding the ordering and sequencing are also criticized " 'the attitudes of psychotherapy clients, the meanings these clients give to their symptoms, and the social and historical context of their distress is marginalized in the process of diagnosis'" (p. 126). Further, the culture-bound syndromes in the DSM-IV are classified to originate from non-dominant groups indicating cultural influences do not pertain to the disorders of the dominant groups.
- Clinician bias: It is suggested that the therapist's diagnostic evaluations of the stressors and responses of the client/patient are based on the clinician's

interpretation. Thus, they are influenced by the clinician's theoretical orientation, values, and biases. Second, if stressors are misinterpreted based on such factors, or are ignored, it is likely the symptoms will be diagnosed as pathological.

- Use of trait descriptors: The DSM-IV manual consists of descriptors such as "'pervasive and excessive emotionality' and 'overly concerned with impressing others by their appearance'" thus, stereotyping women (p. 127).

In addition, a feminist critique has been provided on the prevalence rates and diagnostic categories in the DSM as they also differentiate between males and females, indicating women as more prone to illness (Worell, & Remer, 2002).

Feminist critiques view the PTSD criteria in the DSM-IV from two distinct perspectives. First, they support the PTSD criterions as it places the individual's problem to an external source, thus reducing stigmatization (Worell, & Remer, 2002). Second, they criticize this criterion for exclusions of specific areas such as complex trauma and trauma reactions, included only as an addition to the DSM-IV PTSD category as associated features and mental disorders (Worell, & Remer, 2002). Feminist practitioners explain this through the following examples; Repeated trauma (where the reactions of the individual is not included), or chronic trauma exposure (insidious trauma, which includes repeated, cumulative traumatic experiences such as sexism or racism), or a complex form of trauma (where trauma is repeated and continues as a result of "wife-battering" or "experiences of oppression") (p. 128). In addition, the authors note three additional limitations of PTSD. The first is recognized as the PTSD symptom criterion as not identifying all reactions that may be associated with trauma outcomes (self-blame and substance abuse). Excluding such symptoms from trauma experiences may result in

ineffective treatment preventing the individual from healing. Next, exposure to trauma and trauma reactions that are culturally influenced are not integrated into the diagnostic process. Therefore, diverse groups may not be treated appropriately as their cultural contexts are not considered. And third, an individual's reaction to external stressors, being labelled as a disorder in the individual. This is based on the PTSD diagnosis not acknowledging how socio-cultural factors "create and sustain violent acts against women and that blame women for their own victimization afterward" (Worell, & Remer, 2002, p. 129). Thus, it is important to consider all factors contributing to the mental health of women who have experienced violence. When relying on traditional western developed psychiatric symptoms and criteria to understand the participant's realities, it is crucial to incorporate a cultural formulation to the women's personal narratives illustrating their cultural traditions and beliefs of their suffering and symptoms.

Several mental health practitioners refer to the DSM-IV as a diagnostic classification as it acknowledges PTSD as an appropriate diagnosis for women who have experienced abuse as it integrates several psychological responses associated with violence and abuse (Carlson, 1997; Paul, 2004; Walker; 1994). However, although explanatory models of suffering and embodiment of symptoms (i.e. somatization) fit into the traditional DSM symptomology, they differ from culturally shaped metaphors and symptoms for South Asian Indian immigrant women.

When dealing with specific communities such as Hindu South Asian Indian women, it is crucial to not just consider clinical diagnosis but to also focus on factors such as those suggested by the feminist perspective. Recognizing and appreciating how the women of this research perceive, interpret and function within their worlds is

essential within the therapeutic treatment of Hindu South Asian Indian immigrant women. Contributing factors as such, relate to the women's experiences of traditions and violence which in turn may result in affecting one's mental health. If a holistic view of one's anxieties, distress, and suffering(s) are not understood, there is a risk of misdiagnosis and treatment may not be effective. Understanding the South Asian Indian culture and socio-cultural embedding is thus of significance.

South Asian Population: An Overview

South Asian Indian tradition. Although South Asians are comprised of different nationalities, they are regularly categorized into one ethnic group. South Asians consist of a very diverse population, including Indians, Pakistanis, Sri Lankans, and Bangladeshis. Their heritage is traced to India, Pakistan, Bangladesh, Nepal, Sri Lanka, Bhutan, Burma, and the Maldives (Nathan Kline Institute for Psychiatric Research, 2009; Raj & Silverman, 2002, 2003; Rehman, 2010). Each district has its own traditions, customs, and values based on the regions of the north, east, south, and west of India. Cultural expectations, dialects, religious symbols, clothing, food, music, and folklore, all differ. In addition, there remains a large diversity within the South Asian population with regards to religion, education, language, socioeconomic status and the caste system.

The Hindu caste system, prevalent throughout India, is a social hierarchy used to specify a group of people having a specific social rank. It is rooted in religion and based on a division of labour, and dictates an individual's social interactions and the type of occupations they may pursue (Aharon, 2012; Dowling, 2012). The caste system has four main classes (*varnas*) and is traditionally arranged in hierarchical order with a traditional occupation and status. The caste order is as follows: *Brahmans,* commonly identified

with priests and individuals engaged in scriptural education and teaching; *Kshatriyas,* associated with rulers, warriors, property owners; *Vaishyas*, engaged in commercial activity (i.e. businessmen); and *Shudras*, associated with the semi-skilled and unskilled labourers (Aharon, 2012; Ballhatchet, 1998; Dowling, 2012; Hutton, 1981). In addition to the four main classes there is a group that remains outside the varna scheme, known as the lower caste, *Harijan* (children of God) also referred to as *Parihas* and *Dalits.* This group is associated with jobs (such as toilet cleaning or garbage removal) as individuals from this caste are considered impure (Ushistory.org, 2013).

Discrimination on the basis of caste may be looked at as cultural, traditional and racial in nature that has developed over a period of time through both individual and collective experiences, opinions and prejudices of the Indian society. The Human Rights Watch (1999) note that women are commonly sexually and physically abused depending on the caste they belong to. Additionally, traditional South Asian families maintain old world values, and caste may still remain a consideration for marriage amongst certain families even today (Prashad, 2000; Sarin, 2006).

The Indian culture places an importance on arranged marriage, as it is a cultural element based on the women's heritage and familial background. An arranged marriage is a tradition in which parents propose and settle the marriage of their son or daughter within their specific caste and social status within the community. The marriage is considered to be a union of not only the couple, but one that unites both families. Traditionally, within the South Asian culture, a woman is considered to bring good fortune to her marriage and in-laws. She brings with her gifts from her family, is considered to be *Laxmi* (Goddess of wealth), and the ability to provide the family with

children (preferably male) who may carry the family's name into the future (Das & Kemp, 1997). Such gift giving is recognized as the Hindu *dowry system* in which the girl's family presents gifts or large sums of money to the son-in-law and his family. However, practices such as the *dowry system* have led to discrimination and violence against women.

Socio-cultural practices such as *the dowry system, sati, and the purdah system*; all contribute to the oppression of women while increasing their vulnerability and in fact maintain violence towards women. Many South Asian women's lives are comprised of several discriminatory practices embedded with traditions and customs passed on from generations (Psychosocial Care for Women in Shelter Homes, 2011).

Some women remain victims of "dowry harassment" and victims of violence as a result of the bride's family giving unsatisfactory or insufficient dowry to the groom's family (Sachdeva, 1998, p. 302). There remain several incidents of dowry related violent acts against women. Such acts include but are not limited to, bride burning, physical torture, and pressure tactics, by husbands and in-laws because they are unsatisfied with the received dowry (Sachdeva, 1998).

Sati, the act of self-immolation of a widow on her husband's funeral pyre is the most powerful form of wifely devotion. Not all women were required to commit *sati*, but those that did were praised and honoured as it is a practice that is known to transcend death (Narasimhan, 1990). As noted by Goel (2005), the power and fame for the Indian woman is achieved through loyalty to the traditional role, devotion and self-sacrifice rather than speaking one's mind and exercising self-expression.

Lewis, Dyck, and McLafferty (2012) describe the *purdah system* (or *ghoonghat,* veil covering) as a custom practiced to protect the dignity of women as well as a cultural practice confining women within the boundaries of their homes.Through the practice of *purdah/ghoonghat,* women are forced to communicate from behind a veil (Lewis et al., 2012) or the woman's *saree,* draped over the head and covering most of the face. Only the husband and children of the woman are able to see her face.

The *dowry system* enforces maltreatment as a consequence of not bringing sufficient amounts of money or gifts to one's husband and his family; *sati,* the act to commit suicide for the benefit of others, imposes the sacrifice of a woman's life; and the *purdah* system, although not a violent act encourages oppression. These are some of the worst forms of repression and abuse. Such practices are only a few examples demonstrating male dominance and female subservience, and violence against women within the South Asian culture. Although traditional practices as such have been abolished and are illegal, attitudes and behaviours of some members of this community have not. Some South Asian Indian women are still expected to adhere to oppressive traditions which are taught to women from childhood, as is the notion of *karma.*

The cultural concept to consider are the notions of re-incarnation, *karma, kismet*, and *dharma* as all being part of an individual's life. Re-incarnation is birth after life, in which an individual is re-born after death. *Karma* is described by Juthani (2001) as the belief that a person's status and destiny in their next life is influenced by how they lived their previous life. Their actions within the present life control what their next life entails. *Kismet*, one's fate, is the predetermination adding to the concept that an individual must agree to the challenges or inequalities of life (Sandhu & Malik, 2001). *Dharma* represents

the code of ethics an individual holds onto in order to achieve good *karma* (Juthani, 2001). *Karma* and *dharma* are both related to *kismet* as an individual's life circumstances and characteristics can be viewed as predestined and unchangeable yet open to improvement through conscientious loyalty to *dharma* (Juthani, 2001; Sandhu & Malik, 2001).

Myth and South Asian Indian immigrant women. Within the Hindu religion, the notion of karma exists amongst some individuals. Karma as suggested by Das Dasgupta (2000) provides insight as to why some South Asian women are not able to break away from their difficulties and choose to remain in abusive relationships − they believe they have engaged in wrongdoings in their previous lives. The concept of karma, then, can be seen as another layer in the gaze that silences these women and perpetuates their victimization within their families. South Asian women are supposed to follow a culture of silence in order to protect the traditional structure and values of the South Asian culture (Das Dasgupta, 2000).

As a result of the embodiment and sacred Hindu beliefs of the female body within the Asian subcontinent it is relevant to discuss the importance of such issues. Through traditional stories, women are taught to be the ideal wife and also how to endure adversity. Of pertinence to this topic is the spiritual epic in the Hindu scripture, the *Ramayana*. In this scripture of exemplars, Rama and Sita are perfect representations of the male and female figures. *Sita* is a depiction of the perfect wife "an archetype of a devoted and loyal woman who embodies the izzat of her husband, Rama, and his kingdom by virtue of her purity and piety" (Guzder, 2011, p. 598). *Sita's* strength lies in submission; without identity, power and represents the *pativrata* woman (husband

worshipper), who enters the flames of a funeral pyre, *Agni-Pariksha*, which means witness by fire, to attest to purity as a devoted wife and is almost completely defined in relation to her husband (Kinsley, 1988). Despite her efforts to prove herself as a pure and devoted wife, *Sita* suffers silently through many experienced injustices (Goel, 2005).

In the Sanskrit epic, the *Mahabharata* the character of *Savitri* is also portrayed as the dedicated, unselfish and loyal wife of *Satyavana* who is destined to live only one year after marriage. *Savitri* is portrayed as a loyal sacrificing wife who through perseverance, wisdom, and devotion, conquers death for her husband. Thus, once again the message given in this myth is that through the power of dedication, devotion, wisdom, and commitment to one's husband, a woman has the ability to conquer death, not for herself but for her husband (Nadkarni, 2003).

Finally, the goddess *Kali* (the archetypal mother) is the embodiment of *Shakti* (power), who destroys evil (Mookerjee, 1988). *Shakti* is embodied in several other Hindu goddesses, such as *Durga,* the independent warrior, and *Parvati,* the kind, giving companion. In traditional spiritual Hindu stories, images of powerful female goddesses are worshipped, respected, and portrayed as powerful roles. Found throughout many temples in India, are sacred depictions of women (Mookerjee, 1988). However, Hindu tradition represents women in complex and contradictory roles. She is worshipped as a powerful goddess, yet in the realistic world of Indian culture many South Asian Indian women are self-sacrificing and silent.

Religious traditions also inform the experience of South Asian women. Raj and Silverman (2002) describe how tradition reduces the support to some South Asian immigrant women who experience domestic violence as its teachings encourage them to

accept their fate and to adjust to their circumstances. Being in a patriarchal society, some South Asian women are faced with the pressures of traditional customs and beliefs associated with their religious convictions. Many women accept their circumstances as their fate, or *karma*. A woman can interpret her current hardships as being associated with behaviour in a former life or related to some wrongdoing on her part and thus her karma. This effectively limits any attempts to move out of patterns of domestic abuse because that would imply a rejection of a spiritual belief. As a result, many South Asian women normally place their needs and safety as secondary.

South Asian Indian women and the family system. Many mmmigrant South Asian women are particularly susceptible to the gaze of culture, society, and families as they are expected to adhere to and behave within particular cultural ideals. The traditional Indian feminine ideal is a woman who has a collectivist identity, is the perfect daughter, daughter-in-law, and obedient wife with the qualities of self-sacrifice, modesty and one who may up-hold the standards of community and family life (Goel, 2005). Werbner (2007) and Pappu (2001) noted that within the South Asian Indian diaspora, South Asian Indian women are in conflict with the self as both her identity and destiny is comprised by a collectivist and cultural power as protectors of honour and shame.

The South Asian Indian culture also places significance on the family unit. The family unit consists of a larger group than the nuclear family and can be made up of multiple generations of a family, living together within the same household (Dasgupta, 2000; Natarajan, 2002; Raj & Silverman, 2003). This joint family system may persist even after migration to another country. The family system extends beyond the living situation of the members of the unit. It is also customary for many South Asian Indians to

respect their family values and beliefs. Consulting and following the request(s) of the family prior to making decisions regarding any personal, social, or economic issues is looked upon as a sign of respect and to uphold the family's honour (Coward, Hinnells & Williams 2006; Prashad, 2000). As well, the family system has its own roles and traditions for the members of the family based on age and gender that also contribute to maintaining the family honour.

Respect, *izzat*, is the primary value in the lives of many South Asian women. In a study on shame, subordination, *izzat*, and entrapment, Gilbert, Gilbert & Sanghera (2004) concluded that the concept of family *izzat* had a powerful role within the South Asian woman's experience. When and if South Asian women attempt to step out of these boundaries, it is considered a violation of the social and family hierarchy as the woman is positioning herself above the family (Gill, 2004) and into the negative regard of the gaze.

Cultural values are reinforced by the cultural narratives that define the ideals within that culture. How these values are policed can be understood through the examination of the gaze. The gaze in psychoanalytic terms refers to the act of watching another and the effects on the watcher and the watched (Foucault, 1995). Foucault (1995) has described the gaze as a relationship between the gazer and the gazed at that asserts and distributes power. This power structure and an individual's awareness of being watched causes the individual to self-monitor behaviours and not dare to act out of the proscribed norms of society. It can then become unnecessary to locate or even identify the gazer (Foucault, 1995).

The agenda of the body is attached to the aspect of the gaze. South Asian women are expected to be pure, modest, and virtuous for their husbands and for the family

honour (Tewari & Alvarez, 2009). Traditionally and historically, it is the home and family that represent the primary discursive sites of a woman's identity, as wife and as mother (Abraham 2000a; Ayyub 2007; Dasgupta & Warrier 1996). If abuse includes a transgression, it must be kept secret. They must cope alone with any embarrassment and shame related to this. An abused woman experiences this shame privately because in this sphere she considers the transgression to be related to shame (Devdas & Rubin, 2007). But by the very nature of the gaze, this private shame does indeed become public because the woman incorporates the public sphere into her awareness. The abuse also renders her and her body as impure through cultural projections in the gaze. In effect the gaze eliminates the private sphere for these women.

The gaze then can be seen to enforce the silence of an individual experiencing domestic abuse and can be a controlling device of South Asian women's behaviours because it powerfully supports this notion of the collective identity while diminishing the individual identity (Almeida & Dolan-Delvecchio, 1999; Dasgupta & Warrier, 1997). Using the concept of the gaze as the enforcer and as the means for women to see their own behaviours through the eyes of the collective dominating culture, it is clear that a culture emerges which controls and discourages many South Asian women from voicing the injustices in which they live their lives. The phenomenon of the gaze encourages them to sacrifice their individual identity for a cultural collective identity. Within this milieu, the women are even more victimized because they are in some cases their own enforcers of the cultural code.

Other religious traditional practices and beliefs also shape the multilayered gaze under which these women must live. A wife's devotion is shown through sacrifice such

as the Northern Indian practice of *Kaurva Chauth*, a traditional ritual fast ceremony that is meant to prolong the lives of their husbands in return for a customary blessing of *sada suhaagan raho*, which translates to "always remain married." Through this tradition, the husband is given a high position worthy of his wife's sacrifice and devotion. In the South Asian culture, such traditions reinforce the idea that "the husband is the only source of support and security and that sacrifice is the true mark of a devoted wife" (Goel, 2005, p. 652).

Domestic Violence and South Asian Indians. Faced with oppressive gender roles, many South Asian immigrant women may also remain in abusive relationships due to a lack of economic resources and language barriers since they may be dependent on their spouses. They may not want to leave their restrictive marriages as traditionally marriage is viewed as a relationship for life (Abraham, 2000b; Singh & Unnithan, 1999).

The manner in which many South Asian women experience immigration, their experience(s) in the new country, their values and belief systems, and impact of domestic violence are all important aspects contributing to the development of their own identity. The influence(s) of experiences, values, and beliefs impact the process of resiliency and coping within many South Asian women. Further, there are associations between acculturation and psychological distress, mainly depression (Anand & Cochrane, 2005).

Services and barriers. Based on the duration of a woman's residing time within a shelter for domestic violence, short term therapeutic programs are available to the residents of shelters. Such programs are essential for their emotional and psychological well-being during the recovery process as noted by Riger, et al. (2002). As noted by Domestic Violence (2011), Eisbart (2010), Ortiz, (2012), and the Women's College

Hospital (2013), a well structured short term therapeutic program applied in shelters for domestic violence can be of value to the mental health of women. Through short term therapeutic tasks, individuals are able to examine and take the first steps towards altering their patterns and internal messages that minimize self-value and accomplishments. Carlson and Streit's study (2010) confirmed an art therapy program as a positive support for women who have survived domestic violence. As well, supporting programs were found helpful to the women as they reported emotional support and high self-esteem helped them realize their self worth (Burke, Denison, Gielen, McDonnell, & O'Campo, 2004).

A prime factor of brief therapy is that the therapy does not need to last until all goals are fully accomplished. Once the participant begins to move forward progress should continue as the participant begins to feel a sense of empowerment. This will continue after therapy has ended through continued follow-up sessions gradually changing to occasional support. In contrast, the length of time that it can take to fully modify the effects of the women's trauma can take many years to complete (Haskell, 2004). In a study addressing the negative effects of traumatic life events (including various types of violence), 12 to 16 sessions ranging from 60-90 minutes in length per week were offered in a therapeutic treatment program conducted by Kornor, Winje, Ekeberg**,** et al. (2008). Results indicated the treatment process required a longer time frame for treatment for some individuals. Kubany, Hill, and Owens, (2004) found in cognitive trauma therapy for battered women (CTT-BW), that continued support was essential in treatment as gains such as decreases in depression and guilt, and a substantial increase in self-esteem were maintained at 3 and 6 month follow-ups. Similarly, Foa,

Dancu, Hembree, et al. (1999) noted the importance of follow-up after therapy was completed, as relative gains were maintained through follow-up in all groups of their study. Finally, women recruited from shelters who received a 10-week intervention using trained professionals were twice as likely to be free of violence after participating in a control group at two years follow-up.

The shelter in which the participants of this research resided offers short-term support services including individual counselling, behaviour modification programs, music therapy, playback-theater, yoga, dance therapy, and workshops on the exploration of emotions/feelings as part of their recovery process. The art therapy program adaptable to the shelter environment, as an adjunct therapy to these support services offers a reflective space for the clients.

Within the city where the participants of this research reside (for ethical reasons, confidentiality, and for the safety of the participants of this research, the name of the city, shelters, community centers, and organizations referred to in this section have not been provided) there are a small number of service organizations and community-based agencies available to provide assistance to the diverse cultural profile of South Asian women. Through such community centers and organizations, women may seek assistance. The shelters for domestic violence, often offer mental health programs in the creative arts therapies (art, drama, and music). Additionally, there are mental health clinics and hospitals that deliver culturally appropriate services. However, despite the provision of such services there remain several barriers to help seeking for many South Asian women.

Bateman et al., (2009) note the patient and family are affected by the stigma of illness as religious and cultural beliefs associate mental sickness with guilt and shame. As a result, the fear of being rejected by family members and the community, and the shame associated with it can create barriers from help seeking within mental health settings (Akbar, 2002; Bateman et al, 2009; Corrigan, 2004). Hence, some women may turn to religion as a treatment modality (Akbar, 2002) in order to remain loyal to their culture and make use of culturally syntonic methods of containing their distress.

Shankar, Das, and Atwal (2013) note how oppressive beliefs and traditions against women within strong patriarchal family environments have led mainstream service providers to believe that domestic violence is an issue within the community and that there remains a cultural and religious approval of such practices. Thus, "double victimization" is experienced. This double victimization in some instances may also have severe consequences for the women's physical and mental well- being. This can result in depression, suicide and other types of self- harming behaviours (Shankar, Das, & Atwal, 2013).

In conclusion, the traditional family system has persisted for generations within some South Asian communities and may perpetuate violence toward many women at the hands of their protectors or intimate partners. Within this system, any difficulties women may experience are kept within the family in order to avoid stigma, shame and disrespect to the family (Das Dasgupta, 2000; Gill, 2004; Bateman et al., 2009). Moreover, Grewal et al. (2005) assert family influences as being significant to many immigrant South Asian women's health, including highly acculturated immigrant women.

Within the South Asian communities, the incidence of domestic violence is as widespread as it is in the general population (Choksi, Desai, Adamali, 2010). However this is not because the South Asian culture is violent, but rather it is a result of violence against women being rooted in a global culture of discrimination that denies women equal rights with men. As a result, most South Asian women remain silent about their abuse in order to preserve expected cultural traditions and roles (Ayyub 2000; Bhattacharjee, 1992). This silence requires these women to find another outlet to cope with the abuse that they experience as they exhibit distinct behaviours resulting from their trauma(s): they express the pain, difficulties, and conflict in their lives within the symbolic but embodied depictions of their own bodies. These women must find a way to deal with the effects of this violence and still maintain their affiliations with their particular ethnic community. Introducing these women to a clinical art therapy program may enable participants to rebuild their self-confidence and move towards a new identity during their recovery process and is an alternative to symbolically embody their painful experience and provide a road to healing from the abuse as they attempt to adapt to a new country and confront the abusive situations they are living.

The next section explores the use of art therapy and its use in treatment of embodiment issues. Relevant literature and art therapy pertaining to the research will be identified.

Art Therapy

According to the Association des art-thérapeutes du Québec (AATQ, 2011) art therapy is defined as a multidisciplinary, mental health profession that utilizes the creative process of making art to improve and enhance an individual's physical, mental

and the emotional well-being. It engages in the use of art materials with different populations as a healing modality through creating and expressing their thoughts and feelings in artistic creations as well as in words. Art therapy offers effective therapeutic support for individuals experiencing emotional and physical difficulties.

Influenced by the works of Sigmund Freud and Carl Jung, art therapy emerged as a profession in the 1930s (AATQ, 2011; Vick, 2003). Art therapy was developed by Margaret Naumburg, Florence Cane, and Edith Kramer. Both Naumburg and Kramer's approach is rooted in psychoanalytic theory. Naumburg emphasized free association and Jung's notions of universal symbolism while Kramer focused on sublimation (Kramer, 1979; Naumburg, 1950; Rubin, 1999; Wilson, 2001).

Researchers (Hammer, 1958; Naumburg, 1950; Wadeson, 1980) suggest the practice of art therapy involves the application and integration of knowledge about human emotion, social and behavioural development, and the full range of psychological methodologies. Art therapy may provide individuals with a space where they may work through traumas associated with their experience(s) of domestic violence. Being a therapeutic modality, it provides healing, growth experiences, and stimulates creativity through a therapeutic process, and provides an authentic means of expressing feelings.

By creating images/art as a way of communicating feelings and experiences, individuals may be able to see themselves more clearly, gain different perspectives, and perhaps unblock feelings and issues that may otherwise be difficult to bring to the conscious (Malchiodi, 1999). Research (Lusebrink, 1990; Malchiodi, 1999) asserts that art therapy is effective in dealing with helplessness, reducing psychological stress, providing relief or distraction from pain, increasing feelings of relaxation and increasing

emotional expression. According to Wadeson, art therapy has a valuable role with individuals who have experienced domestic violence and on how artistic expression can be used to help individuals deal with the emotional trauma resulting from physical and emotional abuse (Wadeson, 1980). Malchiodi (2003) notes that trauma affects the mind, spirit, and body of individuals. A traumatic event resides within the individual as a physiological experience; thus, it becomes essential to communicate and process the sensory memories of the trauma in order for resolution to occur (Malchiodi, 2003). Further, art therapy may be perceived as a natural process to embrace due to its natural, expressive ability to tap into the senses. As a result, it can be a powerful method to utilize in trauma recovery (Malchiodi, 2003).

Art therapy may facilitate communication in both verbal and non-verbal ways. Communication of information that is perhaps part of the unconscious as well as information that is in a language unknown to the art therapist may also be possible. The language barrier is an important issue when dealing with immigrant populations. Art is a media where the barriers of language are overcome. It may also reduce the importance of verbalization, so the client does not have to know the language(s) of the host country or that of the therapist. The art facilitates a communication without words, though it is possible to start a verbal process about the artwork and what is being explored in therapy. In addition, the client can choose her rhythm and use her symbolization without the need to adapt it to the therapist's or the host country's culture.

Lagorio (1989) suggests that specific art therapeutic approaches are particularly useful to abused women because art therapy provides a vehicle to attain a realistic picture of the women's situation, enabling them with an opportunity to leave the cycle of

violence. The art products visually document the women's therapeutic growth, providing her with awareness of her process, thus improving her self-worth, supporting emotional expression, and empowering her. Further, the art therapy may provide the necessary tools she may continue to use in order to find her strengths and dignity. Haddon (1989) also provided art therapy to women in a shelter for abused women. She noted depression, ambivalence, and suppressed grief as common emotions experienced by abused women. Therefore, her approach focused on reorganizing the lives of women in crisis, teaching them about domestic violence, providing support through resources and overcoming the effects of victimization.

When working with Hindu South Asian Indian immigrant women shelter residents, art therapy can be particularly helpful as it can help traumatized individuals express their feelings. Trauma research (Garrett & Ireland, 1979; Herman, 1992; Lawson, 2003; Van der Kolk, 1987) and research on PTSD in women (Walker, 1999) indicates that imagery-specific techniques such as art therapy are among the most effective in reducing post-traumatic stress disorder symptoms. Van der Kolk and Van der Hart (1991) suggest that initially trauma is embedded within the brain's memory as a photographic image. Herman (1992) also notes how trauma is encoded primarily in non-verbal imagery and may not often be articulated due to grief or pain. Intrusive and distressing memories may frequently replay within the survivor's mind as flashbacks, nightmares, phobic images, or as moving pictures. They may also be triggered and surface at unpredictable times (Van der Kolk & Van der Hart, 1991). Further, art therapy can be a treatment that may access and recall traumatic memories without causing the individual to relive the intense emotions associated with such memories (Johnson, 1987).

Within art therpay, the symbolic method of working through issues and anxieties in a therapeutic setting (Riley, 1993) allows the individual and the therapist to work with a tangible product that may symbolize the individual's inner world in a direct, uncensored, and concrete form (Kramer, 1979; Naumburg, 1950; Rubin, 1987). The product is not as important as the creation of the artwork. The art becomes a visible record of the therapy. It may reveal emotional patterns and/or produce important insights. As well, it may also create a bridge for resistant individuals to connect to the inner self and to relate to others. This process, known as objectification as the individual's feelings are externalized in the artwork or object, can in turn help the individual recognize and integrate feelings more easily (Rubin, 1999). Additionally, the individual/client is encouraged to interpret their art work (Malchiodi, 2007). The process of talking about the created artwork(s) helps the client gain meaning or an understanding from the artwork(s) and finds a safe way to articulate what the artwork expresses. Healing may occur, and and the feelings associated with the clients issues or trauma may be alleviated and/or resolved through art therapy (Malchiodi, 2007).

Art therapy also can be very useful to address Hindu South Asian Indian immigrant women's needs. While Hindu South Asian Indian immigrant women may demonstrate concrete symptoms of trauma due to domestic violence, these may also intersect with the experience of cultural changes and self-harming behaviours. In the context of an art therapy intervention, the difference in symptoms may not be distinguishable. However, the cultural norms of this population, which limit communication about family problems, make it essential for practitioners to rely on a transcultural model approach to therapy that incorporates the multiple realities of the

individual and accommodates specific cultural norms and the traditional cultural norms of art expression (Golub, 1989). In order to explore how art therapy can address the specific needs of the Hindu South Asian Indian immigrant women in this study, the contextual background of same must be understood.

Therapy in shelters. Shelters are an integral resource for abused women. They help seeking survivors who have limited alternative resources address and support their needs. According to Berk, Newton, and Berk (1986) abused women who participate in more forms of support while in a shelter indicate less re-victimization. This suggests that offering treatment is a key resource that may help the women.

When working with traumatized women in shelters treatment is often received through a variety of services. Initial support is provided to calls that are made through immediate crisis intervention responses (Domestic Violence, 2011). During a woman's stay in a shelter, she is provided with three levels of support. The first including, a safe place to live, advocacy and referrals such as legal and medical information, accompaniment to court, housing information, child care, and assistance with vocational and educational concerns (Riger et al. 2002; Saathoff & Stoffel, 1999). Second, with the high prevalence of mental illness among women of domestic violence, resources and services for mental health treatment to efficiently meet the safety and treatment needs of the women are offered through various individual and group counselling programs (Riger et al., 2002). And third, a follow-up program for women who have left the shelter to offer continued support, referrals to other resources, services in the community and to outreach activities (Domestic Violence, 2011; Riger et al.). The duration of residing in a shelter for domestic violence can range between three to a four month period depending on each

woman's individual circumstances (Gutman et al., 2004; Eisbart, 2010; Ortiz, 2012). Trauma therapy for abused women in shelters are generally organized with the role of a short term focused approach as an adjunct source of support for women receiving therapy (Burman, 2003; Women's College Hospital, 2013). Several studies have confirmed this in the literature on short-term based therapies. In a study conducted on short-term trauma recovery focused intervention, using cognitive therapy with women who presented with PTSD symptoms and had experienced domestic violence, researchers (Kubany, Owens, Lannce-Spencer, McCraig, Tremayne, Williams, 2004) noted that the therapy offered was helpful regardless of the duration of the intervention(s).

It is important for short-term treatment interventions in shelter settings to follow a holistic approach. This includes accounting for the individual as a whole, involving all aspect of the woman's life contributing to the therapy. In collaborating with staff personnel and other support programs offered at the shelter, implementing client-centered intervention(s) are appropriate as they will motivate and engage the women while focus is placed on their individual and specific needs. This in turn promotes a positive experience and outcome in therapy while keeping the woman(s) concerns as the main focus of the intervention(s) (Burke et al., 2004; Gutman et al., 2004).

Short-term and long-term group treatment modalities are effective in providing emotional support for women survivors of domestic violence. It is a safe space to discuss the abuse and have their experience validated while encouraging personal growth/empowerment; relate their experiences to others in similar circumstances; and interaction between group members helps facilitate interpersonal trust. Psychodynamic groups provide members with a new understanding regarding what it means to have

experienced the trauma and abuse, to validate each others response as being normal, and address issues relevant to the dynamics of abuse. However, not all therapy groups and supports group's process the trauma associated with domestic violence (Bornstein, 2004). Nonetheless, according to McGoldrick, Giordano and Pearce (1996), group therapy may be of value in shelter settings. These researchers emphasis the significance of group therapy within a shelter setting. They found the majority of shelters not only encouraged the implementation of culture and one's cultural lens within their work with diverse populations in therapy, but also addressed culture within case conferences, and discussions with residents of the shelter. The shelters also emphasized the value of communicating in languages familiar to the client(s).

In individual psychodynamic therapy, although the traumatic events are discussed in the therapy, the focus of treatment is not on symptom reduction rather it focuses on an insight-oriented treatment approach (Briere & Scott, 2006). The unconscious is explored and there is an emphasis on the intra and interpersonal processes (a certain level of insight capabilities is required). Through this therapeutic approach, the facilitation of the survivor's learned knowledge and coherent narrative of the self, both in the present and in the past, may have a significant impact on psychological recovery (Briere & Scott, 2006).

Cape, Whittington, Buszewicz, Wallace, and Underwood (2010) note brief counselling problem solving and cognitive behavioural therapy (CBT) are useful primary care treatments for depression, anxiety or mixed disorders. In addition, CBT is also known as an "umbrella term" for therapeutic interventions such as, coping skills therapy, cognitive restructuring therapy, and problem-solving therapy. Thus, as the use of CBT is effective within several therapeutic approaches, the relevance to art therapy may also be

recognized as valuable. Several CBT methods such as, cognitive mapping, problem solving, externalizing internal processes, personal constructs, systematic desensitization, and mental imagery, have been modified for art therapy treatments, as art making is a cognitive process and imagery a frequent tool in CBT (Rosal, 2001). Since the primary goal of CBT focuses on helping clients develop an internal sense (locus) of control, in treating PTSD this is an important step in the telling of the trauma narrative. Through art therapy, the externalization of internal processes and the restructuring of dysfunctional thought patterns can occur (Rosal, 2001). Art activities related to this process are included in this research: the drawing of experiences related to before, during and after, and mask making to for expression of the inside/outside self. The CBT techniques allow the art therapist to address feelings or defense mechanisms used to mask the client's emotions. Cognitive mapping aids in identifying faulty thinking patterns, thus, art activities such as drawing enables the client to transfer the focus from the external to the internal locus of control while identifying primary defense mechanisms.

Another therapy approach that works simultaneously to challenge traditional gender roles while empowering survivors of domestic violence is known as Survivors Therapy. This therapy requires the use of both feminist and trauma therapy techniques (Walker, 1991; 1994). The role of feminist therapy is a powerful way of helping abused women as it focuses on systemic sources of oppression and domination (Sharma, 2001). These forms of oppression are connected to the women's cultural and socioeconomic backgrounds, which are determining factors in how domestic abuse is experienced. However, in order to heal and become empowered, there is a need to first process the trauma endured from the domestic violence, which this theory does not address.

Borrowing particular aspects from feminist theory for a holistic approach can then be beneficial in understanding the importance and affects of systemic sources of oppression and domination while treating immigrant women of domestic abuse.

Therapeutic relationship. A sense of safety can be established by being flexible but also by providing structure in therapy. The sessions should be held at the same time and day on a weekly basis and include structured activities. This is a building block in the therapeutic relationship, but more is required. The effectiveness of the therapeutic intervention is dependent on the therapeutic alliance. A sufficient attachment between me, as therapist and the women, as participants needed to and did in fact develop in the course of the art therapy treatment. It is suggested that the stronger the therapeutic alliance, the more the individual will attend, can benefit from the therapy and invest in the process (Riley, 1993).

The relationship between client and therapist is of importance. Developing trust and confidence in the therapeutic relationship is supported by maintaining consistency with regards to all aspects of the therapy sessions. The timing, the rules, materials, space, mode of interaction, and stability are all components essential to making a concise and secure structure for the therapeutic work. Art therapists may offer clients support and reassurance regarding their presenting issues. A supportive environment fostered by the therapist/client relationship enables the client to create art while exploring and sharing the meaning the art may have for the client. Through these means clients may get a better understanding of themselves and the nature of their difficulties or distress (Rubin, 1999).

In providing a protective and safe space that allows the client to heal and grow, the healing movement of the psyche can unfold. The therapist is both witness to this process

and is also actively involved by being receptive, and as a participating observer (Malchiodi, 2007; Rubin, 1999). Thus, the therapist takes part in everything that is occurring in the therapeutic environment. As the therapist fully accepts the client, s/he will feel content, protected and safe in their expression(s). The therapist's actions of care in addition to their own example of individuality are a supporting structure that the client may slowly internalize towards their own two-fold nature of self.

The therapist and the experience(s) of therapy are recognized as the therapeutic container in which the therapist serves as a container for the client's emotions of anger, despair, distress and sadness (Gabbard, 1990). The therapeutic container is comparable to, and symbolically represents maternal holding and nurturing. It provides something that is missing while allowing transformation within a secured space (Malchiodi, 2003). Maternal holding is a term referred to as the mother or caregivers capability to physically and emotionally hold the client through containing, receiving, and giving (Slochower, 1996). Comparably, in therapy the therapist should have the qualities of a good enough mother (Winnicott, 1964) in addition to clinical skills. Such qualities and skills help to support the needs and growth for clients to work through their defenses and to develop within the therapeutic relationship. This notion of maternal holding is briefly described in order to understand the symbolic relation between the mother and the therapeutic space. Winnicott (1964, 1965, and 1988) emphasized how the role of the mother can help her infant become a person with a gradual developing sense of self and the means to use that self within interactions with the outside world. Thus, the role of the mother is to provide the infant with a stable subjective experience in early life, in order to develop a sense of the self (Winnicott, 1965).

According to Winnicott, this process begins during the last stage of pregnancy in the mother's womb. As the fetus grows the mother's internal organs, diet, and routine are affected (Winnicott, 1964). During this process, the mother is attuned to her unborn child and her experience, as she shifts away from her subjective experience. This is noted as helpful to the infant during the formative years. During this time the child must come to see the world as a kind place as s/he slowly becomes aware of themselves as human(s), with the power to influence their external world. It is this care free environment created by the mother that Winnicott referres to as the holding environment in which the child is provided with a sense of confidence about life and his/her needs are satisfied (Winnicott, 1988).

Winnicott further supposes that the child is in a "reverie" that s/he believes is an unintegrated drift of consciousness. Within this space, spontaneous wishes, feelings and desires such as hunger and discomfort arise (Winnicott, 1988). During this time, the mother's responsibility is in providing the child with the objects s/he desires. This is carried out in an almost ideal manner in order for a natural feeling of omnipotence to begin to emerge within the child's developing psyche. Being a natural consequence, this omnipotence is noted as the "good enough mothering," the foundation on which the child may build its paradigm to relate to the outside world, and of his/her sense of self (Winnicott, 1964).

The therapeutic container is noted as comparable to the qualities of the mother's womb (emptiness and nourishment) creating space and receptivity that cultivates growth (Winnicott, 1964). The mother's body or therapist's level of an embodied maternal environment establishes the creation of the inner structures of support enabling the client

to grow (Winnicott, 1964, Slochower, 1996). Thus, the therapeutic container is equivalent to the symbolic active bodily qualities of a healthy mother, who is nurturing and allows for access through receptivity and maternal holding (Winnicott, 1964). Clients may then focus on themselves and potentially turn inward to explore their emotional distress which may eventually come forward.

Another important aspect of the therapeutic relationship is the culture of the client and therapist. Within South Asian culture, there exists the belief that individuals should use their inner drive to alleviate psychological problems, engaging in self-control, and seek assistance from family and close friends. Discussing emotions with others is considered a sign of weakness (Inman &Yeh, 2007). Several authors (Das & Kemp, 1997; Kim & Atkinson, 2002; Li & Kim, 2004) discuss how affect is surpressed, as discussing personal and intimate issues with non-family members is perceived as an act of betrayal. In honouring the family name, individuals must keep distressful/painful issues to themselves.

Accordingly, ethnically matching the client and therapist is of importance as variables such as one's cultural identity, values, and mental health beliefs vary amongst ethnicities and cultures. Researchers (Kelly & Strupp, 1992; Sue & Sue, 2008) assert ethnic matching results in a stronger therapeutic relationship and alliance as individuals sharing the same ethnicity can better relate to each other, share similar values, understandings, and world views, has a better understanding of the familiar social and emotional concepts, and is aware of community resources and social support networks. Similarly, researchers (Gamst, Dana, Der-Karabetian, & Kramer, 2001) have found that matching clients and professionals in the mental health profession by ethnicity, results in

enhancing the client's treatment process, facilitate rapport, and increase a client's sense of willingness to self-disclose (Dana, 2001), and has positive clinical outcomes. Upon establishing a therapeutic alliance, clients are able to speak more informally while expressing interest in the therapists. This is noted to be culturally appropriate as it is regarded as allowing the therapist into the family system as a respected figure (Wali, 2001).

The theory of social influence is also noted as significant in ethnic matching (Simons, Berkowitz & Moyer, 1970). Simons et al. (1970) state "attitude change towards the position advocated by the source depends on the extent to which interpersonal similarities and dissimilarities are perceived as having instrumental value for the receiver" (p. 12). Thus, the client may benefit from a stronger client-therapist working alliance as a result of the relationship between interpersonal similarity, credibility and support (Kim et al., 2002). Likewise, Gray-Little and Kaplan (2000) believe ethnic similarity can decrease the social distance while enhancing the possibility of shared beliefs between client and therapist, therefore facilitating both the therapeutic alliance and outcome.

Language is also an important component that appears to be the most beneficial aspect when working with clients of the same ethnicity. According to several researchers, (Shin et al., 2005) there is an increased ability to comfortably communicate when the client and the therapist speak the same (native) language. Emotions are enhanced and expressed more accurately as they are rooted in the native language of the client (Kelly & Strupp, 1992). Understanding the language within their complete cultural contexts is also of significance as complications may occur during the translation of expressions. The

translation may not be accurate as it is translated in the context of another culture, and definitions and understandings of mental illness vary across cultures.

Sharing information with same ethnic/culture client/therapist may also result in the client becoming reserved and/or resistant within the therapy session(s) as s/he may not want to share personal information with a therapist who is of the same ethnicity. The reasons for this may be; hesitation as a result of belonging to the same community, fear of being judged, stigmatized, and having common acquaintances. Inability to understand the clients beliefs, values, norms, customs, practices, and social behaviours may also result in the client's inability to engage in therapy. Lastly, therapist working with immigrant populations and not having the knowledge of the clients cultural backgrounds may also result in clients indicating a disinterest or dropping out of the therapy (Sue, 1998).

Under such circumstances, the therapist is required to build a trusting alliance, and a secure therapeutic environment in which the client may be reassured of confidentiality and a professional relationship (as will be demonstrated in the case study of Raina, in the case studies). Additionally, cultural aspects are important to be understood and recognized, as is the level of acculturation. Considering the level of acculturation is also of significance as it affects the cultural behaviour and perception of the client (Sue & Sue, 2008; Sue, 1998). Therefore tailoring the therapy accordingly is crucial in meeting the needs of the client. The art therapist should be aware of his/her cultural background, beliefs and values, understanding that the client does not necessarily share them. An art therapist must then explore the impact of the gaze through various social, societal, cultural, traditional, and gendered lenses. Indeed therapists must also address their own

roles as watcher. Any post-trauma therapy must incorporate the impact of the many-faceted gaze. A more detailed look at the gaze will be helpful in understanding how it might be used in therapeutic interventions to facilitate healing and encourage the growth of a self-identity.

The effects of the gaze as discussed by Reiss, (1988) and Winnicott (1964) start in early infant development. Significant in the bonding process between mother and child, it is powerful in communicating emotional messages in later years (Hymer, 1986; Winnicott, 1964). Lacan describes the notion of the gaze during identity formation. He focuses on the "mirror phase" of development where preverbal infants explore their identity through observing their bodily movements and their reflections in the mirror. Responses are imitated and relied upon by the infant, to develop a self-concept (Schaverian, 1995, Smith, 2008). Winnicott also discusses the relevance of mirrors through the interpersonal process of mirroring. In his theory, the actual use of mirrors is not involved, rather the infant sees the mother as a mirror in which the infant sees his/her own image. As a result of the mother's empathetic warm gaze, the infant receives the message of being accepted and recognized (Schaverien, 1999, Smith, 2008; Winnicott, 1964, 1965, 1988).

Experiences of mirroring an individual's psychological development involve responses and receiving messages from the gaze of several individual's other than one's mother. The gaze may give validation or rejection, positive or negative responses, and affect one's judgments, thoughts, and behaviours both towards the self and towards others (Lieberman, 2000). This holds true in therapy as well. Hymer (1986) describes how the gaze of the eye in psychotherapy encourages trust and emotional engagement

within a therapeutic setting, while Weil (1985) focuses on the process of "visual holding" whereby the client feels held by the therapist's gaze in psychotherapy. Through this visual holding, communication may occur without the use of verbal communication. Weil (1985) further suggests how the therapists gaze may also carry out a similar role for clients in therapy to a theory proposed by Greenacre (1971). This theory emphasizes the importance of vision in early ego development of infants.

At the same time it is essential to look at communication styles in order to understand the role of the client's traditional norms when dealing with conflict during clinical interviewing (Guzder, 2011). As well, stories have a strong influence and are part of the cultural upbringing in South Asian society and it becomes a part of an individual's identity (as discussed earlier) hence, such aspects should be given importance. In art therapy there is a range of opportunities for the gaze to be reciprocal and/or have a positive effect on the client. In exploring the gaze in the context of art psychotherapy Schaverien (1995) speaks about the client's gaze turned inward. This "inward gaze" utilizes vision metaphorically as the inward gaze is actually the gaze of the imagination enabling one to interpret their inner experiences rather than the true visual perception. Through this process, the art creations that stem from the inward gaze may connect the client's inner self to their outer reality, enabling them to be seen through the created artwork(s). In sharing the artwork(s) with the therapist, a conscious attitude may be created within the client. The client's relationship to both herself and to her inner reality is strengthened through the therapist's validating gaze (Schaverien, 1995, Smith, 2008). Thus, the gaze, according to Schaverien (1995) is linked in a three-way relationship; through the interaction between the client, artwork(s) and therapist within art therapy.

Art therapy encourages and enhances awareness of the gaze because it plays a role in the holding environment as it is an important method of communication. As well, the therapists gaze is self-affirming (Weil, 1984-1985). Through this process, the client may feel secure by the gaze of the therapist as the "visual holding" enables communication without verbally speaking (Smith, 2008). Yet, as the therapist gaze may seem positive or mutual to some clients. Yet, to others who have had experiences of negative parental gazes, the gaze of the therapist may not have a positive effect. Such a gaze may then seem aggressive or negative. However, over time this negative gaze may change through the process of therapy and be explored in a productive manner through the development of a mutual gaze (Smith, 2008).

Transcultural approach to trauma. Surprisingly, although there have been several cross-cultural art therapy studies, little has been done in the area of South Asian immigrant women with a history of domestic violence expressing trauma through symptoms of embodiment. This is remarkable in light of the successful use of art therapy as an effective treatment for women who have experienced several traumas. Therefore, this section will review a range of cross-cultural art therapy research utilizing pertinent aspects that can be related to this study.

When working with an immigrant population, art therapy becomes a helpful insightful tool of communication. There are several factors that are resolved in art therapy, for instance, the language barrier, the reserved client, or understanding what the client is reporting. For many of these clients expressing through art materials is the only outlet they have of connecting meaningfully with the host society and feeling that they are making a contribution (Rousseau, Lacroix, Singh, Gauthier, Benoit, 2005). As

mentioned earlier, since art therapy can be a non-verbal way of working through issues and concerns in a therapeutic setting, it allows the client/therapist to work with a tangible product symbolizing the client's inner world even when there are communication barriers. The images created in the art therapy session allows for a better understanding of the psyche of the client. As memories, images created through artistic expression permit a chain of emotions and feelings to surface. Further, it may be easier for the client to speak about the image(s)/art creation(s) than about themselves. Through the images, disclosure of important information is used for speaking metaphorically (Rousseau, et al., 2005).

When working with immigrants, it is essential for the art therapist to be aware of the various cultural art forms and the differences, beliefs, and values as well as the symbols and images of non-Western art forms (Campanelli, 1991). This knowledge is necessary because sensory impressions and perceptions are received through cultural influences, as are the verbal interpretations (Dokter, 1998). Therapists require an understanding of an approach to interpreting the various art creations tha may differ with clients as a result of their ethnic background. Thus, an art therapist may borrow from an ethnography approach (involving the researcher sharing, as much as possible, in the experience of the participants) when dealing with the art creations, so that s/he may look at the cultural implications or meaning of the art imagery (Kapitan, 2010).

In addition to understanding culturally different art forms, understanding the cultural background in order to provide an accurate analysis and culturally appropriate service that integrates the principles of transcultural therapy is important. This awareness may help with the need to adjust the therapeutic limits to a transcultural context. In such

instances, the therapist may consider the importance of both the client's outer and inner world. Many of the immigrants' psychological problems originate in the outer world (Fernando, 2002; Kareem & Littlewood, 1992; Kirmayer & Minas, 2000). Thus, this research is undertaken within the context of the Hindu South Asian immigrant women participants own cultural beliefs, and experiences as immigrants.

Embodiment

Since traditional values significantly limit the options for expressing distress related to domestic violence, for South Asian women this distress is often internalized and expressed through the phenomenon of embodiment. The body responds to physical and psychological experiences. The embodiment issues encountered among the Hindu South Asian Indian women in my research can be classified into three types:

- Superficial self-harm includes behaviour such as intentional cutting, burning, scratching, and interfering with a healing wound, hitting body parts and excessive nail biting behaviors (Favazza, 1987, 1998; Milia, 2000).
- Somatic symptoms include headaches, abdominal pain, backache, and chronic tiredness (Samelius, Wijma, Wingren, & Wijma 2007).
- The negative body image can be defined as the feelings and attitudes that the women have towards their bodies based on the meanings, experiences, and influences of abuse on the women's body image (Walker; 1999).

Art therapy and embodiment. Art therapy can be very useful for women dealing with the impact of domestic violence as they often describe the feeling worthless or a loss of the self (Lawson, 2003). Further, for some women who have experienced domestic violence suffering is expressed through body trauma(s). Art therapy can provide a

meditative inner process that enables exploration of inner material for reflection, self-awareness, and self-soothing. Internal experiences can be expressed in images and in art creation(s) as a way to express experiences of emotions (Naumburg, 1966 as cited in Rubin, 1987). The level of control over this process of disclosure is supportive for traumatized individuals as is the possibility of expression in symbolic form (Johnson, 1987).

Johnson (1987) conceptualizes the process of transforming and integrating traumatic memories through art therapy within three stages. First, the individual may gain access to the memory of the trauma through the art making. Second, the individual may examine and rework the traumatic experiences in the process of making art and discussion while modifying the traumas intensity in the process. Subsequently the trauma may become a memory rather than the intrusive, ever-present, re-lived traumatic experience of the event itself as art-making can provide some distance and control, and thus provide a sense of containment for clients (Johnson, 1987; Jacobson, 1994).

Fleming and Cox (1989) stress the importance of the client becoming involved in the art process and using the art in self-exploration as this may prove effective in increasing flexibility of control and self-awareness. As a result, individuals may distinguish themselves from their trauma and start to work through the metaphor or imagery of that traumatic memory as a separate entity. Individuals experience, dialogue with, transform or manipulate, destroy or recreate new images, enabling them to feel empowered to handle the trauma rather than being overwhelmed by it.

Self-Harm

Self-harming behaviour is a term used for a complex group of actions resulting in the destruction of one's own body (Cooper & Milton, 2003; Favazza 1987, 1998; Levenkron, 1998). It is the act of engaging in repetitive self-harming behaviors to change a mood state through the infliction of self physical harm (Favazza 1987, 1998). According to Favazza (1987, 1998) and Levenkron (1998) self-harm is categorized in the following distinct groups:

- Major self-harm: The least common form of self-harm, which involves infrequent episodes of destruction of large amounts of tissue such as self-castration or self-amputation. Major self-harm is known to frequently occur with psychotic or highly intoxicated individuals.
- Stereotypical self-harm: Classified as repetitive, sometimes rhythmic acts that include orifice digging, hitting, throat and eye gouging, hair pulling and self-biting. The most common form of stereotypic self-harm is head banging, associated with impulse control disorders.
- Compulsive self-harm: Consists of repetitive hair pulling, nail biting, and skin picking.
- Impulsive self-harm: Involves superficial skin cutting and burning. This is the most common form of self-harm seen in adolescents and is associated with external stressors and/or triggers, Post traumatic stress disorder, Borderline personality disorder, dissociation disorders, histrionic, anti-social, and dependant personality disorder, and eating disorder.

- Superficial or moderate self-harm: Intentional cutting, burning, scratching, interfering with a healing wound, hitting of one's own body and excessive nail biting behaviors.

Psychiatric diagnosis may not always be present within individuals who self-harm but is noted to be found within the context of psychiatric disorders such as major depressive disorder and borderline personality disorder (Favazza & Rosenthal, 1993; Kerr, Muehlenkamp, Cowles & Gutierrez, 2010). Self-harming behaviour can be understood as a coping method used by women experiencing intense feelings who may resort to this behaviour as a way to express their feelings and emotions. As suggested by Miller (1994), the skin becomes representational of internal chaos displaying how one feels inside and to divert the person away from internally experienced emotion, to release emotion, and provide a way to feel calm and in control (Levenkron, 1998).

Certain individuals who self-harm may not complain of pain possibly due to dissociation, and also because self-harm serves as a focusing behaviour (Cooper & Milton, 2003; Favazza, 1987, 1998; Milia, 2000; Van der Kolk, 1987; Zila & Kiselica, 2001). White Kress (2003) also believes that the act of self-harm may decrease and temporarily eliminate feelings of depression, anger, anxiety, negative self-perception, and emotions, the self-harmer may regularly experience. The symbolic meaning attributed to this suffering and/or trauma histories is that the individual may be trying to feel something emotionally or physically, striving to remove certain feelings, or perhaps to mark boundaries or to relieve experienced strain/anxiety (Hibbard, 1994).

In addition, the inability to express oneself emotionally has been associated with self-harming behaviour (Gratz, 2006; White Kress, 2003). Self-harm is noted as allowing

communication and expression of inner pain, permitting the pain to manifest in a physical form while providing an outlet to express feelings that may otherwise be difficult to verbalize (Cooper & Milton, 2003) and to deal with very painful emotions (such as the intense emotions experienced when abused or recovering from sexual abuse or rape). Another important reason for this behaviour is that individuals may feel comforted because it keeps them in the realm of the familiar. When one has been mistreated and/or abused they may be accustomed to experiencing feelings of pain, discomfort, shame, embarrassment, and guilt associated with the trauma (Favazza, 1987). Strong (1998) hypothesized self-harm may be a re-enactment of the trauma which may cause more manageable feelings and perhaps actually provide relief from intense distressful feelings. Strong (1998) further believed that this unpleasant coping mechanism is successful in relieving negative feelings.

Zila & Kiselica (2001) note anxiety increases in individuals who self-harm and ends in a sense of unreality and emptiness creating an emotional numbness or a state of depersonalization. Termination of the depersonalizing state for the self-harmer may occure when the self-harmer has the ability to prove to oneself that a border exists between the self and the external world (Cooper & Milton, 2003; Farber 2000; Favazza, 1987, 1998). Thus, the cutting of the skin, stimulating nerve endings (proving there are feelings) and enabling the individual to see a border between the self and external world, may be a way for fighting the depersonalization. Likewise, Zila and Kiselica (2001) suggest that the state of depersonalization is frequently preceded by a threat of abandonment, rejection, and loss.

Husain and Cochrane (2004) suggest that cultural aspects also add to the possible reasons of self-harming. Further, in a study on South Asian women and self-harm in Britain, results indicated when treating this population it was essential to look at the impact of cultural factors and personal and familial issues on distress and resilience together (Ahmed et al., 2007). Given the cultural characteristics, domestic violence, trauma, and immigration stress experienced by South Asian women, it is suggested that these women are prone to thoughts of self-harm, depression, and suicide risk (Rao, 1986). Additionally, Rehman (2010) indicates that recent studies suggest that as South Asian female adolescents grow older, they are more likely to engage in acts of self-harm.

Self-harm and art therapy. There has been some research conducted on the efficacy of an art therapy program to assist people who engage in self-harming behaviours. It is suggested by several clinicians that treatment for those who self-harm should focus on the development of the ability to express emotions symbolically, removing focus away from the body. Additionally, the construction of more adaptive strategies for managing self-destructive actions should be a focal point suring treatment (Cooper & Milton, 2003; Milia, 2000; Ross & Heath, 2002; Suyemoto, 1998).

Zila and Kiselica (2001) defined treatment goals for adults who self-harm. The authors suggest initial treatment be focused on creating a holding environment that may withstand the client's "un-integrated" anger and emotion. Subsequently, symbolization and verbalization of intense emotions may be encouraged as alternatives to physical reenactments (Suyemoto & Macdonald, 1995; Zila & Kiselica, 2001). Favazza (1987), Suyemoto and Macdonald (1995), Zila and Kiselica (2001), claim that art therapy being a non-verbal action-oriented treatment modality, may be effective for adults who self-harm.

The treatment may increase symbolic capacities and symbolization is considered an important process of art therapy. Emphasis of symbolic form of expression remains on the non-verbal, enabling the unspeakable to emerge within the art creations. With the use of symbols, the client may engage in the personal meaning of trauma. Further, the clients artwork created during the art therapy may contain symbols and images of profound meaning that the client was unable to express in words (Milia, 1996, 2000). Thus, the self-harming individual may then focus on graphic image(s)/creation(s) symbolizing their experience. In placing focus on the symbol, overwhelming feelings may be expressed without having to refer directly to specifics of their trauma. As well, for these reasons, the art therapeutic treatment may engage adults who may be unable to profit from traditional verbal psychotherapy (Milia, 1996, 2000).

Similarly, researchers (Cooper & Milton, 2003; Milia, 2000) have found that individuals who self-harm may in fact benefit from art. While engaging in the art making, they may uncover, process, and integrate their traumatic memories. This may be beneficial in instances where verbalization and conscious awareness may be resisted. On an unconscious level, individuals who have experienced abuse may be attempting to communicate and master their trauma through the self-harming behaviours (Milia, 2000). Through visual representation(s), the processing of trauma may help break this harmful cycle and in overcoming the need of acting out behaviours.

Another particular advantage of art therapy is that it has the potential to generate order from chaotic feelings and impulses within individuals, as a way of integrating inner and outer realities with a new clarity (Ulman, 1961). As previously discussed, through the safe expression of disordered feelings onto an art object, symbolization may develop.

This in turn allows feelings to be contained and transformed, and perhaps the experience of such emotions more manageable (Shalmon, 2007). Cooper and Milton (2003), and Milia (1996, 2000) note that art therapy provides the opportunity to learn how to externalize emotions into art making. As expression(s) are redirected away from one's body and onto the art materials, there may be a notion of creating an extension of the body. Thus, the art object may be experienced as an addition to the body. This symbolizes a replacement for the skin where within boundaries, aggressive impulses and experimentation may safely be performed. In doing so, aggression and negative affect may be directed into the art as it is appropriately released (Shalmon, 2007).

Further, the destruction typically directed towards the body of the person who self-harms may be converted into a creative force (Cooper & Milton, 2003; Milia, 2000). Milia (2000) states, "feelings of powerlessness often play into the urge to hurt oneself, as it becomes a demonstration of taking control over the territory of one's own body" (p. 179). However, for individual's who engage in self-harm, the process of destruction and creation in art is one that may be used in a productive manner. Similar to the process of cutting one's skin for the purpose of tension relief, art materials may be utilized in a similar style. They may be cut or ripped in a contained safe manner to relieve tension (Milia, 2000). Within the secure expression of emotions onto art objects that will contain and transform emotions, symbolization may be developed. This is turn renders the experience of these feelings tolerable. As well, with the support of the therapist, this experience strengthens the individual's ego in working through them (Milia, 2000). This allows the individual that self-harms to gain control and individuation within her life, to symbolically create a secure self (Milia, 2000) and is also a symptom versus disorder.

Suyemoto (1998) similarly suggests that individuals who self-harm may simply need to visualize physical evidence of their emotions since their capacities for "abstract symbolization" may be fragile. Thus, the art objects created by the individual in art therapy may be effective as it mirrors back the emotional state of the individual. As well, the art creations may operate as a bridge to verbalization (Cooper and Milton, 2003; Milia, 2000; Riley, 2003).

Somatization

The American Psychiatric Association (2003) categorizes somatic symptoms related to psychiatric origins known as the somatoform disorders. Specific somatoform disorders include (1) somatization disorder (typified by recurring, multiple, complaints concerning pain, gastrointestinal, sexual and pseudoneurological symptoms), (2) conversion disorder (excessive anxiety leading to the loss of bodily function(s) including blindness, paralysis, and numbness), (3) pain disorder (severe pain experienced in one or more areas hindering proper functioning, and is thought to be caused by psychological stress) , (4) hypochondriasis (preoccupation of fears of having a serious illness as a result of inaccurate perception of bodily symptoms despite accurate and reassured medical evaluation), and (5) body dismorphic disorder (excessive concern and preoccupation with a perceived defect in either one or several features of the body, causing psychological distress; such anxiety/worry causes clinically significant distress or impairs occupational, social, and other important areas of functioning) (APA, 2005). Somatization is a disorder defined as a long-term (chronic) condition in which individuals develop physical symptoms caused by psychological problems, and where physical causes can not be found (APA, 2005).

Alternatively, it is often recognized as the physical expression of psychological distress. For example, increased blood pressure and increased rate of respiration may accompany the experience of feeling angry or extreme fear (Arnd-Caddigan, 2003). Samelius et al. (2007) further note somatization may fluctuate in severity and may persist throughout ones life based on the individual's ability to handle stress as it becomes a built-in pattern that may result in chronic aches and pains.

Somatization often runs in families and predominantly occurs in women. A common finding in the literature on the mental health of South Asians is that individuals from these communities somaticize psychological distress, as a result of the inability to express their suffering in psychological terms (Husain, Waheed & Hussain, 2006; Ineichen, 1990). The sociocultural factors may additionally contribute to the more prevalent incidence of this condition in certain cultural groups such as Asians. As mental illness is stigmatized within these societies, somatization may provide a socially acceptable way of communicating distress. These researchers believe that as stresses play on the body, the weakest or most prone system becomes the target for somatization. The area affected by somatization has a direct relationship to the nature of the negative thought patterns through mind/body relationships. The symptoms tend to be uncomfortable and prevent individuals from engaging in regular enjoyable experiences (Escobar, Waitzkin, Silver, 1998).

Moore and Jefferson (1996) assert that patients diagnosed with somatization may describe the pain as "unbearable," "beyond description," or "the worst imaginable." These patients may also have the tendency to react to psychosocial distress and environmental stressors with physical symptoms. Specific symptoms and their frequency

may vary among cultures. Individuals in Asia are more likely to report certain types of physical sensations (for example, burning hands, or feet) than Westerners. Draguns (1997) states several cultural influences affect somatization, however it is unlikely that all individuals who somatize behave alike even in homogeneous cultures.

While culture has been indicated as an influence, there are shared symptoms of somatization. Patients describe one or more of the following types of symptoms: headaches, nausea and vomiting, back pain, abdominal pain, stomach upsets, or constipation, persistent lack of sleep, painful menstrual periods, fatigue, fainting, loss of sexual desire and chronic fatigue, each without demonstrable medical causes (Moore & Jefferson, 1996). Furthermore, these individuals appear to have no awareness that their basic problem may be triggered by psychological and socio-cultural factors (Moore & Jefferson, 1996).

Somatization and art therapy. Art therapy may prove valuable for individual's who experience somatization as the art process enables one to visually represent and externalize what is experienced internally. Art therapists working with individuals who present with somatic symptoms may offer support, an open dialogue, and reassurance concerning the presenting problem(s) of the individual(s). Additionally, the positive consistent relationship between therapist and client, the provision of art supplies and art therapy activities may provide gratification of dependency needs (Lachman-Chapin, 1979).

Landergarten (1981) proposed that art could be used for insight into attitudes regarding pain. In Landergarten's study, focus was placed on depictions of pain and autogenic training. Autogenic training involves relaxation and reinforcement of pleasant

feelings through art therapy methods as well as conventional verbal methods (Shapiro, 1985). The description of pain and autogenic training was used for both physical and painful emotions. By directing participants to draw their feelings of pain and to then use the same colours to create something more satisfying, it was concluded that the experienced pain could be symbolically transformed through acts of creativity. Thus, in this instance art therapy was useful in treating the emotional strain coupled with the somatic distress.

In working with cancer patients, Luzatto (1998) discovered that the client's physical suffering plays a major role in the therapeutic dynamic. In order to help clients externalize and contain their symptoms, art therapy techniques were used to address the pain through relaxation and art making. In so doing, the clients were provided the opportunity to explore the meaning of their symptoms, pain, and illness. As well, in a pilot study conducted by Plecity, Danner-Weinberger, Szkura, and Wietersheim (2009), results indicated a significant reduction in somatic symptoms and an inclination to be in an increased positive mood during the course of the day treatment. The evaluation of the conducted interviews showed that the paintings created by the participants of this study primarily dealt with the participants own (current, problematic) issues. The colours that were chosen for the painting(s) were important to most participants, and their difficulties were often depicted symbolically. Subjectively, the participants felt better after the art therapy session and indicated that their main use for art therapy was to express their problems, suggesting that the physical nature of art making and the act of visualizing their images is significant to the clients' understanding of their illness (Collie, 2006).

In creating art, the act of art making generates a heightened sensitivity to bodily sensations, which may then lead to harmony between "bodily states" and the "forms of the external world" (Dreifuss-Kattan, 1990, p. 135). The tactile qualities of art making can offer a way of reducing intellectual defences. This may eventually help in reconnecting the body and mind (Wix, 2003). Further, based on the notion that visual images are a means to communicate between mind and body, Long (1998) noted how individuals experiencing medical illness may use art to influence their body functioning by transforming the somatic images within their minds.

Negative Body Image

Buss (2001) suggests that body image is defined as the mental representations, feelings and attitudes that individuals have towards their bodies. Further, body image can represent the attitude(s) a woman has toward her body and physical experiences (Cash & Fleming, 2002). Rosen (1990) discusses two overlapping elements related to the body: body image and self-concept, describing a positive body image as a higher level of positive versus negative feelings towards the physical self. Self-concept refers to the attitudes and beliefs individuals have regarding their identity, life roles, and appearance (Rosen, 1990). Self-esteem refers to the general feelings of self-worth and is an integral part of every individual. It mediates the relationship between societal factors and body satisfaction. It is correlated with perceived competence and availability of social support. It is through close relationships that one's sense of self worth develops and increases.

According to Bramble and Cukr (1998), one of the functions of body image is to provide individuals with a consistent sense of personal identity throughout one's life. The authors further explain that there are four influences on the growth and development of

an individual's concept of body image: body boundaries, cultural influences, external and internal influences, and the power of others' attitudes. Individuals with a well-integrated body image are more likely to react positively to life's experiences; however, for women who have experienced domestic violence, this may not be the case. One's perception of body image may change as a result of the frequency and extent of domestic violence according to Rosen (1990). In addition, irrespective of one's actual physical characteristics, the self-view and feelings related to an individuals appearance is likely to influence how one believes others view them; social feedback is important in shaping one's perception of appearance, however, one's beliefs and behaviors also influence the nature of feedback (Cash & Fleming, 2002). Thus, individuals who have fewer and unpleasant social and personal interactions will view their bodies negatively.

In a study conducted on self-esteem and abused women by Aguilar and Nightingale (1994) it was concluded that emotional/controlling abuse was highly correlated to low self-esteem and significant feelings of powerlessness and hopelessness. As well, traumatic experiences strongly affect one's sense of personal vulnerability, perceptions of a meaningful world, and positive self-image(s). Walker (1994) observed that once convinced of being helpless, the perception of the abused woman may become her reality. Subsequently, she may become passive, submissive and helpless which in turn may result in causing a low self-perception. Cruz and Essen (1994) note individuals from unstable environments where their personal boundaries were violated and where they were not able to develop a sense of personal safety or healthy limit setting within their environment also had dissatisfaction with their body image(s). The distortion of

body images reflected one's dissatisfaction with their own bodies as well as self-inflicted harm such as eating disorders or self-harming behaviours.

Negative body image and art therapy. A s a means of communicating, assessing, and working with a negative body image or distortion can be achieved by imaging the body through art (Attias & Goodwin, 1999; Cohen & Mills, 1999). The use of art therapy can be utilized to focus on the experience of self, by improving self-esteem. Additionally, the use of the body in art as a primary metaphor for the self-image of individuals can be utilized. This has been confirmed by several art therapists and art therapy clients who have suggested that art therapy can in fact enhance self-esteem (Spencer, 1997; Macintosh, 1994). Further, in order to help decrease symptoms and problems with clients, Beck, Freeman and Davis (2003) contributed to cognitive-behavioural therapies. The CBT focused on working with clients regarding their "faulty" internal thinking to reach an understanding so as to change their thinking to a more adaptive and realistic view. Therefore, the therapeutic approach of cognitive therapy was based on helping clients to identify with their misconceptions and learn new strategies and adaptive views in attempts to replace their misconceptions (Rubin, 1999).

As observed by art therapists, through isomorphic processes, body image distortions may also be translated into distortions in the art images which may then allow the body image distortions to be approached within a less threatening manner (Cohen & Mills, 1999). Once the body image distortions are worked through and resolved, improvement may be seen in emotional containment, bodily pleasure, self-cohesion, and an overall general feeling of self-value (Attias & Goodwin, 1999).

A description of my research design, relevant literature and information pertaining to the methodology I have used will be examined in the following chapter. The first section discusses my rationale for selecting a qualitative study utilizing a narrative approach, followed by a description of the art therapy research program, and ending with a discussion and description of the procedures pertaining to my research design.

Chapter 3. Methodology

Qualitative research necessitates the gathering and analysis of data through multiple sources. This in turn provides credibility and reliability of the case study findings due to the inclusion of multiple perspectives (Patton, 2002). Creswell (2003) emphasizes that qualitative research begins the moment the study is conducted at the site. Through this a more in-depth analysis and understanding of the participant may be achieved. There are numerous and varied methods of gathering data depending on the research, the participants, and the site. As well, it is a more interactive and participant-based method as it provides a wide range of opportunities to collect information such as using art, observations, interview and journals (Creswell, 2003). Qualitative data collection is a multifaceted approach utilizing several methods and skills as a prerequisite to build a strong research design as the data has been "filtered through a personal lens" permitting the researcher to evaluate and make interpretations of the collected information (Creswell, 2003, p. 182). As Ely (1991), emphasizes, in terms of the data collections and analysis process in qualitative research, the researcher is the actual tool. Along with being the tool, in this research the researcher is also the clinician.

The overall theme within qualitative research emphasizes the participants as leader and the researcher as following the path of the participants. Within the case study method, the research participants are regarded as experts on the behaviour being explored. The investigator/researcher was present to question, offer support, and to mirror the individual, working collaboratively to explore and examine the presenting behaviour (Aldridge, 1994).

The general findings of the research study are conveyed through several different measures such as questionnaires, art therapy sessions, artwork(s), observations, and field notes. Through all these procedures, themes, patterns, and results found throughout the study are illustrated. Applying a chronological format was the method utilized to ensure structure and a clear understanding of the data. This is followed by a description of each stage of the research study. Further, depictions of the art therapy sessions, quotations, and participants' visual artworks are integrated within the individual case presentations. Through this procedure a descriptive representation will support the unfolding process of the research in order to be understood by readers. As well, the shelter sample represents a non-probability, purposeful, convenience sample. It represents a range of experiences and personal views adding to the understanding of Hindu South Asian Indian immigrant women, domestic violence, internalized issues and whether the use of art therapy can be another route to embodiment and changes in the self for women in these bicultural predicaments.

Being an art therapist, I have a certain degree of sensitivity to the process of art therapy as well as aspects of the process that make it unique from other therapies. The dual roles of researcher and art therapist allow for a better understanding of the ways the creative art making process may be therapeutic during the recovery process.Within the shelter setting I believe that I can address my primary research question for this study:

How can art therapy address the specific needs of Hindu South Asian Indian immigrant women living in a metropolitan area who are experiencing trauma as a result of domestic violence?

Subsidiary Research Questions

The following secondary research questions will also be addressed in this investigation:

- What is the association between cumulative trauma and the body?
- How are issues of trauma and cultural changes addressed in art therapy?
- What therapeutic changes, if any, has the art therapy process had on the participants?

The purpose of this qualitative narrative research study is to describe the experience of healing through art. This research is specifically designed to examine the perceptions of how three Hindu South Asian Indian immigrant women with a history of domestic violence:

- Express or reveal, or access memory basis of cumulative trauma.
- Associate enduring domestic violence and express body trauma.
- Address issues of trauma and cultural changes in art therapy.
- Create meaning using art in the context of art therapy for issues of embodiment.
- Mastery or change through the art therapy process.

Research Design

This study is a multiple in depth case design using a qualitative narrative method. Qualitative research provides a holistic description, explanation, and exploration of any phenomenon (Berg, 2004), investigates the phenomenon in a natural setting, and

accommodates the complexities and process of the situation, and permits relevant issues that have yet to be identified to emerge from the investigation (Marshall & Rossman, 1989).

The narrative approach involves qualitative research that focuses on theory and practices that are interwoven throughout all stages of the research process (methods used and levels of representation) (Chase, 2005; Riessman, 1993, 2002, 2008). It starts with the narrative form where events are connected in a meaningful way to represent both action and meaning. Narrative inquiry analyzes the life stories of one or a few individuals in order to understand life experiences (Chase, 2005; Creswell, 2003) through various approaches. These approaches are defined and related to: the number of participants, the depth of the story (a moment, a time or life history), whether they are oral or written stories (autobiography, biography) elicited during an interview or heard within a dialogue (Chase, 2005). The analyses of life histories involve interpreting the personal meaning the event(s) had for the storyteller as well as possible themes regarding life experiences among the participants (Chase, 2005). This study used the life story and personal narrative to elicit in-depth stories of a particularly significant aspect of Hindu South Asian immigrant women's lived experience and their healing from trauma in the context of art therapy. As well, it traced the narrative(s) of the women's experience in the therapeutic space of the art therapy.

A qualitative study utilizing a narrative methodology was chosen as a method of inquiry for several reasons. Qualitative research attempts to study phenomenon in a natural setting and to analyze the meaning attributed to experiences by the participants (Creswell, 2003). Further, Creswell (2003) suggests that an integral aspect within

qualitative research is the process of an "emerging" study instead of a set and predetermined process. The qualitative format allows for theories, patterns, and themes to emerge and develop as the study progresses. The narrative research method was especially suitable for this study, as it brought forward unheard voices on a topic about life transitions. More specifically, it examined the experiences of three Hindu South Asian Indian immigrant women engaging in an art therapy program during their recovery process. The participants had undergone the migration experience, had experienced domestic violence, and had been exposed to significant cultural changes. As well, it elicited narratives about the histories of the symptoms the women exhibited, self-harming behaviours such as superficial self-harm, somatization and negative body images. Narrative enabled them to reflect on, make sense of, interpret and find meaning within experience (Kirsh & Welsh, 2003). Through describing their many experiences, these women were able to explore how these events were integrated into their everyday lives (Murray, 2003), focusing on individual experiences.

Narrative research methodology is particularly relevant for these Hindu South Asian Indian immigrant women because it sheds light on subjects that may have not been previously understood (Chase, 2005). Several authors (Chase, 2005; Cheals, Morgan & Coombes, 2003) assert that narrative inquiry is a study that expands our understanding of those whose voices have been silent, silenced or represented by others on their behalf. Murray (2003) has suggested narrative inquiry recognizes pre-narrative types of experiences/disclosure where a narrative may exclude feelings and interpretations, and temporarily not progress, which is common among survivors of domestic violence

(Herman, 1992; Riessman, 2002). It may also encourage support on behalf of individuals who have little power themselves to generate change (Chase, 2005).

Narrative research does not attempt to make broad generalizations, but rather focuses on the experiences of a few individuals for greater depth of information on a particular person or a group of people. It may also be a means to healing (Mattingly & Lawlor, 2000; Rosenthal, 2003) making it well suited to sensitive subjects and individuals. Mishler (1986) and Riessman (1993) suggest narrative inquiry facilitates the understanding of experiences within context as it includes setting, action/resolution, and sub-narratives within narratives. Suitable for all of the questions in this study, narrative inquiry provides a range of analytical methods and contextual frameworks for fitting these pieces together with a consistent and holistic approach (Lieblich, Tuval-Mashiach & Zilber, 1998). Through using a narrative method, I listened to how the stories were told within the clinical art therapy meetings. I explored how suffering was expressed and then how it was represented in the artwork and again listened to the stories told about the art, and how the stories changed over time.

This multi-layered study also examined graphic imagery for its communicative appeal. Wadeson (1980) suggests that this approach "seeks to collect descriptive data, people's own words and behaviour…in art this includes allowing the individual's images to speak in and of themselves" (p. 50). The stories and experiences were told in the words of the participants while relating to their individual experiences and their art.

The methodology of this study was guided by the premise that art therapy can be useful to healing in the treatment of trauma. This premise was derived from the existing literature that supports the use of art therapy with survivors of trauma and research on

specific art therapy techniques for the art therapy component. The present design sought to understand the lived experiences of three Hindu South Asian Indian immigrant women who have experienced domestic violence, who express trauma, and to explain themes of meaningfulness in this process.

The research design included an 18-week program with direct contact with the research subjects within the following activities:

- A meeting for an introduction to the program (Appendix A) and review of the consent contract (Appendix B).
- A meeting consisting of the orienting statement (Appendix C); first assessment drawing (Appendix D); and first informal semi-structured interview (Appendix E). The purpose of the assessment drawing and semi-structured interview was to provide insight into the participant's current feelings, perceptions and backgrounds.
- A second semi-structured interview at the end of the art therapy sessions to determine the effectiveness of the program and the participant's experience (Appendix F).
- Twelve individual art therapy sessions. The directed art tasks were offered to provide the participants with a vehicle to express their emotional and behavioural traumas (Appendix G).
- A second assessment drawing (Appendix H) to provide insight into the participant's feelings and to compare results to the first assessment drawing.
- Two follow-up workshops in response to the 12 therapeutic sessions (Appendix I).
- One follow-up meeting to review a summary of the participant's art therapy experience and to make the necessary changes/additions with the participant(s).

The art therapy program included:

1. Researcher describing the session's activity to the participant:

   The researcher/therapist discusses the materials offered in art therapy, introduces the art activity and describes the art task providing the participant with a structure for the entire art therapy process (Wadeson, 1995).

2. Art making phase:

   During this phase, the participant decides how to execute the activity including a selection of the art materials and the development of the art creation. The participant may select various art materials to use in the creation of art and is provided with the opportunity to decide the manner/style of working. The participant may work on an individual rhythm and energy level. Gradually, the participant's art expression(s) may depict personal expression(s) and experience(s) (Rubin, 1987).

3. The creation of the artwork:

   The participant has created an art piece or image. The art creating phase is the process of making that occurs in time, space and in relationship with the therapist. The product of the therapy sessions is of importance as it represents what the participant has created. The product may also be viewed as part of an extension of the self (Rubin, 1978).

4. Participant's naming of her artwork(s):

   The participant may reflect on the art piece and give it a title or description of what the art represnts.

5. Processing of the artwork:

   During this phase the participant describes thoughts, feelings, and other associations that may be generated by the making and viewing of her artwork(s). The processing of the art creations is a visual journey into healing and growth (Mindell, 1985). This also includes narrative elicitations. Wadeson (1995) recommends the art therapist be

encouraging with positive remarks towards the final product in a nurturing non-threatening environment. The therapeutic relationship may unconsciously or consciously take on the reparative role. As well, the permanence and tangibility offered through the art creations, provides the participant an opportunity to verify and confirm her perceptions. The art work(s) is also a provision for documentation of the progression of therapy, as the art remains as a witness, available for immediate review or later to evaluate changes over time.

According to Landy (1996), creative arts therapists are faced with difficulty when performing research. This is because they may find themselves attempting to satisfy empirical research methods that are not able to take into account the healing process of the creative acts(s). Thus, in studying what Landy refers to as aesthetically-based subjects, the creative art therapy researcher should select research questions that can lead to the "uncovering of the healing properties of the creative arts" (p. 138). For this study, the research question(s) and methodology utilized permitted for some of the healing properties of art therapy to be explored and revealed. The questions in the interview(s) (Appendix E) were based on an invitation for each woman to tell me the story of her experience of domestic violence, experience of migration and self-harming behaviours. This also included asking about their art therapy experience(s) (Appendix F) in whatever way she wished, so she could tell her stories in her own words in the context of her own framework of meaning. Participants were asked open questions in order to encourage open narrative responses and to encourage them to use their own words (Reissman, 2002). To help focus the interviews and encourage insight Patton (2002) suggests using "probes and prompts". Although I have provided a sample (Appendix E & F) of the

interview questions, these were re-phrased differently for different interviews, using conversations with each woman of this study.

Art therapy provided participants with a transitional space in which they could work through losses and traumas associated with their migration experience and the challenges of belonging to two cultures by getting in touch with emotions through artwork, recognizing feelings and helping to identify them. Participants also expressed and worked through a range of emotions stemming from the interaction of diverse past and present experiences, thus confirming that creative expression activities can provide a space for symbolic expression and playful exploration, which may enhance resiliency factors.

The art therapy interventions (Appendix G) were processed for expression of emotions regarding the participant's traumas and psychological suffering. As well, this research provides a framework that seeks to understand the lived experience of the individual in the context of the individual's multiple realities (Marshall & Rossman, 2006).

Clinical Setting

Art therapy sessions took place at a shelter for domestic violence. The shelter is run by a non-profit organization focused on the treatment of women who experience domestic abuse. The facility is located in a large metropolitan area in North America. Treatment was short-term and the art therapy sessions took place in one room, where the participant could create her artwork. The room is large, with a window providing light. The room has a sink and a large table with six chairs and adequate space for art making. The art supplies were kept in a locked cabinet, which is located across the hall in another

room. Verbal processing of the audio tapes took place after art making in either this room or in a second room. The second room is an office located next to the art therapy room, carpeted, with light blue walls, similar lighting and windows. Seating was available to accommodate the participant and therapist/researcher.

Referral Source

The methodology process in obtaining the sample for the research was as follows: All women who were residing at the shelter during the time of this research were invited to participate in the art therapy program on an individual basis. The recruitment method consisted of direct solicitation by the shelter staff. In addition, decisions around how to recruit the participants were based on the criteria for this research. The participants of this research were those pre-diagnosed by mental health professionals and were selected based on a documented history of some or all of the following symptoms: engaging in superficial self-harm, somatization, negative body image, and post-traumatic stress disorder. The participants had previously attended group art therapy and were pre-screened and assessed by the staff members of the shelter as able to take part in the art therapy program and not experience adverse effects in their recovery process. An additional safeguard was that each woman was assigned a counsellor or an intervention worker, who monitored their progress throughout their stay at the shelter, and was always present when the art therapy sessions took place.

Research Participants

Three Hindu South Asian immigrant women participated in this research. The participants were between 18 and 35 years of age. All participants originally came from India and were Hindu by religion. The term “South Asian” is defined (immigrant) women

who come from, India, Pakistan, Bangladesh, and Sri Lanka. Two of the participants were born and raised outside of Canada, while one participant had spent a majority of her life in the West but had gone back to her country of origin at a later stage in her life. There were two case studies conducted in Hindi as the participants were completely fluent in both verbal and written Hindi and did not have the competency for English. One participant was fluent in both her native language and English and chose to speak in both English and Hindi throughout her participation in the research study. In addition three other women from the shelter participated in the research project but the data from these participants were not used for this study as they did not meet the criteria of this research.

Researching Sensitive Topics

Renzetti and Lee (1993) describe issues researchers are faced with when researching sensitive topics such as sexual abuse, marital rape, and AIDS. Bergen (1996) discusses the re-traumatization that occurs for women when speaking about experiences of abuse. In light of this, it is important to note that this study traced the narrative(s) of during the recovery of the participants. As well, the participants in this study have the therapeutic support that may be required to deal with any difficulties that may arise during the process of this study. Given my experience as a clinical art therapist who has worked with survivors of domestic violence, individuals who have engaged in self-harm, issues related to somatization, and my work experience with a multicultural population, I was available to the participants during the process of this study as a support. I was also present in the shelter enabling the women to become familiar with me. This helped with the development of trust in the therapeutic relationship as it takes time for the participants

to feel safe enough to speak openly and develop trust with the therapist/researcher (Peters, 2008; Taylor, Gambourg, Rivera, & Laureano, 2006; Walker, 1994).

As this study entailed a sensitive topic, another element that was relevant to the participants in my study was my personal interest in this subject matter, and my deep respect for these women who have endured such traumatic experiences. The strength of the research that contributed to the cultural understanding of the participant's was my South Asian background. My knowledge and experience working with domestic violence and immigrant women from multi-cultural backgrounds proved useful in understanding the participant's experiences and building a relationship based on trust and non-judgmental listening. Being of the same ethnic background seemed to provide the women with a certain degree of comfort. Speaking the same language and sharing similar cultural values helped to create an alliance and sense of familiarity/belonging.

Protection of Human Research Participants

Several strategies were employed to ensure the protection of the research participants. First, a research proposal was submitted and accepted by the researcher's committee. This was followed by submission of a Scholarly Review Form and a Summary Protocol Form to the University Human Research Ethics Committee. Once all concerns had been addressed, approval for the research to begin was granted (Appendix J). An additional form of protection included utilizing alternative names in all the case studies and artworks presented and discussed in this dissertation. Details of the participants' identities and background information were altered to protect their identities. The age range of the participants was masked and given as between 18-35 years old.

Art Therapy Program

The insights from the literature on domestic violence, South Asian immigrant women, and embodiment described earlier, guides the development of a modified art therapy program for South Asian immigrant women in a shelter setting. The shelter has offered an art therapy program since 1998 and is described by the shelter personnel as being very successful. As the researcher for this program, I am applying the same art therapy model used at the shelter for this research project. Further, as suggested by Nath and Craig (1999) the approach and activities are modified to culturally appropriate ways so western systematic models are not simply transferred to use with ethnic populations.

The art therapy sessions were provided at a routine time set by the shelter management so that the participants did not miss any of the essential services of the shelter. The consent form was written in English. Participants who were unable to understand or read the consent letter were provided with a translation into their mother tongue by the researcher who communicated in English, Hindi, and Punjabi. The researcher read the consent form to give the participant(s) the option to verbally agree or disagree to it (oral consent), and then transcribed that part of the interview for the researchers' records.

Art activities. The art activities utilized for this program were typical art therapy activities used to treat but are not limited to trauma, emotional/physical/sexual abuse, self-harming behaviours, and addictions. The rationale for selecting the art tasks used in this program is that they have previously been used with cancer patients, client's wo have experienced trauma, self-harming behaviours, psycho somatic complaints, body image, and alcoholism. As well, they suit the criteria of this research, and were modified and

selected in order to gain a deeper understanding of each participant's specific needs, personal feelings, suffering, cultural changes, and healing process. The participants determined the pacing and intensity of the experience. For this research project the sessions and activities were structured. The art activities were directed art activities (Appendix G). They are unauthored art tasks that have been pre-developed and previously used in various other treatment programs and at the shelter where this research was conducted.

Based on the therapist's experience, the art therapy interventions were offered on an individual basis for two reasons: 1) The women arrived at the shelter at different times; 2) because it was felt that given the intensity of the trauma and the diverse backgrounds of the participants, the therapist could give each participant full attention through individual sessions.

Projective Assessment Tool: Draw a Person Test

The assessment tool used for this research is an approach taken from Machover, (1949). The draw a person test is a projective technique in which the individual is required to draw a person. Typically it represents the expression of self, and/or the body. Completion of the drawing is followed by asking the individual to give a description about the drawing. The graphic descriptions of the drawing are indicated as reflecting the individual's personality characteristics while reflecting a person's self-esteem, and revealing unconscious projections of conflict and concerns (Machover, 1949). Analysis is based on the assumption that the individual projects her own body or self into the situation. Interpretation of the entire drawing and combinations of indicators when

analyzing the drawing is essential. Additionally, descriptions of the drawing are useful in deriving meaningful conclusions (Machover, 1949).

Instruments

To inductively gain an understanding of the phenomenon being researched, it was necessary to utilize methods of data collection that are both flexible and sensitive within the context that the data is produced. Thus, the central methods of qualitative research include interviewing individuals, recording them, observing them in their daily routines, and recording their behaviours (Creswell, 1994). The instruments used for collecting data included the artwork and participants' reflection(s), field notes from direct observation, a projective assessment technique at the beginning and end of the research, audio-recordings of the two semi-structured interviews, art therapy sessions/interviews and transcriptions, two response follow-up workshops, and a follow-up meeting.

One of the primary strategy for data collection in this study were two informal semi-structured *interviews* (Appendices E & F) as a method of gathering descriptive data from the participant in her own words to gain better insight into how the participant makes meaning of her experience. The questions for the first semi-structured interview (Appendix E) in this study were:

Understandings and experiences of health and healing

1. In your own words, please tell me what does health mean to you?
2. In your own words, please tell me if there are times when you feel unhealthy?

Please give examples.

3. Please tell me if you have had any health problems in your life?

If yes, please discuss what you believe might have contributed to these health problems.

4. Please tell me what does healing mean to you?

5. In your own words, please tell me if there are specific situations that make healing difficult? Please give examples.

Experience of Migration

6. Please tell me about your migration experience.

    What (if any) are the challenges you have been faced with?

    How do you feel this has affected your cultural ethnicity?

    Have you experienced any cultural changes?

Experience and understandings of violence

Responses to the following questions may include personal experiences and/or your understandings.

7. In your own words, what is violence? Please give examples.

8. Please tell me about your experienced abuse.

9. What were the circumstances surrounding your abuse?

Experience of self-harming behaviour(s)

10. Please tell me about your self-harm (type of self-harming behavior)

    When did you start_____?

    What do you recall, that may have happened, that led to this behavior?

11. Please tell me about the circumstances for your_____ your body?

    What was going on for you at home?

    In other areas of your life?

Experience of somatization

12. .Please tell me about your experience of painful symptoms in your body?

Please tell me about your experience.

What pain do you experience/feel?

Where in your body do you feel the pain?

What do you recall, that may have happened, that led to your somatization?

Experience of body image

13. Please share with me, your thoughts about your body.

14. In your own words, please tell me if you see any relationship between the domestic abuse in your life and your view of your body image?

15. Please tell me about your experiences as a woman that you think has influenced your body image or your recovery?

Concluding questions

16. Please tell me what you hope to achieve here at the shelter? What would you like to achieve for yourself?

17. Is there anything you would like to share or add to our discussion?

18. Do you have any questions you would like to ask me?

The semi-structured interviews offered flexibility in both the exchange between researcher and participant and while gathering information (Polit & Hunger, 1999). The experience(s) of all individuals are unique; thus, the experience of a Hindu South Asian immigrant woman who has experienced domestic violence, displaying symptoms of embodiment is a phenomenon that is experienced and expressed differently among all individuals depending on cultural factors, familial structure and dynamics, and the nature

of the abuse. The semi-structured interviews allowed the participants to discuss issues of experience in as little or as much detail as they choose. This in turn gave the participants more control over the degree to which issues emerge. Further, during the interview, participants were encouraged to tell their stories and to speak about their experiences naturally without too much prompting on the part of the therapist, because I wanted to record their own narrative of their experience(s). The second interview (Appendix F) consisted of questions regarding the participant's therapeutic experience:

Experience participating in this research project

1. Please reflect upon your time in art therapy.
2. What do you recall discussing in art therapy?
3. What were the most significant themes that you discussed?
4. What was the effect of the art therapy you received?
5. What did you find helpful from your therapy?
6. What was not helpful in therapy?
7. What did the art creations represent for you?
8. Have you learned anything new by participating in this research project? If so, what did you learn? Please give examples.
9. Is there anything that you learned in this research project that you will use in your life? If so, please give examples.
10. What is your response to the topics covered in the therapy sessions?
11. Are there any topics that caught your attention? Are there any discussions that you remember more than others?

12. Was there anything that you wanted to discuss that was not addressed in the art therapy sessions?
13. Was this project helpful in achieving your hopes, goals, or needs?
14. Is there anything else that you would like to say?

Following termination of the therapeutic experience this interview was conducted to gain insight on the participant's art therapeutic experience. Interviews may be considered as one of the most valuable and rich sources of data in qualitative research. Through these, the researcher is able to understand the experiences of the participant from their perspective and allow for the events that the researcher is not part of to be reconstructed in their presence (Rubin, 2005). To collect similar basic data from each participant, however, I had formulated semi-structured questions, which I integrated naturally into the conversations.

In addition the follow methods were also used to gain pertinent information:

Additional information: Regular staff meetings with the counselling team provided insight into each participant's progress.

Response follow-up workshops: Two group response follow-up workshops were conducted. The artwork(s) created in the two response follow-up workshops will be used to reflect and respond to the participant's experience of her process during the research program (Appendix I).

A follow-up meeting: was conducted with the participants to confirm interpretation of data and enhance the validity of the research findings.

Art therapy interview. Similar to the structured interview(s), the women's experience of her recovery process through art therapy treatment is also very

individualized. Therefore, a qualitative approach permits a specific individual's experience to enrich and to clarify one's understanding of the effects of domestic violence, cultural issues, symptoms of embodiment and the recovery process in art therapy. Both the researcher and the participants are challenged by the nature of the dialogue and the stigma associated with the issues that the participants face.

The art therapy interview(s) were conducted in a private office at the shelter during the art therapy session(s). The art therapy interview were based on Betensky's (1987, 1995) phenomenological approach (1-5 below) to art therapy and consisted of the following sequence of activities:

1. Instructions and invitation to engage in an art activity during each session.
2. Experiencing and orientation to the art materials. The art materials were made accessible to the participant in order to freely experiment with the materials as they challenge sight and touch; stimulate emotional arousal and consciousness.
3. Process of the artwork – Engaging in the art making by participant(s) was in presence of the therapist/researcher.
4. Visual display – viewing the participant's art creation once completed.
    - The art creation was displayed for both participant and therapist to view it.
    - This was followed by "distancing", where distance is placed between viewer and object. This permits more objectivity, as the visual product becomes part of the world, "separate from the creator" (p. 158). Strong emotions and/or thoughts associated with the image were viewed with a certain degree of detachment.
    - Intentional looking: During this stage, Betensky (1987) recommends that the therapist invite the participant to take time to look at the art expression and to

communicate with it or to receive a message "embedded in the art expression" (p. 158) without any distractions. Following this process, the participant's awareness should be "deepened and enriched by new observations which strike him as discoveries" (p. 159)

5. Phenomenological description – Betensky (1995) advises using the phrase "what do you see" (p. 159) in order to emphasize the participant's precise perception of the art expression while underlying the importance of the participant's reality.
6. Phenomenological unfolding – Guiding the participant in unfolding meanings based on the outcome of the previous phases.
7. Participant's writing of a personal reflection of the art creations immediately after each creation.

Artwork from art therapy sessions was a valuable source of data. Yin (1994) states artistic creations include a tool or instrument, a work of art, or any other "physical evidence" created by the participant. Thus, the participant's art creations encompassed within the category of "physical artifacts". In addition, borrowed from an ethnography approach, "the study of how people conduct themselves in the context of their cultures" (Kapitan, 2010, p. 113), the art imagery was looked at through the cultural implications or meanings from the participant's perspective (Kapitan, 2010).

All the artwork(s) were stored in a private box (for three-dimensional work) and a folder, and was available during each session for the participant to view. At the end of each session, all creative productions were digitally photographed. Digital images of the artwork(s) were stored in a password-protected file on my computer. Permanent artwork(s) were stored in a private closet in the shelter facility during the entire

intervention time until the end of the therapy sessions, after which time, the participant was invited to take the artwork(s) home. In the event that the participant did not want to take home all or some of the artwork(s), ethical codes require that I store these productions for seven years after the termination of therapy before they may be destroyed. I obtained permission to take digital photographs of the art creations from the therapy sessions for my personal analysis (Appendix B). The photographs will be destroyed upon completion of the research study.

The multiple data sources also included data collecting from routine art therapy procedures for documenting the participant's process and progress. These methods included digital photographing of the artworks and the participant's interpretation of the created artwork (processing by discussion) and written responses to the art creations. The information in the written response refers to the response provided by the participant when asked about her immediate impressions, reactions, or questions after each art therapy session. Blank paper was provided to the participant for this purpose. The language utilized for the written response(s) was what the participant considered comfortable and suitable. The responses were translated by the researcher.

The participants took part in specific art therapy tasks (as mentioned earlier) designed to facilitate the expression of feelings and perceptions regarding psychological suffering, trauma and cultural changes. There are a number of goals to be addressed when working with trauma issues related to domestic violence, superficial self-harm, somatic symptomatology and cultural matters. They range from first establishing a sense of safety and rapport with the client, to understanding the effects of trauma, examining self-destruction and the origins of bodily suffering, to increasing self-esteem, empowerment

and validation, leading to recovery. Within each of these goals are specific tasks designed to assist in the identification and communication of emotions related to the trauma associated with domestic violence, superficial self-harm, somatization and cultural ethnicity and to increase a sense of empowerment in order for the participant to find her voice.

Observations. It is suggested that qualitative studies (Yin, 1994) contain descriptive data through their written or spoken words and observable acts throughout the research study. Through direct observation of the participant, data was collected by the researcher/therapist. The central methods of qualitative research include interviewing, recording what the individual(s) verbalize, observing individuals in the course of their daily routines, and recording their behaviours. The observation was done during the interviews and art therapy sessions and observation of the participant(s) in their natural environment (shelter setting). This entailed verbal and non-verbal actions and feelings expressed through facial expressions, voices, behaviours, and through the (shelter) environment as their "home". Thus, through this form of data collection the researcher was able to gain insight of interpersonal behaviours (Yin, 1994). During the sessions, I observed any physical and emotional affect in the sessions and engagement in symbolic elaboration of ideas in the art making. I also observed any pertinent verbalizations in the participant's interactions with me, and any of the associations the participants had in the process of art making, or viewing the finished artwork(s). Field notes documenting the observation were written immediately after the observation(s).

Audio recordings. An audio recorder was used to record the two informal semi-structured interviews as well as the art therapy sessions. The initial and final interviews

were semi-structured and sometimes required the researcher to ask additional questions stimulated by the participant's responses. Thus, audio-recording is considered a thorough method of collecting information and a valid data collecting method (Creswell, 1994). I obtained permission to audio-record the therapy sessions for my personal analysis (Appendix B).

Verbatim transcripts. All sessions were transcribed. Interviews lasted approximately 1 to 1.5 hours. Upon completion of the interviews, the recorded interviews on the audio tapes were listened to several times and then transcribed. The audio-recorded art therapy sessions were also listened to several times and then transcribed. They will be destroyed upon completion of the research study. Transcriptions will be kept for 5 years in accordance with APA standards after which time they will be destroyed. As well, the participant's interactions with me, our verbalizations, the participant's emotional affect, art media choices, and interaction with the art materials, were looked at so that the sessions could be qualitatively analyzed for recurring themes.

Follow-up meeting. A follow-up meeting with the participants was scheduled approximately three weeks after completion of the art therapy program to confirm the interpretation of data and enhance the validity of the research findings. Further, participants were given the option to include or exclude what they believed pertinent to the final text.

Confidentiality/Anticipated Ethical Issues

At the outset of the study participants were given an informational letter (Appendix A) about the procedure and nature of the research together with a letter of informed consent (Appendix B). The informed consent letter was to educate the

participants about her voluntary rights as well as confidentiality. A verbal and the written protocol were utilized to address the objectives of the research, and how it was carried out within the study. Prior to starting the study, the participants were provided with an orienting statement (Appendix C) to provide a catalyst for recollection of the participant's trauma(s) and to express emotions about the domestic violence experienced. This lasted approximately 30 minutes.

The participant's rights, decisions, and values were honoured throughout the course of this study. The participant had full knowledge of the extent of the research and her position within the study. The consent form (Appendix B) provided the participants with a full understanding of the process. Finally, all informed consent and confidentiality forms were placed in an envelope and stored in a private cabinet under lock and key at the shelter. The participants were informed that the researcher would be using the interview data and images of their artwork(s) created during the art therapy sessions towards the writing of a dissertation that will be digitally available on the Internet. The participants were also informed that this research study may also be presented in educational settings or published for educational purposes in the future. Additionally, the audio-recordings of sessions were not labelled with the participant's name or any other identifying information and were coded using a number system (for example, 1-5).

As the researcher and professional clinical art therapist, I am obligated to adhere to the codes of ethical practice and professional conduct for the Art Therapy Association of Quebec (AATQ). The participants were required to sign an informed consent (Appendix B) form before data was collected. Due to the sensitive and personal subject matter regarding this research, I ensured the confidentiality and privacy of the

participants and all individuals who were involved, and the facility involved in this study. All names and other identifying descriptive information have been altered and concealed to ensure confidentiality. The participants chose a pseudonym in order to be protected. Finally, the researcher is in compliance with the Summary Protocol Form approved by the University Human Research Ethics Committee which protects and ensures the overall well-being of research participants and makes certain that researchers respect the ethical principles of autonomy, beneficence, and confidentiality.

Data Collection

In order to maintain validity and reliability throughout the study, the following techniques were used to warrant *trustworthiness*: *credibility, transferability, and dependability.*

Credibility procedures that were applied in this research included description, triangulation, audit trail, and member checking. The researcher's understandings were supported with descriptions and examples provided by the participants. This required the results to include enough quotations to illustrate the findings and details to provide the contexts of the participants (Creswell, 2004). The second task to ensure trustworthiness was *transferability*. It is defined as the extent in which the research findings may be applied to other populations or context so long as they are adequately similar to the original one being studied (Marshall & Rossman, 2006). The initial researcher is responsible for providing sufficient detail and depth in the descriptions of the participant's experiences. Transferability was achieved through the detailed demographic information, descriptions of the participants' challenges, the context of the issues, and the inclusion of multiple quotations, and participant's illustration (Marshall & Rossman,

2006). Such richness of the data can assist other researchers in forming their own opinions regarding the applicability of the findings to other research. Qualitative inquiry studies social contexts subject to on-going change, thus difficult to replicate. Concern should be placed on understanding the participants' perspectives instead of trying to replicate the study. *Dependability* in qualitative inquiry is achieved by procedures that were previously discussed: triangulation, audit trail and member checking (Marshall & Rossman, 2006). Finally, the fourth task in assessing the research trustworthiness is *confirmability,* which implies separating the findings from the researcher's bias in order for the results and interpretations to be confirmed by another person (Marshall & Rossman, 2006). Triangulation techniques contributed to minimizing any bias in the findings. As well, confirmability of the data included recording all interviews, transcribing them verbatim while ensuring that I was not leading the participants in my questioning.

Data was collected through several means: questionnaires, note-taking, observations, artworks, and on-going dialogues between researcher and participants throughout the research study. This ensured the process of *triangulation* within the research process. Additionally, an understandable and detailed description of the purpose, process, biases and methods of collecting data were in order. The researcher was also monitored by the research supervisor(s) in order for the protocols to be maintained throughout the duration in which the research was collected (Creswell, 2003).

The data was collected over a period of six months. The research participants were asked to engage in twelve 1.5 hours of individual art therapy sessions designed to

facilitate the expression(s) of personal feelings, suffering, cultural changes, and their recovery process.

Direct observation was done during the art therapy sessions (for example, affect, body language, and emotional investment in the art activity); the observational protocol consisted of descriptive notes taken during the art therapy sessions:

- The artwork generated during the sessions (symbolism, colour usage), and
- The participant's own choice of words regarding associations and observations in response to the art, and written reflection of the art.
- Audio-recorded interviews transcribed verbatim by the researcher, including the interviewer/listener dialogue to capture the narrative in sufficient detail given the analysis method (Reissman, 2008). All the recorded informal semi-structured interviews and art therapy sessions were listened to and transcribed for data analysis. I also took note of any pertinent verbalizations in the participant's interactions with me, and any associations the participant verbalized in the process of art making.
- The draw a person assessment tool administered at the beginning and end of the research to assess and compare participant's self-perceptions.
- Two informal semi-structured interviews. To gain 'rich descriptive data" and to provide a forum for open dialogue, the participant was asked to participate in two semi-structured interviews (Appendices E & F). The semi-structured interviews offered flexibility in both the exchange between researcher and participant and while gathering information (Polit & Hunger, 1999). Through this, the participants were able to answer the semi-structured questions and other questions related to the content of their answers. Further, the semi-structured format enabled the participant

and researcher to immediately provide clarification or explore issues further and enable subject matter/reactions to emerge. The participant was asked questions that arose from descriptions and answers. This provided information that was not originally anticipated by the researcher. The questions were based on a series of questions designed to explore expressing emotions of trauma/suffering as well as personal and life experiences that may have led to such practices. Therefor participants were only asked questions relating to their individual experiences of self-harming behaviour(s). The second interview (Appendix F) consisted of questions regarding the participant's therapeutic experience.

- Regular staff meetings with the counselling team also provided insight into the participant's progress. Additional participant records from the site, such as intake notes and personal histories, were collected for data purposes only on an as needed basis.
- Confirmation meeting: A follow-up meeting with the participants to confirm interpretation of data and enhance the validity of the research findings. During the follow-up meeting, the researcher read a document containing a summary of the themes extracted from the art therapy sessions and the semi-structured interviews. The participants were asked to suggest changes, additions, and/or deletions to the text to ensure that it represented an accurate reflection of their experience.
- The field notes constituted a record of the observations made during the interviews, participant observation in the shelter, and art therapy sessions. Field notes were written immediately after each interview. This included the main issues or themes; impressions about the narrator-listener relationship (interviewee-interviewer); things

that stood out as significant, interesting, illuminating or important; emotions and energy level; and new or outstanding questions for the second interview (Creswell, 2003). Field notes were written immediately following each art therapy session and observation within the shelter setting. They highlighted observations, issues, concerns and further questions for clarification and consisted of information that the researcher recorded about the circumstances of the interview and the impressions made during the interview (characteristics of the participants, details on the data collection, documentation of the environment, nonverbal behaviours, communication processes, and rapport). These provided important dimensions when analyzing the interview data.

To reduce research bias, *triangulation,* a form of ensuring rigor was used. Streubert and Carpenter (1999) describe triangulation as multiple viewpoints in understanding the completeness or confirming the results regarding the description of a phenomenon. There are four types of triangulation described in the literature – data, theory, methods and investigator (Krefting, 1991; Streubert & Carpenter, 1999). Two types applied to this research. First, the collection of data at two points in time (initial and follow-up) provided two perspectives from the same participant. The second type applicable to this study was the artwork(s). Method triangulation refers to different types of data collection and in this study the use of creating art verified and validated the women's holistic and integrated sharing of their experiences. Additionally, what the participant verbalized in the interviews was reviewed against art creations from the art therapy sessions.

Finally, catalytic validity was also used for this study. Catalytic validity refers to the extent in which research changes those it studies so that they understand the world in new ways and use this knowledge to change it. Lather (1995) suggests that catalytic validity is to help participants to understand their words in order to transform them. Cohen, Manion, and Morrison (1996) suggest that the research should improve the participant's experience of the world as well as empower them to understand and transform their "oppressed situation". As a result, the research may focus on "what (future trends) might be" and "what could be" (ideal possible futures) (Cohen et al., 1996). With this in mind, it is hoped that this research may offer an opportunity for creating safer communities by bringing out the violence immigrant women experience in our communities behind closed doors. In addition, this study may provide health professionals with insights into abused women's views and strategies; how women cope with their suffering; and how providing a safe space for disclosure and/or expression of emotions through art therapy may reduce the incidence of subsequent violence. Thus, with the use of a variety of data collection methods: documentation, physical evidence, direct observation, informal semi-structured interviews, audio-recording and transcriptions, the collected data will represent the participant and will provide varying perspectives that contribute to the development of a holistic image of the participant.

Data Analysis

There were two goals for the analysis: (a) to use a cross-case comparison methodology of what the women stated regarding the art therapy in relation to their recovery process and (b) to generate significant representations of what the individual women mean by what they stated. To achieve the first of these, analysis of categorical

content (specific topics raised) was conducted and holistic content (overall meaning) for every interview. To achieve the second goal, I analyzed exemplar narratives for their narrative structure and for their meanings in relation to the women's beliefs regarding themselves, domestic violence, symptoms of embodiment and healing.

Within qualitative research, analysis and interpretation starts with the beginning of the data collection. The first step of analysis of this research began during the interviews where I paraphrased, condensed, and reflected meanings back to the three participants. This helped both the participants and myself (researcher) to clarify any discrepancies or contradictory understandings of themes, as this feedback was used to refine the participant's conceptions (Creswell, 2003). Additional data sources were used throughout the study process to gain further understanding of participant experiences, identify initial patterns and relationships, verify, check, confirm and add completeness when themes were identified from the transcripts. The art and stories added depth and clarity to the experiences and meaning that the participants described in their interviews and in the art therapy sessions.

This qualitative approach is based on inductive analysis without preconceived categories or hypotheses. This allows the data to speak for itself instead of serving as examples supporting or refuting theory that already exists. I allowed the participants to tell their own stories in their own voices, without subscribing to a particular narrative subjectivity, and to allow their own account of themselves to form the basis for the analysis. Also pertinent to my research were the two features Agar (1980) identifies as key to ethnography that I utilized in my study: (1) that "whatever the interests of the [researcher, she] must understand the way that group members [of the culture being

studied] interpret the flow of events in their lives;" and that (2) the researcher "in her struggle to describe" the schemata and frame which group members bring to their own understanding of cultural events and experiences, she should "turn to the holistic search for pattern as a guide" (p. 242). Maxwell (1992) calls these "contextualizing strategies"; they were viewed as essential for me to maintain faithfulness to the participants.

In addition, Creswell (2003) identifies six major steps to analysis and interpretation, which were followed in my research:

1. Organize and prepare the data for analysis by transcribing interviews, scanning materials, typing field notes and sorting/arranging data into different types.
2. Cautiously read all the data, forming impressions/recording ideas to gain a general sense of the information. To write down notes in margins and record thoughts regarding the data.
3. Begin detailed analysis by using a coding process to "chunk" or group materials. Taking text or paragraphs and placing them in categories with labelled terms based on the actual language of the participant.
4. Utilize the coding process to produce descriptions of the setting, subjects, categories, and themes that arise from the data collected, descriptions being details about the places, individuals or events. Then, "use coding to generate a small number of themes or categories" (p. 193).
5. Advance how themes and description will be represented within the qualitative narrative.
6. Make interpretations, draw conclusions and note implications (pp.190-95).

Finally, in accordance with the following methodological steps (Kvale, 1996) several strategies determined the validity of this study's findings. The multiple data sources that were used borrowed from several approaches. The data gathered during the informal semi-structured interviews, data related to the artwork(s), data from direct observation and notes, the data from the audio-recordings, assessment drawings, and data from the follow-up interview were reviewed to identify themes and findings related to trauma, domestic violence and self-harming behaviours. Specific steps included the following:

Process for Translation

The audio-recordings were done in Hindi and English; all were transcribed. There were three sets of audio-recordings from three participants; two were in the Hindi language and one was in the English language. The audio-recordings that were done in Hindi were transcribed in Hindi by the researcher. Following this, the two participants were welcomed to review their transcribed Hindi documents.

Once the participants agreed to the accuracy of their transcribed documents, the researcher translated the transcribed Hindi documents into English. Upon completion of the transcription of the Hindi documents into English, an independent professional translator reviewed the transcribed documents and compared them to the Hindi transcribed documents. This was done to ensure the translations accurately reflected the content of the audio-recordings. Thus the results were compared and discussed between the researcher and participants and the researcher and the professional translator to arrive at a consensus amongst the researcher, participants, and professional translator. The audio-recording(s) that was done in English was transcribed in English by the researcher.

The participant reviewed the transcribed English document. This was done to obtain agreement for accuracy of the transcribed document. Additionally, all three participants were invited to listen to their audio-recordings, if and when necessary, for clarity and accuracy.

Analysis

The following analysis model was used from class notes (Anonymous, 2007).

Content analysis. Upon completion of each interview, I listened to the interview recordings three times, making note of repetitions and of moments of emotion or insight. As proposed by Morse and Field (1995) the recordings were transcribed verbatim including all details such as pauses, incomplete expression, sounds, reiterations, and emotional expressions in order to analyze the data line-by-line. I made sure to keep all the information in its original form. In typing the transcriptions, I replayed the audio-recordings repeatedly to clearly hear the participant's verbal descriptions. I also reread the transcriptions and made notes of the connections to my research questions, cross references or correlative ideas connected with the literature and theory discussed in the research. This helped me to become familiar with the data as suggested by Colaizzi (1978). I was also able to gain a sense of the themes spread throughout the interviews and of the participant's experience. Reading the interviews many times was beneficial. In doing so, I became aware of my own experiences with the phenomenon and my own process, and with what was read on the subject, in an effort to bracket out any external data (Creswell, 2003). I made a list with four categories pertaining to each woman's experiences of domestic violence, cultural change, suffering(s) and experience of embodiment, and her art therapy experience. Everything each woman stated about her

experience was written in sentences on a list. I then assigned each phrase a code. This was my rough analysis of content. I placed these into the categories and then into a rough model which included the four categories and details from my notes. This temporary model was for my use and it helped me maintain everything the women voiced. It also helped me see what had been said and to identify items that required reconsideration. As the temporary model emerged, I made a chart to keep track of the parts of the interviews. As well, I wrote a synopsis of each interview from a narrative perspective (Lieblich, 1998). This process helped me identify what to include in the next stage of analysis.

Context and coding. In order to prepare for an in-depth narrative analysis, during this stage I identified emerging themes/information and main ideas emerging across the sessions through note keeping in the margin section of the transcripts for simple identification (Smith, 1995). These "extracted themes" or "meaning units" were done by a process of "unitizing" the data. This part of the process extracted meaning from the raw data. Then analysis of the data was performed with the assistance of Hyper Research, a computerized software program designed for use in qualitative research. This process started with the transcription of the audio-recordings of the interviews. The text transcriptions were then exported in the Hyper Research program for coding. Using the manual coding option in the program, the text (from the source file) that I wanted to encode was selected and coded. A master code list was developed as I coded the data and each interview was reviewed at length with the appropriate codes being linked to passages in the transcriptions. An example of some of the codes were: "CONTROLLING – exercising power or authority over an individual," "ABUSE – physical or psychological maltreatment of an individual," "HUMILIATION – the act of destroying an individual's

dignity," "DISEMPOWERMENT – feeling the loss of power and control in oneself," "SADNESS – feeling grief, sorrow, unhappiness," "SUFFERING – feeling pain or discomfort," "PAIN – feeling strong emotional distress," "GROWTH – being provided with support and comfort," "FRAGILITY – feeling vulnerable," "LOW SELF ESTEEM" and "ISOLATION – separated from others." The following text segment illustrates my coding method

LOW SELF ESTEEM [Devi] I can not draw. This looks like a child's drawing. This is what I made what I feel like.
LOW SELF ESTEEM I feel ugly and I can not look in the mirror I look so ugly (*soft voice)*
DISEMPOWERMENT My husband use to tell me that. But hitting is better than his words…When you get hit (*crying*), you get hit and it hurts for a while (*pause*) and you know you won't feel it after, but the mental
DISEMPOWERMENT abuse, stays with you. The words he would say to me, hurt me a lot (*pause*) I feel like nothing, I am nothing…
ABUSE He would yell at me and tell me I was stupid, that I was an idiot, and it was my fault (*crying*).
HUMILIATION He kept on saying how ugly I am how disgusting I am…
CONTROLLING [Devi] - He has threatened me, tells me that his behavior is my fault,
ABUSE calls me names, and tells me
HUMILIATION that I need to be a better woman (*sigh*). He told me that he is the head and I need to listen to him, that I should step up and do the right things to keep him and
DISEMPOWERMENT should know my place as a woman (*eyes looking down*).
[Abha] - Well this seems so difficult to deal with.
SADNESS [Devi] - Yes it really affected me (*crying*). And see I am still so upset, why did he do this to me. What did
PAIN I do to ruin his life. He chose to marry me and brought me here (*strained voice, crying)*.
Why if he was to do this why?
[Abha] - I can understand your frustration and pain.

I added more codes as I continued to code the files and adjusted them accordingly. For example, I had used the code "POWERLESSNESS", "HELPLESSNESS", "INABILITY" and "UNABLE" at the beginning of my coding process, but as I continued

to develop a coding system combining those that overlapped and limiting the number of codes, I switched this code to "DISEMPOWERMENT" as I felt this was a better suited code. Once this new list of codes were drawn up, I tested them again.

After generating the coding catagories and modifying them, I assigned them as abreviations to the units of data as indicated in the example below

Assigned abreviations:

G - GROWTH
F – FRAGILITY
I - ISOLATION
DP – DISEMPOWERMENT
SF – SUFFERING

Assigned abreviations to the units of data:

G [Devi] - I have no one here *(forehead in palms*). I met a worker here who is helping
me but
F that's all. It is so hard (*strained expression; wiping tears*). For
F two years I had no one I use to sit alone in my house waiting.
[Abha] - What about family friends or family, extended family?
I [Devi] - He only had a brother here and his wife but they never spoke to
I me. I never saw anyone else (*sighing, staring into space)*.
[Abha] - This must have been hard for you.
I [Devi] - Yes and I had no where to go because I had no money and he would
DP not give me any either.
[Abha] - This must have been very hard then.
SF [Devi] - Yes it was, but this is why I left (*crying*).

Once all the interviews were transcribed and coded, narratives were generated that extracted specific data from the files.

Identifying narratives, recordings, and writing of analysis. Creating a representation of my analysis and my understanding was now complete. In this reading, I made a representation of both my analysis and understanding(s). To keep the texts together, I used colour-coding (highlighting) for my subsequent steps. For each

participant, I used a separate colour so that I did not lose track of each womans voice. An example of how I proceeded is as follows: Each woman's narrative was electronically written in a specific colour; Raina in black, Jaya in dark blue, and Devi in dark green. I identified in *light blue* the parts of each interview that contained stories relevant to the research topic. Within these text segments, everything each participant stated about (a) symptoms of psychological distress, in *yellow,* (b) how enduring domestic violence and expressing suffering is associated, *in purple*, (c) how the use of art in therapy helped address trauma, *in green,* (d) how art making in the context of art therapy helped or did not help, *in pink,* (e) and what visual representations are represented in the artwork(s) *in red*. I then compared my initial and later impressions and understandings of each interview. This was done to assure the narrative synopses for each interview were accurate by reviewing the synopses, my interview notes, and my field notes. For any discrepancies, I reread and reassessed the text. I recorded the pertinent sections of the texts using the final version of my coding scheme. I also highlighted in *orange* all the segments of the text when I was unsure of the content or meaning. By coding the texts in this manner, I was able to follow each theme throughout the text. Transitions between the themes, the context of themes, and the relevance of the themes were noted. I wrote new narrative synopses for each interview and integrated my interview notes, my field notes, the answers to the interview context, and the art therapy contexts into each of the original synopses.

Storylines and exemplars. These readings corresponded with the writing of the results. In order to complete the analysis (categorical content) of what the women stated in the interviews, I coded the interviews in the same manner as indicated earlier in the

Context and Coding section. An example of the coded sections of the interviews is illustrated in the following text.

The assigned abbreviations were listed as the following:

AW – AWARENESS
DF – DIFFICULTIES
C – CONFIDENCE
SP – SUPPORT
AN- ANXIETY

Assigned abreviations to the units of data:

AW [Raina] We did several art activities in therapy that helped me understand why I was feeling the way I was and how to help myself. It was also

DF difficult at times because we made things that dealt with the abuse and pain I suffered.

C I think to be more confident and believe in myself.

SP I enjoyed talking to you and hearing your feedback. I also liked the individual sessions

DF [Devi] We talked about my problems with my husband.

AN I sometimes felt I worked so much that I was upset about things I had forgotten.

SP I have gotten support and I feel that I may be able to trust new people. Normally I am afraid. Not worry so much and to take care of my self.

DF [Jaya] The troubles I had when I lived with my in laws and my husband… I don't know I just did what I was suppose to.

SP I can talk about my pain and sadness… Everything was good.

C To think about myself and learn to be confident.

I then categorized the coded sections of the interviews into storylines. They represented what the women stated about how the art therapy did or did not help. Based on individual passages on this theme, I wrote a thematic overview of each storyline. The subsequent passage about sense of self represents an exemplar of the storyline that corresponds to how art therapy was helpful.

Issues related to the women's sense of self were brought to the therapeutic forum through the art directives on several levels. For the women in this study, I believe dealing with these issues was ultimately a positive experience, though the process was a painful part of their therapeutic work. The artwork helped the women achieve self-esteem, self-awareness, experimentation, hope for the future, and a new way of living that helped move them in the direction of personal transformation.

In writing the thematic overviews of the storylines and minor themes to represent what the women expressed, I focused on the diversity of the women's narratives. To complete the narrative analysis of what was most meaningful to the women, I used one or more exemplar narratives for every storyline. These were analyzed in detail based on narrative structure, and what the women expressed regarding themselves, domestic violence and embodied expressions of suffering and art therapy treatment (Agar, 1980). Further, I presented the exemplars as excerpts from the particular woman's narrative on the theme of the storyline. The excerpts were taken from several sections of the sessions or from just one part to show the development of the storyline within the particular woman's narrative. The presentation of each exemplar narrative was followed by a relevant discussion of its meanings in relation to the woman's expressed beliefs about herself, domestic violence, symptoms of embodiment and healing. Thus, the women's

narratives represented their own structure of meaning and indicated how and why the events or stories recounted in the narratives were of importance to them.

In-depth exploration of artwork(s). Upon completion of all the artwork, an in-depth exploration of the same, using the participants' own words discussing the imagery associations, the use of colour, amount of detail included, themes, mood of the artworks, and shapes and sizes of objects were considered as indicated in the case studies section. An attempt was made to describe the artwork produced by the participant. I assessed the themes and content of the artwork(s) based on the participant(s) perception(s). I also described the participant's verbal associations gathered during processing of the art tasks and the participants written responses to the art creations. A discussion of the results followed, regarding the art therapy tasks and if they met the intended goals for treatment.

Chapter 4. Summaries of Case Studies

The case studies will demonstrate how art therapy is a treatment modality that benefits the three women of the South Asian community. Focus is placed on the personal narratives expressed in a culturally sensitive environment in which the participants could work through their traumas during the process of recovery.

I have condensed my interviews from Appendix E and the art therapy session reports into these summaries. In addition to the participants' artwork and their associations to it, an assessment of significant events indicative of the therapeutic process in the sessions are also included. Each summary represents the images and the stories shared with me during the study. Each woman was encouraged to tell her story in her own words, and the summaries utilize these words within the framework of the structure presented by the researcher. Additional segments of the women's narratives are presented in Appendix K. As suggested by Steele (2003) in using drawings in short term trauma resolutions, part of the process is the participant's individual understanding and re-experiencing of the traumatic experience. The therapist's interpretations may destroy this process. Allowing the participants to make their own interpretations is important in achieving accuracy, to the client/therapist relationship, and the client's trust within the process. Similarly, art therapy is especially powerful as an approach. The role of the art therapist is to use the art as a tool to therapeutically work through the client's problems.

Case I – Raina

Raina, 25, is a Hindu-Punjabi woman whose family originated from the *shudra* (semi-skilled/unskilled caste). She was born in India and was educated in two Western countries before returning to India with her North Indian parents at the age of twenty-one.

As a young girl, although Raina had adapted and learned Western ways at school in Alberta, she was well-versed in her own culture and traditions. Having traditional values, Raina made strong attempts to embrace the life of the daughter-in-law to preserve the same value system and customs as she had while living with her parents in her country of origin. She explained:

> "जब शादी हो जाती है हम साथ रहते हैं और हमारे ससुराल वाले और हमारे पति की सेवा की उम्मीद होता है. यह मेरा कर्तव्य है और परिवार के लिए सम्मान है. अगर मैं उन्हें सम्मान नहीं किया, तो मेरे माता - पिता को शर्मिंदा किया जाएगा."
>
> *When we get married we are expected to live with and serve our in-laws and our husbands. It is a duty and respect for the family. But sometimes I did not care to respect them but would do so because if I did not, it would reflect on my parent's upbringing and they would be put to shame.*

Raina recalled her experiences as a teenager when she lived in Canada with her parents. She remembered having arguments with her parents about her friends, citing that the latter influenced her to attend parties, drink and harm herself during her adolescent year. She also recollected how on occasions she would turn to scratching her inner forearms as a release when feeling pressured, upset, or anxious. She said this was a common behaviour among her peers and that at times it still comforted her. She also bit her nails to the point that it caused bleeding and pain. She remembered using a safety pin to remove the skin around her nails causing both pain and comfort.

Raina married a first- generation Indian man who lived in Canada with his parents. Raina's parents had introduced her to her husband. After spending some time with him and his family Raina married him, referring to her marriage as "semi-arranged." A year after the wedding in India, Raina came to Canada to join her husband and his family. She lived with her husband's family immediately after arriving. Her husband's family had a family-run business where he would occassionaly help.

Almost immediately after her arrival in Canada, Raina worked part-time in a packaging company, enrolled in French class, and became the caretaker and caregiver for all the members of her husband's family. This included her husband's parents, her husband's brother and his wife and their two children. She was in charge of cooking, cleaning, and caring for the children. Raina, with no family or friends, felt lonely and isolated. While she enjoyed getting to know friends of her husband's family, these friendships were extremely formal and she realized that her role was that of the "servant" who prepares for the friends' visits and cleans up after them when they leave. Whenever she failed to complete her tasks, her mother-in-law became angry with her. She received no support from her husband, who backed his mother in these issues and rebuked Raina telling her that it was her duty to serve the household. She did, however, develop strong attachments to the children in her care. She attended to all their needs and the children in fact slept with her.

Raina described how her life was shortly after her arrival to North America. Her husband began to beat her, informed her that he was not attracted to her and would never want to have children with her. Raina's mother-in-law refused to accept that her son was at fault for his abusive behaviour. According to her, Raina deserved what was done to her

and it must have been Raina who provoked this behaviour from her gentle and kind son. Raina was also financially dependent on her husband. This is a frequent occurrence with many immigrant women who are not employed for reason of being labeled as independent or because it does not fit the traditional and cultural role of women, as discussed in the theoretical discussion of this paper. For Raina, the lack of money seemed to result in further isolation and depression, resulting in a sense of helplessness:

"मेरे कोई स्वतंत्र जीवन नहीं था । अगर कुछ भी, जरूरत था, पूछना परता ता.

और वह तय करते अगर जरूरत था या नहीं ।"

I had no independent life, no money. If I needed anything, anything at all, I would have to ask and he would decide if I needed it or not.

As a result of the distress Raina was experiencing, she attributed her current suffering to past life failures (*karma*) and felt that perhaps she should accept the suffering, especially as any actions she would take to alleviate this suffering would bring shame on her family and their reputation. She would not receive family support because of the stigma attached. So she had to bear the blame for not obeying her husband and keeping him happy, even though she knew how unhappy she was.

Raina's belief in *karma*, her destiny, kept her enduring the abuse by her husband and in-laws. However, there came a time when Raina could no longer bear the abuse and she ran away from her husband's home. She ended up in a police station, where she was offered protection in a shelter. Upon arrival at the shelter, Raina informed her parents of her decision to leave her husband. Her parents did not support her decision and advised her to return to her husband and his family. However, Raina refused to go back to her husband and his family. She chose to remain at the shelter.

I met Raina soon after her arrival to the shelter where she was alone and felt abandoned by her family. At the shelter, initially Raina was observed to be withdrawn, restless, and suspicious towards the staff and other residents. She would often spend hours staring at the walls. She complained of headaches. She refused to eat the food. She started feeling fearful whenever she met new women at the home and when the shelter workers invited her to join workshops or meetings. However, as time passed, Raina became a little more social and began to enjoy being part of the home life of the shelter. Although she did not trust others she at times spoke and interacted with other residents about herself. However, the shelter personnel noted that Raina also made efforts to avoid thoughts, feelings, or conversations associated with the trauma and continued to avoid activities offered by the shelter.

Raina spoke about maintaining relationships with her family members, more specifically, her siblings and parents. She stated that she was unhappy with her aunt and subtly suggested that she was the individual who introduced Raina to her husband and portrayed the family as suitable for her. Even though Raina was unhappy, her family wanted her to stay with her husband to resolve the issues to avoid harming the family's reputation. Raina's family worried that her behaviour might adversely affect the future marriages of her siblings. Based on her actions, no "good family" would want to marry into her family because of the shame she has brought to her family. This concept is discussed by several researchers (Goel, 2005; Natrajan, 2002) who emphasise there is a stigma attached to women who stray from traditional norms, how their actions and behaviours affect the well-being and honour of the family, and how the South Asian woman's identity is a collectivist one rather than one that is autonomous.

During the course of this research project, Raina was being followed by a psychologist for her psychosomatic and self-harming behaviours. Raina reported having headaches, stomach pain, and a constant feeling of being sick all the time. She described getting headaches from her sensitivity to the light and feeling so tired that she could barely lift her head. She felt that it was the actions of her husband towards her that prevented her from healing from the abuse. He would humiliate her and insult her, verbally abuse her and laugh at her all the time. He insulted her body and as a result she began to dislike her body, be ashamed of herself, and lost her confidence and self-esteem. As well, Raina began to re-engage in some of her self-harming behaviours.

Raina recollected how she had in fact stopped self-harming for some time but when she was faced with her marital difficulties, her self-harming behaviours were triggered. Raina indicated that the abuse from her husband and his family triggered her harming behaviours but not extensively. She would silently harm herself in the privacy of her own space as it made her feel better when she was anxious, upset, worried or afraid. This is in accordance with the theoretical information on self-harming behaviours. Cooper and Milton (2003) explain how expressing painful emotions through self-harm are communicated when verbalization is difficult, and provides the individual with a sense of control, as While Hibbard (1994) explains the symbolic meaning attributed to suffering as an attempt to remove an unwanted feeling or relieve distress. For Raina, based on her history of self-harm perhaps this behaviour helped her feel in control when nothing else was.

Evidence of Raina's self-harming behaviours showed on Raina's fingers and inner arms. Signs of fresh scratches were visible on her arm. Her cuticles were slightly

red with blood and some areas of her skin around her nails were slightly lifted off. She stated she began to occasionally self-harm when she was upset:

"खैर, जब मेरे पति मेरे अपमान किए, मैं अपने आप और शरीर को नफरत करती थी । अपने आप को मैं बदसूरत लगती थी ।

Well, when my husband humiliated me, I would look at myself and hate my body, myself, I looked ugly to myself.

"लेकिन मैं अभी भी यह करती हूँ... नाखून काटने और पिन ...हो सकता है यह मुझे अच्छा करता हो । मैं सिर्फ ठीक होने चाहती हूँ । मैं पहले जैसे खुश होने चाहती हूँ । मैं अपने पुराने जीवन को वापस चाहती हूँ ... "

I still do this though…the nail-biting and the pin…maybe it makes me feel better. I just want to get better. I want to be happy like I use to be, I want my old life back…

Raina spoke about her traumatic abusive incidents as in a matter of fact manner with a flat affect. As noted by Walker (1994) traumatic events are persistently experienced by abused women in the following ways: recurrent and intrusive distressing recollections of the event, and acting or feeling as if the events were recurring. When in conflict with other residents, Raina expressed experiencing such symptoms. She displayed symptoms of increased arousal, such as difficulty falling asleep, irritability and passive outbursts of anger; difficulty concentrating; and exaggerated startle responses.

Continuing with her recollections, Raina discussed her feelings of anger and sadness. She felt angry with herself for letting her husband abuse her. She felt guilty and

blamed herself for not being stronger. She lightly scratched her inner forearms as she discussed her painful experiences while in the shelter. She stated:

"जब से मैं छोटा थी मैं प्यार और खुशी महसूस नहीं किय । दोस्त भी नहीं है. मेरा परिवार मेरे साथ खुश कभी नहीं थे । मेरे साथ कुछ गलत होगा. मेरे माता, पिता का कहना है कि मैं ग़लत हूँ । मुझे शर्म आती है जब मैं पति कै बारे मे सोचती हूँ । मुझे गाली दी । मैं मरने चाहती हूँ. मेरे परिवार ने मुझे धोखा दिया है । पता था कि वे मेरे लिए अच्छा नहीं है । मैं किसी पर भरोसा नहीं कर सकती हूँ ।. मैं अवांछित और एक बेकार व्यक्ति हूँ. मुझे कोई नहीं चाहता है। मेरे पास जाने के लिए कोई जगह नहीं है । "

Since I was young I have not felt love and happiness. I don't have any friends. My family has never been happy with me; something must be wrong with me. My parents say I am wrong. I feel ashamed when I think about how my husband abused me. I feel like dying. My family betrayed me they set me up with a man they knew was no good for me. I cannot trust anyone. I am unwanted and a useless person. No one wants me. I have nowhere to go.

Raina had experienced so much pain and suffering in her life, I was pleased that she accepted to take part in the art therapy program. I felt the therapeutic space could offer her a certain degree of relief, support and positive outlook for her future.

Art therapy summary of workshops

Session 1: A safe place. Raina entered the art therapy room in a confident yet curious manner. She was excited to participate in the session. Prior to starting the activity, I discussed what the activity entailed to make sure that Raina was comfortable taking part in all components of the activity. The first part of the activity instructed Raina to close her eyes, and to try to think of a place that she considered safe for her. The question "What is a place where you feel safe?" was asked by the art therapist. Raina thought for a bit and to better understand what a safe place was, she discussed her idea of a safe place. She came up with an idea of her safe place in her mind. She began to make her art.

Raina chose a white 17 x 11 sheet of paper and water paints. She began to paint while recalling her past interest in art, mainly in painting flowers and outdoor places when she was a little girl in India. As she painted she noticed some magazines and attempted to integrate cuttings from the magazines to her painting. She asked the therapist how to incorporate the magazine cutouts into her painting and proceeded to glue four cutouts. She was not sure where to put them and placed them on a separate piece of paper. After looking at the paper with the cutouts, she picked them up and placed them at the bottom of her painting. As she glued on the magazine cutouts she spoke about her love for "मेहंदी," "henna," and recalled how she used to put on henna at weddings and big celebrations. The therapist asked her if she wanted to share her memories and Raina recollected how she would take pleasure in sewing, knitting, and embroidery when she was younger:

I enjoyed it so much. But then I stopped because I was no longer a little child. Have you ever tried henna?

Therapist: *I have at wedding ceremonies and traditional holidays. In India henna is used in weddings, on brides representing love between a husband and wife.*

Raina: *That's true but it did not work for me…*

As she continued to paint her "safe place" (figure 1) she spoke about her parents and how they did not approve of her interests and felt it was more important for her to focus on getting married:

My parents never wanted me to waste time on this kind of stuff. They said it was a waste of time. They just wanted me to get married quickly. I never did but it's like that there. Are you from India?

Therapist: *I am from India, I understand.*

When Raina learned that the art therapist was from the same country as her, she concluded that the therapist understood what she meant:

Raina: *So then you must be knowing about this? It's hard to be a girl in India. You have to live up to family expectations and always worry about what everyone else is thinking. It's hard to do this because you want to please everyone and then you end up ruining your life.*

Therapist: *Yes I agree with you. It is difficult being a girl in India as you must follow the cultural traditions and family expectations.*

Raina: *The entire family decides what is best for you without even considering what we want…and think they know better.*

Figure 1 - Raina's safe place image

Raina then shrugged her shoulders and became quiet as she quickly completed her artwork. She described her artwork as a peaceful place of safety with hidden chambers, a place that was difficult to get to and where no one could find her. Raina placed emphasis on the image of the married couple as it represented what she hoped for and what it meant to her, *a happy marriage* as illustrated in fairytales.

Upon completion of the art, the therapist asked Raina to name, or to provide a title to her artwork. Raina thought and immediately came up with "hidden castle." Raina was content with her artwork and discussion and took part in the cleanup and putting away the art materials.

Art Therapy Summary. Raina's story of her artwork reflects her childhood, culture and home country. Her safe place is located in her home country. Through her art she focuses on both the positive and negative aspects of growing up in a traditional home with family and cultural expectations. Raina seems to be struggling with an experienced sense of failure and disappointment in her development of a sense of self. She gravitated towards creativity but did not succeed as this was blocked by her parents' values and she found herself complying with their expectations.

Raina created an image of a safe, peaceful, and hidden place where she could hide and was protected. In discussing Raina's drawing, she reflected on how her drawing reflects a vacant entrance without any visibility to where it leads. Her painting also echoes a sense of emptiness and a profound feeling of isolation, which Raina voiced feeling at this point in her life. There were no people portrayed in her image, which according to Furth (1988) is an important symbolic representation of something that is absent from the person's life. However, Raina's imagery and verbalizations of the second half of her work reflects her ideals of a happy marriage and indicates a sense of hope as she unites marriage to fairytales suggesting a happy ending after turmoil.

Upon entering the therapy session, Raina appeared happy and content to take part in the session. She seemed eager and curious as to what the session entailed. She was comfortable in selecting the art mediums and was familiar with art. However, as she

discussed the traditions of her culture her disposition changed. She became quiet while her body language suggested ambivalence. Perhaps this sudden shift in mood is a possible dissociative occurrence consistent with PTSD. She also seemed to increase the pace of her art making, perhaps suggesting her desire not to revisit her difficulties surrounding her memories growing up in a traditional setting.

The art directive focused on the theme, a safe place. The main goal of the task was to identify the perception of personal safety; to better understand the participants coping behaviours; to build self-esteem; to experiment with different materials and improve decision-making skills. The art task was successful in meeting the objectives as Raina was able to create a safe space, use the art material of her choice, and was able to make her own decisions regarding her art creation.

Session 2: The uniqueness metaphor. Raina was invited to think about herself and to create an image of what represented her as a woman. Raina was eager to begin and chose to work with water paints on an 8.5 X 14 size white sheet of paper. Metaphorically Raina represented herself as flowers. She relayed how she identified with her drawn flowers since her childhood and were flowers that were found in her country. Raina named her artwork(s) "the flower trees" as they appeared as tree's to her. When asked to elaborate on her painting Raina described her flower images as a representation of happiness, but also one that required care. She related the image to herself indicating her fragility. At first Raina represented herself through the metaphor of a flower but then switched her representation to a tree with flowers growing on it. She did two paintings, both in full bloom and colourful. She related her drawing to her childhood, familiarity, and her country. She further described the flowers as making one happy and as showing

growth. Metaphorically, Raina spoke of how flowers need to be taken care of and nurtured or they would die, perhaps making reference to herself.

She made different shapes and sizes both big and small. One tree was stronger than the other. The first one was standing tall with the roots exposed throughout the tree providing life to the flowers and leaves. It has been suggested that "the branches may be said to represent the channels through which energy is distributed from the trunk out of the crown, as well as the channels of flowing energies received by the individual from his environment (Bolander, 1977, p. 181). Raina described the second tree, although it has life and is standing tall; it is leaning towards the left, almost as though it requires support to stand straight. Some of the flowers and leaves are wilted downwards and some have fallen off. The roots, represented as the veins of the tree, are faded into the trunk of the tree, barely visible. Raina suggested this may perhaps represent her health spiraling downwards.

Figure 2 – A Raina's uniqueness metaphor image

Figure 2 – B Raina's uniqueness metaphor image

Art Therapy Summary. In addition, the art task promoted self-esteem in that Raina was in control of what materials to select, use, and create a unique self. Both Raina's drawings are in a vertical format. A vertical orientation may suggest making an announcement or a statement. The use of two separate papers indicates an inner division at a confusing period in her life. At the bottom of image 2-B a tiny worm is sitting on the ground. This indicates an unconscious awareness to the dangers that were present in her life.

On the back of her drawing, Raina drew a face, seemingly floating in midair. The absence of a body is normally associated with unconscious feelings of powerlessness (Malchiodi, 2007). Without a body, an individual cannot function. When encouraged to address this image, Raina's response was suggestive of the profound sense of powerlessness Raina experienced in her abusive relationship. This art task took on the role of an insight-oriented task as Raina related the image(s) to her past experiences offering insight into her difficulties. However, Raina seemed more relaxed in this session. Perhaps the self-initiated image of the face on the back of her drawing was indicative of the developing relationship between the "client – therapist," becoming comfortable, and the beginning of trust in the therapeutic relationship.

Raina was directed to create an image that represented her. The goal of this art activity was focused on exploring one's personal experience(s); the distinctiveness of being a woman. The objectives of the art directive was met in that Raina explored her personal experiences and had addressed the distinctiveness of being a woman through the subject matter of the symbolic flower-tree making reference to her identity.

Session 3: Self-portrait. The third art task was to create a self-portrait; an excellent tool for gaining a deeper understanding into Raina's feelings regarding herself and her body. Participants were offered to trace pictures of faces and full bodies, or to draw their individually created self-portrait representing themselves.

Raina was happy to trace a picture to represent herself. She chose the image of a face and traced it out onto a sheet of paper. She stated it would help her to outline the face, the eyes, nose, mouth, and hair, since she was not able to draw herself. Since the directive was to create a self-portrait representing "two sides of the self," one to portray what others see, and on the reverse side a portrayal of what others do not show, or keep from others, Raina decided to use an 8.5 x 11 white paper stating she was comfortable with a smaller size paper.

Raina's self-portrait (figure 3 C) represented a happy individual and a sad and angry individual on the reverse side (figure 3 D). Raina was content with the portrait of the happy individual:

> यह मुझे ज़्यादा अच्छी लग रही है. . .हां वह खुश लग रही है, लेकिन जो दूसरी लड़की को हुआ है उस पर नाराज और दुखी है । इस वजह से आँसू दिख रही है ।
>
> I like her better. . . . Yes she looks happy but the other girl is angry at what happened to her and she is sad. That is why you see tears.

After this Raina asked to stop the therapy session as she was unable to continue with her description of her drawing. The art elicited an emotional response reminding Raina of her hardships and how it made her feel. Raina described how the absence of colour strongly related to her on an emotional level and how the graphic details of the tears had a strong impact on her as it seemed to replicate a mirror reflection. Raina suggested continuing the discussion in our next meeting but remained in the art therapy

room with the therapist and asked if she could stay to help put away the art material. The therapist agreed to her helping and remaining in the room.

While cleaning up, Raina observed the therapist turn off the tape recorder; once turned off, Raina began to continue with her story behind her self-portrait. She explained the importance of the tape recorder being off and how her story was a secret. She was not comfortable having her voice recorded as "someday, somewhere, someone may recognize" her voice. The therapist reassured her that no-one would be able to hear the audio-tapes and reviewed the protocol form regarding confidentiality and the therapist's ethical obligations towards the participants of the study. However, for the remainder of the meeting, Raina wished to speak without the presence of the audio-recorder. She did agree to the therapist's note taking so that the information could still be used in the research study.

Art Therapy Summary. Raina described both sides of her self-portrait. One side represented happiness without revealing any feelings or thoughts, while the other side represented anger and sadness surrounding problems with her husband. She also described the angry and sad portrait as depicting her life growing up and how she felt now: angry, sad, frustrated, and lost. Raina also discussed how the image had a strong emotional impact on her as she was able to visually see her inner world. Raina had many concerns regarding her self-concept: inadequacy, rejection, fears, self-control, and trust issues.

Figure 3 – C Raina's self portrait image

Figure 3 – D Raina's self portrait image

Raina's selection of the traceable face image indicates a desire to evade the body. She merely glanced at the traceable picture with the full body and was quick to choose the image of the face. The art task, having Raina trace an image of a face, seemed to connect with dissociated memories reconnecting them to her consciousness. As Malchiodi (2003) asserts, the nonverbal qualities of art enable the memory to acquire graphic and visual form on paper, providing the client a chance to express the trauma narrative verbally. However, the art task and graphic details of Raina's image seemed to trigger re-exposure to her past experiences. Thus, it was imperative to manage the session in a careful and structured manner so not to overwhelm Raina and so she could feel safe in a holding environment. The session was stopped as proposed by Raina, but the alliance was maintained in order to re-direct Raina's emotions. As well, as suggested by Steele (2003) rather than focusing on the symptoms of the trauma, interventions should focus on themes in order to avoid having the client focused on the traumatic memories. Feeling more comfortable with the audio-recorder off, Raina shared memories and details of her life, focusing on her difficult adolescent years.

This exercise was an excellent tool for gaining a deeper understanding into Raina's feelings regarding herself and her body. As well her difficulty handling intense emotions is perhaps a possible dissociative occurrence. Perhaps this exercise was introduced too early in the therapy sessions and may have been easier to manage at a later point in the therapy as Raina had difficulty addressing her body issues. The exercise proved to be one that was painful for her to continue with. Thus, the objectives were met on a certain level: Raina was able to explore and describe the two faces of her emotions but had trouble exploring the meaning and expressing how she dealt with the two sides of

herself. Further, the objective to address the importance of self-acceptance was not addressed as a result of having to terminate the session based on its outcome.

Session 4: Symptoms of embodiment. Raina was not in the best of spirits in today's session. She seemed anxious and irritable and voiced getting tired of staying at the shelter. She was eager and ready to move to a new place, a place of her own. The therapist began the session with the beginning of the session focused on recapping the previous week's art task to ensure that Raina was well supported. Raina did not invest too much in the discussion and stated being ready to commence the next activity.

Raina was familiar with the art activity as she had participated in a similar activity in a group workshop where participants were encouraged to show pain on the outside of the body and pain that is felt on the inside of the body; the pain that no one is aware of. The therapist discussed the objectives of the activity and Raina started by listing some of the psychological and emotional symptoms of her pain. Once her list was complete, the therapist directed Raina to draw a representation of the list of her symptoms in any form she was comfortable with. Raina chose to use flowers and pictures from a magazine to symbolize her symptoms of pain. While creating her image (figure 4), Raina continued to describe how the pain she was feeling had not always been present and how she had internalized fear.

Raina completed her art image and then looked at the words she had written down earlier on at the beginning of the session. She verbally read out each word or phrase and she had the ability to grasp the metaphor and relate it to her image; she wrote down her words on her image.

Figure 4 - Symptoms of embodiment

Art therapy summary. This art task helped make connections between events and symptoms of pain. During processing, Raina expressed that she enjoyed this art task as she had the flowers she was familiar with and was able to "add" into this image, a part of her life that she rarely focused on. She was proud of herself for being able to make the connection between her abuse and somatic complaints. Raina also displayed increased self-esteem after completing her image. By the end of her description Raina was tired. For the majority of the session she had spoken about her difficulties and abusive experiences and this was equivalent to reliving those experiences. Thus, it was important to respect Raina's need to terminate the session. This art task, involved the exploration of thoughts that Raina carried in her mind. The goal was to identify the symptoms that may have originally developed as responses to trauma and to explore the link between abuse and behaviour leading to symptoms of embodiment, and to learn how to express emotions. Raina's disposition seemed distant and anxious, consistent with symptoms of post traumatic stress disorder. Although she participated and completed the art task she seemed to struggle with it. Perhaps she was reluctant and afraid of having to revisit the previous week and experienced difficulty in the session. However, in expressing the emotions related to hurt and abandonment, Raina had explored her somatic symptoms.

Session 5: Past, present and future image. Raina was calm today and was very quiet. She sat opposite the therapist and calmly drew flowers and followed the art activity directives. She created six drawings. The first two represented who she was in the past (figure 5, E & F); the third and fourth, who she presently was (figure 5 G & H); the fifth who she wanted to be in the future (figure 5 I); and the sixth drawing represented her married life (figure 5 J).

Figure 5 – E Image of Past

Figure 5 – F Image of Past

Figure 5 – G Image of Present

Figure 5 – H Image of Present

Figure 5 – I Image of Future

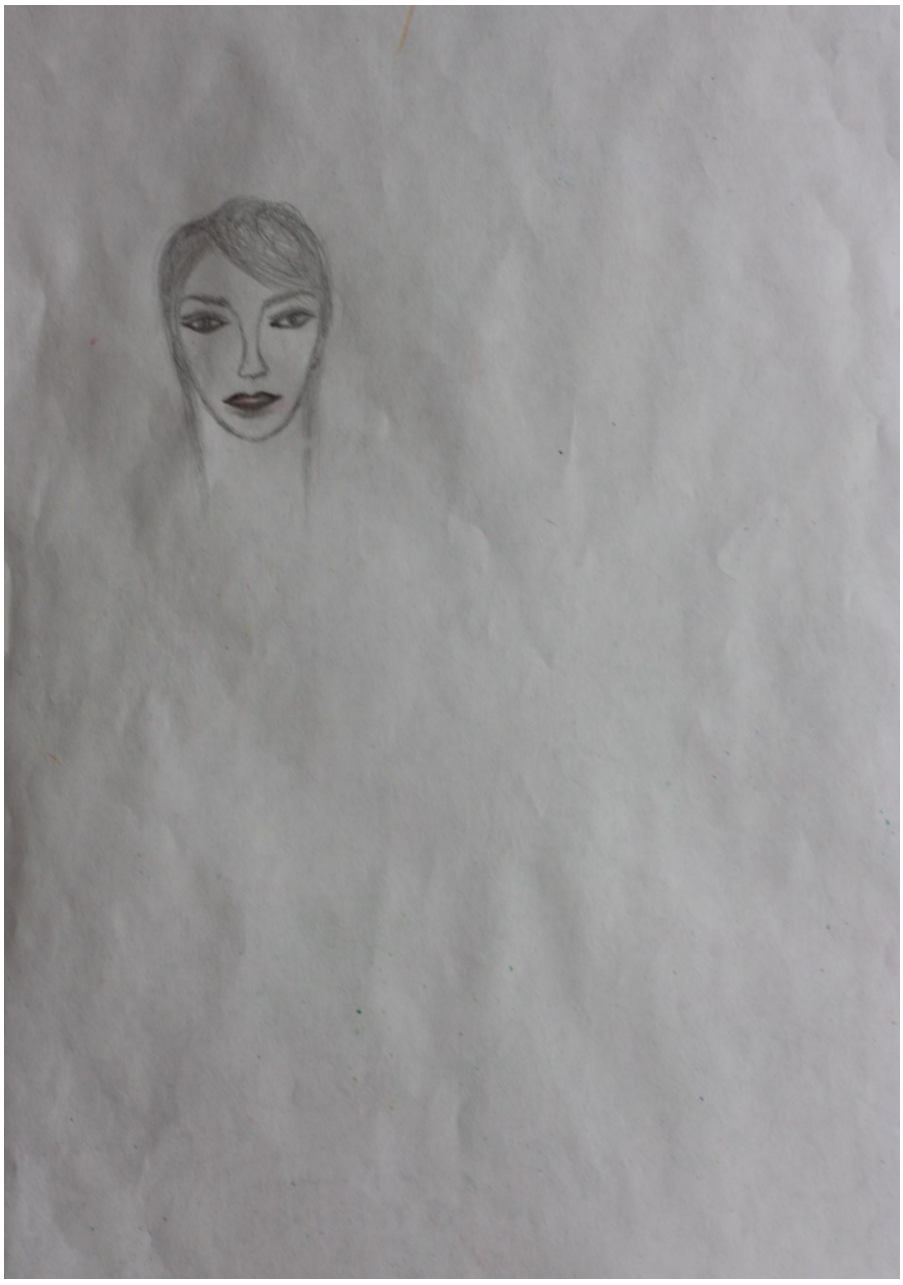
When I asked Raina to elaborate on her drawings, Raina seemed to be struggling with a description of her images. Malchiodi (2003), states that a directive to draw "what happened" provides structure so that a narrative can be told in detail. As well, clients may experience relief in being asked about a traumatic event. Thus, Raina was prompted with the phrase, "try to draw a story about what is happening in the drawing." Raina then proceeded to doodle on a piece of paper while attempting to create a story about her drawings. She picked up her drawings and began to describe them as representative of her memorable times with friends and family (figure 5 – E & F). Next, while thinking, Raina picked up figure 5 - G and figure 5 – H, and explained how it represented who she presently was, indicating her feelings of emptiness, sadness, and uncertainty. Raina's hopes for the future were represented in Figure 5 – I. This image represented her desire to be happy and have the life she once had. Although all the figure -5 images illustrate similar flower drawings, they each depicted different meanings and emotions for Raina.

On the reverse side of Figure 5 – F, Raina created an image that represented her after marriage. Her image comprises of a face without a body. Raina described her drawing as empty and lonely. In discussing the absence of the body, Raina indicated a dislike to her body and expressed a preference to her flower images as they were "देखने में सुंदर है I (pretty to look at).

Once Raina's description of her drawings was complete, Raina was asked to name her work. She named them "my life."

Figure 5 - J

Image of Present (on the backside)



Art Therapy Summary. In today's session, Raina created additional drawings on her own and seemed a little more assertive. Flowers are an important symbol in Raina's artwork(s) as it connected her to her childhood and positive experiences in her country. The spontaneous drawing of flowers was a natural process from her early childhood years. Raina described her old emotional injuries from her childhood years along with the memories of her traumatic experiences with her husband and her in-laws; she was able to make the connections between her traumatic experiences and the changes it caused. There was also reference to her abusive relationship and how it changed the course of Raina's life with both positive and negative outcomes. A major challenge Raina is faced with is accepting her new life and carrying the past into the present and future as they all overlap. Raina did assert that her future also had a positive outlook. Trust was also an important goal of the art task as Raina had to share past and present experiences with the therapist.

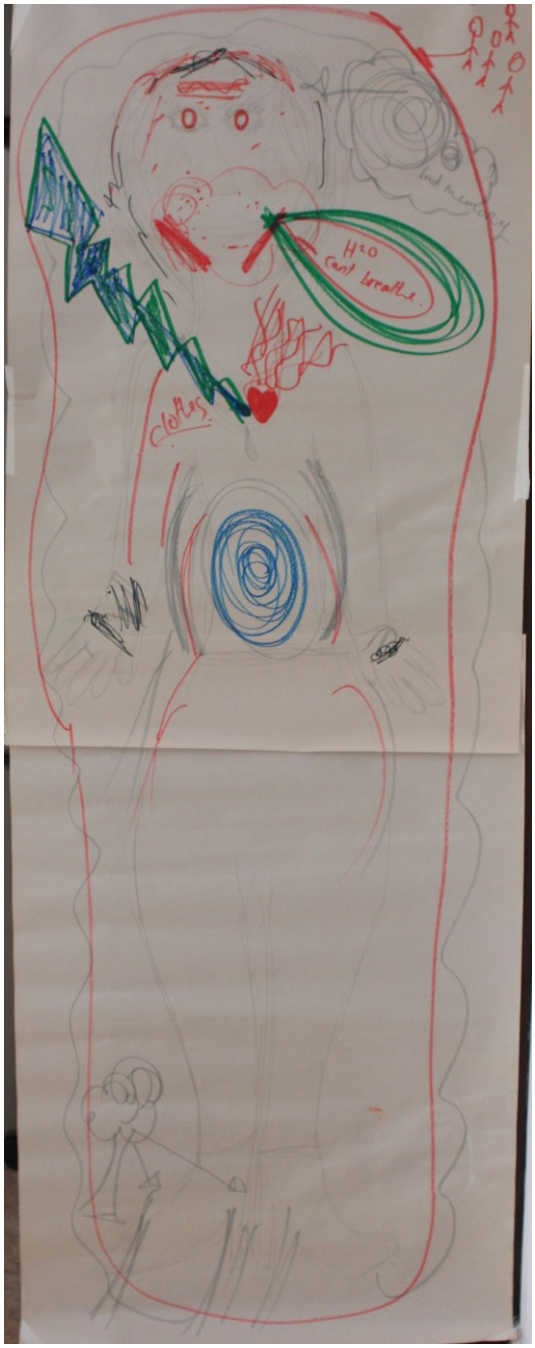
The focus of the art activity was to create an art image representing "Who I was, who I am, and who I want to be." This art task was used to gain important information about Raina's perception of herself; to develop an awareness of change over time; to develop an understanding of how changes brought about by trauma affect different aspects of her life; to discover the benefit and opportunities that come with struggle; and to focus on the empowered and disempowered self. Raina seemed to come out of this exercise with some hope. This task encompassed several objectives that were brought up through the artwork and the discussion in the session. The importance of Raina's perception of the self, an awareness of change over time, and how trauma affected her life was met, as indicated above. However, the session was not able to meet the objective

of the benefits and opportunities that may result from difficult situations. For Raina, she only felt despair from her past experiences and expressed feeling content in her younger days. As well, the re-establishment of hope for the future seemed minimal and potential changes of the disempowered self to the empowered self were not addressed as; Raina had a difficult time investing in this part of the session, and perhaps the avoidance being an indication of dissociation. Another pertinent aspect of the session was Raina making a cultural connection with the therapist through her art. She discussed her admiration for *henna* suggesting her drawings had some resemblance to *henna* images and assumed that I also was aware of *henna* since I was of the same cultural background.

Session 6: My body. This art task was to create a body image that may represent how one uses the different parts of their body to communicate how they feel, and represents what is going on inside of them, physically and mentally; to draw the emotions they presently experience. In today's session Raina was invited to trace the outline of a projected life-sized body and to fill it in. Although Raina had not ever participated in this form of art before, she managed well. Her art (Figure 6) represented what was going on inside her body, both physically and mentally. She named her art: "bigger than life".

Raina continued to add details to her drawing, slowly becoming increasingly comfortable as she spoke. When she was done, the therapist sat with Raina for a while as Raina continued to describe her artwork. She spoke about how the life size image helped her visualize her actual pain and in addition brought awareness to the reality of her suffering. She expressed feeling a sense of relief while engaging in creating art in therapy but also about her insecurities and fears of her abuser.

Figure 6 - Raina's body image



Art therapy summary. Raina had become anxious in today's session. She invested well in the art activity and was able to visually see the areas of her body that were affected by her traumatic experiences. Her initial comment to her image was

यह मैं हूँ ? देख मेरे साथ कितना कुछ हो रहा है ।

That's me? There is so much going on with me…look at me.

Insight began immediately as she processed her artwork and started to discuss her work. Raina described her image as being stuck to the ground like a tree. The somatic symptoms are evident in her stomach, chest, neck, and head. She graphically demonstrated and described how she was diagnosed with panic attacks which were portrayed through her inability to breathe; she felt unable to speak and feels the area around her mouth was full of pins. She also stated that despite wearing clothes she felt pain so strongly that she felt everyone could see it as well; she felt she was watched by the other women, and represented herself as stick figures in her image. Raina also included the past effects of her self-harming behaviour in her image as it was something she was struggling with at present; and symbolically referenced her low self-esteem by creating hair that was "*destroyed and falling out"*

"मेरे बाल गिर रही है और इतना खराब हो गए।"

Raina worked intensely on the art task. When she had finished and began to process the image she stated how she was aware of her anger and sadness contained inside her body. Raina was an outgoing woman and she had progressed in treatment to be able to recognize that she had difficulty coping. Her self-harming behaviour had been a coping behaviour she used when she was younger, yet at times of anxiety and stress

continued to revert back to it on a superficial level. She thought of herself as unattractive as a result of her low self-esteem.

Sessions 7 and 8: Body casting. Raina was invited by the therapist to cast a part of the body that represented where she experienced pain or discomfort. One side of the cast would represent the good feelings experienced and the other side would represent painful experiences. She was offered to use a part of her own body or that of a mannequin. She opted to use the face of the mannequin to create a mask. She described her rationale for choosing the face over the entire body stating that she disliked her body: "The face is better to work with. I dislike my body. . . . I always have."

Once the casting of the face was complete Raina decided to add something of her own to the activity. She used a mask that she had previously made at the shelter and put them together as two faces (Figure 7 & 8). She then stated: *"One we all see and the other one only me."* Describing how the mask had two sides, "*Here she is happy and here she is not."* On the inside, Raina wanted to show pain so she *"tried to put it inside to show the strong headaches."* I commended her on her initiative, creativity, and ability to express herself. She decided to name her art "Hidden." When I asked her to elaborate on this title, she stated that sometimes pain can be hidden but sometimes it cannot, and that as individuals we should not have to carry such *"heavy secrets."* As Raina continued to describe her artwork, she spoke about herself, "*just her suffering and sadness is shown here and the other side she is there but not happy, I hope one day I will be."*

Raina continued to describe her mask and made connections between her traumatic experiences. She continuously rotated the mask describing the connections between the positive aspects of her life as well as the negative.

Figure 7 - Raina's body casting

Figure 7 - Raina's body casting (Hidden side)

Figure 7 - Raina's body casting (Front side)

Art therapy summary. The art task touched on two important aspects: first, it was beneficial in allowing Raina to be assertive, confident and express her emotions; it provided her with insight into the struggles she dealt with on a regular basis. She wanted the mask to give the impression of a blank and empty appearance and revealed how her art represented her failed attempts of a content life. Second, the emotional intensity that was involved in this task was too difficult for Raina to go through with. She avoided touching issues related to her body (as was seen earlier in the art task in session 3). This dissociation is indicative of the painful emotions that she avoided. For this art task, it was felt that it was important to address the trauma in a less direct way. In the processing of the image, the therapist focused on trauma specific questions (Steele, 2003), enabling the therapist to be a witness to the participant's experience. It also allowed the therapist to assist Raina in remaining focused on the theme of the art task and to add details to the narrative. The activity had several objectives: to understand that emotions and feelings that are strong and overwhelming do subside; to express emotions of pain/suffering; to be more in touch with the body and visualize how internalizing pain connects to the body. Raina clearly depicted her emotions of body trauma in her artwork and made the connections to her body. In her discussion about her work, she discussed how she was aware that 'time was a healer" as a result of her past self-harming behaviours. However, she was having trouble believing that the overwhelming emotions she was experiencing would eventually settle as her self-harming tendencies often re-surfaced.

Sessions 9 and 10: The recovering body. Today Raina was asked to draw "your recovering body," focusing on a body that would symbolize her journey from abuse to recovery. She had decided that she would not use the materials offered to her and

requested to use a roll of paper so she could decide the length and size of her paper. As she drew (Figure 8) she spoke about the image she was creating. The therapist engaged in her conversation which led to a description of Raina's experiences. She described her married life to be one in which she was initially content and happy. She occasionally pointed at sections in her image to support her descriptions. However, as she continued to speak about her marriage, she became upset. Raina was eager to stop discussing her painful experiences in the session. She seemed to be tense, uneasy, and anxious. As seen in the previous sessions, such symptoms are possible unconscious occurrences. Raina was unable to process the painful emotions she experienced, perhaps avoiding re-experiencing difficult emotions. The therapist respected Raina's decision and allowed her to share only what she wanted to in order to maintain flexibility of method. After the focus was shifted away from Raina's painful recollections, she seemed to be more at ease. She remained in the therapy room for another half hour and talked about her challenges and support at the shelter.

Art therapy summary. The issue of body image became the focus of the discussion as Raina processed her artwork. She described how her body image had been a struggle for her most of her life. She was never content with her appearance and often gave the impression of a strong exterior that would protect her. Yet, in moments of weakness, Raina would lower her defenses and her urge to self-harm would be triggered. Although Raina had worked on the body activities within the art therapy program she had difficulty investing in these activities. The activities revealed overwhelming emotions she experienced daily indicating she had difficulty in dealing with her body issues or verbal

recall. However, the fact that Raina continued to attend the art therapy sessions indicated her desire to deal with, and perhaps gain some healing from her past traumas.

Figure 8 - Raina's recovering body

Thus, due to Raina's reactions to the activities, in order to redirect and provide her with support, the therapist worked with Raina in an art activity that included making an image and an exchange in dialogue to help her recognize the positive aspects of her body image. Raina made a collage of what she felt was a positive body image and took the art piece with her to hang in her room as a reminder and a positive support.

Finding it difficult to continue with the art activity, Raina asked for the audio recorder to be switched off and sat for some time with the art therapist. The goal of this art task was to discover the unique things within us and about us, and to explore the importance of our own individuality; to help recall past and present events that may help pave the way to a positive future. However, the objectives of this activity were not met as Raina's traumatic experiences seemed to overwhelm her ability to invest in all the objectives of the exercise, and her symptoms of dissociation consistent with PTSD were evident. Thus, the art task was re-directed in an attempt to focus on its initial objectives. In doing so, I tried to contain Raina's emotionally-charged experience and to help her transform her difficult feelings, and thoughts into a visible form. In doing so she could learn how to immerse herself in the images and emotions, enabling her to capture and contain the associated feelings. Through this task, Raina was able to focus on a positive body image and to explore her individuality. Through a dialogue she was also able to gain some hope regarding her future as she spoke about the support she was receiving at the shelter and her strength in leaving her partner. The discussion also seemed to help Raina become aware of her strengths and many positive aspects of herself.

Session 11: Bridge drawing. This session began with a continuation from the previous week. Raina spoke briefly yet quickly about her artwork the recovering body

and informed me that she was done and did not want to elaborate on this work any further. The directive activity in this session was to draw a personal bridge to recovery that symbolized Raina's journey from abuse to recovery. She was offered photocopied pictures of various styles and sizes of bridges to choose from if she needed.

The bridge represented treatment. Raina was given the directive to work on a bridge with one side of the bridge representing her past and the other side representing her future goals, and to place herself somewhere on the bridge. Underneath the bridge, she was informed that she could place obstacles that she felt may interfere with her progress. Once she had completed the drawing (Figure 9), Raina named it "bridge of hope." She placed herself to the left and marked an "X" to represent herself. The bridge was drawn in a flat manner so the obstacle which she described as her past traumas, memories, cultural stigma, and coping strategies could not be seen. When asked to elaborate on her bridge drawing, Raina was content with the information she had already shared.

Art therapy summary. The art therapy session helped Raina to safely explore her feelings of loss over her family, friends, country, and her marriage. Her drawing is complete with symbolism. Although she stated that the left side of the bridge is her past (pointing to the empty flower shape) there are three more empty shapes across the bridge. She referred to the little white circles as her future representing happiness, education, and family are more apparent in the center and right side of the bridge. She described herself as living a content life in which she would be able to make her own choices as she would no longer face the pressures of her culture.

The empty flower served as a metaphor that separated her from her loved ones and the abuse she endured. This was described as her losses and as a representation of who she was as a person growing up, in India, and presently in North America. At first Raina drew the bridge to be open and then she stated she wanted to close it by drawing a black border on both ends.

Figure 9 - Raina's Bridge Drawing

This indicated her feelings of confusion, fear, and her desires. The shapes coloured in blue represented a river that was only on one side of the bridge. The bridge served as a divider between the river and the opposite side, which was land indicating the bridge was representative of a strong support. However, of significance is that Raina has not shown the foundation of the bridge that provided strength to the structure. This foundation serves as a metaphor, for her family, instilling strength to bear hardships and suffering. Raina's bridge may be looked upon as positive as she had made borders securing the bridge, it had a strong foundation separating the river from the land (perhaps representing a form of protection), she had several white circles representing hope for a positive future, and her past was also represented as contained.

Similar to other artworks, Raina's bridge drawing gives a sense of isolation. There were no people present in the drawing. The river and the land on both sides of the drawing also seemed empty. According to Furth (1988) an image that is centered within a drawing reflects the root of a problem or what is important to the individual (p. 47-49). In this image the big vacant shapes gave a sense of emptiness and speak of a sense of loss, indicating a manifestation of her trauma. Raina was able to identify her obstacles with insight and this reflected her self-awareness of what she needed to do in order to recover. Upon completion of her artwork, Raina pointed out that her bridge continued on both sides of the page, indicating "*no end and not beginning,"* similar to what "*recovery seems like."*

The objective(s) of the art task was to identify any obstacles that there may be in completing treatment and to list specific coping skills that would help in recovery. Giving visual form on paper to future goals, obstacles and coping skills is a reflective way to

determine the stage of treatment; to explore the metaphor and symbolism; to prepare in advance for any obstacles that may hinder progress/moving forward. Through the visual Raina was able to see the obstacles that were preventing her from moving forward, mainly her ability to recognize the difficulty she was having with regards to her body image. With the support of the therapist, Raina created a list with specific coping skills and methods that she could possibly use in her recovery. However, Raina was also aware that she would require further professional support to deal with several traumatic issues she was being faced with. The discussion and list seemed to provide Raina with some hope and assurance for her future although she was aware that she would require ongoing support despite reflecting and being aware of her needs.

Session 12: Termination - Review of Artwork. Raina's continued attendance at the art therapy program was indicative of the therapeutic alliance, her desire to participate in the sessions, and her willingness to work through her traumas. Given these indications, the therapist proceeded with the art directives while maintaining flexibility and a supportive environment for Raina.

The therapeutic alliance was initially a little hard to establish as a result of her resistance during this period of her life. It was important to have a clear understanding of her history and background in order to understand how she related to others in her life and her experiences. Through this, the therapist was able to work slowly with Raina while understanding her resistance in some of the art directives, mainly those related to the body. These exercises were difficult for Raina to complete. Based on Raina's history, trauma experience and identity, the therapist realized the strong emotional content surfacing within the therapeutic sessions were deep-rooted emotions that Raina had been

struggling with for a long period of time. It was important to allow Raina to proceed at her own pace and maintain her comfort level. In view of the difficulty Raina experienced in art directives relating to the body, the therapist felt that, in this particular case, introducing these activities later on in the art therapy program may have been the safer road to take. Perhaps then Raina would be able to engage with more ease and comfort.

The issue of control was important and it was crucial to allow Raina to feel that she had control over the art making and her relationship in therapy. In the art making her choice to take initiative and add to the art directive in sessions 5, 7 and 8 reflected Raina's need for control and to perhaps maintain a safe distance while demonstrating a positive response.

Control over the therapeutic relationship, the therapeutic process, what she wanted to show, to disclose and communicate to the therapist, and how she interacted with the therapist, was of significance. Thus, the selected directive approach was one that encouraged Raina's creative therapeutic journey. It provided a safe and contained forum with a transitional space encouraging chaos and control, the conscious and the unconscious, the opening of one's mind and the ability to be spontaneous (Rubin, 2005).

In reviewing all of the art creations from the beginning to end, Raina stated:

उनके यादे मुझे अबभी रोज परेशान करते है उनके असर मेरे साहस को बर्बाद कर दिया लेकिन मुझे लगता है कि मैं खुश हो सकती हूँ

His memories still bother me in my everyday life…He affected me and ruined my self-esteem…but I know I can be confident, happy…

Raina had distanced herself from some of the art tasks as she seemed too close to her experience(s) of suffering. As a result she was not able to make sense of her

experience(s) with words. However, in art therapy sessions 3, 9 and 10, the art making provided a means of "wordless" expression that was symbolic of an outlet of Raina's experienced difficulties. Although Raina had experienced difficulty in some of the art tasks, in others the art making seemed to help bring her out of her suffering within the safe framework of art therapy. Through the art therapy she was able to visualize the identity losses that her traumatic experiences had brought as the art therapy offered a means of expression that was safe and provided distance from the suffering she was experiencing, and hope for the future.

Some of the challenges Raina was faced with were to identify and de-sensitize the power of negative emotions in the present by visualization. This was necessary in order to acknowledge and regulate difficult emotions instead of suppressing them. At times, it also seemed hard for her to feel safe with her emotions as she worked hard to find the ability to regulate her mood while under the stress of negative experiences. Several dissociative symptoms consistent with PTSD (feeling disconnected, difficulty handling intense emotions, sudden mood shifts, avoidance, and anxiety) were also apparent in the sessions and may have been Raina's coping strategies for experience(s) too painful and overwhelming for her to handle in a more adaptive manner.

As well, particular artworks were difficult for Raina to look at and she expressed a desire to get rid of them as they served as a memory of her traumatic and disturbing experiences. These artworks were destroyed by Raina in this session and discarded. To conclude Raina was sad to terminate the sessions as she had built a strong alliance with the therapist and also received support with several aspects of her recovery. A profound statement made by Raina was:

यह जो थेरेपी है मुझे जिंदगी जीने के लिए सहायता दिया...किसी को मारना या किसी को पीटना मैं समझ गई ठीक नहीं है जो मैं पहचान नहीं सकीय मुझे अब पता हुआ ...मैं हिम्मत रखने की कोशिश करूँगी...

The therapy sessions helped me to see that I can still live a full and complete life…I also recognize what abuse is...I got help for some things that I did not know were abuse. . . I will try to be brave....

Raina was able to identify the emotional abuse in her daily interactions with her husband, which she thought was a "normal way of life" as abusive behaviour(s). The abuses included his belittling, denying her contact with her family, not providing access to financial resources and decisions, humiliation, and treating her in a manner to make her feel worthless.

I believe the overall focus of the objectives within the art therapy sessions helped Raina to externalize both emotional and physical aspects of herself, and to see herself from a distance. The art also helped Raina to connect some of the fragmented elements of the self together and present them in more coherent manner where the finished image takes on a role of the "other" while reflecting back to the individual unconscious aspects to the individual (Schaverien, 1995). The art creations are thus present as evidence of this process.

Case II– Devi

Devi is a 20 years old, Hindu Gujarati woman, from the *kshatriya* caste. She was born and educated in India and is the eldest child in the family. Devi married a North Indian man who lived in Canada. Her marriage was an "arranged marriage," decided by

her North Indian parents and her North Indian in-laws who lived in India. Devi's husband was considered to have a "good job" as he was employed in a transportation company in a "foreign" country.

Devi immigrated to Canada two years after her marriage. Devi's migration experience was filled with many challenges. She had to cope with the language barrier, culture shock, her fear of being in a new country, isolation, and the loss of her social network and support system back in her native country:

> "मैं यहाँ किसी को जानती नहीं हूँ । मैं बहुत अकेले महसूस करती हूँ और यह कठिन है । अकेले अपने पति के साथ मुझे लगता है कि मैं पागल हो रहीं हूँ ।"
>
> *I don't know anyone here. I felt so lonely and it was hard. I felt like I was going crazy being alone with my husband.*

Devi lived alone in an apartment with her husband and lacked any contact with the world outside that apartment. Devi was alone except for evenings when her husband would come home after work. Her husband did not allow her to go out anywhere unless he was there to accompany her. On occasion, she would see her brother-in-law and his wife, but they were not very friendly with her. Devi recalls how she often felt upset, lonely, and sad. She spoke to her mother regarding her loneliness but was told to try and adjust to her new life.

As time passed, Devi's husband began to spend more and more time away from home. She was left alone more frequently, falling deeper into sadness. Slowly she reached a point where she never left her apartment. Her husband rarely bought food and she vividly recalls only having milk, bread, and tea in the fridge.

Finally, when Devi expressed her sadness and unhappiness to her husband he told her that she did not work and there was no need for her to go anywhere. Her place was in their home. He told her she was useless and he was ashamed to be seen with her. Devi quietly accepted his point of view. Eventually as time passed, Devi's husband became verbally abusive towards her. He would humiliate her and constantly put her down. It was not until Devi went to see her doctor that she realized how depressed and fearful she had become just to go outside. Her husband's abuse had affected her so deeply that she was not even able to speak. Devi's doctor provided her with support which is how she was referred to the shelter. Devi recalled telling her husband that she was going to seek help for her depression and his reaction was to laugh. Through support, Devi built enough courage to decide not to return home.

All of Devi's family members reside in India and are well settled. Her father is a well-known public figure in their community and had an excellent reputation which the family was determined to preserve by following cultural traditions and customs. When Devi informed her parents that she was living in a shelter, her parents were devastated and refused to accept her decision. Her parents held her responsible for any shame that her actions might bring to the family. In addition, her parents were in contact with Devi's husband who described a happy married life with Devi that changed when she became influenced by Western culture in Canada. He attributed her leaving the marriage as being a result of this influence. Her family told her that she should remain with her husband who was an honest and good person. They also reminded her that she was destroying the family reputation and making it difficult for future marriages for her siblings. She was also making her family very unhappy. When Devi refused to return to her husband, her

family cut off contact with her. Devi was devastated to endure the loss of her family in addition to all of the losses she was already feeling. However, despite her family's rejection of her, Devi wanted to maintain a relationship with her family and maintained hope that she would eventually be reconnected with them. Devi did not know anyone in Canada and because she had left her marriage she was cut off from her family and had already lost touch with friends in India. As a result of jeopardizing her family members in India, Devi felt the loss and waste of her time spent with her husband. She felt the loss of her social network, her marriage, financial resources, and extended family.

Devi was diagnosed with Post Traumatic Stress Disorder (PTSD) and Somatization. Devi's experience of abuse had affected her to the point where she lost her confidence. She explained how she understood what it meant when a person hurt someone both mentally and physically. She was unable to speak to anyone unless she knew them very well. She panicked all the time and was unable to go out in public.

Devi also displayed dissociative symptoms, such as detachment, an absence of emotional responsiveness; a diminished awareness of her surroundings (e.g. seemed to be day dreaming); problems with concentration and attention. She had persistent symptoms of increased arousal, such as difficulty staying asleep. She also had chronic guilt and shame, self-blame, a sense of personal ineffectiveness, a sense of being permanently damaged; alterations in her perception of her abuser, distorted beliefs and idealizing him, stating:

"मैं अभी भी उसे प्यार करती हू ,सब कुछ होने के बाद भी"

I still love him even after everything.

At the shelter Devi was very compliant and made attempts to attend all workshops/ programs offered at the shelter. She also made efforts to comply with all the suggestions requested by the workers at the shelter, but she only spoke when spoken too.

I observed that Devi was not very social and displayed anxiety when placed in a situation where she had to interact with others in the shelter. She was often afraid and had a hard time communicating with other women in the house. She kept to herself most of the time. She would sit in front of the television and watch for long periods at a time. When approached by other residents, she would reply with one-word answers. She spoke in a gentle and quiet voice and did not make eye contact. She was very obedient to the commands of other women residing in the home. She complied with all the regulations of the shelter. She would eat alone and quietly.

Devi understood what it meant to be healthy and recalled how she sometimes felt sick while living with her husband. She stated that she only began to suffer from headaches after her marriage. She associated her headaches with the anxiety she felt towards her husband and feared not being able to recover from her headaches because she was constantly terrified that he would suddenly appear, even at the shelter. She reported having severe headaches to the point where she could not function. Her headaches occurred on almost a daily basis during which she would be unable to function. She also disliked her body and had a difficult time accepting her self and who she had become. Her perception of her body became distorted as a result of the verbal abuse she sustained:

"मैं अपनी शरीर से नफरत करती हूँ । मैं बदसूरत लगती हूँ ।"

I hate my body, I feel ugly.

As a result of her traumatic marriage, Devi experienced alterations in her system of meaning: loss of trust, hope, and sense of energy (i.e., despair); loss of previously sustaining beliefs; and loss of belief in the future. She displayed low self-esteem and viewed herself as a helpless victim of fate. Her life became something beyond her control and she found herself unable to act in her own interest. She also presented the following behaviour: repeated and intrusive distressing recollections of the event; dreams of the event; inability to communicate with others; panic and fear; avoidance of activities and excursions (afraid to leave the shelter, needed to be accompanied); diminished participation in significant activities that could aid her in her recovery; increased solitude and desire to sleep, diminished range of affect; had a foreshortened sense of the future and failed to participate in planning or preparing for the future.

Once in Canada, the language barrier and the isolation imposed on Devi by her husband, resulted in causing further difficulties for her. She did not know how to approach the other women at the shelter as she had become accustomed to being isolated. Devi spoke extremely limited English. She required a translator to help her understand what was being said in meetings within the shelter and when attending outdoor meetings (for example, with her lawyer). The translator was not provided on a daily basis so that Devi was often not able to communicate or understand what was being said. Other residents attempted to include her in activities or casual conversation but she would not engage. This caused tension between the residents as some felt that she was arrogant. This caused communication problems with other women in the shelter, alienation, isolation. However, Devi was not affected by this because she was unable to understand what was going on.

In addition, Devi did not speak to any of the workers at the shelter unless they shared the same cultural background and spoke her language. Her support worker was from the same cultural background and was able to speak to her in her language but when she was not there, Devi waited for her return even when she required support and information about an important issue. Devi believed that others would not be able to understand her culture and traditions. Despite this Devi made attempts to adapt to her host country, in spite of feeling sad and guilty that she was letting go of her cultural values for a new western society. She discussed how she was a devoted Hindu and had strong religious ties until her traumatic experiences in Canada. She voiced her anger towards her faith and not feeling protected, and blamed her circumstances on her destiny:

मैं भगवान में विश्वास नहीं करते हैं तो मैं यहाँ नहीं होगा.

I don't believe in God; otherwise I would not be here.

Art therapy summary of workshops

Session 1- A safe place. In the first art activity Devi was asked to draw a safe space. The primary objective of this exercise was to identify Devi's perception of personal safety; to experiment with different materials, improve decision-making skills and to build trust by sharing her explanation of art creation.

Devi seemed apprehensive to draw, so collage was introduced to her. She asked if she could use her own pencil that she had brought with her. Devi's first image (Figure 10), "A Safe Place" consisted of a collage with images that made her feel happy and safe. She included an older woman, a younger woman, children, animals, and a little home by the lake. Her image included words: "incredible, happy family, in touch, and monkeying around." When the therapist asked her to describe her work, she stated:

I made a drawing of things that make me happy. A mother, a child, a sister, animals. This was all taken away from me. I like cute things like this parrot wearing roller skates. I like this tiger because he must be nice since there are baby pigs sitting on him. I want to be happy. But I still feel afraid and chained down. I am afraid to do anything on my own. I am afraid to speak. I have no voice.

She then turned to her image:

I am the girl sitting on the edge of the bridge but you see she is chained down. She is still stuck like me. This is why I put her here you asked me to put myself somewhere where I felt I am today well I still am afraid and have headaches. I feel ugly and sad, but hope I will look like her.

Later, Devi proceeded to place a religious symbol on her image, but retracted her gesture, stating: *"I believe in God but I do not pray anymore because I feel like I do not fit in with the people here in Canada, and God is not looking after me."*

She then placed the symbol back in the magazine and began to write words that described her feelings on a sheet of paper.

Figure 10 - Devi's safe place image

Art therapy summary. This art task allowed Devi to recall memories of her childhood. She discussed her life in her home country with contentment. The nonverbal qualities of the art allowed her memories to take visual form on paper, giving her the opportunity to verbally express herself which then lead to the trauma narrative.

The therapist hoped for Devi to connect with her, through her sharing of her safe place and was pleased with Devi's initial positive response. Also, despite the use of her own pencil brought to the session, the therapist was happy to see her using the art materials provided for her despite her hesitation. I felt that perhaps she trusted me enough to use the materials I was providing her. As well, Devi made several cultural references regarding the traditional role of South Asian Indian women and was content that I understood her. Devi's demeanor was timid, indicating uncertainty, and she was very emotional, having to stop to wipe her uncontrollable tears during the course of the session. However, she was able to stop crying and collect herself at the end of the session as she seemed to have externalized her emotions and expressed feeling "some relief" after speaking about her experience.

Session 2 - The Uniqueness Metaphor. The objective of this art activity was to explore the personal experience and uniqueness of being a woman and to build self-esteem. Devi was invited to think about herself and to create an image of what represented her as a woman. At first she was reluctant to draw: "I cannot draw." And was then unhappy with her image (Figure 11): "This looks like a child's drawing. This is what I made, what I feel like. I feel ugly and I cannot look in the mirror I look so ugly."

Devi spoke about her drawing and how she felt it portrayed her, "*I feel like nothing, I am nothing. . . ."* She also spoke about how she wished to drape a cloth over

the woman's head and around the woman's face in the image but felt it would not be appropriate and if any of the other women in the shelter were to see her drawing they would wonder why the woman was dressed inappropriately. On the reverse side of her image she drew a picture of her husband shouting at her while holding a "mike" (microphone) to her ear. The bottom half of the drawing represents his words used when yelling at her. Devi then proceeded to copy each word and cross them out with a thick black marker. She then drew an image of a male figure and crossed it out. She proceeded to tear up the last two drawings and put them in the garbage. The process of creating the images seemed to be more important than the actual final product as Devi made her art and destroyed it. I sat back and observed her as she engaged in her creative energy. I communicated my recognition and acceptance of this process. The images created were a visual record of Devi's thoughts as she symbolically revealed information about herself.

Art therapy summary. Upon describing her drawing Devi stated that the activity helped her communicate her feelings of pain, loss, and sadness. She explained how she had an extremely difficult time speaking and felt her voice was stuck in her throat. She further described the fear she had developed after living in what she described as isolation. Devi's drawing suggests the absence of body parts, which is associated with unconscious feelings of powerlessness (Malchiodi, 2007). It is also suggestive of the deep sense of powerlessness she experienced in her abusive relationship. The drawing signified her low self-esteem, a distorted body image, fear, somatic complaints, her distress from her fragile identity, and the experienced abuse by her husband. It may also be symbolic of dissociative symptoms that are regularly associated with PTSD. As well; the image Devi created connected her past and present struggles.

Figure 11- K Devi's uniqueness metaphor image

Figure 11- L Devi's uniqueness metaphor image

The woman Devi drew in her image showed a woman's head in a profile view, focused on looking behind. The ear is made very large and is not proportionate with the head, which was suggestive of trying to listen to something. The shape distortions of Devi's drawing are indicative of problematic areas that for Devi symbolize somatic or physical areas of concern (Malchiodi, 1999).

Session 3 - Self Portrait. The third art task was a self-portrait; an excellent tool for gaining a deeper understanding into feelings regarding oneself and their body. The art therapy activity focused on creating a self-portrait representing two sides of the self. The front side shows what others are permitted to see; and on the reverse side what no one else gets to see; what is kept from others. Devi thought for a little bit before starting her drawing. She decided to use pastels and stated that she felt like a child again. She completed her drawing and titled it: "मेरे दो चेहरे," "My two faces." She began to describe her work:

> *This side is how I want others to see me, happy, like everyone else. On the other side it is how I really feel. He made me feel so terrible. I cannot even speak in front of people anymore; I get afraid. My body starts to shake. . . .*

Devi was very upset after remembering her past experiences with her abusive husband. She tearfully expressed her anger towards her husband and her personal feelings of worthlessness. Devi expressed feeling such deep sorrow that she had no more tears to shed.

Art therapy summary. The therapist felt the art activity had successfully helped Devi to communicate her feelings of pain, suffering, loss, and deep sadness. The drawing signified her low self-esteem and the expression of the self-portrait on both sides was a

blank stare which seemed to represent characteristics of those who do not have the ability to confront their feelings directly. Her large and overly coloured lips symbolized her isolation and silence as indicated through Devi's whispers: "चुपचाप" which translate to "quiet." The art task gave insight into Devi's daily struggles and valuable measures for change. The images also offered Devi a reflection of the mask she wears on a daily basis.

Devi seemed depressed and appeared to have feelings of low self-esteem, self-worth, and a poor body image. Thus, in conjunction with the next art activity, it was thought by the therapist to focus on Devi's positive aspects, with the goals in therapy to decrease depressive symptoms, decrease isolation, and improve her feelings of self-worth by providing in the following art tasks a focus that would encourage success and self-esteem.

Session 4 - Symptoms of embodiment. In this art task, Devi was asked to explore thoughts that she carried in her mind. The objective was to identify the symptoms that may have originally developed as responses to trauma and to explore the link between abuse and behaviour leading to symptoms of embodiment, and to learn how to express emotions.

Devi was hesitant to start her artwork and was more comfortable going through magazines. She stated she wanted to see if she could find an image that she could use for the drawing she was going to make. I provided Devi with the time and space to search for her image(s). After half an hour, Devi found an image she wanted to use.

Figure 12 – M Devi's self portrait image

Figure 12 – N Devi's self portrait image (reverse side image)

Devi's symptoms of embodiment were represented in an image of a face (Figure 13). She drew a black shape on the forehead of the picture and wrote down how she got headaches, could not look at the light, and as a result slept most of the time.

She then proceeded to paint a black square around the face which represented a house. She named her image "खाली घर," "Empty Home" and continued to elaborate:

> *I made this a house because my home was empty…and I never said anything because I was afraid.*

The therapist engaged Devi in further discussion on her feelings. She expressed feeling anxious and how she had become accustomed to staying indoors. As she discussed her emotions, Devi continuously cried making references from her past to present self and vice versa. The focus of therapy was to allow Devi to express the painful thoughts, feelings, and emotions that arose and to then re-direct the focus to the positive feelings she carried in her body prior to coming to Canada.

Art therapy summary. The image Devi created symbolizes isolation and loneliness. It reinforced her circumstances of living with her husband but being left alone in her apartment without any connection to anyone else. The image of the face takes up almost the entire space of the home, which she describes as her loneliness and feelings of being trapped in a small space. Through Devi's artwork and verbal descriptions her feelings of disappointment were obvious as she described her past self as a happy person full of life who was never affected by such sadness. She also articulated her feelings to environmental and emotional stimuli, manifested through physical symptoms such as headaches. Devi was receptive to this art activity and it was an informative mode of expression.

Figure 13 - Devi's symptoms of embodiment image

Clearly Devi's demeanor was indicative of being depressed. Yet, although this art task may seem direct and perhaps complex to grasp, the therapist felt that by creating a visual representation of stressful emotions, Devi would be able to recognize her individual experience of stress as "it is useful to use art therapy directives that are concrete rather than vague. To get a picture of how a person experiences stress…" (Malchiodi, 2003, p. 273).

In re-directing the session towards the positive, I discussed the different emotions and ways to regulate them through positive thoughts and experiences. We further discussed Devi's responses in her art image to the stressful situations as she attempted to replace them with alternative responses that lessened her negative mood. I reflected Devi's positive experiences and provided recognition for her ability to identifying and discuss emotions; brainstorming and trying new emotion regulation strategies in response to her anxiety; her interpretations of her art image(s); and her ability to discuss and express in her art, the uncomfortable emotions she experienced.

Session 5 - Past, present and future image. This art task was used to gain important information about Devi's perception of herself; to develop an awareness of change over time; to develop an understanding of how changes brought about by trauma affect different aspects of her life; to discover the benefit and opportunities that comes with struggle; focus on the empowered and disempowered self; to validate and normalize emotions related to traumatic experiences. In this activity, Devi used stick figures and collage to represent herself. She stated that she was not able to draw. As the art task consists of drawing three sections, the past, the present, and the future, Devi was quick to

place herself in the past and future sections but had difficulty with the middle section, stating she did not know how to represent herself (Figure 14). She decided to leave this section empty. Malchiodi (2003) discussed a similar treatment technique in which the art task involved three sections portraying; the first section as perceived difficulties, the second section on how the client may journey to the third section where the hardships no longer exist, and the last section showing the desired outcomes of the difficulties. She noted how the middle section often took time, therefore resulting in the therapist and client working together in order to visually represent a way of getting the client to resolve the dilemma of reaching the third space. Thus, after describing her fears and uncertainties, Devi emphasized the left side of the page indicating her vulnerability. She created a very powerful image of feeling stuck and firmly being held down in a vacant room by an oversized pair of arms.The middle section was left empty and when asked to elaborate on this section of the image, Devi responded she was not sure what to place in the centre but placed herself in the form of a small stick figure in the future section.

Art Therapy Summary. Devi's image gave a strong representation of her life. Her ability to portray her abuse and need to escape was graphically obvious. The therapist understood the emptiness of the middle and future section of the image as representative of Devi's loneliness and isolation. Although Devi had hopes and envisioned herself in the future, the therapist felt a strong sense of sadness envisioned by Devi.

Figure 14 - Devi's past, present and future image

Session 6 - My body. This art task was to create a body image that may represent how one uses the different parts of their body to communicate how they feel; that represent what is going on inside of them, physically and mentally; to draw the emotions they presently experience.

Devi's eye contact and body language seemed uncertain. After the directions were given she appeared uncertain and unsure on how to proceed. I re-explained the activity to Devi, and as she slowly started to draw, I encouraged her to continue with her drawing each step of the activity. Devi participated in drawing a life-sized outline of her actual body size through a projected image (Figure 15). She filled in the drawn body with

images and words that had meaning for her. She then elaborated on her artwork, first writing it down on a piece of paper and then described experiencing headaches and emphasized not being able to use her voice and noted the two places in which she felt pain: her head and her throat.

Figure 15 - Devi's body image

Art therapy summary. The art activity enabled Devi to express herself on a level that she was comfortable and secure with. It provided her with an opportunity for insight into the feelings she kept inside. Devi was depressed and withdrawn during the session. She fought back her tears and struggled to maintain control. The art intervention allowed Devi to visually view her image of her experienced emotions and body trauma living in her body. The therapist intervened in Devi's art process to guide her through the traumatic experience and help her work through her feelings and somatic reactions of receiving painful images. The therapist asked Devi, "What do you want to do to alleviate the pain you are experiencing?" Devi responded, "I want all this to go away", pointing at her experienced pain in her head and throat. The therapist then asked, "How can you do this?" Devi responded, "I can remove it". "How can you do this?" Devi then picked up a paintbrush and coloured over the body pain she wanted to be rid of. The therapist responded, "What does she need to feel better?" Devi suggested placing images of happy people, representing her family. The use of her image to alter her traumatic story was a way to heal or repair it creating a positive perception of her experienced pain. Art therapy allowed Devi to re-pattern her feelings and body pain and feel better. Devi expressed an internal loss to the perceived ideal self and to some extent the loss of wanting to live her life as she did prior to her marriage. She was comfortable and secure in sharing this information and explained that she meant "living" as just "being present", without any motivation or desire to do or participate in anything.

Sessions 7 and 8: body casting. Devi was invited to cast a part of the body that represented where she experiences pain or discomfort. One side of the cast would represent the good feelings experienced and the other side would represent painful

experiences. The activity had several objectives: to understand emotions and feelings that are strong and overwhelming do subside; express emotions of suffering; be more in touch with the body and visualize how internalizing pain connects to the body; to emphasize the good/positive qualities and strengths; validation and normalization of emotions.

Devi made a cast of a head and neck to represent her pain and discomfort (Figure 16) using a part of the mannequin rather than her own body. She chose to decorate both sides of the cast: one side to represent the healthy side of her and the other side to represent her experienced pain. Because Devi had expressed her anxiety about speaking, the therapist did not ask Devi to elaborate on her artwork but welcomed her to speak or to ask questions if she wanted to. Devi disclosed feeling comfortable in the session and discussed her art creation, suggesting her art creation emerged as a living, breathing being experiencing her life. I reflected this back to Devi and she elaborated by describing how the art creation reminded her of her life. This experience allowed Devi to become open to receiving images related to her emotional and somatic traumas.

Devi was more at ease than she was in the past sessions, but she required being prompted. She was very submissive and shy and waited to be told how to proceed. Upon completing her art piece, Devi was concerned of the final appearance. I assured Devi that processing feelings through the use of her artwork(s) was more important than the actual quality of her artwork(s).

Art Therapy Summary. This task was helpful in gaining insight into Devi's despair which was evident in her verbalization and graphic details in her artwork. The art task also provided Devi with the opportunity to be in control and to enhance her self-esteem and confidence as observed in the session.

Figure 16 - Devi's body casting

Session 9 and Session 10: The recovering body. The objective of this art task was to discover the unique things within us and about us, and to explore the importance of our own individuality and uniqueness; to help recall past and present events that may help pave the way to a positive future. Devi went through the magazines until she came across an image she wanted to use for the art activity. She selected one magazine cut-out (Figure 17-O). During this activity, the therapist attempted to keep Devi engaged in a dialogue in order to offer positive feedback and promote empowerment and self-esteem. Devi responded positively. While speaking to the therapist Devi tore the first art image she created and said she wanted to do another one. She selected a face that covered the entire 17 x 11 sheet of paper. Once she had completed this image, Devi proceeded to make another image. In this one she glued two cut-outs; the first of a dark silhouette, and the second of a cracked glass (Figure 17-P). She described the image as herself, first as the broken glass and then as an empty person but one who is still able to stand. She suddenly turned the paper over and glued on three images of people who she stated "are very happy" (Figure 17-Q).

Devi then proceeded to take a sheet of paper and write down some words. She did not finish her task of writing down the words as she was distracted by the time and had to leave for an important meeting.

Figure 17- O Devi's recovering body

Art Therapy Summary. Devi was using art to escape from her trauma-related memories. The manner in which Devi portrayed the effects of her abuse and then an image with happy individuals seems to fit into what Malchiodi (2007) considered to be a healthy indication of empowerment and need for control over devastating emotions as she utilized the art; to access her memories of trauma- related event, to cope with the emotions, and to take a break from the memories of the trauma. The art task helped Devi to verbalize her emotions. It provided her with the opportunity to speak in a safe space. Emphasis on the face was positive progress as she was very insecure and unhappy about her appearance and it offered Devi's perception of herself. The task was also effective for Devi as it seemed to activate more verbalization with no hesitation, than in past sessions. It also gave insight into her traumatic experiences of abuse, isolation, loneliness, and helplessness. Devi's act of tearing her first image may have been her need to get rid of her old self and recreate a new self. The second image was a powerful image of a healthy and vibrant-looking woman. Hammer (1958) stated that many "individual's concept of self is focused in the head and face" (p. 105). Devi's self-concept was complete with issues of trust, insecurities, low self-esteem, and fear of rejection, a desire to be loved and very fragile. The words "forget them all and meet simple" seemed to be a symbolic representation of the picture placed at the bottom of her image. Devi described it as a happy family and stated that perhaps she may meet someone who is "simple and kind to her."

Figure 17 – P Devi's recovering body

Figure 17 – Q Devi's recovering body

Session 11: Bridge drawing – Devi was absent for session 11 as she had an appointment with her lawyer.

Session 12: Termination - Review of Artwork. Devi's artwork represented the losses she had experienced in her life. Her artworks resemble Wadeson's (1980) description of artistic characteristics of depression; a large amount of unfilled space, limitations and the use of reduced colours. Although most of her work was made up of large images, filling almost the entire page, Devi was unable to complete the images as she would become overwhelmed and anxious, an indication of symptoms of PTSD. Consistent with the psychological manifestations of domestic violence, Devi also displayed cognitive changes (minimizing the severity of the abuse to reduce the pain caused by remembering the abuse) and denial (dissociation as a defence mechanism to help her cope with experienced fear and trauma).

Through the creation of the artworks Devi expressed she was able to recognize her emotions, her thoughts about herself both in the past and present. She identified the present woman she was, a broken and vulnerable individual, with the same woman she used to be, happy and content. She discussed how her artwork was helpful in that it focused on issues of loss, self-esteem, fear, trust, somatization, and body image. In addition, she learned about circumstances such as cultural issues that she was attempting to leave and was unaware of. As well, one of the most important obstacles Devi seemed to begin to overcome was her ability to speak without experiencing a tremendous amount of anxiety which in turn may decrease her somatic symptoms. Individuals who experience stressful events and have difficulty expressing themselves through words may be more at risk of somatic disturbances.

Devi's experience of social isolation profoundly affected her and was portrayed within her art and discussions with the therapist. She experienced a lack of social integration and social interaction. Abraham (2000b) notes that often immigrant women experience such isolation as a manifestation of abuse: "…isolation refers to the individual's perception and reality of being emotionally and socially alone, economically confined, and culturally disconnected" (Abraham, 2000b, p.222).

In the last session Devi stated:

When I look at my work I feel sad, I still am afraid but I am finding it helpful to come here and speak to you. You can speak my language and understand where I am coming from. I am still afraid. I don't know what to do. Something deep inside of me continues to have hope and keeps me hanging onto the possibility that things can change. I know that through God all things are possible and I keep trying…

Case III – Jaya

Jaya, 35, a Hindu Punjabi woman, from the *Brahmin* caste, was born in India. Jaya had experienced several losses in her life. Jaya's first husband died in the military and her brother in law was also killed by the army. Jaya's family resided in a small city in India. Jaya's father died at an early age and her brothers took care of the family. They were financially in debt and struggled to make ends meet. When Jaya's first husband passed away, she and her three children moved back to her mother's home. Jaya describes the circumstances as being difficult and stressful as there were several family members and very little money to survive on. Jaya was given the opportunity to move to Canada. With her family it was decided that she would move and try to make a better life

for her and her children. She immigrated to Canada in hopes of starting a new life, leaving three children with her mother in India.

Upon arriving to Canada, Jaya experienced loss, separation, grief, a difficult adjustment to a new society, and traumatic experiences. She was also limited in her use of the English language. She understood very little with hand gestures. She spoke Hindi and therefore the language barrier was a hindrance for her. She also had a difficult time understanding Western culture because she was not exposed to it prior to her marriage. Although she had been living in Canada for a few years, her social network was limited to her community and temple.

However, despite these factors, Jaya was able to unofficially work for a family friend who spoke the same language as her. Financially, this helped her support and provide for her family back home. Jaya was also content and made friends at her community temple where she met her husband and his family. She married a second time, to a Hindu Punjabi, with the consent of both families. Her husband's parents and extended family immigrated to North America in the 1970s. Her husband was a well-educated accountant. He promised to help reunite her with her three children who came to Canada a year after their marriage. Thus, when Jaya re-married and was reunited with her children, her family was happy that she and her three children were leading new lives and were well settled.

Initially Jaya was happy but, as time passed her husband began to be controlling and eventually abusive. He had become physically, verbally and emotionally abusive with her. The police were involved and the shelter became the home of Jaya and her

children. Jaya was living at the shelter for six months. Jaya recalls how she had lived with her husband for five years and was very controlled by him:

"मैं केवल ब्लॉक के अंत तक जा सकती थी. फिर भी मेरे पति मेरे पीछे रहते थे । उसने यह इसलिए किया ताकि मैं किसी बात नहीं कर सकती।"

I was only allowed to go for short walks up to the end of the block. Even then my husband would be following behind. He did this so I could not talk to anyone.

Eventually Jaya informed her family in India of her unfortunate experience(s) of abuse resulting in her separation from her husband. Initially they were devastated but were content that she was in a safe place. As time passed Jaya began to feel like she was a burden on her family and was destroying the family reputation. She hoped that she would somehow try to manage her life in Canada and took it upon herself to start a new life without burdening her family.

Initially when Jaya came to the shelter she was withdrawn, often cried, was irritable, and expressed a wish to end her life. Her food intake and sleep also decreased and she lost interest in doing any work. Jaya presented with dissociative symptoms such as numbing, detachment, and an absence of emotional responsiveness. Persistent symptoms of increased arousal, such as difficulty falling and remaining asleep were also noted. Jaya spent most of her days alone.

Jaya dealt with many issues around her immigration status, her trial against her husband, and several day-to-day issues. She was isolated as a result of being unable to communicate in English or French; she required a translator to speak on her behalf; she carried strong beliefs in her faith which caused a split with the other shelter residents. She felt other residents did not respect her religion and culture. Food was also an issue as she

refused to eat Western food. She only ate specific Indian food. However, although finding it difficult, Jaya also made attempts to adopt the Western culture while maintaining her traditional values and customs. She did make attempts to fit in with the women at the shelter and was able to care for her children when they were at the shelter and was very warm and caring towards them.

Jaya stated that her physical health was slowly deteriorating. She spoke of chronic pain (back pain, leg pain, and stomach pain) and changes in her self-perception, including chronic guilt and shame, self-blame, a sense of personal helplessness, and a sense of being permanently damaged. She stated that this chronic pain started once her problems began in India soon after her first husband's death. Jaya was well informed about her health related problems and had a good understanding of her physical and mental well-being. She stated her doctor in India had explained that this form of pain was known as "body memories," in which the physical sensations associated with traumatization recur in a manner similar to a flashback, without conscious connection with the traumatic scenario in which the physical sensations were experienced. Jaya's perception of her body image was very negative. She felt trapped in fear, secrecy, and shame that had silenced her from seeking help.

Jaya experienced an alteration in her system of meaning: loss of trust, hope, and misery; loss of some of her previously sustained beliefs; and loss of belief in the future. She had low self-esteem and viewed herself as a helpless victim of fate. Jaya had no friends or relatives in Canada. She also expressed feeling ostracized from the community:

"मैं अब मंदिर नहीं जा सकती क्योंकि हर कोई सवाल पूछता है और फिर वे मुझे पसंद नहीं करते है जब उन्हें पता होता है की मैं अपने पति को छोड़ दि हूँ ।"

I don't go my temple anymore because everyone starts asking questions and then they don't like me when they find out I left my husband.

Her life was something beyond her control and she found herself unable to act in her own interest. She felt highly insecure and her fear of rejection was very high. Her basic sense of self-worth and her confidence in her own abilities were unstable. She frequently turned to the worker, art therapist, and music therapist for emotional support and reassurance as she felt she lacked inner resources as a result of the abuse she endured from her husband:

"मेरे पति मेरे साथ नहीं रहने चाहते हैं तो वह अपमानजनक होने शुरू कर दिए । मैं उनेके लिए सब कुछ करने की कोशिश की, लेकिन कोई फर्क नहीं हुआ । मैं अच्छी नहीं हूँ ।"

My husband did not want to be with me any more so he started being abusive. I tried to do everything for him but it did not matter… I am no good.

Jaya felt that she had lost her family and friends and that she gave up everything to come to new country for a better life. She felt that she had also lost her support system. Jaya expressed a real uncertainly about expectations in the future.

Art therapy summary of workshops

Session 1: A safe place. Jaya was invited to create a safe space with the primary objective of identifying her perception of personal safety; to experiment with different

materials, improve decision-making skills and to build trust by sharing her explanation of art creation.

Jaya entered the therapy room, uncertainly and looking down at the floor. She waited for the therapist to tell her where to sit and what to do. She sat at a distance from the therapist and seemed uneasy. She picked up a dark grey 8 x 10 piece of construction paper and used pencil crayons to draw her picture.

Jaya drew two images (Figure 18 R & S). In the first she drew some clouds, a tree, a house, a boat and a river.

Figure 18 – R Jaya's safe place image

Figure 18 – S Jaya's safe place image

Jaya then began by drawing a small and faded house. To the right, she drew a plant called *tulsi* which is worshipped by many living in India. She then proceeded to write "शुभ लाभ" which translates to "prosperity" or "good success". She did not speak during the session and only responded to the questions I asked her. At times she would tilt her head to motion yes or no. For Jaya, her safe place was in her home country. She had strong religious connections to her faith.

Art therapy summary. Jaya offered important information regarding herself through the imagery, her verbalization, and her overall demeanor. Many themes emerged through her artwork: such as, culture, traditional values, home, religion/faith, and safety. Jaya was very submissive, fragile, shy, compliant, and respectful. She would require some time to develop a therapeutic relationship with the therapist. Despite being able to communicate in the same language, Jaya was guarded and was reluctant to reveal any information pertaining to her personal life possibly as a result of unfamiliarity and as a result of the high value of privacy on family issues. The lines in her first drawing were quickly drawn, sketchy and fragmented. Lines drawn as such are an indication of anxiety according to Hammer (1958).

Session 2: The Uniqueness Metaphor. Jaya was absent for session 2 as she was meeting with her shelter worker with the presence of a translator for legal issues.

Session 3: Self-Portrait. The third art task was a self-portrait; an excellent tool for gaining a deeper understanding into Jaya's feelings regarding herself and her body. Jaya made her double-sided portrait on a 17 x 11 white sheet of paper utilizing pastels (Figure 19 T & U). The therapist sat across from Jaya and as she observed Jaya she would smile at her each time Jaya glanced at her. Jaya seemed content and maintained good eye

contact and body posture. As she drew her images she would often pause and look at her image. Jaya had become comfortable with the therapist after seeing her at the shelter throughout the days after her first therapy session. She confided in the therapist of her fears of perhaps knowing common individuals in the community as they both shared the same cultural background. After being re-assured that all information from the sessions were confidential, it seemed Jaya was ready to invest in the sessions. However, it seemed as though Jaya felt she was required to inform the therapist of her reasons for being at the shelter, as though the therapist was an authoritative figure to whom she felt obligated to give an accounting. The therapist further explained to Jaya that she could focus on what she was comfortable with and was not obligated to speak about anything that made her feel uncomfortable. Jaya expressed understanding the process.

Art therapy summary. Jaya described her first self-portrait, the portrait of ourselves that we show to others, as someone who was feeling content and was happy with her life. She described the colour of her skin as "fair" and said this was because it is considered "beautiful in the Indian culture" and people regularly told she did not look Indian. She further described her hair as a "modern woman" and drew it short although her hair was long.

Figure 19 -T Jaya's self portrait image

In the second portrait, what one does not show to others but keeps to oneself, Jaya drew a sad person with eyes looking down (Figure 19 – U). I pointed out the difference in the colour she chose to represent the skin. Jaya said she coloured the skin red because she was actually darker than the colour she used in the first portrait. She made her hair longer and said "all Indian women have long hair." Jaya said this portrait was a reflection of how she truly felt but was not able to let anyone know. I asked Jaya to elaborate on her description of her portrait. She used the words, sad, tired, lonely, afraid, uncertain and unable to speak to describe her feelings surrounding this artwork.

Jaya's images seem to have integrated the two sides of Jaya, as a traditional woman and as a Western woman. I then asked Jaya to elaborate on her images. She collaborated and discussed how the self-portraits were the developing sense of self. I proceeded to pick up both self-portraits and hold them at a distance for her to view. Upon looking at the images from this perspective, Jaya was able to see her inner struggle in attempting to adapt to a new country, and wanting to belong. The images served as a representation through which she was able to externalize and have a certain degree of control. They also documented the internal changes she was experiencing in concrete form and allowed Jaya to see herself in a tangible form, and contained her difficulties in attempting to adjust herself to a new culture. I reflected the changes that were indicated in the self-portraits and in herself as I witnessed the process of Jaya's art making.

The aspects that were the most evident during the art therapy session was Jaya's low self-confidence, her insecurities, and her identification with her culture. As well, her cultural characteristics such as showing high regard and respect for the therapist, and waiting for instructions at each step when creating her art were also apparent.

Figure 19 U - Jaya's self portrait image, reverse side image

Session 4: Symptoms of Embodiment. For this art task, Jaya was asked to explore thoughts that she carried in her mind. The objective was to identify the symptoms that may have originally developed as responses to trauma and to explore the link between abuse and behaviour leading to symptoms of embodiment; and to learn how to express emotions.

Jaya sat down and wondered how she was going to create an image that represented her thoughts. She told the therapist that she did not know how to do this. Together, it was decided that Jaya could use words to express her thoughts. She discussed how her doctor had diagnosed her with somatic symptoms and depression. At first she did not understand what the diagnosis meant.

When it was clarified to her she assumed she had an illness that could be treated by medication and then she would be fine. However, as time passed her symptoms of distress increased and she could not understand why this was happening. She noted that she understood that she was unhappy with her marriage as a result of her husband's violent and abusive behaviours and was aware that this made her upset and sad. I tentatively listened to Jaya as she spoke; occasionally nodding to acknowledge what she was sharing. I felt in doing so, Jaya felt validated and accepted as she would pause and expressed being understood by me:

> *You understand what I am saying…This is my second marriage; I had to try to make it work. What will people be thinking when they find out. You can understand…And women have to be very different in India…*

In discussing her past, Jaya began to make the connections between her symptoms of distress and her experienced traumas. She described how the first symptom was that of

headaches immediately after her husband would get upset at her or when he yelled or humiliated her. This eventually progressed to severe backaches. The headaches and backaches would suddenly take place even when she was away from him. As she spoke, Jaya realized that her husband's abusive behaviours were always present in her mind and perhaps this was the reason for the sudden headaches and backaches. Jaya also stated that despite being away from him and in a safe place she often thought about the abuse she sustained while living with her husband and wondered if they would ever leave her mind. Her recurrent thoughts (symptoms of PTSD) regarding the experienced abuse were overwhelming for Jaya. In discussing this concern with her, I emphasized her body traumas did not represent all of who she was which seemed to be a crucial aspect of her process. Jaya was able to make a collage representing the specific areas of body trauma (Figure 20).

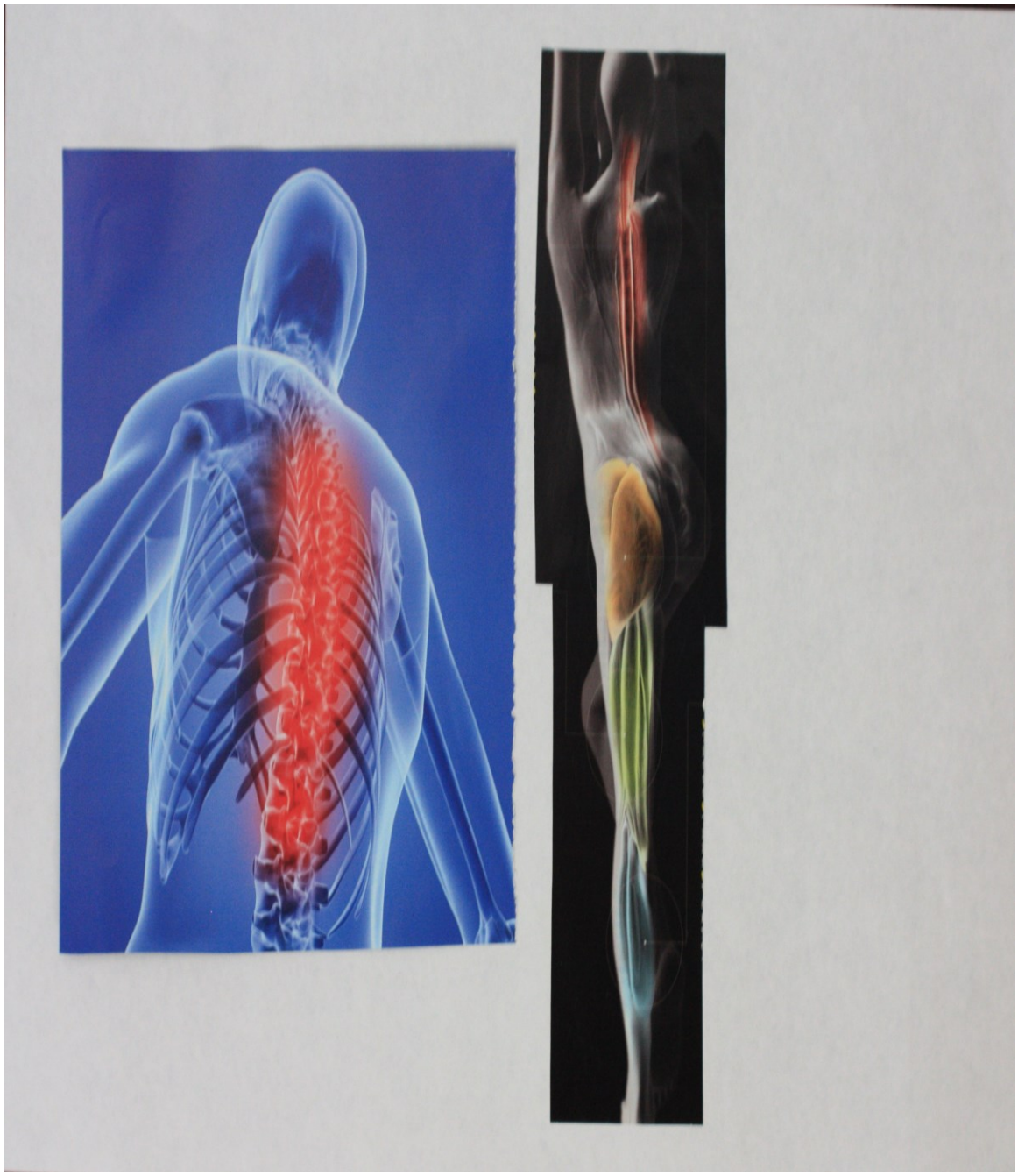
Art therapy summary. Jaya's verbalization and imagery focused on themes of somatization, abuse, and sadness and evoked spiritual terminology related to the role of Sita (as discussed earlier). Through this activity Jaya explained that she had gained insight into personal struggles, disappointments, support systems and internal strengths. The activity offered important information regarding Jaya's emotional and physical state. Additionally, Jaya's choice in the pictures for her collage was accurate in representing some of her symptoms of embodiment indicating her ability and understanding of the art activity despite it being taxing for her. The art activities to date seemed a challenge for Jaya. First, she had never participated in art; second, she had difficulty grasping abstract concepts and metaphorical statements, which seemed a common indicator for individuals

who have not participated in creative expression activities; and third as a result of cultural inhibitions.

Thus, the fact that the therapist was familiar and understood the participant's culture played an imperative role in the therapy session as she was able to understand the participant's manner in expressing emotions. As LaVoy et al., (2001) explain, when cultural preconceptions regarding the meanings of emotional expressions are imposed, the risk of miscommunications may take place.

Further, in witnessing this session, I believe that the art activity may have been intense for Jaya as she was dealing with physical symptoms of suffering which may easily lead individuals to look at interrelationships between their physical conditions and emotions. However, in also witnessing Jaya's state in the session I was well aware of the safe environment of the therapeutic space in which Jaya was afforded a contained place for exploration. I carefully responded to Jaya's feelings in a supportive and contained manner until she felt safe enough to leave the session. Further, the end result of the artwork could possibly allow Jaya to communicate her experiences to others.

Figure 20 - Jaya's Symptoms of Embodiment



Session 5: past, present and future image. "Who I was, who I am, and who I want to be." This art task was used to gain important information about Jaya's perception of herself; to develop an awareness of change over time; to develop an understanding of how changes brought about by trauma affect different aspects of her life; to discover the benefit and opportunities that comes with struggle; focus on the empowered and disempowered self; to validate and normalize emotions related to traumatic experiences.

Jaya was eager to engage in the art making process this week. She entered the room and sat directly across from me. Being aware of the routine and her familiarity with the materials, Jaya chose an 11 x 17 white sheet and eagerly waited for me to start with the activity. Jaya chose to do a collage for this activity as she felt more able to express herself through cuttings of images that captured her emotions rather than drawing them (Figure 21). The art therapy task alerted Jaya to the several roles she played in her life and to the diverse changes she had experienced. She also described how she wanted to show in her artwork, how she was simultaneously frightened to stay in her marriage and to leave her marriage but could not find the images to represent this.

Jaya focused on a picture of a neighbourhood with homes, suggesting that she felt isolated from her community, where no one spoke to her and she lost contact with friends. I noted how the image was similar to an earlier story she had told me about herself. I asked her to describe what she had created. Jaya explained how the picture was similar to her, empty without people. She was afraid of what her family and community would think of her. Jaya feared the impact of being ostracized from the community and worried about the impact it had on her children and the future of her children.

Figure 21 - Jaya's Past, Present and Future Image

Art Therapy Summary. This activity was a very powerful activity for Jaya as it served as a symbol of the changes in self. The activity also provided her with the opportunity to express the challenges and fears she was faced with. This art task also helped to bring a new perspective to pain and suffering. Jaya explained that through the visual representation where she was able to see in concrete form and the dialogue between her and the therapist helped her learn to view her struggles as an opportunity for change and to recognize that growth comes from one's trials. She also described how the representation of how she felt inside and outside of herself helped her to focus on the differences and similarities between the empowered self and the disempowered self.

The art therapy sessions seemed to have become a space where Jaya was able to invest her thoughts, emotions, and, sadness. She anxiously waited from week to week for the art therapy to take place. However, it is felt that it was not just a result of Jaya's progress in the art therapy but also because she had made a cultural connection and because she had no one else to communicate with. As well, she also seemed to be building trust in the therapeutic relationship.

***Session 6: My Body*.** This art task involved creating a body image that represents how one uses the different parts of one's body to communicate feelings; what is going on inside of the person, physically and mentally; to draw emotions as presently experienced. Through a projected image, Jaya created a life-size image of a projected body (Figure 22). Once this was done, Jaya proceeded to fill in the body with words to communicate how she felt.

She was happy to make the projected image, but laughed at the final product as she expressed finding it awkward. In the process of engaging in the art, Jaya used words but suggested that she would try to make something and attempted to make images to represent her emotions. As she drew, she laughed at her work suggesting it looked like the drawing of a crazy person:

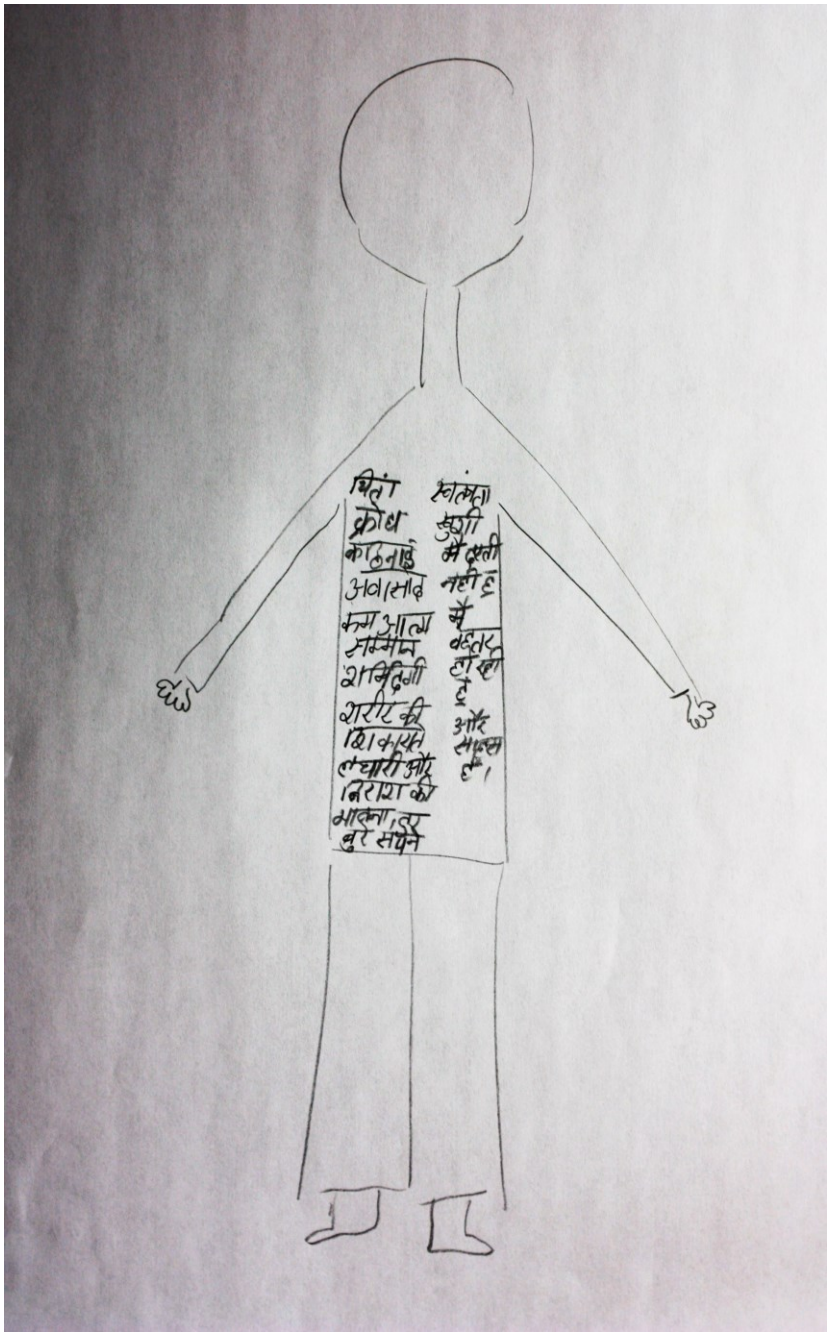
"लग रहा है कोई पागल आदमी बनाया है ।"

It looks like some crazy person made this.

Upon completion of her artwork I asked Jaya to discuss what she had created. Jaya came to the realization that she was revealing emotions that she felt but did not realize where they were coming from. I felt Jaya's artwork seemed to deeply draw her into her emotions. This activity was important to her as the size of the image had the impact of being a real life individual. Jaya was content that she was able to express what her emotions looked like and felt like but expressed feeling tired and sad.

Art Therapy Summary. The task was intense yet had a positive impact on Jaya. It helped to release tension and stress and helped her understand how to reduce anxiety. The visual image she created helped her to be more in contact with her body and feelings and to empower her. Jaya also experienced how to decrease shame by learning that her individuality can be notable for the reason that these things make us an individual and different from others. The activity also helped her to validate and normalize emotions related to traumatic experiences. Further, trust was an important issue in this session. As Jaya was able to trust me, the therapist, it indicated how she eventually may be able to trust others and herself again.

Figure 22 - Jaya's body image



Sessions 7 and 8: Body casting. Jaya was invited to cast a part of the body that represented where she experienced pain or discomfort. One side of the cast would represent the good feelings experienced and the other side would represent painful experiences. The activity had several objectives: to understand the emotions and feelings that are strong and overwhelming do subside; to express emotions of pain/suffering; to be more in touch with the body and visualize how internalizing pain connects to the body; and emphasize the good/positive qualities and strengths; validation and normalization of emotions.

Jaya created a body cast of a back (Figure 23). She used the mannequin as the base for her art piece. When she had completed the cast she used paint to decorate the cast. Similar to other artworks she had created, Jaya wanted to use words to represent both the painful experiences and the positive ones.

As she worked on her art piece, Jaya wrote words that she wanted to use on her body caste. She wrote the words happy, healthy, free, secure, and confident to represent the good feelings. For the other side she wrote no financial support, low self-esteem, fear, no where to go, reputation, abuse, isolation, suffering, pain, unhappy, headaches, and backaches. She glued these words on her art piece but as she continued to work she covered them up in paint. She then proceeded to write some very strong and hateful words that she directed to her husband. She also glued them onto her art piece but then also covered them up with the casting material and immediately turned the art piece over and added the word "new life" to her art piece. She continued to work on her art until she felt she was happy with it, suggesting its realistic imagery of a person's back.

Figure 23 - Jaya's body casting (Front side)

Figure 23 - Jaya's body casting (Back side)

Art therapy summary. Jaya described this activity as helping her with conflicting emotions. She described how she was not able to understand the emotions she was experiencing. Jaya was able to visually express positive and negative emotions and learn what it meant to her. She was also able to see what symptoms were causing her anxiety and fear. After discussing her artwork, Jaya stated learning that overwhelming emotions of discomfort and feelings may subside and that she was able to recognize self-care, embrace body awareness, and explore memories stored within the body. Of importance is the symbolic meaning behind the words she glued on and then covered up. For Jaya this was an act of releasing her anger and getting rid of both her anger and her husband.

This activity allowed Jaya to express deep feelings in a safe and contained environment. It also provided her with insight into her true self. Jaya was able to make connections between her feelings and her imagery in this session. The imagery and verbalization she provided identified her experienced abuse, traumas, and somatization.

Sessions 9 and 10: The recovering body. The objective of this art task was to discover the unique things within and about us, and to explore the importance of our own individuality and uniqueness; to help recall past and present events that may help pave the way to a positive future.

Jaya seemed eager to start the art task today. She recalled the previous week's art activity and expressed feeling happy with her art creation. She seemed to continue what she was working on in the prior week as she began by writing down some of the same words she had written in the last week and asked to see her artwork so that she could make sure she had all the words. Once this was done, Jaya began to engage in the art task (Figure 24). While thinking of a body that would symbolize her journey from abuse to

recovery, Jaya used the following words to describe how she felt and placed them on one side of the body drawing:

"चिंता, क्रोध, ध्यान, कठिनाई, अवसाद, कम आत्म सम्मान, शर्मिंदगी, शारीरि कां शिकायतों, लाचारी और निराशा की भावना, डर, और बुरे सपने ।"

Anxiety; Anger; Difficulty concentrating; Depression; Low self-esteem; Shame and embarrassment; Physical complaints; Feelings of helplessness and hopelessness; Fear; and Nightmare,

On the other side, Jaya wrote:

"स्वतंत्रता, खुशी, मैं डरती नहीं हूँ, मैं बेहतर हो रही है, और साहस है"

Happiness, free, I am not afraid; I am getting better, and courage.

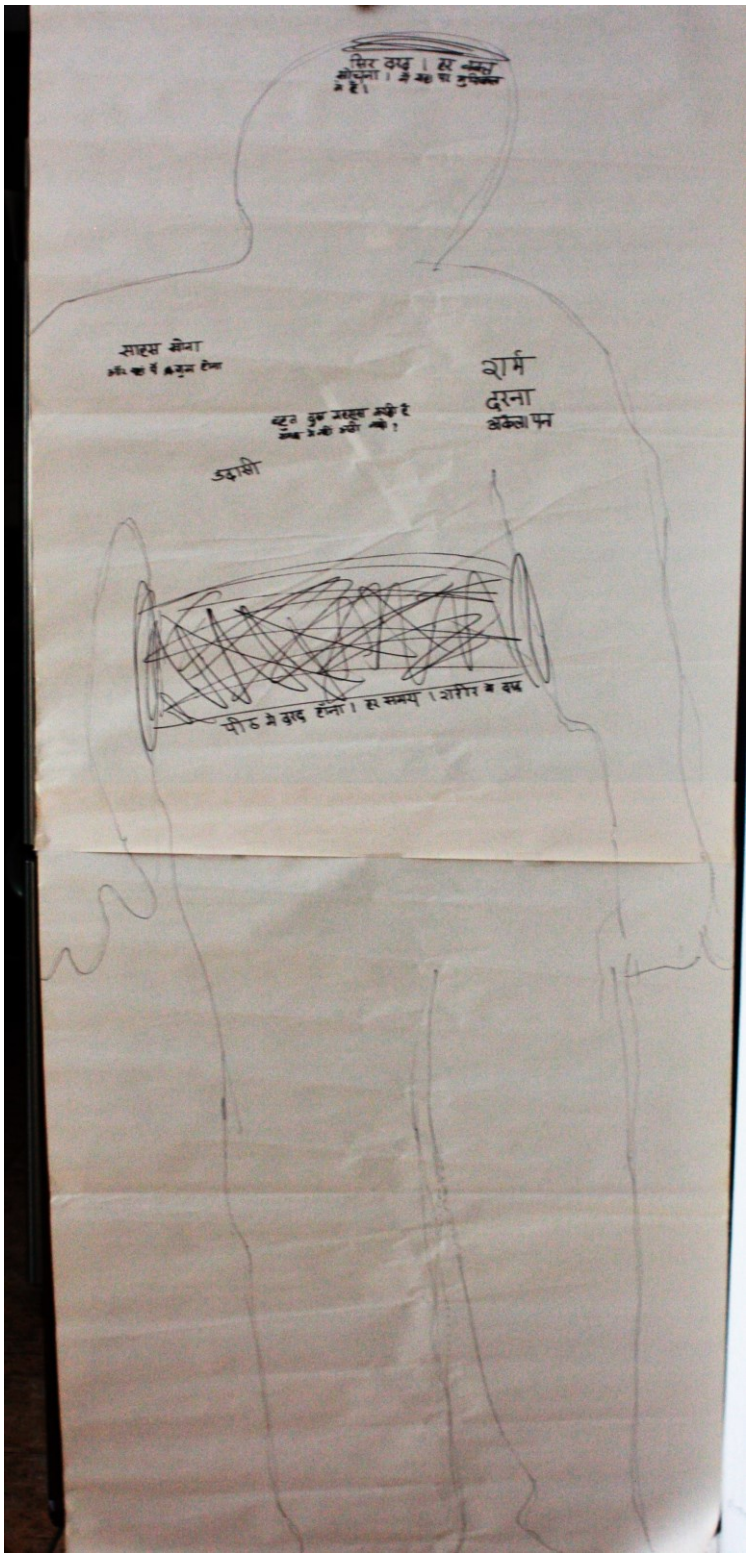
Jaya had a difficult time with this activity as she was unsure about her recovery process. She indicated that she did not feel she was feeling fully recovered:

"मैं पूरी तरह से ठीक नहीं हूँ।" *I am not completely better.*

Jaya explained she was still feeling the pain of her trauma and worried about her future. As well, she had the awareness of requiring more time to heal.

Art Therapy Summary. The art-work Jaya created helped her to realize the strength and many positive aspects she recognized within herself. She also stated feeling validation and normalization. Jaya described that the activity helped her discover how to shift away from the experience of the sadness and suffering. She noted that through recalling past and present events a positive future was a possibility. The visual indicators on her artwork helped Jaya to see her past, present, and future coping behaviours. She also expressed feeling self-empowered to a certain extent.

Figure 24 - Jaya's recovering body



Session 11: Bridge drawing. The objective of the art task was to identify any obstacles that there may be in completing treatment and to list specific coping skills that would help in recovery. Giving visual form on paper to future goals, obstacles and coping skills is a reflective way to determine the stage of treatment; to explore the metaphor and symbolism; to prepare for any obstacles that may hinder progress/moving forward.

At this session, Jaya was silent and worked quietly in selecting her art materials. Jaya started on the left side of her 17 x 12 sheet of white paper and began to glue her cut-out images from magazines (Figure 25). On the left side of the bridge drawing, Jaya did a collage of pictures illustrating the abuse she experienced. She used pictures of men whom she thought looked aggressive. She also placed pictures of women in pain or being victimized. She felt it important to include a monster at the top left, as she felt it represented her husband's real character. And finally, she had felt it important to put fists and one arm pointing a finger, on the "past" side of her artwork. She felt that this was all behind her now and that she was ready to move forward. Yet, Jaya's selected images of her past completely overfill the left side of the paper in a manner that demonstrates the presence of her trauma in her life. In the centre she glued a photocopy of a bridge. She placed a young girl to represent herself, but then proceeded to put a big, strong chain and lock on the girl's feet. Underneath the bridge is an "obstacle" and she describes it as a "weak person struggling to get away." On the top right Jaya colours in dark blue clouds and places a shiny butterfly representing her freedom and ability to fly away and be free. Jaya also draws a flower and a tree symbolizing growth. To symbolize Jaya's future, she puts a picture of a young, happy girl and dog at the far right; graduating girls, a happy couple, a little girl, and a novel at the bottom of her collage. She placed the words: मैं

ठीक हूँ, लेकिन अभी भी अंदर से डरती हूँ, *I am fine but still afraid on this side.* Jaya's collage is consistent with the words that make reference to her fears.

Art Therapy Summary. Jaya's collage had several images suggestive of loss and sadness. She described the dark blue clouds as can indication of such an anxiety. In discussing the art image Jaya and the therapist realized that the black-and-white picture of the man and lady at the bottom of the image and the little girl in a traditional Indian outfit serve as unconscious reminders of Jaya's parents and her culture. Jaya invested a great amount in this drawing as it was important for her. She added in elements of growth, such as the flower and a tree. The flower is bright and big in size but the growth is limited as there are no leaves. The tree also looks restricted to three flat ended branches with two broken branches limiting its growth as well. Further, the broken tree branches may also be an unconscious symbol of Jaya's broken spirit during this period of her life. In general, Jaya came to the realization that the future side of her image exhibited isolation, featuring single subject images. The bridge also seems segregated from the rest of the collage, almost as though it is floating in midair without any support. Jaya stated that one can go back and forth on the bridge but is not certain where it leads to. Roads featuring a back and forth way are suggestive of "indecision and vacillation" (Hanes, 1997, p. 13). Furth (1988) points out that what is central in a drawing is what is of most significance to the individual. Thus, Jaya concludes the bridge is enabling her to move forward. Jaya notes of significance to her are the butterfly, the lady sitting on the bridge with a lock on her foot, and the lady crawling away under the bridge. She feels she can identify with these images the most and has also placed all three in the centre of the art piece.

Figure 25 - Jaya's Bridge Drawing

Session 12: Termination - Review of Artwork. Jaya could clearly see her progression in the art process and was very pleased, but was not interested in reviewing her artwork. She suggested "just talking". She discussed how she felt well supported in the therapeutic forum and also felt she had made a friend. This was because we both shared cultural and spiritual similarities and Jaya had developed an attachment to our relationship. She spoke about how she looked forward to our meetings and was accepting of the art tasks because she felt comfortable in my presence. The therapist-client relationship was explained to Jaya; however, she did not seem to fully understand it and stated she knew she would still see me around the shelter at some point during the weeks ahead.

In her discussion of her overall experience of the art therapy meetings Jaya explained how she found the art therapy sessions helpful. She explained how she kept her true feelings and insecurities to herself as she feared if she disclosed her real self, she and her family would be stigmatized. Jaya also spoke about her health and the outcome of the abuse she experienced and gave insight into her recovery while having a positive outlook for the future:

> "मैं अकेले जीने की कोशिश कर राही हूँ जहां मैं खुश हूँ...समय के साथ शायद मैं ठीक हो जाउगी..."
>
> *I am trying to live an independent life where I can be happy...I think with time I will be better…*

Chapter 5. Findings

This chapter presents an overview of the outcome of each of the twelve art directives within the research protocol and the follow-up activity. The twelve art directives address several themes suggested by Steele (2003) who recommends that art therapists focus not only on the symptoms of trauma with the client, but also on fear, terror, and anger; psychological, emotional, and physical harm; as well as personal responsibility. In addition, the conclusions of my findings integrate information pertaining to the research questions:

- How can art therapy address the specific needs of Hindu South Asian Indian immigrant women experiencing trauma living in a metropolitan area as a result of domestic violence?
- What are the associations between cumulative trauma and the body?
- How are issues of trauma and cultural changes addressed in art therapy?

The research was not designed to address each question in each session. Rather, the sessions were structured to use Steele's (2003) model and then elicit participants' responses through the outcomes of each session based on the individual narratives of each woman. As well, the analyses of the art creations were examined based on the participants' descriptions. With this input, it is possible to draw conclusions about using art therapy to facilitate and support the healing process for this particular group of women. A synopsis from my interview (Appendix F) pertaining to the question: What therapeutic changes, if any, has the art therapy process had on the participant(s), is included at the end of this chapter.

Art Therapy Sessions

Session 1: A safe place

This activity focused on familiarity with the materials, decision-making skills, and building trust. It was important to establish a sense of safety and to demonstrate the therapist's commitment to this safety by continuously re-establishing trust, to ensure that the participants feel safe enough to begin connecting their emotions to their experiences. Normally, during the initial stage of the therapeutic relationship there is a degree of uncertainty on the part of the client. It is important to explain the process of the therapeutic forum while conveying clear and consistent messages and devoting oneself to the client during the therapeutic sessions; this promotes a secure therapeutic alliance in which the client develops a required sense of security in order to be able to disclose and to take risks. Following disclosure it is important for the art therapist to ensure that the client is listened to and also supported.

It is also important in the beginning sessions for the therapist to be consistent and non-threatening as described by Rubin (1978) the "early period is a time for making the situation as pleasant as possible . . . a time for helping him to learn what is expected of him in both doing and reflecting upon his artwork" (p. 79). Thus, development of the therapeutic alliance is important. The therapist's primary approach is normally a supportive method and the focus directed toward encouragement of the client, providing her with an opportunity to work on strengths and healthy strategies while gaining a sense of mastery in overpowering circumstances and learning to increase a sense of control and power (Herman, 1992).

The important role of the art therapist in this activity was illustrated by Jaya in the first session. Jaya drew an image that included some clouds, a tree, a house, a boat and a river − all characteristics of landscape around a home − any home, any landscape. However, after Jaya felt the initial support of the therapist, she drew a small and faded house representing her home in her native country. Jaya became comfortable enough to be more specific about herself and her history and to share her personal place of safety, her home.

All three participants created an image of a safe place related to their country of origin and included aspects of their childhoods, indicating a need to be culturally connected. Two participants, Raina and Devi, were comfortable and able to elaborate on their art creations. However, the third participant, Jaya, remained guarded.

Raina's story of her artwork reflected her childhood, culture, and home country. She focused on both the positive and negative aspects of growing up in a traditional home with family and cultural expectations. Raina seemed to be struggling with a deeply held sense of failure and disappointment in her development of a sense of self. She created an image of a safe, peaceful, and hidden place where she could hide and was protected. She reflected on how her drawing showed an empty entrance that did not reveal what was beyond it. This painting of an entrance could echo a sense of emptiness and profound feeling of isolation and uncertainty, but also represented an entrance to another, unknown phase in her life. In discussing the traditions of her culture, her disposition changed; she became quiet; her body language suggested ambivalence as the pace of her art making increased, suggesting her desire to not revisit her difficult memories growing up in a traditional setting; and displayed dissociative symptoms consistent with PTSD. Raina

further indicated hope for the future, as her imagery and verbalizations of the second half of her work reflected her ideals of a happy marriage and indicated a sense of hope, as she associated marriage with fairytales − happy endings after turmoil.

Devi recalled her childhood by verbally expressing her trauma narrative and was very emotional doing so, having to stop to wipe her uncontrollable tears. Her demeanor was timid and indicated uncertainty. As well, she was apprehensive to draw, an indication of resistance. Thus, with this in mind, the therapist respected her choice as she chose to use collage as her art medium.

Jaya was able to offer information regarding herself through the imagery, her verbalization, and her overall demeanor. Many themes emerged through her artwork: culture, traditional values, home, religion/faith, and safety. The art session provoked anxiety in Jaya, as she had never participated in creating art, and the resultant emotional content she was disclosing. Jaya was very submissive, fragile, shy, compliant, and respectful. She required more time to develop trust with the therapist. Unlike the other participants, Raina and Devi, who appeared to have built an immediate alliance with the therapist, Jaya was guarded and was reluctant to reveal any information pertaining to her personal life, possibly as a result of unfamiliarity and her traditional high value placed on privacy in family issues.

Through discussions with the three participants, a common response emerged, including the belief that they were failing to measure up to both their families' expectations and the traditions of their culture. The women expressed being shaped by such influences. Thus, through this session some of the participants' specific needs were

disclosed and addressed. Given a lack of experience with therapy, perceiving concrete gains in a first session was particularly important.

Session 2: The uniqueness metaphor

This art activity explored the uniqueness and personal experience of being a woman and helped to build self-esteem. Raina and Devi attended their individual sessions, while Jaya was absent for hers. Both participants were able to re-visit their past and present struggles in this activity. Both their experiences of trauma and their needs were addressed.

Raina related the images to her past experiences, offering insight into her difficulties. Raina represented herself through the metaphor of two trees with flowers growing on them. She related her drawing to her childhood, familiarity, to her country, happiness and as growth. Raina spoke of how flowers need to be taken care of and nurtured or they will die. One tree was stronger than the other. The first one was standing tall with the roots clearly providing life to the flowers and leaves. Raina's second tree leaned towards the left, requiring support to stand straight; its leaves were wilted had fallen off. The roots and the veins of the tree were faded into the trunk, barely visible, symbolic of Raina's downward-spiraling health. At the bottom of image 2-B a tiny worm sat on the ground, indicating an unconscious awareness of the dangers that were present in her life. Raina's work was an accurate representation of how she saw herself.

On the back of her drawing, Raina drew a face, seemingly floating in midair. The absence of a body is normally associated with unconscious feelings of powerlessness (Malchiodi, 2007). Without a body, an individual cannot function. When encouraged to address this image, Raina's response was suggestive of the profound sense of

powerlessness she experienced in her abusive relationship. Furthermore, the lack of a body could be noted as a dissociative response to fear and stress, as dissociation involves the detachment and partitioning of emotions and associated information. As well, it is linked to resulting distortions of memory and the self (Brown, 2002) all commonly associated in those suffering from traumatic experiences.

Initially Devi was resistant to participate in this session because of her declared inability to draw. This may have been a result of dissociation or what Herman (1992) explains as avoidance of situations that remind trauma survivors of traumatic experiences which may limit the range of activities the individual participates in. However, through support from the therapist, this activity helped her communicate her feelings of pain, loss, sadness, fear, isolation, and a loss of her voice. Devi's drawing, like Raina's, reflected absence of body parts, with the associated unconscious feelings of powerlessness (Malchiodi, 2007) and is suggestive of a deep sense of powerlessness experienced in her abusive relationship. The drawing signified her low self-esteem, a distorted body image, somatic complaints, her distress because of her fragile identity, and the abuse experienced and also symptoms associated with PTSD.

The art task was helpful in that Raina was able to complete the task. It helped to promote self-esteem in that she was in control of what materials to select, use, and to create a unique self. This was important as there was a need to build Raina's self-confidence as she indicated feeling powerless. The use of two separate papers indicates an inner division at a confusing period in her life. For Devi, her drawings are indicative of problematic areas that symbolize somatic or physical symptoms of pain for her. As

discussed earlier, the association of trauma and the body is apparent for both participants in this session.

Session 3: Self portrait

All three participants created images with two sides representing themselves. The self-portrait activity elicited self-images of two of the participants, Devi and Jaya, while Raina's image was preconceived. Each woman drew a self-portrait of choice. The women were surprised at their final self-portraits. Devi and Jaya did not draw age-appropriate images. The self-portrait activity enabled the participants to gain perspective of their growth over time and was of value in their healing process.

During the art therapy sessions it became increasingly evident how deep were Jaya's connections to her culture. She viewed the therapist as a successful professional and constantly showed high regard and respect for her, expressing cultural identification with her. Although she was able to make her own choices, she waited for prompting at each step when creating her art in this session, while verbally expressing her lack of experience in creating art and perhaps feeling she required the therapist's guidance.

Raina expressed another important aspect of her preoccupation with her cultural community. In this case, it was concern that the cultural community might find out that Raina had transgressed by leaving her abusive husband, and even worse, that she was talking about this. Raina was very intimidated by the audio recorder; she had difficulty disclosing her experiences and she was uncomfortable with her stories being recorded.

Perhaps Raina's discomfort was also related to the associations she was making with her childhood years in the angry and sad portrait she created. Her paintings reflected the complex issues with which she was coping and her dissociation consistent with

PTSD. Her image represented, on one side, happiness without revealing emotions, while the other side represented anger, sadness, frustration, and loss. Her representation was symbolic of her experiences of abuse and low self-esteem, vulnerability, and helplessness, and triggered these negative emotions to the surface.

Similarly, Devi communicated feelings of pain, suffering, loss, and deep sadness. The drawing signified her low self-esteem and the expression of both self-portraits had blank stares, which seemed to represent characteristics of those who do not have the ability to confront their feelings directly as a result of feeling overwhelmed and hopeless. Through Devi's verbalization, it was clear that the emphasis on the large and overly coloured lips in her self-portrait symbolized her isolation and silence. The art task gave insight into Devi's daily struggles and was valuable measures of change. The images offered Devi a reflection of the mask she wore on a daily basis. Her second image was of a sad person with eyes looking down, with attempts to portray a "culturally appropriate" woman. Devi's portrait was a reflection of how she felt but was unable to reveal to others. She used the words sad, tired, lonely, afraid, uncertain and unable to speak to describe her feelings surrounding this artwork.

The visual processing of the self-portrait elicited several emotions in the participants: for Raina her image had a strong emotional impact on her as she was able to actually see her inner world. Her self-concept consisted of many concerns: inadequacy, rejection, fears, self-control, and trust issues. For Devi it brought to the surface feelings of low self-esteem, low self-worth, and a poor body image. For Jaya, self-esteem issues, sadness, and the inability to speak were the most apparent.

The selection of a traceable face image by Raina indicated a desire to avoid the body. Her actions surrounding her choice were important. She merely glanced at the traceable picture with the full body and was quick to choose the image of the face. Raina's tracery of a facial image appeared to be connected with dissociated memories, reconnecting them to her consciousness. Although it was Raina's traumatic experiences that were being discussed, the graphic details of her image seemed to remind her of her past experiences, with the result that the therapist had to re-direct her emotions as she was displaying symptoms of reliving her traumatic experiences. This, however, is common to individuals experiencing trauma. As previously indicated, Herman (1992) emphasizes how trauma survivors often exhibit symptoms of intrusion, and relive the traumatic events through bodily and visual sensations, flashbacks, and dissociations.

Jaya related her artwork to cultural associations of beauty and characteristics of individuals in her country. She also made associations to the host country: of others assuming she was a non-Indian woman, having fair skin, and drawing the hair in the self-portrait as a modern woman, all unconscious associations to some of the changes she wanted, or the feeling that she didn't belong anywhere.

Session 4: Mural – Symptoms of embodiment

The fourth session provided the participants with an opportunity to perceive how their symptoms of suffering and body image transformed through their individual healing process. The activity offered important information regarding their emotional and physical states. The art process enabled the women to visually represent and externalize what they experienced internally (somatization). All three participants were able to make connections between their experienced abuse, symptoms of pain, somatization, and

sadness. They described the insights they gained: Jaya, on her personal struggles, disappointments, support systems and internal strengths; Devi, on her daily struggles and valuable measures for change; and Raina, on her personal world.

It became clear during this session that Raina was finding the sessions difficult. Her disposition had become distant and anxious stemming from the previous week's difficulty with the self-portrait. The intensity of the previous week's and current week's art activity provoked a powerful re-living of her traumatic experiences and avoidance connected to dissociation. While this may appear troubling, with support this response is not regarded as a negative outcome, as proposed by Steele (2003) who explains the advantages to a structured trauma intervention. In his study, Steele (2003) re-exposed his clients to traumatic memories through drawing. Through this exposure, access to traumatic memory was conducted in a safe environment which is regarded as the most important method in treating trauma survivors to re-tell, re-organize, and to integrate their experiences into their consciousness. Thus, this activity had a positive outcome for Raina as she was contained in a safe environment. Additionally, Raina described how she was becoming more aware of her reality, that she was no longer in an abusive environment. The activity indicated resistance (to speaking) as well as triggering Raina's emotions. The therapist assessed Raina's situation and respected her wish to terminate the session.

Two participants, Jaya and Devi, were able to express their emotions through creating their images. Initially Jaya was hesitant to start her work but eventually explained that she had gained insight into personal struggles, disappointments, support systems and internal strengths. Interestingly, it was in this session that Jaya became less guarded and more communicative, a more willing participant in the therapeutic

relationship. However, the activity triggered an emotional response from Jaya, as it brought back memories of her abusive husband's behaviours and made apparent her symptoms of PTSD.

Devi's image symbolized isolation and loneliness. It reinforced her circumstances of living with her husband, his escalating abusive behaviour, of living alone in her apartment for the majority of time without any connection to her family, relatives, or friends. The isolation Devi experienced was one of the main elements that surfaced in her discussions and her art therapy process. She struggled with the effects it had on her.

All three participants commented on the vulnerability of expressing their emotions, telling their stories and sharing them with the therapist. Processing centered on the idea of trusting another to respect their emotions without being judgmental. As well, cultural issues were discussed as the vulnerability was not based solely on exposing emotional information but also on cultural influences related to help-seeking by abused women as family issues are regarded as private and personal matters that should be kept within the family unit (Mehrotra, 1999).

Session 5: Past, present and future image

This art task was used to gain important information regarding the participants' perceptions; to develop an awareness of change over time; to provide an understanding of how changes brought about by trauma affect different aspects of one's life; to discover the benefit and opportunities that come with struggle; to focus on the empowered and disempowered self; to validate and normalize emotions related to traumatic experiences.

The past, present, and future activities helped the participants visualize their experiences through the perspective of a time continuum. Malchiodi (2003) refers to this

art task as a "visual map or timeline of a survivor's experience," suggesting how it helps to integrate information from an individual's past into their present and future life. This art activity enabled the participants to gain perspective of their growth over time and was of value for the participants' healing process. Two of the participants, Raina and Jaya took part in this activity.

Both participants recalled their past lives with sadness, fears, and feelings of isolation. The activity was a powerful one, serving as a symbol of the changes in the self. Raina was able to reconnect to her past childhood memories in her native country, bringing her to a place of comfort. She described past emotional injuries from her childhood years, along with the memories of her traumatic experiences with her husband and her in-laws; she was able to make the connections between her traumatic experiences and the changes they perpetuated. There was also reference to her abusive relationship and how it changed the course of Raina's life, both positively and negatively. Additionally, dissociative occurrences consistent with post traumatic stress disorder were also evident in this session.

For Jaya, the activity provided her with the opportunity to express the challenges and fears she faced. The activity alerted Jaya to the several roles she had played in her life and to the diverse changes she had experienced: being a faithful daughter by following the cultural tradition of marrying within her caste system, abiding by her family's and husband's rules as women frequently do not have a voice or sense of identity. Furthermore, as Abraham (2000a) states, this identity is submerged within a collective identity of the family unit, resulting in the inability of women to communicate their individual needs and desires. Jaya explained that through the visual representation

she was able to “see” her feelings in concrete form; this was a learning experience for her. As well, the dialogue with the therapist helped her learn to view her struggles as an opportunity for change and to recognize that growth results from one’s trials. She also described how in the representation she felt “inside and outside of herself”; this helped her to focus on both the differences and similarities between the empowered and the disempowered self.

Raina remembered her past, using flowers symbolically in her artworks, connecting her to her childhood and to positive experiences in her native country. The spontaneous drawing of flowers was a natural process but also served as a reminder, in Raina’s words, of the “role” of a “good, traditional daughter” and later of a “good wife.” Thus, it was clear from Raina’s statements that the flowers represented the cultural and traditional role of a South Asian woman.

While processing the artworks, each woman's unique experiences were characterized by different obstacles and challenges. Tradition and cultural issues were addressed as the participants both described how they felt they deserved the abuse they had endured. Additionally, this interpretation of their experiences highlights feelings of worthlessness and fault, resulting in a negative narrative of identity through which individuals will interpret past and present experiences, impacting future decisions (White, 1995). Thus, once the women had completed their session discussion and descriptions, the focus shifted to the development of a preferred way of being in order to help the participants break away from their negative narratives. To change the shift from the negative to the positive, I supported the women as they described their traumas, to help them deal with their emotions and view their experiences with a new, and more positive,

perspective. Emphasis was placed on the efforts they had made to break away from their abusive environments.

Session 6: My body

There were three main aspects to this art activity: to create a body image that represents how one uses the different parts of her body to communicate how she feels; to represent what is going on inside of the participant both physically and mentally; and to draw out the emotions experienced in the present. All three participants were able to engage in the sixth art directive and graphically develop their feelings through imagery and verbal information regarding the art. This activity was intense for all three participants.

Raina's somatic symptoms were evident in her stomach, chest, neck, and head. On a symbolic level she presented her image as being what she described as "stuck to the ground like a tree". While this may be viewed as positive and may show her as grounded, she was more engaged with the notion of her being stuck and too rooted. She graphically demonstrated her panic attacks, portrayed through her inability to breathe and speak and the feeling that the area around her mouth was full of pins. She also verbally expressed the feeling of being watched by others as her pain was exposed (consistent with symptoms of PTSD), despite wearing clothes to cover her body. Raina's fear of recording her voice and her feelings of being watched are reminiscent of the impact of the gaze. The past effects of her self-harming behaviour were also included in her image and symbolically referenced her low self-esteem by creating hair that was "destroyed and falling out". Raina's art reflected anger and sadness and made her aware of her weakness in coping with stressful events. Her self-harming behaviour had been a coping skill she

used when she was younger, yet at times of anxiety and stress she continued to revert back to this behaviour. The art therapy helped Raina with both somatic and self-harming issues. Through the art therapy she was able to externalize her experienced somatization onto the art image and make associations between her trauma and body pains. This is consistent with the previously mentioned findings of Luzatto (1998), where clients were able to explore the meaning of their symptoms, pain, and illness through the externalization and containment of their symptoms through art therapy techniques. In addition, as discussed in the literature review on atr therapy and self-harm, Raina was also able to use a more adaptive strategy for managing self-destructive actions. Instead of using her body, she was able to focus on expressing emotions symbolically (Cooper & Milton, 2003; Milia, 2000)

For Devi, the art activity enabled her to express herself on a level that she was comfortable with. It provided her with an opportunity for insights into feelings she kept inside. The art directive evoked emotions of sadness and a realization of an internal loss of the perceived ideal self and, to some extent, the loss of wanting to live her life as she had prior to getting married.

Jaya was able to release tension and stress through this activity. It helped her understand how to reduce anxiety and decrease shame by learning that her individuality can be notable for the reason that these things make people individual and different from others. The visual image she created helped her to be more in touch with her body and her feelings; to empower her, and validate and normalize emotions related to traumatic experiences.

For all participants the created artworks were used to embody the participants' negative issues while enabling them to distance themselves from their difficulties as described by Schaverian (1999). Schaverian explains how the image, through exploration, can take on new meaning and can either reduce or even destroy harmful effects. Thus, the individual is then able to deal with the problem objectively as she views the issues at a distance. Such decisive factors are pertinent in helping individuals deal with unresolved difficulties which in turn may increase their self-value (Greenberg, 2008). In addition, the art task helped the women to

Sessions 7 and 8: Body casting

The seventh and eighth activities served as a representation of experiences of both good and painful emotions, and brought strong, overwhelming emotions to the surface. To some extent this experience empowered the women. Devi and Jaya were able to express that their emotions and visualization of their artworks helped them to gain insight as to how internalizing pain connects to the body. For Raina the art directive was very difficult, resulting in the modification of the session.

The art directive did, however, help Raina to be assertive, confident and express her emotions. It provided her with insight into the struggles she dealt with on a regular basis. She wanted her art creation to give the impression of a blank and empty appearance and revealed how her art represented her failed attempts at a content life. However, the emotional intensity that was involved in this task was too difficult for Raina to complete the session. She avoided touching issues related to her body; symptom of dissociation. As a therapist listening to the participant's response, I needed to adapt the session to provide Raina with a safer environment. I re-directed the focus of the session because Raina was

not ready to address the issue of her body. In the processing phase of the session, I engaged Raina in separating her feelings of inadequacy from unhappiness in order to help her work towards feelings of worthiness. We addressed the fears she carried with her and recognized the steps she had taken towards positive successes.

For Devi the challenges were different. This body casting task was helpful in gaining insight into Devi's despair, which was evident in her verbalization and the graphic details of her artwork. The art task also provided Devi with the opportunity to be in control, and to enhance her self-esteem and confidence, although she displayed some initial resistance to the activity: "I have never done this before."

Watching Jaya's process during this activity, I was content that the activity allowed her to express depth of feeling in a safe, contained environment. The imagery and verbalization she provided identified her experienced abuse, traumas, and somatization. Jaya described this activity as helping her with conflicting emotions by providing her with insight to make connections between her feelings and her imagery. She was able to visually express positive and negative emotions and learned to understand their meanings. She was also able to see what symptoms were causing her anxiety and fear; that overwhelming emotions of discomfort and feelings subside; to recognize self-care, embrace body awareness; to explore memories stored within the body; and to release anger.

All three participants were able to use this activity to associate experienced somatic symptoms in the art works. Although the art task elicited intense emotions it was a helpful activity as it was consistent with the literature on somatization and art therapy. As visual images are a means to communicate between mind and body, art may influence the

body functioning by transforming the somatic images individuals hold in their minds (Long, 1998). The women were able to express their problems, indicating that the physical nature of art making and the act of seeing their images was crucial to their understanding(s) of their body trauma's (Collie, 2006). As well, as discussed by Wix (2003), the tactile qualities of art making helps reduce intellectual defences which may eventually help in reconnecting the body and mind.

Sessions 9 and 10: The recovering body

In this session all three participants completed the artwork, focusing on their individual responses to both the positive and negative aspects of their bodies.

For Devi, this activity seemed to activate more verbalization without hesitation, providing her with insight into her traumatic experiences of abuse, isolation, loneliness, and helplessness. Devi's self-concept was replete with issues of trust, insecurities, low self-esteem, and fear of rejection, a desire to be loved and a sense of fragility. Through the act of tearing her first image, she appeared able to get rid of her old self and recreate a new self. The second image was a powerful image of a healthy and vibrant looking woman, Devi described as feeling confident.

Jaya described how the activity helped her to discover how to shift away from the experience of sadness and suffering. She noted that through recalling past and present events a positive future was a possibility. The visual indicators on her artwork helped her to see her past, present, and future coping behaviours. She also expressed feeling a certain sense of self-empowerment: the artwork she created helped her to realize her strength and her many positive aspects. She also stated feeling validated and normal.

The art directive elicited a positive outcome for all three participants although Raina had difficulty in expressing her past traumas. It triggered overwhelming emotions that seemed to remind Raina of certain traumatic experiences. She described how her body image was a continuous struggle for most of her life. She recollected how she often gave the impression of a strong exterior, but on the inside she felt weak, leading to her self-harming behaviours. Raina's history, trauma experience and identity losses were apparent in the art therapy session. Images can at times reflect unconscious material emphasizing fears and anxieties, while verbal explanations depend on rational descriptions resulting in a creative process "offering a bridge between the conscious and unconscious" where difficult emotions containing identity losses are easily accessed (Reynolds and Prior, 2003, p. 786). Although Raina experienced dissociative occurrences, through this process, Raina was able to make simple choices such as what to create and what materials to use, a positive step for her as the very act of creating enabled her to feel in control. While she exercised choices, she expressed her individuality and identity, gaining some independence. The therapeutic space provided Raina with a forum in which she was heard and seen restoring a sense of lost voice (Long, 2004).

The art making provided the participants opportunities to discover "notions of potential rather than concepts of pathology" (Aldridge, 1993, p. 285). They were able to make connections and come to terms with their individual body traumas, which were important steps toward creating an integrated identity; while anticipating in the art activities provided evidence of personal achievement. This in turn strengthened self-confidence which connects ones identity and belief in the things that one can carry out (Christiansen, 1999).

Session 11: Bridge drawing

Serving as a metaphor from the past to the present, the bridge drawing elicited feelings of loss, confusion, fear, growth and hopes for a better future. Of the three participants, two, Raina and Jaya, completed this directive. Both participants' drawings are symbolic of their past, present and future. Their illustrations were very different but shared similarities in some of the emotional content. Raina's abstract illustration helped her to explore safely her feelings of loss of family, friends, country, her marriage, and the abuse she endured. She indicated feelings of confusion, fear, a sense of isolation, and hope. Whereas Jaya's collage had several images suggestive of loss and sadness as she described the dark blue clouds as an indication of anxiety.

In discussing the art images, the aspects related to culture were: Jaya emphasized a black and white picture of a man and lady and a little girl in a traditional Indian outfit which for her served as unconscious reminders of her parents and her culture, representing her desire to maintain her culture in the host country. Raina did not show the foundation of the bridge, which is a support that provides strength to the structure of the bridge. The foundation of the bridge serves as a metaphor for Raina's family, instilling strength to bear hardships and suffering, therefore resulting in Raina not feeling like she had strength.

Both Raina and Jaya included elements of growth: For Jaya, the flower and tree represent the growth as limited and an unconscious symbol of her broken spirit during this period of her life. In Raina's work, the representation of the bridge serving as a divider between the river and the land on the opposite side is symbolic of a form of protection; the bridge represents a strong support separating the past from the future. And

as described by Raina, the several white circles represented hope for a positive future, and her past was represented as being contained. In general, both Raina and Jaya indicated an awareness of their circumstances, but also their uncertainty about their futures. Raina pointed out that her bridge continued on both sides of the page, indicating "no end and no beginning," similar to what recovery appeared to be. Raina explained that recovery appeared to be an on-going process for her that had "no end" yet at the same time was "not beginning" as she had already begun her recovery.

Jaya came to the realization that the future side of her image exhibited isolation, featuring single images. The bridge was also segregated from the rest of the collage, as though it was floating in midair, unsupported. Jaya stated that one can go back and forth on the bridge but was not certain to where it led. She concluded the bridge enabled her to move forward but noted the significance of the butterfly, the lady sitting on the bridge with a lock on her foot, and the lady crawling away under the bridge. She felt she could identify with these images the most and had also placed all three in the center of the art piece.

The women were able to process their traumatic experiences in the clinical art therapy sessions. The use of visual imagery and the act of creating, enabled the women to express and work through their traumas while creating art, through metaphors and personal narratives. The art creations and verbal expressions enabled the women to view and to express their experiences in a safe, contained space in which they began to build self-esteem, courage, and a sense of empowerment.

Session 12: Termination

Each participant was given their art folder and box which contained their art work(s), for their individual last session. The progress of the artworks was reviewed, as they represented a concrete record of the women's emotional and thought narratives. Each woman described how she was pleased to have taken part in the art therapy program where she was provided the opportunity to graphically display her emotions, issues of self and traumas, and hopes for the future. Realizations regarding the self and traumas manifested in embodied experiences, cultural aspects of each participant and the expression of pain and suffering were addressed in the therapeutic forum. Of importance to the women in this study was:

Raina's art therapy process revealed a high level of anxiety, anger, and lack of self-esteem, loneliness, sadness, and discomfort with her body. She experienced a high degree of anxiety during the first few sessions, which subsided during the middle phase of the research, and then rose slightly towards the end. Raina was able to invest in the art therapy program and gain insights regarding her difficulties, express her traumas and work through them on a symbolic level. Raina's experience of trauma and abuse was intense; safety was of great importance to her in the therapeutic forum. Luzatto (1998) suggests that the frame of the paper itself, used to create an image within art therapy, can in fact serve as a safe container for the expression of pain. While the participants placed their emotions and thoughts on paper, they were able to move towards a deeper exploration of the images together with the therapist.

Although Devi had experienced periods of anger, anxiety, and discomfort with her body, as the sessions progressed she could regulate her affect better. She also

preferred art as a method for retelling and processing her experience instead of verbally restating her experiences. Thus, the art served as an expression of her experiences. Through her artworks and brief descriptions, Devi was able to make associations with her suffering and to work through her disturbances. Although putting such experiences into words seems helpful, through imagery, individuals may express negative thoughts symbolically without having to name them, providing a balance between silence and expression. The creation and the processing of the art had the effect of making the experience less overwhelming as the therapist helped Devi to explore the meanings and feelings evoked in the images and how it related to her experiences.

Jaya attended the art therapy program but was initially reserved and non-trusting. She displayed a level of comfort during the fourth session. Her artwork captured her experiences of self at the various stages of recovery, with emphasis on her cultural identity. She identified with the therapist on a cultural level and was able to make gains in several areas of her recovery. Jaya was the most verbally articulate of the three study participants. She was most able to remember the past while holding onto future possibilities. Jaya had experienced several losses and many traumatic events in her life which taught her coping strategies and helped her to move forward in life. She also viewed independence as something to move toward. Devi and Raina were also working towards independence and indicated hope for the future.

The following are synopsis of the women's responses to the second interview (Appendix F) used for this research.

Raina reflected on the troubles she had at home with her husband and in laws and how several art activities in therapy that helped her understand why she was feeling the

way she was and how to help herself. She recollected how she found the process difficult at times as her art brought out intense emotions surrounding the abuse and pain she suffered. It triggered painful memories and emotions that she felt overwhelmed by. As well, she was pleased about being able to engage in a process in which she felt she was able to symbolically represent her emotions and speak about them on a metaphoric level.

The most significant themes for Raina were the body, the bridge, the casting work, and the self portrait. She expressed being able to relax and spend time addressing her emotions. Although Raina was able to communicate in English she expressed finding the choice to speak in her native language helpful. As well, in verbally discussing her difficulties, Raina was able to gain insight that helped her.

In response to the question "what was not helpful in therapy?" Raina responded that she was already aware of the pain she felt in her body and that it would take time to heal. However, she felt that although she found some of the art activities difficult, they helped her to project her pain and release internalized suffering. Viewing her traumatic experiences in art images were at times hard to look at. In addition, Raina discussed how speaking to the therapist was helpful for as she was able to focus on her self in the individual sessions and not be shy or ashamed as she may have been in a group setting.

Raina explained how the research project helped her to believe in herself and to be more confident. The themes on the body and on the past, present and future were the relevant for her. Working on issues such as self-harm and somatization were intense experiences for Raina. However, she discussed how although she was not sure if she would be able to be rid of the symptoms of experienced body pain and completely stop

self-harming, through the clinical art therapy treatment process she learned how to release painful emotions, work them through, and project them onto art creations.

Devi recollected discussing her hardships with her husband and how her life had completely changed once she was married. For Devi, she recalled how the focus of the clinical art therapy was on how she suffered enormously and her extreme anxiety and fears. The most significant themes for Devi were themes related to the body and her ability to discuss her internalized suffering and pain. She described how the visual images helped her to see and connect her pain to different areas of her body. She was able to make connections from her experiences of her childhood to the present time (both happy and sad) during the follow-up activity, body maps. She explained how she was able to see a visual journey that was hers although she was not aware of many instances until she was able to visually view them in her body map image. She also discussed how she was able to make a mind-body connection after she had externalized her emotions in the sessions. She spoke about how they were intense and emotionally draining for her, yet realized the importance of such an experience and process.

Being able to connect to the therapist through language and culture was also important for Devi as she felt it eased her process and there was a cultural awareness that made her feel comfortable. The sessions helped Devi to come to terms with many of her uncertainties and helped her realize the importance of taking care of herself. She felt she gained some confidence and the ability to perhaps trust others. In addition, she described how she felt she was able to redirect her pain and suffering from her mind and onto the art creations. Devi discussed how she continues to suffer from symptoms of pain and

anxiety but feels she is happier than she was in her past. She believes the clinical art therapy helped her make several gains in a positive direction.

Jaya recalled discussing the troubles she had when she lived with her in laws and husband. She enjoyed all of the themes that arose from the art therapy session(s). She felt the effect of the art therapy participation had a strong impact on her, mainly her pain and sadness. Although she expressed finding everything "good" in her art therapy sessions she also explained how she initially did not understand the process and was a little afraid to participate as she felt the process may reveal information that may have resulted in causing her and her family harm (deportation, loss of job). In response question 8, "Have you learned anything new by participating in this research project?" Jaya replied that the participation in the project helped her to think about herself and to learn to be confident. In addition, she felt that she was able to externalize her emotions which provided her a sense of relief and alleviated some of her pain. She explained how she was aware of the long journey ahead of her but felt she was able to take steps forward towards a healthier life.

Follow-Up Activity

It was important to have clear, focused goals, while being a collaborative process between the participant and therapist. Jones and Unterstaller (2001) note abused women having to cope with multiple stressors, including immediate safety concerns, mourning the loss of an intimate relationship and at times family, accessing resources to improve their safety, lack of social support, and concerns of their children. The goals of the program addressed some of the needs of the participants within a context consistent with the participant's current needs at the time, while the overall approach encouraged self-

esteem and empowerment consistent with the existing theoretical literature on the treatment of abused women (Ortiz, 2012).

In the follow-up activity the women reflected on their time in the research project and their participation in the art therapy protocol. Each described how they enjoyed participating in the art making but at times found it difficult as it brought up intense emotional content that they were either not familiar with openly discussing or were not aware of. It was mentioned that the graphic details were hard to see as it made them aware of how real the pain they experienced actually was. Each woman created a body map representing their personal experiences as a conclusion to the art therapy process (figures 32, 33, & 34).

For the two follow-up workshops, the women were invited to participate in an art directive, "Body Maps," that encompassed their overall experiences of migrating to Canada, their abusive experiences, and their body traumas. The process of body mapping involves the visual representation of the many features of an individual's life, including their bodies and the world in which they live. Body mapping is the narration of one's personal story through the creation of a body map utilizing art-based methods. It carries symbols and metaphors with personal meanings, significant and understood in relation to the individual's overall experience and story (Gastaldo, Magalhães, Carrasco, & Davy, 2012).

The body maps created by the research participants tell the stories of the women's embodied experiences and the significant aspects that have shaped who they are today. The final body map creation was a mapped story which reflected on the women's past, present, and future lives described by visual elements on their body maps. Also, in

keeping with the beneficial aspects of body map research, the body maps created by the women will be made visible to the public (while maintaining confidentiality), giving them a voice at the community level, while promoting awareness about their experiences of suffering through their art.

Figure 26 - Raina's Body Map image

Figure 27 Devi's Body Map image

Figure 28 - Jaya's Body Map image

Chapter 6. DISCUSSION AND CONCLUSION

This chapter discusses the women's narratives emerging from the clinical sessions and the relevance of cultural issues in the treatment of the three participants of this research project. Based on the participant's experiences, it may be suggested that ethnic matching of the client/therapist in the context of clinical art therapy can lead to better functioning when one's culture, traditions and world views are understood and integrated in treatment. A discussion on the findings that emerged from the study is presented first, followed by limitations of the study, and recommendations for future research.

This research captures the voices of three Hindu South Asian Indian immigrant women and how their experiences of domestic violence, the effects of culture, tradition, social and geographic isolation, and the reality of limited treatment modalities contributes to their emotional distress. For some women, traditional cultural restraints and silencing of women in gendered hierarchies of the South Asian community emerge as obstacles to accessing services for mental health and domestic violence. This in turn can lead to mental health disturbances including psychological issues such as distress, experiences of trauma, problems encountered as a result of PTSD and symptoms of embodiment. Embodiment is the process through which the body experiences stress and manifests symptoms of suffering (MacLachlan, 2004) such as superficial self-harm, somatization, and self-defined negative body images.

The primary purpose of this project was to investigate the use of a culturally modified clinical art therapy program to work with three Hindu South Asian Indian immigrant women who expressed their suffering of domestic abuse through embodiment. In order to provide treatment that was meaningful and effective, a clinical art therapy

model was developed for a domestic violence shelter. The therapeutic modality offered a reflective space for the women to therapeutically work on their traumas and was adapted according to the needs of these women. A direct way to support the cultural values of the women was to match the participants with a therapist of the same ethnicity and who spoke the same native language.

Rastogi and Suthakatan (2002) have worked with South Asian Indian clients and found that when the therapist is empathetic and provides support, the client will be more prone to speak openly regarding intrapsychic conflicts. My therapeutic approach was non-judgmental, supportive, culturally adapted and modified so that the cultural customs, values and beliefs of the participants were taken into account in order to understand and to respond to their cultural needs. Cultural modifications were made to support the women in their self-disclosures through ethnic match, language and cultural understanding(s).

The importance of ethnically matching the participant with the therapist significantly supported the development of a positive alliance and cultural safety for the women. To have a therapist coming from the same culture/ethnicity who understands traditional roles and customs, values of obligation, duty, conformity, obedience, and family honour, was an important part in the positive experience of therapy. This was noted as helpful in the efficacy of treatment, the therapeutic relationship and outcome in therapy. This is most evident with Jaya in Session 1. She was able to share detailed information regarding herself once she felt supported by the therapist. Additionally, the cultural impasse was addressed in the therapeutic space of the art therapy modality as it offered another, less threatening access to the wounds to the feminine body and psyche.

It was noted that the participants identified with both the participant role and with an identity associated with their ethnicity. Although the therapist was not part of the same caste as the participants it did not raise an evident resistance or obstacle with the clinical art therapy research program, nor did the issue of caste ever arise. I speculate that there may be two reasons for this: first the women were most likely aware of my caste, as such information is revealed through last names; secondly, the cultural safety of common ethnicity was repeatedly raised as a positive therapeutic experience. They were content in working with me as a therapist since they identified with me as a north Indian sharing a similar ethnic and cultural background. Examples of the participant's identification with me while making references to particular cultural aspects are demonstrated by Raina in session 1 & 5, by Devi in session 1, and as described in Appendix – K: Additional Dialogues, supplemental information. In modeling the role of a Hindu South Asian Indian woman, I exhibited a cultural style of relating to another person that is respectful, compassionate and equal. I also dressed in traditional clothing, and was fluent in the same language as the women. This helped to facilitate a culturally comfortable therapeutic space which created a sense of community for the women.

As mental illness is defined differently across cultures, the significance of understanding the language of the participant is a key element in therapy. As well, complications may occur during the translation of expressions and may not be accurate as it is when translated in the context of a particular culture. Language facilitated the clinical art therapy sessions as it was in the language of the participants and at times in English. This was a vital tool of communication for all three participants especially for Devi and Jaya who spoke in Hindi. Raina, although fluent in both languages also mainly spoke in

the Hindi language. As noted by Bowman (2010), language matching enables a satisfactory communication of concepts that may not be easy to translate. Since emotion is rooted in the native language of the speaker, better expression of emotion may also be achieved as other languages are cognitively rooted. In speaking the same language as the women, I was able to understand important social and emotional concepts that could have otherwise been misunderstood. It also helped the women to clearly understand exactly what the research project entailed, feel comfortable, and freely express themselves.

Cultural understandings led to discussions surrounding culture and traditions within the therapy session(s) and to the demonstration of several familiar cultural associations throughout the art works. For example: Figure 5 represents traditional flowers for Raina; Figure 10 demonstrates familiar animals found in Devi's country of origin (tiger and parrot); Figure 11 – K depicts a person wearing a *duppata* (traditional scarf) wrapped around the shoulders; and Figure 11 – L depicts the image of a tamarind tree (on the left side of drawing) found in several parts of India. In Figure 18 – R and 18 – S, Jaya represents her place of safety as a home situated in India with the religious *tulsi* plant. All of these associations are related to the women's country of origin. In addition, I was also able to read the hindi writing included in several images (Figures 15, 18 – S, 22, and 24). This allowed for a complete understanding of the women's expressions, the significance of the images, and the importance of understanding their cultural associations.

As previously noted in the literature review, the religious, mythic and spiritual aspects of the Hindu culture play an important role for many individuals as it did for the participants of this research. In Hindu tradition(s), there remain several reasons for

psychological disturbances such as one's *karma,* family disputes, and *nazar* (the evil eye) (Laungani, 2005). This was evident throughout the clinical meetings. Based on my cultural understanding and familiarity, emotional and traumatic issues were considered with sensitivity while respecting the participant's ability and willingness to engage in the therapy, disclose or share information, and while working at the participant's pace, to focus on their strengths. For example, being familiar with views of *karma* and suffering within Hindu traditions, I was able to appreciate the women's identification with the consequences and understandings that suffering is not viewed as a form of punishment but rather as a "natural consequence of the moral laws of the universe in response to past negative behaviour" (Whitman, 2007, p. 609). In not being aware of this cultural view, there is a risk that the women's acceptance of circumstances may have been viewed as passivity or being withdrawn. An additional association made to *karma* by all three women was in references to having bad *karma*. The therapist first confirmed the same understanding of *karma* within the Hindu tradition. Second, the therapist acknowledged the women's "bad *karma*" by acknowledging that their lives encompassed difficulties. The therapist then validated the pain and suffering the women experienced and supported them in the emotions they were feeling. In discussing *karma*, the therapist reframed the concept of *karma* to offer options of agency and hope of which they were worthy. Thus, the women were more receptive to the clinical therapeutic program through this integration and validation of their world-views and belief systems, which ultimately aided in their recovery process.

Another example in reference to cultural understanding is how the women used religious mythology to speak about underlying problems. Being familiar with Hindu

mythology I was able to engage in the discussion(s) participants communicated while making references to their stories. I followed Kasturirangan and Williams' (2003) concept of how Native women's stories often depict weaknesses, poor choices, and dysfunction, yet may also reflect resistance and resilience. Thus, therapists can draw on these strengths to help participants develop culturally congruent ways of coping. As discussed in the literature review, many of the Hindu traditional stories represent Hindu South Asian Indian women as being passive and submissive. However, focusing on the strengths of the Goddess's *Laxmi, Kali, Durga and Parvati* promoted resilience and empowerment. The women were able to relate to the positive aspects of these Goddesses as a point of reference and as a source of strength through the use of non-direct communication to share their individual story. This was of significance as spirituality plays an important role in helping certain individuals re-build their identity after trauma (Brewin, 2003). This is demonstrated in Appendix – K: Additional Dialogues, supplemental information. In addition, knowing what challenges the participants were facing with regards to their religious context was valuable in insuring that I was supportive.

My clinical skills were relevant to the formulation of individual interoperation versus formulation of systemic or more externalized and general elements in the working through of distress. Avoiding stereotyping is fundamental to cultural competence in clinical work and I have tried to avoid stereotyping by allowing the specific cultural values of the client to emerge in the process. The clinical sessions follow the lead of the client as the significant participant. This was evident in the case studies in Sessions 1 and 4 for Raina; Sessions 1, 3, 9 & 10, and 12 for Devi; and Sessions 1, 4 and 5 for Jaya.

Clear non-verbal communication also created an atmosphere of trust and respect. Understanding nonverbal cues to which cultural significance was attached was important in transcending barriers to communication. For example, some South Asian women may deflect direct eye contact as a sign of respect. Therefore, I was attuned to nonverbal cues such as avoiding eye contact or looking away as a sign of respect, rather than avoidance, evasiveness, or disinterest. Interestingly, Devi discussed and portrayed this cultural gesture in her second self-portrait image in Session 3. Another example of non-verbal communication is how certain South Asian individuals may have a tendency to move their head towards the left and right simultaneously to acknowledge the person speaking. This gesture does not confirm a "yes" or 'no" response. However, those who are not attuned to this nonverbal cue may mistake this sign as a "yes" response. Therefore, it was important to combine knowledge and body language to be proficient in interpreting both verbal and non-verbal cues from the women. Misunderstanding may have occurred if these differences were not understood or recognized. In addition, crucial to understanding non-verbal cues is the impact of silencing in systemic relationships where women are silenced by the pressures placed on them by their husbands, members of their husband's family and society. Being silenced can result in inner pain, depression and a sense of feeling trapped (Jack & Ali, 2010). Thus, it was important for me to understand and be sensitive to the women's non verbal cues (body language and gestures) in order to rework projected authority and the outsider role of the therapist. An example of this is indicated in the sessions with Jaya. In session 1, upon entering the therapy room Jaya is uncertain and is looking down at the floor. She waits for the therapist to direct her where to sit and how to proceed. As well, she is uneasy and seats herself at a distance from the therapist.

In understanding Jaya's actions, I sat at a distance from her and created a safe yet interactive environment. I allowed Jaya to select her own art materials and to independently choose what to draw in her image thus enabling her to be in control. In session 3, I sat across from Jaya and made friendly facial gestures to her by smiling. This encouraged her to maintain good eye contact and she was comfortable working independently. Being sensitive to Jaya's non-verbal cues and body language was important in helping her break the silence that she was accustomed to.

Clinical art activities and visualizations. The clinical art therapy modality was a short-term 12 week program. Clinical art therapy programs that are short-term can be effective as focus is placed on the progress that naturally occurs in the session-by-session process of therapy. The modality was beneficial in reducing emotional suffering, lowering shame and avoidance, assisting in developing coping strategies, enhancing self awareness and increasing self esteem. The activities were focused on facilitating and encouraging the women to tell their trauma narratives through the art making, as the therapist served as a witness of the trauma stories. Although the activities were culture generic, as mentioned previously they were culturally modified to suit the needs of the women. The manner in which I engaged the women in the activities was to work with each woman's needs, values and goals, as each participant was unique in her individual strengths and weaknesses. This is supported by Courtois, Ford and Cloitre (2009), who note the importance of recognizing the client as an individual (strengths, resilience). As a researcher, I placed emphasis on the importance of viewing the client through a holistic approach as the treatment of trauma is specific to each individual depending on their individual strength(s) and resources. Therefore, with reference to the beliefs proposed by

feminist critiques and feminist psychological practitioners, in addition to the participant's symptoms of trauma, the inclusion of external contributing factors such as the women's culture, value system(s) and beliefs were of relevance during treatment. Similarly, in relation to the feminist therapy and trauma therapy techniques that address forms of oppression linked to women's cultural and socioeconomic background, the art therapy modality used in this research considered such factors. Although feminist interventions are based on Anglo-Western or European perspectives and may not capture the realities of ethnic minority groups (Yick, 2001), I was able to integrate some aspects of this approach such as recognizing the cultural diversity of the women and the factors affecting the way they experienced domestic abuse.

As discussed in the literature review on art therapy, the therapeutic process provided a space where the participants could self-engage, realize their strengths and vulnerabilities, develop individual understandings of their experiences, and begin to use their own sources of strength. By acknowledging this strength, the women experienced an increase in self-esteem. At each stage of the process, the program remained adaptable and valued the self-expression of the participants. This was attained through my ability to culturally relate, understand and address cultural issues regarding the participant's highest values and their underlying belief systems regarding their place in their community. This was particularly useful as a framework for healing. It helped maintain continuity during the therapy sessions as the flow of conversation(s) was not interrupted in attempts to understand cultural elements and behaviours. For example, I was aware that the participants followed concepts of inequality practiced within the South Asian culture (i.e. certain members of the community believe that women are responsible to

safe-guard family honour). Therefore, self-blame for the abuse was based on traditional values and for the stigmatization of the family unit break-up as a result of going against cultural norms. Accordingly, within the therapeutic context, struggles as such were externalized as existing outside influences that shaped the women's trauma experiences and responses to trauma. In addition, being familiar with the cultural and familial influences (the concept of *sharam* (shame) and *izzat* (honour)), helped me to enable the women to transfer their shame to their abusers, thus further externalizing the shame they felt. An example of the cultural relevance of the therapist/client is indicated in a passage from Jaya (Appendix K – Additional dialogues, Session 1 – Safe space) which demonstrates the cultural understanding between myself and Jaya regarding her strong religious connections to her faith. As well, Jaya and the therapist were also able to engage on a spiritual/religious level as demonstrated in a discussion on the Hindu scripture the *Ramayana* (Appendix K - Session 4: Symptoms of embodiment). A further example (Session 5: Past, present and future image), identifies with the research on socialization of role dependency and subordination of women based on the hierarchy nature of the South Asian community. In this instance, the participants discuss the expectations of the traditional roles of women. A further example is specified by Devi. She expresses distress (Appendix K – Additional dialogues, Session 4 – Self-Portrait) regarding her abuse and how mistreatment is culturally tolerated. In her conversation she culturally relates to the therapist as indicated in her choice of words: *"why do **we** accept this in **our** culture…"* and "*but in doing this **we** have to suffer."* Similarly, Raina expresses her awareness of an established cultural understanding between us in Session 4: Mural – Symptoms of embodiment, during her discussion of bodily pain and how culture promotes the

internalization of emotions in women. Thus, sharing similar cultural understandings proved positive within the therapeutic forum as it enhanced mutual understandings and reduced the clients concerns regarding misunderstandings and being judged by the therapist. Validating the participant's views helped them recognize that they were not to blame for the experienced violence. It also helped to lessen their shame while enhancing self-esteem. Thus, in exploring the meaning and place of violence in their individual worlds, they could examine what was endured in a manner that helped restore self-esteem and reduce their sense of shame.

The art therapy activities were organized within a structured environment, showing compassion and understanding of the participants' emotional state, and a non-judgmental approach in discussing the art creations within the therapeutic space. This was clear in establishing trust and maintaining safety with the participants. This is evident when Raina experienced difficulty with some of the art directives and the audio-recordings. She felt it would reveal the confidential content of her sessions and feared her voice would be recognized. Perhaps this fear stemmed from both of us belonging to the same community. I made every effort to help her feel safe and build her trust by respecting her choices and needs as demonstrated in Raina's Session 3 – Self portrait. I also maintained close interactions with the participants in the therapeutic space and research environment and throughout the daily routines in the shelter. There were several reasons for this. First, this helped establish safety and trust which are the primary objectives in all therapeutic treatment modalities for trauma recovery. Establishing a relationship of safety was important as safety is the most significant aspect of therapy. Peck (2012) suggests that trauma survivors may in fact display difficulty in trusting the

therapist as a result of affect dysregulation, lack of trust, and insecure relationships. As a result, the therapist support and empathy may be regarded as a threat as this is out of the realm of the clients experience(s). A common principle in the literature on the treatment of trauma within all therapeutic approaches is the notion of the traumatized individual's need to feel safe. Once safety is established, the client may move forward in therapy (Briere & Scott, 2006; Kalsched 1996). Similar to traditional orientations of psychological treatment, it is only when safety is established that the client can begin to engage in processing trauma and begins the healing process on a deeper level (Crenshaw, 2006). Secondly, this helped the women become familiar with me, which was important given the short time frame of the women's stay in the shelter, their unfamiliarity with the shelter community, and their individual reservations. Thus, familiarity facilitated the therapeutic process as the participants and I established a comfortable alliance. They were able to see that I was trustworthy and dependable. Establishing a climate of trust and safety through my close interactions facilitated by my availability, reliability, responsiveness, listening, understanding, respect, and constancy were significant attributes in creating a quality relationship with all three participants. Jaya's guarded demeanour and traditional high value for privacy of her life, in the first session was eventually lowered as she began to trust and feel supported by me. However, for Raina, in addition to the distressing content that had surfaced in the sessions, her initial resistance to therapy may have also resulted from the cultural stigma attached to receiving mental health services. Although all three participants were receptive to the therapy, their thoughts regarding help-seeking were influenced by traditional South Asian beliefs on illness and psychological distress. Furthermore, Raina was concerned about

privacy; my presence outside the therapeutic forum may have potentially undermined the therapy and disrupted the therapist-client alliance as a result of stepping outside the therapeutic boundaries. Yet, I maintained a professional role within the shelter setting, and discussed the significance of clear and consistent boundaries and confidentiality with Raina. As a result, she was assured and able to commit to the therapeutic ventures and collaborate with me in the work involved.

The art activities were tailored so that there was minimal risk of failure resulting in validating the women's feelings regarding their work. As well, based on my experience working with this population and in recognition of the general lack of experience of art among the study participants, it was important to use materials and directives which were the most comfortable, easy to work with, and suited for this research. Standard art supplies used were: markers, pastels, pens, and pencils (to establish a better sense of safety as clients are better able to control and manipulate these materials); paint (for its fluidity); casting with plaster gauze (to create a feeling of a real life image with a 3-D effect) and collage (to stimulate emotions). I also made sure to include certain materials that were of cultural relevance to the women. For example, I provided magazines that had images related to the South Asian culture to use for collage. An example of this is Raina's image of a traditional Hindu wedding and the image of *mehndi* (henna) (Figure 1 – Safe place). When the women were uncertain as to how to precede with the art supplies, familiar materials associated with their culture helped them engage in the activity. This is evident in Raina's body-casting image (Figure 7 – Front side) which resembles a traditional *Kathak kali* dancer. For this session, I had provided images of traditional masks along with other standard art materials. Another example of

the cultural association is the women's use of traditional fabric (used in Figures 26, 27 and 28). In this way, the use of the cultural associations linked to the art materials allowed the participants to feel comfortable and in control as they selected the materials and used them within their comfort levels. As well, they were also able to create images that reflected their personal stories which elicited a variety of responses from them.

The underlying objectives of the main goals of therapy enhanced agency, insight and possibilities of transformation, progress, recovery, and healing. The art directives at times, evoked projective material from the participants; observed the artworks as visual psychological representations, and stimulated conscious, subconscious, and unconscious associations of their experiences through associations and perspectives. These were assessed together with the participants' comments, self-appraisals, criticisms, attitudes and behaviours. Once the directive was explained to the women, they were able to invest in the art tasks. As trauma therapy requires the client to recall their past experiences, most clients seem to avoid this so they do not experience overwhelming thoughts and emotions related to their traumas (Peck, 2012). Therefore, it was important to engage the women through the use of activities that focused on helping them work through their traumas and on what they were bringing to the therapeutic forum. For clients who have experienced trauma, working through traumatic experience in art therapy provides a protected environment for lowering defenses, releasing emotions, and offering opportunities for insight. The notion of "working through" is a term also used in other therapeutic approaches such as the psychodynamic approach. Similar to art therapy, it is a process in which traumatized clients can make sense of traumatic events and reconstitute the memories in a manner that creates a rational narrative memory. It may also be valuable in

accessing repressed, dissociated, or denied client information and help foster improved self-soothing in women who have experienced abuse (Liebmann, 2000). Examples related to accessing information are: In Session 2 - The uniqueness metaphor, Devi's reluctance to participate in the activity may have been the result of being reminded of her traumatic experience(s). Her image is symbolic of dissociative symptoms that are frequently linked to PTSD. Raina's mood shift in Session 1 - A safe place, is also related to PTSD, as is her dissociation in Session 3 – Self portrait. As well, this session also evoked repressed memories of growing up in a traditional setting and the difficulties endured by Raina.

Most of the trauma recovery literature emphasizes the importance of helping survivors restore control over the body, manage emotions, and to establish a safe environment (Briere & Scott, 2006). These elements were implemented in the clinical art therapy program. Certain activities focused on addressing body trauma and suffering through the art making process. In doing so, the participants were more able to identify and explore the meaning of symptoms, pain, and illness. The women reported positive changes in their body image, an increase in self-esteem as well as an increase in emotional control. These findings indicate that participation in the art therapy program had a positive influence on the women. Although the emotional content may have evoked strong emotions from the participants, I was confident that they would feel secure and safe in the therapeutic container as they were being guided at a safe pace in the therapy session(s). As Ogden, Minton, & Pain (2006) state, the goal in therapy thus becomes to regroup through calming the body, disregarding self-depreciating feelings and allowing the sensation(s) to decrease. Being aware of the client's ability to self-regulate was also

of importance. This is evident in the case of Raina (Session 3 - Self-portrait & Session 4: Mural – Symptoms of embodiment). When intense emotions triggered feelings of her past experiences related to the body, they were contained and re-directed. Re-living traumatic experiences in a holding and supportive environment was a safe method for containing Raina's traumatic memories. In addition, as noted in the literature on self-harm, self-harming behaviours are often triggered when one is faced with intense emotions. The safety of the therapeutic container allowed Raina to project intense emotions onto the art as she felt safe, thus, enabling her emotions to be contained and transformed. Another example from Session 3 – Self portrait, is with Devi. This art task evoked feelings of low self-esteem and self-worth, as well as poor body image. Therefore, for the following week the goals in therapy were to decrease depressive symptoms and isolation, and to focus on Devi's positive aspects to encourage success and self-esteem. As well, in Session 4 - Symptoms of Embodiment, in dealing with physical symptoms of suffering, the art activity appeared intense for Jaya. Thus, it was made certain that Jaya be given the time and space to feel secure and safe prior to terminating the session. According to Peck (2012) such experiences require the therapist to help the client(s) deal with what is referred to as hyperarousal (like an erupting volcano in therapy) or hypoarousal (disappearing into the wall). In this case, I helped the women to decrease a certain degree of their hyperarousals in order for their therapeutic work to be contained within their "window of tolerance" (p. 162). This window, in which the client may work, eventually expands as the therapist demonstrates coping-skills to help the client manage overwhelming emotions and provides psychoeducation to the client (Peck, 2012).

In working therapeutically, the women felt that their art therapy experiences had drawn them closer to their individual needs and enabled them to have closure with regards to their negative feelings toward their bodies and poor self-esteem. In reference to body pains associated to somatization (Raina - Session 4 and Devi - Session 2, 7 & 8), the art process enabled the women to visually represent and externalize what was experienced internally (Devi – Session 4, figure 13; Session 6, figure 15; and Jaya Session 9 & 10, figure 24). The act of creating an image which depicts the body was beneficial in dealing with unresolved issues that lowered the women's sense of worth. The art represented the women's feelings or pain through the embodied image(s). These images differed from symbolic meaning, as embodied images take on a complete entity of their own. Through exploration of the embodied image(s), meanings are made. As discussed earlier, this objectified manifestation functions as a container for emotions that may be very powerful to manage inside the individual psyche. This allows viewing from a distance which helps to deal with the issues objectively. Thus, the women's negative feelings of self-esteem were more easily dealt with through the creation of image(s) that depict the body. The embodiment of negative impulses could then be destroyed or kept until the affect could be incorporated within the women (individually) at a later time. The art then, was an object of transference. The women's past emotions were brought to the surface, thereby reducing the effect they had on the women's feelings of self-worth. As in all therapist/client dyads, transference is part of the way the client and therapist relate to each other.

Further, based on the women's (lack of) experience in creativity, it was thought helpful to have a structured program in a comfortable environment where the main goal

was to enhance self-esteem. The structured nature of the art therapy exercises allowed alliance building, disclosure, working through, reflection and closure at termination to minimize regression or distress. The women were given directives but could use the directives based on their abilities and what they chose to focus on. In engaging in the process of the art therapy directives, the study participants gained a sense of control and a certain level of autonomy. By creating art, participants were taking action and this act of doing was experienced as empowering. As well, art therapy can continue as a tool for the client to access her interiority and reflective space indirectly or directly. The process was different for each woman as they all comprised of individual characteristics and differences in experiences.

Imagery and themes related to shame, low self-esteem, and feelings of sadness, anger, guilt, and vulnerability, childhood memories, cultural associations, and hopes were portrayed and described by the women. Images of happiness were also shared, possibly as an example of defending against a deeper, more painful emotion. Negative themes were also represented in the participants' works: helplessness, lack of control, and a sense of being overwhelmed, all themes related to symptoms of trauma, suggesting the art resembled the internal emotional view of individuals who are survivors. The women's art expressions also indicated their experiences of grief and loss. Grief and loss were present in the emotional, physical and psychological aspects of the women's lives. They experienced multiple losses such as their home country, culture (to some extent), belonging to a community and family members through marriage and migration. Additionally, the women experienced a loss of self in the form of experiencing a loss of individuality and being acknowledged (session 9 & 10 for Raina). Of significance were

the women's grief-related emotions: feelings of sadness, depression, anger, guilt, pain, loneliness, emptiness, confusion and fear. The clinical art therapy provided an environment for such emotions and addressed issues around loss. Examples of grief and loss are indicated in several sessions: In sessions 2 & 3, Devi was able to communicate her emotions surrounding her pain, sadness and loss. Jaya was able to grieve the loss of her past life in session 5, and in session 11 both Raina and Jaya explored emotional losses. Sessions 6, 7 & 8, the women explored the losses associated with a healthy body, the body trauma's they experienced and feelings of grief. In the *safe place images* (figure I), the women's drawings indicate the loss of: a home, family, country of origin and positive memories. In grieving their losses while integrating and recreating positive memories of loss, the women were able to begin to repair some of their feelings over their multiple losses (sessions 2 & 5 for Raina). Thus, in the process of creating art, the expression of negative feelings and the recollection of both happy and sad memories surrounding the women's grief and loss enabled them to consider the value of their lives. As well, coping with loss by focusing on the women's strengths and abilities helped increase self-esteem (session 2 for Raina; session 11 for Raina and Jaya; and session 7 & 8 and 9 & 10 for all three women).

It may be suggested that the therapeutic art tasks were moderately effective. The three participants appeared to have benefited from the directives on different levels. They were able to graphically display their emotions, feelings, inner suffering, and to some extent, an improved outlook on the future. This was done through the process of transforming and integrating traumatic memories through self-exploration in the art therapy. The women were able to express body traumas/emotions symbolically. Through

the externalization of emotions into art making, the women were thus able to view their traumas from a distance and to project their emotions without having to refer to specific details of their traumas. With regards to Raina's self-harming behaviours, the construction of more adaptive strategies for managing self-destructive actions was achieved on some level through the activities. The treatment was focused on creating a holding environment that could withstand the extent of her "un-integrated" anger and emotion. Subsequently, symbolization and verbalization of narratives of complex emotions were encouraged as alternatives to physical internalizations of suffering. Recounting the traumatic events was considered as part of the recovery process.

In trauma therapy, Fair and Frank (2012) stress the importance of using an empowerment approach where the client is provided with several choices in order to determine their individual path. Having the ability to make their own choices with regards to the art therapy program played a significant role for the women in this study. It acted as a metaphor for the control that was taken away from their lives as a result of their abusive experiences; thus, it was important to allow the participants to make their own choices throughout the program. The element of choice promoted self-esteem as the participants were able to take control (Raina, Session – 2). Further, as stated by Hiltebrand (1999), choice can extend to empowering individuals to make choices regarding their extent of participation in the activities as well as the choice to refuse to participate in an activity (as observed with Raina).

To modify behavioural and emotional responses, therapies (such as Dialectical Behavior Therapy (DBT)) attending to physical sensations and action patterns point to a more effective treatment for trauma survivors as compared to those that focus on insight

and understanding (Kubany, 2004). The clinical art therapeutic modality in this research proved effective to some extent in working through the trauma symptoms the women presented with. The art materials tactile qualities stimulated sensations that helped the participants express and understand their thoughts and feelings thus, increasing control over them. Similar to therapies that are dependent on insight and understanding, such as cognitive behavior therapy and psychodynamic therapy, valuable insights into the participant's emotions through the process of art making were also gained. The women achieved a certain degree of insight into themselves and expressed interpretations and making meaning of what they created. This helped them to externalize several emotions and difficulties they were experiencing, which in turn lead to positive changes, growth and healing. I was able to support them in their discovery of what underlying thoughts and feelings were being communicated in the art-work and the meanings attached to them. Raina's description of her artwork in Session 1 – Safe place, reflects her childhood, culture and country of origin. Through this initial art activity Raina gained insight towards both the positive and negative sides of her childhood; her experienced sense of failure and disappointment in her development of the self; influence of parental values and expectations; the realization of her loneliness, isolation, and a sense of hope for the future. In session 6 - My body, Devi was provided with insight into her internalized feelings as she was able to visually view her experienced emotions and body trauma. In Session 4, Jaya gained insight into personal struggles, disappointments, support systems and internal strengths. Session 11 – Bridge drawing, reflects Jaya's realization of unconscious reminders of her parents and her culture, which in turn, brought awareness regarding the importance of the deep rooted cultural and family values. She also gained

insight through this collage image, realizing that the future side of her image demonstrated isolation. Thus, when the women reflected back on the process of creation and in analyzing the finished product, they were brought closer to insight. The insight gained helped in developing a better understanding of themselves, what they needed to further explore and to communicate to the therapist. As well, it was a necessity to adapt and reframe the negative memories surrounding trauma in order to alleviate their deep and lasting impact.

Engaging in the art therapy treatment increased the women's symbolic capacities enabling the unspeakable to emerge in their art creations, thus engaging them in the personal meaning of trauma. The art vividly symbolized impulses and created an objective representation. It gave the participants the option to visually show, making their experiences of trauma visible, and to tell their narratives to the therapist. Feelings were able to be contained and transformed, while supporting the experience of intense emotions. Although the therapy evoked intense emotions related to the women's trauma(s), it is supported by the in-depth and detailed narrative reconstruction of trauma. As noted by Courtois, Ford and Cloitre (2009), the processing of traumatic memories where clients are encouraged to feel emotions associated with their trauma, help them learn to tolerate their traumatic memories and associated emotions, while gaining self-efficacy.

It was noted that the participants struggled with understanding the symbolization applied to their visual imagery. The art therapist offered explanations of symbolization to support the women to make their own links to possible associations and implications of

their images. This helped the women to realize and make connections between their art expressions and their feelings associated with them.

The clinical art therapy modality assisted in bringing the women self-awareness. This was confirmed in the response to the last question in the questionnaire: What changes, if any, has the art therapy process had on the participant? All the women responded with some positive feedback and shared how the visual representation had helped them. Of importance was how the art images revealed specific awareness that the woman were unaware of or had not previously understood. Through the visual art therapy process, the women felt supported to express their suppressed emotions, suffering, and experiences. As they observed their progress through their created visual artworks, they were able to integrate their past traumas with their present-day realities of safety and effective coping. The therapeutic process assisted the women in self-regulation which helped them tolerate self- awareness towards their bodies and their suffering. This was an important gain in therapy as self-regulation is noted as a central concept in the treatment of trauma (Briere & Scott, 2006).

While working to clarify and validate the women's thoughts, emotions, and states of mind, the women focused on control of the body and gradually moved outward toward control of the environment. As their self-esteem and overall better functioning had increased, they began to restore their perception of safety and power. They began to apply this increased sense of control in the context of their lives, thus beginning to reduce their other symptoms. All three participants also reported the sense of beginning to have a higher self-acceptance, a slight increase in feelings of autonomy, and a hopeful, purposeful outlook for the future since their escape from abusive environments. The

outcomes of the case studies in this research confirm a self affirming impact of the therapeutic witnessing. The participants' artworks were also objects of the viewing. The women were provided the opportunity to experience certain reparative aspects within their treatment processes. Through the images, they could disclose important information. This in turn facilitated a verbal expression of their feelings through various art processes; visual, symbolic expression through art therapy to describe and reflect the inner process. Speaking on a metaphoric level was simpler for them as compared to having to speak directly about themselves. As well, the images allowed for a better understanding of the participant's consciousness as the memories and images allowed a chain of emotions and feelings to surface while providing them easier access.

The therapeutic witnessing also affirmed helping the women work through the losses and traumas associated with their experiences and the challenges of their cultures. It enabled communication and expression through art materials while connecting meaningfully with their emotions. As noted in Session 6 - My body, the fear Raina expressed regarding her voice being recorded and of being watched are reminiscent of the impact of the gaze. Therefore, to create distance from the cultural, familial, and societal gaze it was crucial to approach each case in this study through a different way of viewing as it seemed to have helped bring about acceptance and changes within the participant(s) self-narrative. By creating an environment that was non-intrusive and empathetic, the opportunity to belong to both the host country and country of origin was provided. Culture may then be utilized as a tool to understand the participant(s) in the treatment process. As well, through the therapeutic relationship, the value of, and exchange of the gaze of the "other" (in this instance the therapist) through the sharing of the artwork(s)

were experienced by the participant's helping to develop a conscious attitude in the participants. In addition, a certain distancing from their own experiences was reparative as giving words to feelings and experiences are a way of gaining distance. As well, standing at a distance or somewhat outside of one's culture also provides some distance from traumatic experience(s).

There were three aims of art therapy that were of significance: communication, normalcy, and empowerment. It was observed how the research participants returned to a certain level of normalcy by reconnecting with a sense of community within both the shelter environment and the extended programs offered outside the shelter, and to the self as part of the healing process. While engaging in art therapy, the action of the process of drawing and then speaking, gave concrete form to the women's experiences. It also helped the women to relate to others and form new relationships at the shelter, feel a sense of belonging, improve self-esteem, connect with the self, and gain a sense of empowerment through the active process of art making, which helped them feel less victimized, less helpless, and less powerless. This is indicated by Raina in Session 11: she was able to identify her obstacles with insight, reflecting her self-awareness of what she needed to do in order to recover from her trauma(s); in sessions 7 & 8, the art task provided Devi with the opportunity to be in control and to enhance her self-esteem and confidence; while Jaya was able to describe how the representation of her internal and external feelings helped her to focus on the differences and similarities between the empowered self and the disempowered self, all illustrations of feeling less helpless and powerless. This was of significance as Briere and Scott (2006) note how

disempowerment and disconnection from others are core experiences of trauma, while empowerment is a critical part of trauma-based therapy.

The participants indicated that they felt supported by the therapist, as both the participant(s)/therapist shared the experience of witnessing the traumatic events as it unfolded in the art. They were able to invest time in their art, enabling them to view and track their experiences across the therapy sessions. This helped with the integration of past traumatic events. Additionally, the women felt culturally safe with the therapist, generating a feeling of connectedness and familiarity. Thus, the process of healing was experienced on several levels: communication, coping, and connectedness on some level(s) to those in the shelter setting, and eventually the activities that were part of the shelter programs.

The art images offered insight and a form of externalization for painful emotions. As a therapist, I was a support through which Raina, Devi, and Jaya were able to safely explore issues in a non-judgmental space, and create and communicate. Within this space the participants were given the opportunity to find acceptance of them selves. This was of importance as Sibbett (2005) explains how acceptance is connected to the experience of being given a voice and being heard. Being seen is also of importance in art therapy, as the concept of bearing witness is pertinent to helping individuals learn to accept themselves as they must be seen in order to validate their suffering. The participants in the study describe their experiences of viewing (witnessing) as primary healing factors within the art therapy process. The witnessing and viewing of the art productions are integral to the art therapy process because of the significance of the art object for the creator. Both the participant and therapist viewed the content of the participant's actual

healing process. This was done symbolically; through representation in the artwork, metaphorically in the participant's experience and through empowerment as a result of the joint witnessing. Furthermore, the women had ownership of the objects they created. This gave them perspective over the externalized trauma represented by the art object. The witnessing component was important in helping the participants disclose their experiences of trauma as the witnessing experience helped them cope with the fear activated by revealing their traumas.

In addition to the abuse, trauma and individual factors (low self-esteem, humiliation, loss and grief), experiences of injustices imposed on the women (social behavioural norms such as subordination and submisseveness); societal factors (isolation and separation from family) also surfaced in the therapy. The women were condemned for opposing their cultural traditions and values and accused of adopting a lifestyle of the Western world. Having to endure such change is a difficult struggle and in fact may be as painful and disturbing as the experienced abuse. Thus, there is a binary aspect in the change that the women made when leaving an abusive situation: first, it is empowering, and second, it is traumatic. Once they break free of their husbands, families, and traditions they are left in the void, unaccepted, and they have to redefine their identities. The women must endure daily struggles with this change in subjectivity. The consequences of suffering from the traditions and inequalities of their country of origin and abusive environment(s), have led the women to the beginning of self-assertion by breaking away from the injustices done to them. The women began to make changes when they first left their spouses and came to the shelter. They participated in the supporting therapeutic programs as steps toward their recovery. Clearly the impact of the

host society surfaced in the therapeutic forum as playing an integral role in providing the drive for these women to move out of abusive environments. Being in the host culture gave them the options of aligning with host culture values and the options of the social and legal framework not available within the country of origin.

Through this examination, the women were provided with an understanding and realization of the self through the options of aligning with host culture values and the options of the social framework not available to them in their home country. They had the opportunity to explore the influences that determined their identities and with the support of reflective function and insight, realize the impact these factors had on their trauma. Once their internalized emotions were explored, the construction of an alternative narrative began. The traumatic memories brought to therapy were incorporated into narratives about the women's lives. Thus, framing the traumas as experiences in their lives removed them (to some extent) from being attached to their personal identities. The re-interpretation and telling of their stories enabled them to position their traumas on a larger scale. This in turn enabled them to construct an emerging narrative of change about the self and start to make alternative choices regarding their lives (Mangar, 2011).

Hybridity. In offering the women a view of the alternative framing of hybridity and host culture values, the women asserted a desire for independence. They were able to share their experience despite occurrences of shame within their communities and demonstrated their aspirations to gain control in their lives. This is a direct result of their experience of living in the host society. Thus, their abilities to step away from their cultural traditions, cope with the demands in their lives, attempt to function in the host society, and make independent choices, points towards an emerging independence. They

demonstrated their abilities to find their way through the pressures placed upon them as their traditional views were being challenged. Frequently, their efforts resulted in a struggle between their cultural values and adjusting to the host culture.

All three women were suffering within the traditional framework of their marriages. Their attempts to find a balance through the predicaments of the South Asian value system, culture and male dominated gendered hierarchy resulted in escaping their distressing environments, thus leaving their husbands and in-laws. They expressed a desire to be content, make independent choices, and have their own identity. However, attempts to make changes often conflicted with the virtues of the Indian femininity. Glimpses of mythical characters such as *Sita, Sati,* and *Savitri*, are seen in the case studies presented within this research, of Raina, Devi and Jaya as they attempt to preserve cultural training, tradition, and possibly the influence of myths.

The women were faced with the process of forming a hybrid identity within the diaspora context of natal identities and host culture values. Indications of attempts to adopt parts of a western identity are portrayed in the case studies. Jaya describes herself as "a modern woman" when describing her self-portrait (session 2); and Raina's Bridge drawing (session 11) in which she describes herself as comprising of an individual growing up in India and North America. On one hand, the host culture offered independence, social mobility, egalitarianism, access, legal rights, development of the self, and the moral freedom to choose their individual paths. On the other hand, the South Asian culture provided continuity of attachment, a collective identity, culture, holding, and continuity, a sense of belonging, respect, and honour. However, the identity attached to traditional roles and responsibility, although encompassing the majority of women's

identity had to be redefined as they struggled to balance the South Asian expectations with those of the host culture. Such tensions of hybridity added another layer of pressure and responsibility on the women, as they had to negotiate two sets of cultures and search for their place in society.

Living in Canada provided the women with the opportunity to voice their desires to leave the pressures of traditional family life and their sufferings. In doing so, the dissonance of value systems challenged internalized values and their ego ideals shaped in early family culture as all three women were rejected by their families of origin. Self-progression was being achieved, yet their new sense of self suffered because the women believed their families considered their progress and adaptation to the host culture to be shameful and disrespectful. Thus to survive, it has been necessary for these women to adopt a way of living in the world that alienates one from the culture of origin. In order to ameliorate this strong sense of disorientation it is important for these women to hold on to some of their cultural values, traditions, and a sense of belonging. Follow-up programs such as those offered in shelter settings play vital roles in which the women can be supported, nurtured and allow some sense of belonging. Such programs provide a sense of community, offers support, information and tools that can lead to personal empowerment and autonomy. Group art therapy follow-up programs offered in shelter and community settings may also be beneficial. Through programs as such, trauma narratives can be constructed through storytelling so that the women are comfortable sharing personal information and in making sense of emotions of grief or loss in all that was given up. As well, highlighting ways in which culture may be a source of resiliency and strength may enable the women to maintain some of their cultural values. The

therapist may foster a sense of community and help facilitate the transition into a new community.

The therapist's identity is also of significance as it is through a hybrid lens and also as the therapist represents a role model offering an individuation by an acculturated Indian woman who is not depressed or oppressed in the South Asian gaze. Through the interaction with the therapist, there was an emergence of a self-identity because the women realized they no longer wished to be defined entirely by their cultural collective identity. They also realized they did not have to rigidly follow their values and traditions as they spent time with the therapist. Based on this it can be concluded that the role of the therapist provided the women with the notion that they could begin to be autonomous with a voice to make their own choices.

It was important to spend more time on symptom management in order to help the women make connections between their current behaviors and the impact of their trauma(s). It was also important to allow the women to voice their narratives about their experience and to link their feelings and behaviours to the abuse endured, the emotions felt, and the reactions they experienced. Trauma memories are experienced physically, and emotionally, thus, recovery treatment emphasizes the need to help the traumatized individual make mind-body connections to help gain awareness of what s/he is feeling and discover how to manage intense affect. Slowly, as the women begin to feel a greater sense of control over their bodies and environments, they may feel increasingly safe with themselves and those familiar to them in the shelter environment. Among the ultimate goals for trauma recovery is for the "survivor" to establish a trusting relationship and develop hope as indicated in the case studies.

The follow-up activitiy resulted in the body maps of each woman's journey, encompassing a narrative of a series of significant life events. The experience of a hybrid identity, combined with victimization and trauma, places demands on the journey to the self. A desire to free themselves of the traumatic and cultural strains in their daily lives was expressed and supported through a culturally modified clinical modality. As the women face the future, the challenge that remains is for them to continue to try and make conscious choices for their well-being and while adjusting to a hybrid identity.

In terms of the assessment tasks on participants' feelings completed at the beginning and then at the end of the study, it was noted that in all three participants, initial images of the human figure drawing the images were drawn larger in the later drawing (Appendix D & H). This indicates an increase in self-esteem and confidence (Machover, 1949). Finally, the results of this research should be interpreted with caution as each case is based on the participants' individual narratives and generalization should be avoided. The outcomes of the case studies are not representative of all South Asian women as it is a heterogeneous community. The women of this small qualitative research only represent a very little part of the community and the case studies are descriptions of individual experiences. The findings may not be generalizable to all South Asian Indians as the three participants were individuals of Hindu Indian origin. Thus, it may be concluded that art therapy, body mapping and a structured set of exercises created for victims of violence may be adapted for immigrant women, particularly those who are in a vulnerable state and accustomed to oral cultural traditions as a transition or adjunct to other interventions empowering them from a safe space to deal with the impact of violence. The art therapy modality proposed in this research offers an acceptable method

of providing a space to express emotional distress through creativity. The similarity of ethnic, cultural and linguistic backgrounds of the women and therapist is definitely a distinct advantage for handling trauma of domestic violence.

Update:

Once the research participants left the shelter they joined a follow-up clinical treatment program offered by the same shelter. In meeting with the women four months after their participation in the research study, I learned that Raina was going to move to another city to seek support from a South Asian women's group. Devi and Jaya lived close to each other in second stage housing and had become friends. Both were employed in the same place for work. Devi learned that her husband had re-married. Jaya's husband left the city to be closer to his relatives. Both Devi and Jaya were no longer in contact with their families as their families had asked both women to return to their abusive environments. Also, both women feared that any contact with their families would result in potential danger as the women's husbands had threatened their families.

Limitations of the study

The findings of this study indicate that the participants have not completely recovered from their symptoms of trauma. Examining the needs and experiences of women after they leave the shelter may provide valuable information. A study that follows up with former residents after they leave the shelter residence and are no longer involved in the shelter community, would contribute important data on the service and resource needs of the women during their time of transition. The method sample was limited to a single agency (the shelter). The sample presented in this study was selective; limited to ethnic match, the criteria of the research project, and the women who were

residing at the shelter at the time of this research. Women residing at the shelter from other cultural backgrounds may have voiced different stories. Due to the small number of participants, the study findings have limited transferability. The research is limited by the choice of selecting a group of participants diagnosed with specific symptoms. Looking at all the symptoms abused immigrant women present with rather than specific symptoms, may have produced different findings. It would be useful to see if the positive benefits of clinical art therapy can persist in follow-up after the pilot intervention for longer periods of time, and how regularly art therapy should be given to extend these benefits. Future research to identify the duration of effect of this approach and the optimal number of sessions needed to produce long-term effects of this clinical modality would be needed. As well, the research is limited in the assumption that changes from the therapy sessions can be assessed within a relatively short time frame and if the participants' progress was a result of the effectiveness of the clinical art therapy modality alone or as part of the additional support programs the participants received at the shelter.

Recommendations for future research

There is a scarcity of support services offering treatment programs that focus on ethnic match and the mental health of immigrant women and domestic violence. Stigma issues concerning mental health access remains significant, therefore, focusing on mental health issues through less obvious treatment methods may allow easier accessibility. Another area that could be further explored is the limited research on therapeutic approaches and specific cultural adaptations in the mental health treatment of Hindu South Asian Indian immigrant women in Canada. Available research focuses mainly on

studies in the United States and in the United Kingdom, providing clinicians with an awareness of cultural factors generalized to the South Asian population.

To substantiate the cultural adaptations and innovations of the modality presented, a larger number of participants would be needed. However, the scope of such a project would have been enormous considering all that would have to be taken into account. It is important for health care professionals to have an understanding of the diverse cultures of women as it plays an enormous role in women's health issues and when coupled with domestic violence the problem(s) are magnified. There are no research studies specific to Hindu South Asian Indian immigrant women, the effects of body trauma, and culturally modified clinical art therapy as a treatment modality. Indeed, a holistic approach to healing and recovery for this specific population is needed in the overall treatment process. The inclusion of a clinical art therapy program modified to the specific needs of these women can prove to be empowering, giving a voice to each woman. Additional programs of this nature are required to help women express the inexpressible. Attending to mental health and the cultural context in which violence takes place is of importance. Diaspora Asian women living in North America, Australia and the United Kingdom are all looking for ways to promote adaptation as acculturation and hybridity are clearly part of the process of identity change for these women.

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APPENDIX A: DESCRIPTION OF THE STUDY

Study Title: Voicing the body

Purpose: The purpose of the study is to explore the art therapy experience of South Asian immigrant woman with a history of domestic violence and self-harming behaviors such as superficial self-harm, somatic experiences and negative body images. Art therapy can provide a therapeutic space where women who have experienced domestic violence may visually express a range of emotions which can enhance self-awareness and help reduce emotional stress.

This project is being conducted by Abha Singh who is a graduate student of Concordia University as part of her dissertation. The Primary Research Supervisor of the project is Dr. Jaswant Guzder who can be reached at (phone number) at McGill University in the Department of Psychiatry, and Dr. Rosemary Reilly who can be reached at (phone number) at Concordia University, in the department of Applied Human Sciences.

Principal Researcher: Abha Singh **Contact Information:** (phone number)

Nature of Participation: This study comprises an 18 week art therapy program with South Asian immigrant women over the age of 18 who express suffering with the use of the body. During these 18 weeks you will participate in the following activities:

- A meeting for an introduction to the program; reviewing the consent contract;
- A meeting to review the orienting statement; an assessment drawing; first informal semi-structured interview;
- 12 individual art therapy sessions;
- The second semi-structured interview; a 2nd assessment drawing;
- Two follow-up workshops in response to the 12 therapeutic sessions;
- One follow-up meeting to review a summary of your art therapy experience;

Additional details:

- The sessions will be for 1 and 1/2 hours each;
- The sessions will be held between February 2012 and July 2012;
- The meetings will take place at _____;

The sessions will take place at a time set by the shelter management so that you will not miss any of the essential services offered to you from the shelter. Participation in this study is completely voluntary and confidential. Absolutely no personal information will be gathered as part of the study.

Participant Qualifications:

1. The participants are required to be over the age of 18.
2. The participants are required to be immigrants of South Asian origin.
3. The participants are required to have been diagnosed by a doctor or psychologist as being diagnosed with self-harming behaviors such as superficial self-harm, and/or somatic symptoms, and/or negative body images (e.g. intentional cutting, scratching, interfering with a healing wound, excessive nail biting and pain).
4. The participant(s) will be required to have an ability to discuss her feelings, thoughts, and experiences related to cultural changes, domestic violence, self-harming behaviors such as superficial self-harm, somatic experiences and negative body image(s); and to participate in art making activities.

APPENDIX B: CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Voicing the body

This is to state that I understand that I have been asked to participate in a program of research being conducted by Abha Singh, a PhD candidate in Humanities at Concordia University;(phone number), (e-mail address), under the supervision of Dr. Jaswant Guzder who can be reached at (phone number) at McGill University in the Department of Psychiatry, and Dr. Rosemary Reilly who can be reached at (phone number) at Concordia University, in the department of Applied Human Sciences.

PURPOSE

I understand that the purpose of the research is to explore how art therapy can provide a safe space in which participants, who have experienced domestic violence and self-harming behaviors such as superficial self-harm, somatic experiences and negative body images may express emotions through art, which may help reduce emotional stress during the recovery process at the shelter.

PROCEDURES

All women residing at the shelter are invited to participate in weekly art therapy sessions. If I decide to participate in the study, I will be meeting with Abha Singh art therapist/researcher, on a weekly basis for 18 weeks for interview meetings and 12 art therapy sessions of 1 and 1/2 hours each between February 2012 and July 2012. I understand that this project involves:

- The researcher observing you in the shelter setting;
- The art therapy sessions and the interview meetings being audio-taped and transcribed;
- Digital photographs of all artwork and writing about the art;
- Keeping the transcripts for 5 years and the digital photos for 7 years after which they will be destroyed;

My consent to participate in your research paper is independent of my participation in the art therapy sessions and/or other services at the shelter;

A copy of the thesis will be digitally available on the Internet through the Concordia University Library and that this research study may also be presented in educational settings or published for educational purpose in the future.

CONFIDENTIALITY

It is understood that your confidentiality will be respected in every possible way. Neither your name nor, the name of the shelter, nor any identifying information will appear in my dissertation nor any other published work that will be created from this project or on your artwork. Any identifying information will be changed to preserve confidentiality.

RISKS AND BENEFITS

There is no deception used. I do not think that these art therapy sessions will cause you additional distress. However, this study involves remembering painful memories which

may cause emotional grief. In the unlikely event that you experience emotional distress from participation in this study, the principal researcher shall make every effort to minimize such an occurrence. In addition, the staff at the shelter will always remain present and my clinical supervisor will be on call.

No compensation is offered for participation.

CONDITIONS OF PARTICIPATION

- I understand that I am free to withdraw my consent, discontinue my participation, and terminate the interview(s), at any time without negative consequences at any time before the research paper is completed, without explanation, by contacting Abha Singh, art therapist/researcher, at (phone number);
- If I withdraw from the study before it ends, I understand that all relevant tapes, transcripts, digital photographs, or any other data already collected will be kept and used as needed in this study.
- I understand that the removal of data prior to my withdrawal will not be possible as it will be utilized towards the publication of this research;
- I understand that my participation in this study is completely CONFIDENTIAL;
- I will receive a copy of this signed consent form for my records;
- I understand and give permission to:

	Yes	NO
Photograph the art works	___	___
Audiotape the two interviews	___	___
Audiotape the art therapy sessions	___	___

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

NAME: (please print)_____

DATE :_____

SIGNATURE: _____

If at any time you have questions about the proposed research, please contact the study's Principal Investigator at McGill University in the Department of Psychiatry, Dr. Jaswant Guzder at (phone number), and/or the study's Secondary Investigator at Concordia University in the department of Applied Human Sciences, Dr. Rosemary Reilly at (phone number).

If at any time you have questions about your rights as a research participant, please contact the Research Ethics and Compliance Advisor, Concordia University, 514.848.2424 ex. 7481; ethics@alcor.concordia.ca

APPENDIX C: ORIENTING STATEMENT

(Prior to the first meeting with the participant, the researcher will read the following orienting statement):

Before we start, I would like to give you some background information related to the study to set the stage for the interview. Many women are being abused by their partners or husbands. It is known that domestic abuse affects people of all cultural, social, economic, and age groups. Further, as a method of coping with stress, anxiety and trauma, women may engage in self-harm and experience symptoms of somatization (for example: headaches, nausea, back pain, abdominal pain, and persistent lack of sleep). A therapeutic approach such as art therapy may help women who are experiencing physical and emotional psychological distress resulting from domestic abuse, cultural changes, self-harm, somatization, and negative body images. This program will be a place where you are able to voice your experience and tell your story in your words. You will also be making art in a therapeutic context which may help alleviate some of the stress you may be experiencing and which may be a representation of your emotions.

I would like to focus on understanding your feelings related to domestic abuse and about the cultural changes you are living through. As well, I would like to understand how this affects the body and how you as an individual express emotions through the use of the body. When considering the body I would like to hear your views about self-harming your body, symptoms of somatization and the negative body image you may have or experience. I would also like to identify possible methods through art therapy to help reduce psychological stress and empower you. I wonder what the art therapy experience has been like for you and if engaging in art therapy can be helpful to you. The

art therapy program will be the same format with similar art activities as the art therapy program you have already participated in at the shelter. However, this program will continue for 18 weeks includes individual art therapy sessions. I may ask you to elaborate or clarify some points to be sure that I have completely understood your experience. If you feel uncomfortable about answering any of my questions or discussing certain aspects of your experience, please let me know. Do these guidelines seem clear to you? Are there any questions you would like to ask before we begin?

APPENDIX D: IMAGES OF ASSESSMENT DRAWINGS I

Figure 29 - Raina's Assessment drawing – 1

Figure 30 - Devi's Assessment drawing – 1

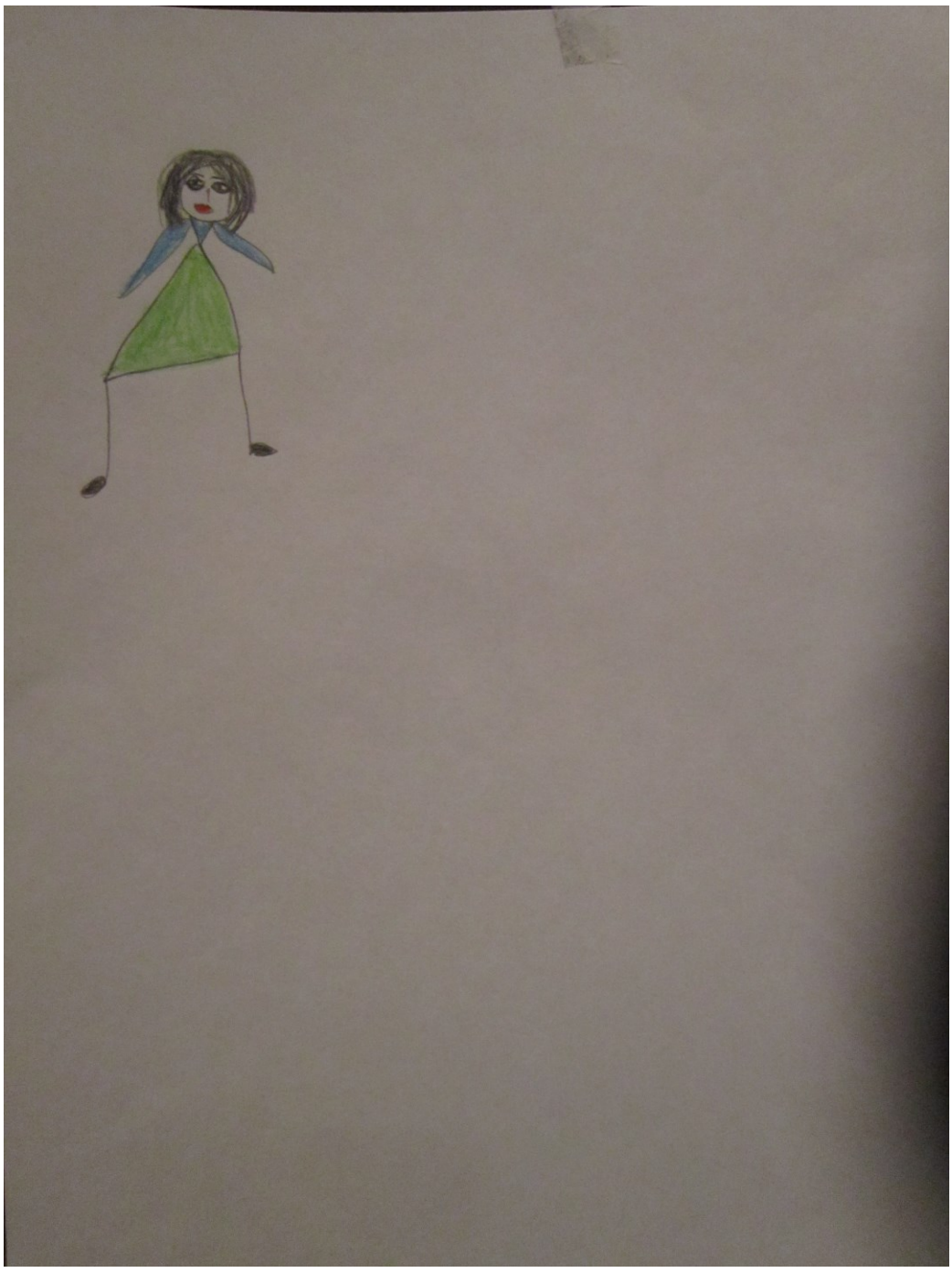
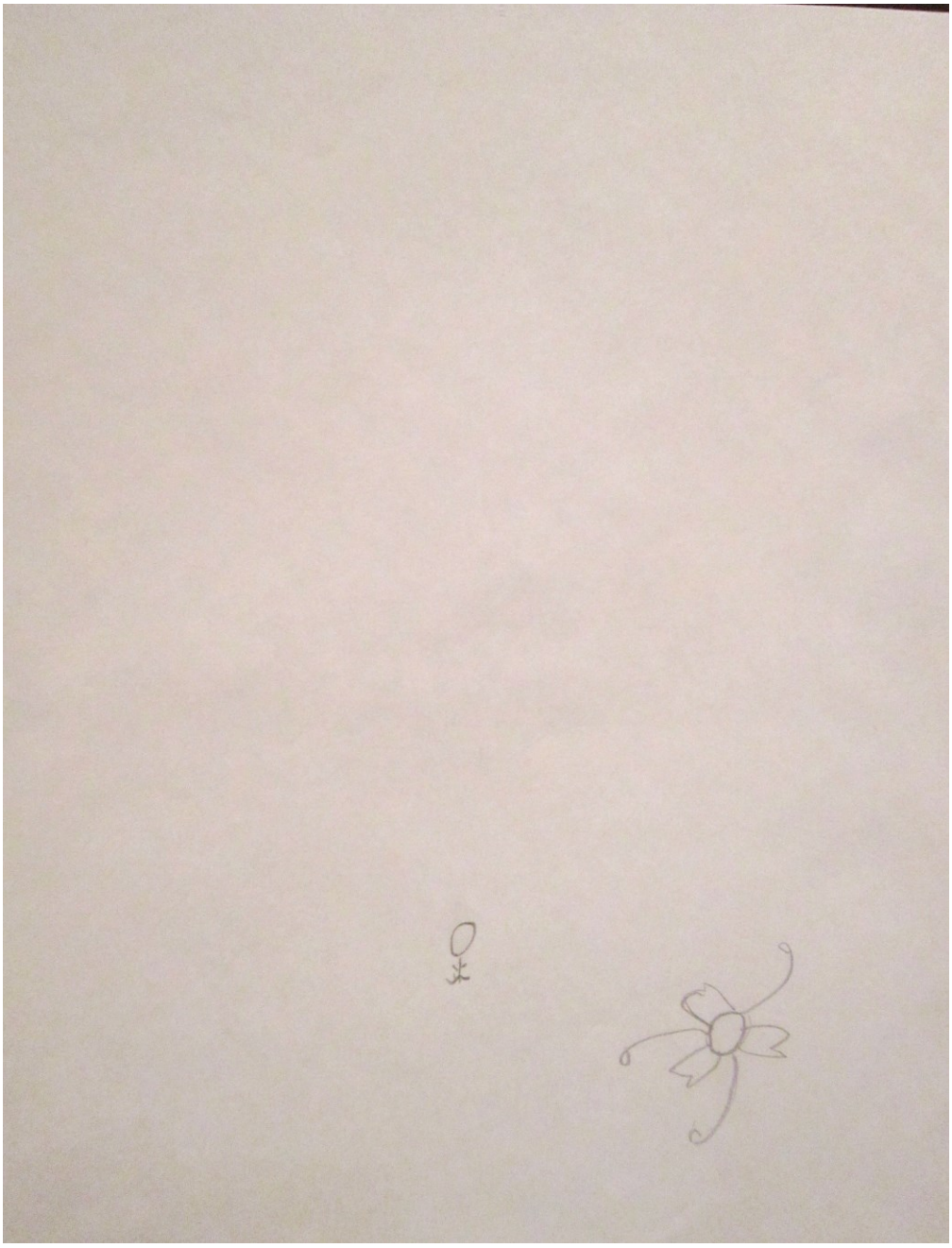


Figure 31 - Jaya's Assessment drawing – 1



APPENDIX E: SEMI-STRUCTURED INTERVIEW QUESTIONS I

(Please note that the participants will only be asked those questions pertinent to their individual experiences)

Interview question(s):

Understandings and experiences of health and healing

1. In your own words, please tell me what does health mean to you?
2. In your own words, please tell me if there are times when you feel unhealthy?
Please give examples.
3. Please tell me if you have had any health problems in your life?

If yes, please discuss what you believe might have contributed to these health problems.

4. Please tell me what does healing mean to you?
5. In your own words, please tell me if there are specific situations that make healing difficult? Please give examples.

Experience of Migration

6. Please tell me about your migration experience.

What (if any) are the challenges you have been faced with?

How do you feel this has affected your cultural ethnicity?

Have you experienced any cultural changes?

Experience and understandings of violence
Responses to the following questions may include personal experiences and/or your understandings.

7. In your own words, what is violence? Please give examples.
8. Please tell me about your experienced abuse.
9. What were the circumstances surrounding your abuse?

Experience of self-harming behaviour(s)

10. Please tell me about your self-harm (type of self-harming behavior)

When did you start_____?

What do you recall, that may have happened, that led to this behavior?

11. Please tell me about the circumstances for your_____ your body?

What was going on for you at home?

In other areas of your life?

Experience of somatization

12..Please tell me about your experience of painful symptoms in your body? Please tell me about your experience.

What pain do you experience/feel?

Where in your body do you feel the pain?

What do you recall, that may have happened, that led to your somatization?

Experience of body image

13. Please share with me, your thoughts about your body.

14. In your own words, please tell me if you see any relationship between the domestic abuse in your life and your view of your body image?

15.Please tell me about your experiences as a woman that you think has influenced your body image or your recovery?

Concluding questions

16. Please tell me what you hope to achieve here at the shelter? What would you like to achieve for yourself?

17. Is there anything you would like to share or add to our discussion?

18. Do you have any questions you would like to ask me?

APPENDIX F SEMI-STRUCTURED INTERVIEW QUESTIONS II

(Please note that the participants will only be asked those questions pertinent to their individual experiences)

Experience participating in this research project

1. Please reflect upon your time in art therapy.
2. What do you recall discussing in art therapy?
3. What were the most significant themes that you discussed?
4. What was the effect of the art therapy you received?
5. What did you find helpful from your therapy?
6. What was not helpful in therapy?
7. What did the art creations represent for you?
8. Have you learned anything new by participating in this research project? If so, what did you learn? (examples)
9. Is there anything that you learned in this research project that you will use in your life? If so, please give examples.
10. What is your response to the topics covered in the therapy sessions?
11. Are there any topics that caught your attention? Are there any discussions that you remember more than others?
12. Was there anything that you wanted to discuss that was not addressed in the art therapy sessions?
13. Was this project helpful in achieving your hopes, goals, or needs?
14. Is there anything else that you would like to say?

APPENDIX G: DIRECTED ART THERAPY ACTIVITIES

(The participant(s) determine the pacing and intensity of the experience. These activities are typical art therapy activities modified for this project & depending on the participant(s). Self-esteem is a general goal of all activities.)

1. A Safe Place

The art intervention - Safe space.

Materials - Paper, glue, tape, scissors, pencil crayons, markers, pastels, and assorted collage materials.

Introduction - The session begins with a brief discussion on a safe place. The participant is asked to close her eyes if comfortable with doing so, and to take a few moments to visualize their own safe place, followed by the directive.

The directive – To create an image of your safe place. The participant decides how to precede, what materials to use and the specifics of the image.

The goals of the art task – The primary goal is to identify the participant's perception of personal safety, creation of a safe space, experimentation of materials, and improvement in decision-making skills.

Rationale – Re-establishing personal safety is one of the first and foremost steps of trauma treatment.

2. The Uniqueness Metaphor

The art intervention -Uniqueness metaphor.

Materials - White paper and glue, collage materials.

The directive – Think about yourself, what comes to your mind? Create an image of what represents you.

The goals of the art task - To explore the personal experience.

Rationale - To promote self-esteem through a basic skill in completing the task. The image created is a metaphor of the participant's unique self.

3. Self Portrait

The art intervention – A self-portrait representing two sides of the self.

Materials – Drawing paper. Acrylic and water paints, oil/chalk pastels, markers, pencil crayons, pencils, and assorted collage materials.

The directive – To portray two sides of the self; the front side an image of what the individuals allows others to see; and the reverse side to portray what the individual does not show.

The goals of the art task – To explore how one views herself or feels inside /represents feelings towards self; to identify the roles portrayed by the participant and to identify defense mechanisms; to understand how roles and defense mechanisms can contribute to the participants suffering; to explore the meaning of wearing two faces; to express emotions; to address the importance of acceptance of the self.

Rationale – This task is used as a tool to gain insight into personal struggles, disappointments, support systems and internal strengths. Survivors of domestic violence may still be absorbed with prior injury, a negative self-image, and the need to guard against further harm. Therapeutic space may present as a safe place to share; to give participant control over their expression(s) as the participant reveals in the art product only what she wishes to reveal.

4. Mural – Symptoms of Embodiment

Art intervention - Symptoms of embodiment.

Materials – A sheet paper, assorted collage materials, markers, coloured pencils, chalk, and acrylic paint.

The directive – Draw the symptoms of trauma; identify some of your symptoms and draw how it affects you. Prior to beginning, the participant will be asked to list some of the psychological or emotional symptoms of trauma. The image will represent the participants thought(s) or feeling(s).

The goals of the art task - To explore the concept of the thoughts that the participants regularly carry in their minds, to identify the symptoms that may have originally developed as responses to trauma; to explore the link between abuse and behavior leading to symptoms of embodiment; express emotions.

Rationale – Activity is used as a tool to gain insight into personal struggles, disappointments, support systems and internal strengths - bringing awareness to the participant(s).

5. Past, Present and Future Image

The art intervention - Who I was, who I am, and who I want to be.

Materials - Markers, pastels, coloured pencils, scissors, glue, white paper, magazines and assorted collage materials.

The directive - Create a collage representing change in your life. Create an image of who you were in the past, who you are now, and who you want to be in the future.

The goals of the art task –

- To develop an awareness of change over time; provide hope for future;
- To develop an understanding of how changes brought about by trauma affect the participant in different aspects of her life. These include social, familial, health related and psychological changes.
- To re-establish hope in the future by allowing participant to visualize what it means to her;
- To build trust by sharing past and present experiences;
- To discover the benefit and opportunities that comes with struggle;
- To help participant focus on their empowered and disempowered self;
- To validate and normalization emotions related to traumatic experiences.

Rationale – To bring new perspective to pain and suffering, which might help to decrease symptoms of depression and anxiety by learning to view life's struggles as an opportunity and recognizing that growth comes from our trials. Participant may focus on the differences and/or similarities between the empowered self and the disempowered self; image may provide hope for a positive future.

6. My Body:

The art intervention - To draw a life-sized outline of a real body size. The participant(s) may then fill in the drawn body.

Materials – Coloured paints, markers, crayons; words/pictures from magazine cuttings; fabric pieces. Projector to trace full size body image

The directive – Create a body image that may represent how you use the different parts of your body to communicate how you feel; that represent what is going on inside you, physically and mentally; draw the emotions most experienced. Think where in the body you feel your emotions and draw it in as many areas as you like.

The goals of the art task – To release tension and stress in order to reduce anxiety; to create a visual image and feeling connecting it to feelings and thoughts of emotion(s). To visially see image and make mind/body connections.

Rational - To decrease symptoms of suffering by learning that our own uniqueness can be celebrated for the reason that these things make us an individual and different from others with a sense of uniqueness, can help. To express emotions; to be more in touch with the body and visualize emotions connected to the body; to validate and normalize emotions related to traumatic experiences.

7 & 8. Body Casting

The art intervention – Participants caste a part of the body representing themselves where they experience pain or discomfort. Participant will be given the option to use a part of their own body or that of a mannequin.

Materials - Molds and plaster gauze, various paints, collage materials; images or words from photographs and magazines.

The directive – Decorate both sides of the cast. One side to represent the positive experiences and the other side to represent the experienced pain, both emotional and physical; incorporating words into the art creation is a way to express directly feelings and thoughts.

The goals of the art task –

- To understand that emotions and feelings that are strong and overwhelming do subside; to express emotions of pain/suffering;
- To be more in touch with the body and visualize how internalizing pain connects to the body;
- To build self-esteem and emphasis the good/positive qualities and strengths;
- Validation and normalization of emotions.

Rationale – To help reduce symptoms of anxiety and fear by learning that overwhelming emotions and feelings will not last forever.When one can remember that these emotions and feelings can come and go, they may experience less stress. To visually expresses positive/negative emotions and what it means for the participant. A safely mediated activity, with emphasis on painful experiences is a medium to promote the beginning of psychological change, self-care, embrace body awareness, and explore memories stored within the body.

9 & 10. The Recovering Body

The art intervention – Draw your recovering body.

Materials – Watercolour/acrylic paints and brushes, collage materials, glue, various object.

The directive - The participant will be asked to think of a body that would symbolize their journey from abuse to recovery.

The goals of the art task –To discover and celebrate the unique things within us and about us; to explore the importance of being comfortable in our own individuality and uniqueness. Visual indicators may show the participant's past, present, and future coping behaviours. Self-empowerment may occur once the participant moves away from personal physical pain, and suffering to a positive self-image – therefore gaining control of their lives; to explore individual needs on a mental and physical level. To understand that meeting these needs are important aspects to a healthy mind and body. To be able to shift away from the experience of the pain and discover other aspect of ones self. The art-work

created can be used to remind participant of the strength and many positive things they found within themselves; Validation and normalization.

Rationale - To remind participant of the strength and many positive things one can find within themselves. When one can recognize the need to address self-care emotionally, physically, and mentally, they can become an active participant in their recovery. Being aware of and taking action on these needs can help to decrease symptoms of trauma and anxiety, alleviate symptoms of depression and anxiety, and develop confidence. To explore and look at the positive aspects of ourselves can be used as tools in everyday life to help manage and decrease symptoms. By creating a representation of positive qualities, one can become aware or their overall wellness. By being an active participant in one's wellbeing and recovery, one may improve symptoms of depression and anxiety as well as feel empowered to continue to work towards objectives and goals.

11. Bridge Drawing

The art intervention – Draw your bridge to recovery.

Materials – Paper, markers, coloured pencils, oil pastels, water paints/brushes.

The directive - The participant will be asked to think of a bridge that would symbolize their journey from abuse to recovery and then be directed to draw a bridge with their past on one side of the bridge and the future goals they want to accomplish on the other. Participant is directed to place herself somewhere on the bridge. The bridge represents treatment. Underneath the bridge, participants will be directed to place obstacles that would prevent a successful recovery and possible setback(s). Participant(s) may draw in their style of preference (i.e. abstract form). The symbols used will be metaphoric and symbolic representations of their recover process.

The goals of the art task - To identify what the participants' obstacles may be in completing treatment and to list specific coping skills or tools that would aid in recovery. Giving visual form on paper to future goals, obstacles and coping skills is a reflective way for the participant to determine where she is at in

treatment. To explore the metaphor and symbolism; to recognize road blocks or detours that may be encountered.

Rational - By looking at a visual, participant may plan to prepare for things in the future as well as making changes to things that have not worked or slowed us down in the past. Having a visual representation of this plan can bring comfort from having set plans and goals for things we might face in the future, which could help to alleviate fears, worries, and anxiety symptoms. Making plans for the future in spite of regret from the past, with anticipation for positive change can also improve symptoms of stress/depression.

12. Termination - *Review of art work.*

The goals of session –

- Review of all the art creations; view progression; positive and/or negative experiences.
- To discuss the importance of maintaining a healthy lifestyle mentally, physically, with the aid of creativity; to the continuation of self-care, creativity, and for their own recovery and wellness; listen to participant's views, feedback, and feelings.

APPENDIX H:IMAGES OF ASSESSMENT DRAWINGS II

Figure 32 - Raina's Assessment drawing – 2

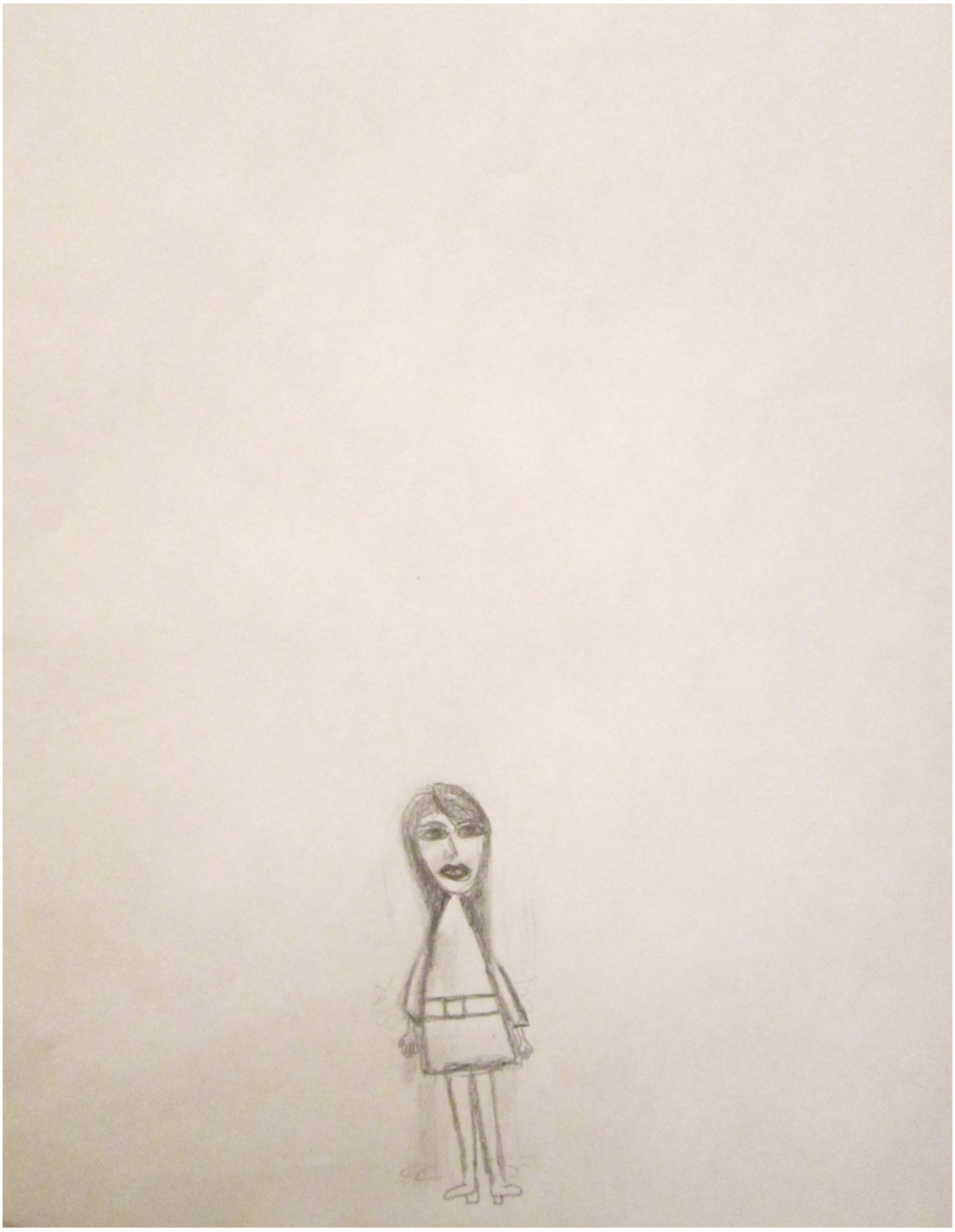


Figure 33 - Devi's Assessment drawing – 2

Figure 34 - Jaya's Assessment drawing – 2

APPENDIX I: ART RELEASE FORM

Art Release Form for art work(s) produced in follow-up workshops

This is to state that I, _____, hereby authorize Abha Singh PhD candidate in Humanities at Concordia University; (phone number), (e-mail address), under the supervision of Dr. Jaswant Guzder, who can be reached at (phone number) at McGill University in the Department of Psychiatry and Dr. Rosemary Reilly who can be reached at (phone number) at Concordia University, in the department of Applied Human Sciences, to use and/ or display the art work(s) created by me during the 3 response follow-up meetings in a program of research titled « Voicing the Body » by Abha Singh.

- I understand that my identity will be kept completely confidential and no identifying information will be given;
- I understand the setting where the art work(s) were made will be kept strictly confidential;
- I understand that my name will not be used in conjunction with any presentation, discussion or display of the art work(s) created in the 3 response follow-up workshops;
- I understand that my artwork(s) may be displayed in professional and/or educational setting(s);
- I understand that my art work(s) in this research study may be published for educational purpose in the future;
- I understand that my art work(s) in this research study may be utilized for verbal presentations on this research;
- This consent to disclose may be revoked by me at any time except to the extent that action has been taken in reliance thereon.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE TO THIS ART RELEASE FORM.

NAME _____

_____ _____

Signature Date

_____ _____

Witness Date

APPENDIX J: ETHICS APPROVAL

CERTIFICATION OF ETHICAL ACCEPTABILITY FOR RESEARCH INVOLVING HUMAN SUBJECTS

Name of Applicant:	Dr Rosemary Reilly
Department:	AHSC
Agency:	N/A
Title of Project:	Voicing the Body
Certification Number:	UH2011-160

Valid From: January 30, 2012 to: January 29, 2013

The members of the University Human Research Ethics Committee have examined the application for a grant to support the above-named project, and consider the experimental procedures, as outlined by the applicant, to be acceptable on ethical grounds for research involving human subjects.

Dr. James Pfaus, Chair, University Human Research Ethics Committee

01/29/2009

APPENDIX K: ADDITIONAL DIALOGUES

Case I – Raina

Background Information

Shortly after her arrival to Canada, Raina's husband began to beat her. He informed her that he was not attracted to her and would never want to have children with her. Raina's mother-in-law refused to accept that her son was at fault for his abusive behaviour. According to her, it must have been Raina who provoked this behaviour from her gentle and kind son. Raina must have deserved what was done to her. Without family or friends, Raina felt helpless. When asked how this made her feel, Raina stated:

हाँ, यह मुश्किल था लेकिन यह है कि कई लड़कियों को यह होता है.
मेरे ससुराल वाले मुझे अच्छी तरह से नहीं रखा, केवल मेरे ससुर ने कभी कुछ भी नहीं कहा और न ही मुझे मारा. मेरे पति ने मुझे मारा, उन में से बाकी मुझ पर गुस्सा और चिल्लाना या मुझे गाली देना...
उन लोग घर में सब काम कराते, मुझे सोने नहीं देते, और मुझे कहीं नहीं जाने देते.
Yes, it was difficult but this is what happens to many girls.
My-in-laws were not nice to me; only my father-in-law never said anything nor hit me.
My husband hit me; the rest of them would get angry at me and yell or mistreat me…
They would make me do all the work in the house and not let me sleep and not let me go anywhere.
कोई मुझे मदद नहीं की क्योंकि मैं एक बहू हूँ.। उन्होंने मेरे साथ बर्ताव किया जैसे मैं एक नौकर हूँ मैं 5:00 जाग कर नाश्ता बनाया करते, और फिर दोपहर का भोजन बनाने के लिए इस्तेमाल करते, और फिर बद में मैंने सभी सफाई कि । मेरी सास ने यह भी कहा कि मैंने अच्छा खाना नहीं बनाया. । वह मुझे कुछ और बनाने के लिए बोलते । फिर हम कुछ और बनाते ।
No one helped me because I am a daughter-in-law. They treated me like I was a servant. I used to get up at 5 a.m. to make breakfast and then lunch, and I had to clean up after everyone. My mother-in-law also said the food I made was not good food. She would tell me to make something else and then I would have to stop what I was doing to make something else.
फिर वह मुझे रसोई, व्यंजन बताने के लिए बोलते और फिर अपने कमरे में आने के लिए बोलते उसके पैरों की मालिश के लिए, जबकि वह सो सकते । कभी कभी मैं सिर्फ दोपहर में तीन बजे के बाद खाना खाती थी ।मैं रोना चाहती हूँ, लेकिन नहीं किया क्योंकि वह कभी कभी मुझे उसके पैर के साथ लात मारती और मुझे बोलती कि मैं उसे परेशान कर रहीं हूँ ।

Then she would tell me to clean the kitchen, and do the dishes and then come to her room so that I could massage her feet while she slept. Sometimes I only got to eat at three in the afternoon. I would want to cry but did not because when I did she would sometimes kick me with her foot and tell me I was disturbing her.

Raina's husband would often drink alcohol and when he was drunk, he would force her to watch inappropriate movies and drink alcohol with him. When she did not comply, he would become irritated and abusive towards her. He would demand that she obey him because he was her husband and her "god". She was very unhappy about her life with him but felt that this was her destiny.

यह भाग्य के बारे में है. मेरे किस्मत उदासी जीवन जीवित है। मैं अपने पिछले जीवन से दंडित किए जा रहीं हूँ और अब मैं परिणाम भुगत रहीं हूँ। जो हम हमारे पिछले जन्मों में बुरा करते उसकी सज़ा इस जीवन में किया जाता है, और हम इस जीवन में इसके लिए दंडित कर रहे हैं ... मैंने कुछ किया होगा ... इसलिए मैं अब पीड़ित हूँ.
It's about destiny. I was destined to live a life of sadness. I am being punished for my past life and now I have to bear the consequences. Whatever bad we do in our past lives is carried through to our present life and we are punished for it in this life…I did something…so I am now suffering.

Raina attributed her current suffering to past life failures and felt that perhaps she should accept the suffering, especially as any actions she would take to alleviate this suffering would bring shame on her family and their reputation. She would not receive family support because of the stigma attached. So she had to bear the blame for not obeying her husband and keeping him happy, even though she knew how unhappy she was. Yet Raina questioned herself:

लेकिन मैं कैसे करती? मैं पागल हो रहीं हूँ । मैं इस तरह से इस जीवन जीना नहीं चाहती हूँ ।
But how can I? I am going crazy; I don't want to live this life like this.

Her husband treated her badly in the presence of his family. When they were alone he could be nice to her on occasions, but she describes how he became angry and abusive. She recalled:

वह एक अच्छा आदमी था पहले; क्यों इस तरह बन गया है मुझे पता नहीं है।
He was a good man before; I don't know why he became like this.
मेरे लिए उससे बात करना कठिन है.। वह कुछ सुनना नहीं चाहते है । वह मेरी बात नहीं सुनता और वह गुस्सा हो जाता है। जितने बात करने की कोशिश करते हैं, और अगर मैं बात करने के लिए जारी हूँ, वह मुझे थप्पड़ मारने के लिए तैयार होते है ।
It is hard for me to even talk to him. He does not want to listen to anything I say and the more I try to talk the angrier he gets and if I continue to talk he slaps me.

मेरे लिए मुश्किल है, क्योंकि अब उससे डर लग रहा है। और वह मेरे पति है।. मैं कोई नहीं है. कोई भी मेरा नहीं है।

It is difficult because now I am afraid of him and he is supposed to be my husband. I am no one; I have no one.

Raina expected things to turn around for her and continued to listen by her husband and her in-laws:

मैं आशा कर ती थी कि मेरे भाग्य बदल जाएगा, लेकिन यह नहीं होने जा रहा था. इसके बजाय और बुरा हो गया । मैं इतना वजन खो दिय और हमेशा बीमार थी।

I hoped my fate would change but it did not. Instead it got worse. I lost so much weight and was always sick.

She recognized that she was not like this before and recalled the happy period before she came to Canada, and cried.

At this point, Raina's headaches and stomach pain worsened. She would get upset with her situation and escape to take hot showers to cope with her anxiety. As her situation worsened her escape involved using hotter and hotter water to the point that she was almost burning herself. She did not care because she was happier doing this than having to endure the abuse of her husband and in-laws:

मैं पागल व्यक्ति जैस थी । कोई बात करने के लिए नहीं, और करने के लिए कुछ भी नहीं, तो मैं ऐसा करने के लिए उपयोग करती थी ।

I felt like crazy person, no one to talk to, and nothing to do, so I used to do that.

For Raina, the shower became her private space, a place she could remain and no one would bother her. At times her mother-in-law attempted to place rules on the shower, but Raina was able to manage to escape from them. She described pleasant memories of her new home: first the hot showers and second when her mother-in-law took naps. These gave Raina some quiet time away from the daily stress, abuse, and anxiety.

Raina expressed regret about her marriage, recalling a better time before:

मैं क्यों इस आदमी से शादी कर ली पता नहीं है. मैं पहले एक अच्छा जीवन जी रहीं थी

I don't know why I married this man. I had a nice life before.

जो वह मुझे करने के लिए कहा, मैंने किया लेकिन खुश नहीं थी । वह मेरे अपमान किए

I did what he asked me to but was not happy. I felt used, disrespected.

Session 1: A safe place

"*I feel safe in a place that is far away from here…It is in my country."*

She was then asked to describe her artwork. Raina stated:

I see a beautiful palace where there are guards and hidden chambers! (Laughing)

She was prompted to further elaborate:

See this picture," (pointing to the bottom left corner of her artwork) "*I tried to copy it but it does not look the same. I like it. It's a place that looks peaceful and quiet. See here it is high up so it is hard for people to get there. No one can find me here. It is safe.*

She then proceeded to point to the magazine cut outs on the bottom right side of the artwork:
Well, these pictures I put because I like mehndi *and this one I put because they look happy getting married like a happy couple should. See, they should be living in this big palace and live happily ever after as they do in fairytales.*

Raina was asked to share what fairy tales meant to her:

Well, I guess everyone is happy after something goes terribly wrong. . . . Maybe I will live happily ever after at some point as I have so many troubles right now . . . . Well, here it is my safe place.

Session 2: the uniqueness metaphor
She decided to represent herself as flowers (figure 2 A & B):
I made flowers because I did not know what else to make. . . . And I made two because I had a lot of time left so I thought I should make two. I use to make drawings of flowers since I was young. I enjoy it. I always made them. They have these types of flowers in India.

Raina named her artwork(s) "the flower trees". When asked to elaborate on her painting

Raina stated: *It is supposed to be flowers but when I look at it from here it looks like trees*

with big flowers growing on them."

The therapist asked her if the flowers had any meaning for her and she replied:

Well, I like all flowers but since I was little I always drew this type of flower. I don't know why. I just like them…they are pretty so they make you happy. They have to be taken care of though, or else they will die. One needs to water them, change the soil, the pots, and give them sun. Otherwise they will die.

She attempted to relate the flowers to herself:

Maybe I am growing like they are and maybe I am like them . . . they look nice . . . they are big and small . . . some are big and small, the colours are different in both paintings, this tree is straight and this one looks like it is falling and some flowers are fallen down. . . . I don't know why I did that . . . okay, so maybe one tree is stronger than the other.

Session 3- Self-Portrait
Upon describing her artwork, Raina thought for a long while before she named her artwork. She called it "*Me and My Secret Side.*" And began to explain her reason for this title: "*Okay this girl is happy and no one can see what she is thinking . . . and this*

one, she is angry and sad about what happened to her. All her problems with her husband."
Upon describing her artwork, Raina thought for a long while before she named her artwork. She called it "*Me and My Secret Side.*" And began to explain her reason for this title: "*Okay this girl is happy and no one can see what she is thinking . . . and this one, she is angry and sad about what happened to her. All her problems with her husband.*"

Session 4: mural – symptoms of embodiment
The therapist discussed the objectives of the activity and Raina started by listing some of the psychological and emotional symptoms of her pain:
I can think of pain in my chest, my legs when I walk, my stomach, my head and my entire face. It has changed so much I have aged and look so old now. I look in the mirror and I see someone else. So I can put down face…I did not want to tell anyone how I was feeling because I was taught never to reveal my emotions…well you must already know…Speaking about emotions is something our culture does not encourage,
Therapist: You are certainly right especially since you have experienced this.
Once her list was complete, the therapist directed Raina to draw a representation of the list of her symptoms in any form she was comfortable with. Raina chose to use flowers and pictures from a magazine to symbolize her symptoms of pain.
I made flowers because I like to draw them. And I did not know how to make pain so I used this from the magazine. See here it is the lady running and she is healthy and fine. But here on the inside her chest hurts…and this lady it shows pain here and here, and here. She has a lot of pain like me.

While creating her image (figure 4), Raina continued to describe how the pain she was feeling had not always been present:
My headaches I used to get often but when I came here I got them more and they hurt more almost like my head would fall off. . . . And this pain this is my chest pain it only happened after my husband mistreated me. I thought I may have a heart attack but it happens when he hits me. I just get scared and I feel a pain here . . . it just feels like something is there and my heart beats so quickly…I feel so scared.

She described how she had internalized fear:
Whenever I used to get hit or even now in my sleep, I have dreams about it and then I wake up because my heart is beating fast and it hurts everywhere here" (pointing to her chest and stomach).

She continued to discuss her artwork and was comfortable describing her artwork:
Well this shows all the pain I feel at different times. Some are there and some have gone except my face has changed. . . . I look so old and wrinkled I look like I am almost 50 years old. When my family sees me they won't recognize me. I look old now…yes I know I have, and this is pain in my leg because one time he pushed me and I fell and hurt my leg and when I told him he kicked me there…yes he did hit me a lot I thought I was going to have to do something because he won't stop so one day I went to the métro and told the security guard there, I was sitting all day at the métro and then by evening he came

and asked me if I needed help and I told him . . . he called the police and they brought me to the police station then here. They said I would be safe here. . . . I did not want to go back home because I knew I would get beaten again and I could not take it.

Raina completed her art image and then looked at the words she had written down earlier on at the beginning of the session. She verbally read out each word or phrase and she had the ability to grasp the metaphor and relate it to her image; she wrote down her words on her image.

Session 5: past, present and future image

I made these flowers (figure 5, G & H) to show who I am now, I feel empty and sad. I don't know how my life will be.

Figure E & F :

This one is the past me, happy and enjoying my life with my family and friends. I had nice friends although we did things we should not have like scratching my arms with pins and drinking.

F – J: This is when I got married and everything that happened to me.
F 5 – I: And this one is for the future, I want to be happy again and live a good life. On the back side this is me. I am happy. I just wish I could go back to home and be with my friends and family. Even though I had some problems as a younger girl, it was still okay. We were able to deal with them. But this marriage is very difficult and has destroyed me. I try to follow the expectations of my family and look at where it's got me. I was being the nice and proper girl that I was, like all Indian girls are. But it's so hard to live alone here and be so independent. Even when I tried, my husband was not happy. . . . At least at home I have my family to live with . . . you don't feel alone and lonely. It's different here. . . . I was always surrounded by family and we did a lot of social activities together with family and close friends.

Session 6: my body

It made me see where my pain is and seeing it life size made me realize that the pain is real… see here in my head, my stomach, my chest, and my leg. These are all the places I have pain and suffer a lot. I feel terrible on certain days I cannot function at all. The stomach pain is so strong sometimes I feel like just cutting it out and then I feel like I cannot eat any food. I feel sick in my stomach. I feel nervous and then I can't breathe because my chest hurts so much. . . . And so then there is my leg it hurts but not so much as the other areas.

When asked to further elaborate, Raina was not sure what else to say:

I don't know how, there is so much going on with me. But I know since I have come here to the art with you, I am feeling more relaxed I don't have to worry about my husband causing me sadness and pain any more. But I am finding it hard to be here with so many different women…it's not my home, I feel like everyone is watching me…but I can finally be away from him…but I still am afraid what if he finds me what will I do. I feel paranoid and every time I hear a noise I get scared.

Sessions 7 and 8: body casting
The face is better to work with. I dislike my body. . . . I always have.
She then stated: *"One we all see and the other one only me."* Describing how the mask had two sides, "*Here she is happy and here she is not."*
On the inside, Raina wanted to show pain so she tried to put it inside to show the strong headaches.
As Raina continued to describe her artwork, she spoke about herself:
Just her suffering and sadness is shown here and the other side she is there but not happy, I hope one day I will be.

Sessions 9 and 10: the recovering body
This side of the body is when I first got married and we were happy. Then this side is of my marriage. . . . I tried to show the bad part of my marriage when he punched me with closed fists in my face, my stomach, and one day he even gave me a black eye. He told me I was ugly, stupid, fat, and that he is the only one that is stupid enough to have any feelings towards me. After he hit me, he would kiss me on the forehead and apologize . . . and I would forgive him. Then he would bruise my face again. He ruined my life, and my self-esteem. I am angry because I want to be a happy girl that just wants to love and be loved. . . . I am always afraid and sensitive, self-conscious. He and his family are living normal lives, free from pain . . . and all this confusion that comes from being abused. . . . I hate myself . . . look at me.

Session 11: Bridge Drawing
Okay, over here it is supposed to show me like I use to be, happy in my home, my country and with my family. I will live a full and complete life, finding love, getting married, and sharing my love with my children. I will help other women to know the warning signs of domestic abuse. And I will be happy again.

This is a bridge made of wood like we have back home. The left side is my past, and it is empty. The right side is my future and the circles represent my happiness, education, and family. I don't think I will forget my past and it will always be there to bother me so this is an empty colourless flower and these other shapes and flowers to show that.

Session 12: Termination
I see anger and sadness, sensitivity self-conscious. When I first came here I was hurt and confused. I was being physically, mentally and emotionally abused. I should have left sooner but I did not know how. I was worried about my family and what they would say. But finally I had to leave and I just did it.

Many times I felt I was lost and did not know who I was anymore. I had changed and I was lost. I did not know anything, but when I started to come here and do the art I remembered who I was and thought I am not completely lost.

Case II– Devi

Background Information

She had attempted to take a French language class and described how difficult it was for her in class:

मैं एक फ्रेंच वर्ग ले रहीं हूँ. और मैं बात नहीं कर सकती । मैं बहुत घबराती हूँ. । मुझे पसीना आती है, और मेरे दिल को इतनी तेजी से धड़कती है. मैं इतना बेवकूफ लगती हूँ.। जब मैं आईने में देखती हूँ. मैं अपने आप को नहीं पहचानती. मेरे पति ने मुझे इतनी बुरी तरह से व्यवहार किया वह; वह मेरे साथ इतना बुरा किए ।

I am taking a French class and I cannot speak. I get so nervous I start sweating and my heart beats so fast. I look silly. When I look in the mirror I do not recognize myself. My husband mistreated me so much; he did such terrible things to me.

मुझे थोड़ा सा बदलना था इसलिए कि मैं अपने दम पर बातें कर सकती थी। मैंने कभी अकेले कुछ भी नहीं किय । मैं हमेशा अपने घर में अकेले थी। मुझे बाहर जाने के लिए डर बन गया था।

I had to change a little bit so that I could do things on my own. I never did anything alone. I was always alone in my apartment. I became afraid to come out.

वह मेरे साथ अच्छ नहीं थे और मुझे चोट पहुंचत । मैं उससे पूछने की कोशिश की , की आप ऐसा क्यों किए लेकिन उन्होंने कहा कि मैं बेकार हूँ । तो अब मैं उसे विश्वास करती हूँ । अब मेरी आवाज बाहर नहीं निकलती

He was not nice to me and would hurt me. I tried to ask him why but he said I was useless so now I believe him and I have trouble speaking. My voice won't come out.

Devi related the abuse in her life to her view of her body image:

मेरे पति ने कहा कि मैं आकर्षक नहीं हूँ और वह मुझे ताने मारते तो फिर मैं यह विश्वास करना शुरू की । जब एक व्यक्ति को हर समय अकेले रहना है वे पागल हो सकते हैं।

My husband said I am not attractive and he would taunt me. So then I start believing it. When a person stays alone all the time they can go crazy.

मुझे लगता है कि मैं लोगों के साथ सहज महसूस नहीं कर सकती हूँ , क्योंकि मैं कैसी लग रही है, यह मैं नही हूँ । मेरा शरीर बहुत कुछ सहा है।

I feel I am not comfortable with people because of how I look, it is not me. My body has suffered a lot.

अब मैं अकेला हूँ और पारंपरिक कपड़े अन्यथा मुझे लगता है कि हर कोई मुझे देख रही है नहीं थे. अगर मैं अपने देश में था क्योंकि मैं अब एक मग़रिबवासी की तरह पोशाक जा कभी नहीं हो सकता शादी ।

I am alone now and don't wear traditional clothes; otherwise, I feel everyone is looking at me. If I was in my country I could never be married because I dress like a Westerner now.

Devi also often listened to sad Hindi songs. She was not motivated to do anything new. She needed prompting and needed to be told what to do. She was unable to make decisions for herself and constantly asked her support worker what to do.
Devi had neither employment experience nor any financial resources.

Session 1: A safe place
Devi: *I studied so much and got a good education and my parents were happy. I miss them and my baby sister. She always wonders where I went, see here it says that. I found it in the magazine.*
I can see my future like this side and I can feel free and happy but where do I go? In the community here someone knows someone so I have to stop going to the public places. Then my parents have asked me to remain here and if I go back to my country I will be killed and this is what my husband told me. In my country we are not able to leave our husbands; it is our duty to stay with them. Once we get married, we are part of the husbands home not our homes. Like the expression, daughters are strangers in their homes. In my culture we are taught to be a good daughter-in-law and wife, it is the daughter-in-law who must maintain the peace of the family.

Therapist: *It is a cultural belief in many Indian families, that daughters become the daughters of their in-laws…once married she becomes a member of another family.*
Devi: This is why I am afraid to go to the area I lived in, here in Montréal. I don't use the metro because I am afraid I will see him and he will say I have to go back with him…because I belong there…there I am stuck in my home. I go to class and then I come home and I am always alone it is lonely. I don't even like television anymore.

Session 2: the uniqueness metaphor
My husband use to tell me that. But hitting is better than his words. . . . When you get hit, you get hit and it hurts for a while and you know you won't feel it after, but the mental abuse stays with you. The words he would say to me, hurt me a lot, I feel like nothing, I am nothing. . . . He would yell at me and tell me I was stupid, that I was an idiot, and it was my fault. He kept on saying how ugly I am, how disgusting I am, how he hates to look at me.
On the reverse side of her image she drew a picture of her husband shouting at her while holding a "mike" (microphone) to her ear. The bottom half of the drawing represents his words used when yelling at her. *"See on the back this is him shouting at me and here at the bottom are his words."*

Session 3: self-portrait
I never use to be like this, he made me like this and I feel angry at myself . . . he use to belittle me, cursed at me, and found faults with me and as time passed it became more frequent. He abuses alcohol and in the beginning I thought it was related to stress but we don't drink in my religion. But I know now that it is about control. . . . I learned about the cycle of violence with Sharon. He has threatened me, tells me that his behaviour is my fault, calls me names, and tells me that I need to be a better woman. He told me that he is the head of the family and I need to listen to him, and should know my place as a woman . . . look at me, look how I look, I dislike my face, my body. . . . I do not understand. Here the workers were saying that this is abuse…why do we except this in our culture…everyone is fine with this…

Therapist: It is a form of abuse and you are right is questioning why our culture accepts this form of abuse as the norm. In many Indian communities it is accepted as women are taught from a very young age to be submissive and accept how they are treated in order to maintain the family reputation within the community…

Devi: *But in doing this we have to suffer…look at what has happened to me…*
In discussing her experiences with the therapist, Devi continued to express how much her husband's behaviour affected her:
Yes it really affected me. And see I am still so upset, why did he do this to me? What did I do to ruin his life? He chose to marry me and brought me here. Why, if he was to do this, why? I can understand your frustration and pain. . . . I have no one here. I met a worker here who is helping me but that's all. It is so hard. . . . I had no one; I use to sit alone in my house waiting. . . . Yes and I had nowhere to go because I had no money and he would not give me any either.

Session 4: mural – symptoms of embodiment

I made this a house because my home was empty. He would only buy bread, milk and nothing else. All day this is all I had to eat for two years…and I never said anything because I was afraid.
The therapist engaged Devi in further discussion on her feelings. She expressed feeling anxious and how she had become accustomed to staying indoors.
I became so afraid to go outside; even the light bothered me. . . . I never was like this before; I do not know what happened to me. (Crying)
I get headaches so terribly all the time. I can't even look at the light. I have to stay in bed all the time. I can't speak to anyone. Look how long it takes me to talk to you."
(Crying)

Session 6: my body
With her eyes looking down, she softly spoke with hesitation:
They are what I believe and feel: Isolation, no communication, I have no money; I have fear of being ostracized within the community, physical abuse, the unknown, fear of deportation, and no trust.

She then elaborated on her artwork, first writing it down on a piece of paper and then stated:
I have headaches and then my throat keeps my voice inside. I try to speak but I can't. I am so afraid especially when I go somewhere new and then I feel like such a dummy…how can I live this life, why am I living this life….I do not want to live.
Devi emphasized not being able to use her voice and noted the two places in which she felt pain: her head and her throat:
My head hurts, yes, but my voice gets stuck and I start shaking so I don't speak because I am afraid.

Sessions 7 and 8: body casting
Devi made a cast of a head and neck to represent her pain and discomfort (Figure 16). She chose to use a part of the mannequin. She chose to decorate both sides of the cast. One side to represent the healthy side of her and the other side to represent her experienced pain.
As she attempted to work on her art piece Devi stated:
I never did this before; I am making the head to show my headaches. I always have pain in my head it is terrible. . . . I feel so nervous and anxious when I have to speak…I get so afraid and I feel like my voice is stuck in my throat.

Upon completing her art piece Devi stated:
Okay. . . . But don't laugh at it if it looks strange. . . . I don't know how to do this.
Sessions 9 and 10: the recovering body
I want to look like I use to, young, my age. I have so much suffering and pain. I know that none of this is okay and I know that what he is asking of me is impossible. I know what he is asking is wrong. And I know that what he has done is wrong. It has affected me so much this is why I look like this but this is what I want to look like. Maybe one day I will look better. Look at my body it is so ugly now. I can't even look at it. But in my heart I still care for him and hope for change. And in some way, I keep thinking that if I had said the right thing or maybe not given him an impression that he could control me, our relationship would be what it should be. But what else could I do I was dying there and how much more could I take.
Therapist: *what would be the right thing to say to him?*
Devi: *I do not know, I tried to reason with him…I know there is nothing else to say but I wish I was able to make my marriage work. It affects all of my family…not just me…my family's reputation is ruined…"*
Therapist: *There is a cultural stigma, you are right about this, but have you spoken to your family members about this, how they are and if it has affected them?*
Devi: *I have and this is why I can not go back home because it is not acceptable…*

Session 12: Termination
I also know that if I truly let go and keep filling my life with good things, this will pass. So, I ask myself why I keep thinking of these thoughts and keep believing his words. I just want to be happy like I was before. I know he was wrong but I still like him…I will live my life and I know how to do it now. I learned so much here, but I still don't understand why he ruined my life…I did everything for him and I am still alone. Because

of me, my family is also suffering. I cannot even go back home as I will not be accepted there. I tried to stay with him and do what my mother told me I should but I could not do this any more.
Therapist: You are very justified in feeling the way you are, but you have to realize that you can not change people…
Devi: I know because I did try to change him…or hope he would change…
Therapist: But at least you have made a change for a better life for yourself…despite the pressures of your culture, traditions, and values. You did try to make it work for as long as you could and you also tried very hard to follow and respect your family…

Case III – Jaya

Background Information

मेरे पति मेरे मजाक हमेशा करते थे । उन्होंने कहा कि मेरे शरीर पुराने माताओं के शरीर जैसा है एक जवान औरत जैसा नहीं । पहली रात पर वह बोले कि मेरे छाती बड़ा है और एक बूढ़ी औरत की तरह बदसूरत है और हँसना शुरू कर दिए।

My husband made fun of me all the time. He said I had the body of old mothers, not a young woman. On my first night he said my breasts were big and ugly like an old lady and started laughing.

Although finding it difficult, Jaya made attempts to adopt the Western culture while maintaining her traditional values and customs. She made attempts to fit in with the women at the shelter.

मुझे सब देखते है इसलिये मैं कोशिश कर रही हूँ की मैं अपने खुद की कपड़े नहीं पहनने।

I am trying not to wear ethnic clothes because everyone stares at me.

Jaya was able to care for her children when they were at the shelter and was very warm and caring towards them.

अगर मैं अपने पति के साथ करीब होने की कोशिश की वह मुझे धक्का दिए...मैं अच्छी नहीं हूँ ।

अगर मैं अपने पति के साथ करीब होने की कोशिश की वह मुझे धक्का दिए...

Then if I tried to be close with my husband he would push me away. . .

Session 1: Safe space

Jaya: *I made a picture of my home where we had a river in front and trees. I use to pray every morning to this tree that was there in the garden it was a "tulsi" tree.*
Therapist: *Yes, I can see how happy you were. And the tulsi tree, the tree associated with purity and is considered highly sacred and is used for all religious purposes among Hindus.*
Jaya: Yes. Everyone has one…
Therapist: *Yes they do, it is considered very auspicious to have a Tulsi plant in the front yard of many Hindu households, and Hindus worship it in the morning and evening…*

Jaya: *And a household is considered incomplete if it doesn't have a tulsi plant. The tulsi is planted in a structure like this [pointing to her image]*.
Therapist: *And it has images or symbols of God on all four sides…*
Jaya: *Like I have tried to make… I still wear Tulsi beads given to me from a yogi to purifying my mind, emotions and body.*
Therapist: *Yes, Tulsi beads are always worn by yogis and spiritualists in India…*
Jaya: *Yes, you understand why I am wearing this…it's good you understand me.*
Session 3: self-portrait
The therapist asked Jaya what she was thinking. Jaya stated:
Before I was afraid to speak and to say anything to my husband because he used to get so angry. He would start pushing me around and he would grab my upper arm and drag me. He would bruise my arm every time he grabbed me like that…he was never happy unless he was beating me up. As time went on things got worse. When he would go to work he called my place of work several times during the day to check up on me. He told me not to talk to anyone, just do my work. . . . And I did all the housework and cooking myself.
Jaya completed the first self-portrait and continued to speak:
I left my family in India for a new life with my husband. . . .moving to Canada, the abuse began.
She began to colour the face. Firmly she pressed the pastel and continued to speak:
It started with verbal abuse, and then escalated to physical abuse…there were a number of obstacles to overcome. I did not know where to go. Language barriers, immigration status, I didn't have my work permit or health card. I had no family here. No friends. So I went to the police and they said to live in a women's shelter, where I could get help to change my life. I could get support and not be afraid. . . This is me now. But I look worse now than I did before.
The therapist further explained to Jaya that she could focus on what she was comfortable with and was not obligated to speak about anything that made her feel uncomfortable.
Jaya expressed understanding the process and stated:
I am worried what people must think of me, this is my second marriage and I am having problems again. I was living happily but then I thought I have a long life ahead of me and my family also supported my marriage so I got married. Already I have put my family to shame…But I did try to live and attend to my husband…

Session 4: mural – symptoms of embodiment
Jaya's list of some of the psychological or emotional symptoms of trauma included;
I feel sadness, fear, loneliness, pain, I cry a lot. I feel like I have to live such a long life all by myself and by thinking of this I get headaches and I just want to sleep…I feel pain in my back a lot all from the top to bottom, why did he treat me so terribly?
I felt in doing so, Jaya felt validated and accepted as she would pause and stated:
You understand what I am saying, how can I even say anything to anyone after everything I have already gone through in my life? This is my second marriage; I had to try to make it work. What will people be thinking when they find out. You can understand…
Therapist: I do understand. You tried everything to make it work and you are correct in wondering what others will think as there is a cultural stigma that follows you when you step out of the expectations of tradition and culture.

Jaya: And women have to be very different in India…passive, submissive, anything can happen but we have to hide everything…this is how it is in India…
Therapist: They do, passive, submissive, loyal to the family despite what may be happening to her…in India culture plays an important part in defining the role of women…
Jaya: I am supposed to be Sita…but it does not matter who my husband is…every home is like this, woman are suppose to bow down to men and completely devoted to their husbands.
Therapist: That may be so in many households where women are expected to be Sita, completed devoted to her husband regardless of what she has to endure…
Jaya: Then it should be the same for men also, they should be like Rama…but who follows all this…I just don't know anymore…I became ill because of all this…

Session 5: past, present and future image
Jaya immediately spoke about the circumstances of her artwork:
I am happy to be on my own and away from my husband. See I put this picture of a shark biting his head – this is him. I love children and I want to live in a nice community where no one talks about you. In my community, everyone talks about you and I am so sad by what people think about me.
Therapist: *Yes I know about the cultural stigma. Do you remember we discussed this last week?*
Jaya: Yes I do.
She proceeded to elaborate on her artwork and while gluing on the images she remarked:
I am a girl who does nothing, just take care of house work…I am just somebody…I hope I can be…I don't know…maybe someone who is happy. But my husband ruined my life.
The art therapy task alerted Jaya to the several roles she played in her life and to the diverse changes she had experienced. I asked Jaya the question," What can you tell me about yourself?" She stated:
I was always a sensitive and soft-spoken person. I never got upset at anyone and always respected people for who they were…but I was happy like everyone else, I was doing my work. But later when I came here I slowly, slowly, changed. I was not able to feel confident and anything I did was not good enough. I had to ask permission for everything like a child does. I was also so afraid of this place, the people, not knowing anything about the culture, the language so I stayed home a lot. Then slowly I went to the temple and made friends with my own people…after marriage I was so afraid and then I got into a depression and was always sick…I had headaches, body aches…I was afraid to leave my husband but for my children I had to…but I could not…but then I did.
Jaya described how she wanted to show in her artwork, how she was simultaneously frightened to stay in her marriage and to leave her marriage but could not find the images to represent this.
Jaya focused on a picture of a neighbourhood with homes, suggesting that she felt isolated from her community, where no one spoke to her and she lost contact with friend. I noted how the image was similar to an earlier story she had told me about herself. I asked her to describe what she had created. Jaya explained how the picture was similar to her, empty without people. She was afraid of what her family and community would

think of her. Jaya feared about the impact of being ostracized from the community and worried about the impact it had on her children and future of her children:
I am afraid for my children and the hard life they have…I took them away from my husband because it was not a good life. I will make a better life for them. Here they can go to school and not worry about things like we have to in India.
Therapist: *I am sure you will make a wonderful life for them…and in India, although society may have changed their thoughts about marriage and divorce in many areas, you are right in assuming that they are better off here as you know your family and friends best.*
Jaya: *They will be labelled as the children of a divorced mother…from a broken home…I can live with the thoughts about myself but I do not want to put my children through this, and my relatives and friends there will definitely not accept them…*

Session 6: my body
As she created her art she stated:
I made back pain here because it is what hurts the most...I felt vulnerable and fragile after the abuse incidents. I would want to isolate myself and stay in the house because I had feelings of shame and very little self-esteem. When I did eventually leave the house for a walk, even though I was being watched, I would suffer from panic attacks and feel very self-conscious, which would make me want to hide away even more. The effects of abuse were low self-esteem and fear. I lost all my confidence and it affected all my relationships. I found it hard to trust people.

Sessions 7 and 8: body casting
Jaya stated:
I made this section to show the good side when I was not married and now what happened to me. I put words because I cannot make it. The good side says happy, healthy, free, secure, and confident. The other side which shows the bad side of my life says no financial support, low self-esteem, fear, and nowhere to go, reputation, abuse, isolation, suffering, pain, unhappy, headaches, and backaches.

Sessions 9 and 10: the recovering body
Once this was done, Jaya began to engage in the art task (Figure 24).
While thinking of a body that would symbolize her journey from abuse to recovery, Jaya stated:
This is how I live every day of my life in fear. This is the reality for me because of my husband's abuse. I felt powerless, fearful and intimidated. He used to scare me so that I remained quiet and obedient. I use to feel afraid of the consequences if I was to leave but now I don't. I can finally live my life. But sometimes I still feel very sad and don't want to do anything. I am safe now but I lost so much time and don't know how to do anything any more.

Jaya explained she was still feeling the pain of her trauma and worried about her future. As well, she had the awareness of requiring more time to heal. *"I will get better slowly, it will take some time*."

Session 12: Termination
In her discussion of her overall experience of the art therapy meetings Jaya told the therapist the following:
Jaya stated:
I was very insecure, and I showed to the world a different side of me, but behind all of this I felt scared, insecure and very unhappy. The way I talked to everyone at home it was a show to hide away my insecurities because I felt if I exposed myself, people wouldn't accept me and that me and my family would be judged… The abuse made me feel like I was worthless.. But he did not care about me. I was always alone. I still feel sad and afraid and that I am not worth much. I still have pain and headaches. My back hurts, but this all continues to happen. I am trying to live an independent life where I can be happy…I think with time I will be better…I learned from the art…

Supplemental Information:
1. Jaya: *The people I know here [referring to her family and friends in her community] can only see my situation from an Indian background and give me their thoughts, telling me what I am doing is wrong. Then I feel angry at them, but seeing you [therapist] helped me.*

Therapist: *Helped you…*

Jaya: *I come to you [the therapist]… and you listen to me, show you understand my reasoning... I just need some emotional support, someone who can understand me.*

Therapist: Yes, of course.

2. Participants also made explicit links between cultural issues and their interactions with their therapist during the second interview:

Jaya: *I feel that in Indian families there is always a taboo view, where you do not discuss your feelings...*

Therapist: *Yes you are right in believing this, because this is true of many Indian families. Izzat is very important in Indian families…*

Jaya: *I think it is for the best that you are the same as me... I feel comfortable…at first I thought I would feel uncomfortable because I thought you would think I am wrong, but then I knew you won't think like that because you are helping me and you are different from the people I know. You understand why I have left….*

Therapist: *I am happy you feel this way and are comfortable coming to the sessions…*

Jaya: *Yes, because I know you can understand and it lightens my burden to come and work through my problems…it is true that I carry power and bring fortune to my family like Godess Laxmi but I [smiling] am not a God!*

Therapist: *I can understand…*

Devi expressed: *I am coming to therapy, because I can not talk to other people here... I think that you [the therapist] fully understand why I can not approach others about things like my in-laws or family because of our culture.*

Therapist: *Yes, I can understand your reasoning and of the differences between the western and Indian culture.*

Raina: Raina: *You helped me realize my culture more…my actual cultural situation… before I felt guilty about going against my parents.*

Therapist: *I helped you realize your culture situation…*

Raina: *Yes, I tried to live out their dreams and expectations and did not even realize that this was culture…I mean I did, but then I did not make the connection until we discussed it. You can understand my situation and what my family is like.*

Therapist: *Yes I do understand…and I am happy you were able to make the connection through our discussion on culture.*

Raina: *Yes…now I really see why my parents do the things they do and why I now do not feel guilty about feeling angry at them…I knew Indians do this but it was just what we are suppose to do. Make the connection to culture, expectations and all this is something you do not really think about.*

In addition, Jaya spoke about the stigmatized nature of expressing emotions:
It is good that I have therapy in Hindi because I have a better emotional vocabulary in Hindi, and because Hindu culture does not encourage people to talk about emotional things, and near men… [Pause, with eyebrows rose]."

Therapist: *Yes, you can not speak about emotional concerns or feelings within the Indian setting because of the values they have and because of the value placed on a gendered society in which there is male domination…*

Jaya: *And even if it is important they do not care to even ask…they treat women badly and expect us to still be happy…we just do not talk, we are not encouraged to talk about our emotions.*

Therapist: *Yes, not encouraged to talk about feelings…*

Jaya: *It is hard, we are people, not animals, and people learn to even love animals… Our people, you know what they are thinking…that to obey your parents and family no matter what…then it is good behaviour…I feel uncomfortable discussing with such people…*

Therapist: *You feel uncomfortable to talk about your parents and family with such people…*

Jaya: *Yes, I do not want to. I know they will talk ill of me so I do not want to talk about my life to them…here I feel open, when you say "let's what happens"', I feel like talking about everything…but somehow if it is an Indian person from the community who does not understand the ways life should be lived; being nice to people, and treating them well, then I will think "what should I tell them?" 'Should I say this or that?"*

Therapist: *Yes, I understand what you are saying about individuals from the community and their cultural perspective…they also have cultural expectations.*

3. There were also non-specific changes within the art therapy program that could be identified by both the general, and at times vague, language used by the participants, for example, when expressing feeling worse or feeling better. As seen with Devi, she described: feeling bad and desiring to be with her partner, but because she had gained some new awareness of her distress, she judged that she had experienced positive change by the end of therapy. Towards the middle of the art therapy program, the women noted that they began to feel better when in the art therapy session and anticipated the following week's session. However, this may not be specifically related to the art therapy or the resolution of the specific problems itself. Instead, it seemed to be a change influencing how the women felt as a result of taking part in the art therapy and feeling comfortable with the therapist. As described by Devi and Jaya, they felt their problems did not feel as overwhelming and felt better when with the therapist.

Devi: "जब मैं तुमसे मिल हूँ पता नहीं क्यों मुझे अच्छा लगता है। मुझे लगता है कि मैं अपने लोगों के साथ हूँ ।"

When I come to see you, I don't know why I feel better. I feel like I am with my own people.

Jaya: "मैं तुमसे मिलके खुश हूँ । आप मेरी समस्याओं को समझते हो और आप मेरी मदद कर सकते हो । मैं यहाँ अकेले हूँ और केवल आप मेरी भाषा में बात कर सकते हैं । मैं हमेशा आप का इंतजार कर ति हूँ इस तरह से मैं आप से बात कर सकति हूँ..."

I am happy to meet you. You understand my problems and can help me. I am alone here and only know you who can speak my language...I always wait for you to come so that I can speak to you…

4. Therapist viewed as and carries out the role of an professional seemed to be consistent with the womens value system. This is indicated by two participants who valued the therapist's educational and professional background:

Raina: *I had gone to school hoping to become a teacher…but unfortunately…you are lucky to have a higher education and a profession that is respected. Then you don't have to worry about what others have to say…I would like to someday go back to university and complete a degree similar to yours…I would really impress my husband's family!(laughing).*

Jaya: "आप कनाडा में पढ़ती थी...अच्छा, आप एक अच्छी शिक्षा है...फिर तो आप को सब कुछ पता होनी चाहिए...तो आप मेरी परेशानी को समझ सकते हो..."
Did you go to school in Canada...oh, you have a good education… then you must know everything… then you can understand my troubles...

5. One participant, Jaya, had expressed visiting a *pundit* (spiritual leader) for support for her difficulties, as she had in her country of origin. She had a strong belief in spirituality. Even after coming to Canada she often visited her temple and sought support through spiritual ceremonies and teachings. As time passed, Jaya felt let down by her spiritual dedication and beliefs as a result of her abusive experiences. In discussing her karma in the therapy sessions Jaya came to the realization that her ambivalence and disappointment were natural reactions to her circumstances. She still had faith in her spirituality:
मैं सोचती थी यह क्यों हो रहा है? मैं गुस्से में थी क्योंकि मैं भगवान कापूजा हर समय कर ती थी और यह सब हुआ...अब मैं ठीक हूँ, लेकिन मैं बाद मैं चली जाऊँगी क्योंकि मैं कई लोगों को मंदिर मैं जानती हूँ ...
I wondered why is this happening. I believe in God, I pray all the time...I was angry because all this happened to me...but now I am okay but I will go to the temple later because I know many people there...

6. Raina stated, "*You understand what it is like to grow up with such pressures and expectations. I am sure your family had the same beliefs as all Indian people do." We can't be expected to be like characters in make belief stories…Sita is just a character not a reality…we can choose who we can be like from any story…*
Similarly, Jaya expressed her comfort with the therapist: "मैं खुश थी जब मैं तुम से मुली क्योंकि मैं केवल एक भारतीय को जानती हूँ ।" *"I was happy when I met you because I know only one more Indian lady here."*
However, based on the discussions I had with the participants, initially there was some uncertainty and hesitation to participate in the art therapy program. One participant in particular, Raina, was resistant to the therapy and found some sessions very intense. She did however, continues to attend the sessions and accepted the program directives and feedback from me.
Devi, was hesitant to participate in the study despite expressing satisfaction with the shared cultural background. Devi had concerns that her difficulties would be revealed within the community and was hesitant to speak about herself during the first semi-structured interview. Her ambivalence and reluctance about seeking help from me as a professional, as someone from her community, appeared to revolve around issues of shame, concerns of a same ethnic therapist knowing common individuals in the community, and confidentiality: "लोगों को पता होगा कि मैं मुश्किल मैं हूँ ।*" "People will know that I am faced with difficulties."* Yet, after being reassured and becoming familiar with the therapist, as with the other participants, Devi's trust was slowly gained:

Devi: *When I first learnt to name the feelings I had when I was with you [therapist] I felt good that I was able to say it…you know how it is in India, you can not say anything if you are an Indian, especially in India.*
Therapist: *Yes, it is different there. You have to follow traditions…*
Devi: "आप जानते हो कि यहाँ के लोग हमारी संस्कृति समझ में नहीं होगा, शायद तुम मेरी समस्याओं की व्याख्या कर सकते हो । तुम मुझे समझ सकते हो । आप हमारी परंपराओं जानते हो।" *"You know that the people here will not understand our culture; maybe you can explain my problems. You can understand me. You know our traditions."*

7. The families of the women influenced many of the womens choices and kept them grounded in traditional family values as described as uncomfortable by the women. Raina shared a similar mindset and confirmed the strength of the South Asian family in the following passage:
When we get married we are expected to live with and serve our in-laws and our husbands. It is a respect for the family. Sometimes I did not want to respect them but did because if I did not, it would reflect on my parent's upbringing and they would be put to shame. (During this instance Raina spoke only in English).

8. Devi – In relation to therapist:
आप यहाँ रह सकती हो तो शायद मैं भी यहाँ रह सकती अपनी रिवाज के साथ इन लोगों के बीच । आप मेरे जैसे हिंदू हो । मैं अपने आप को बदल सकती हूँ और किसी भी तरह रह सकती हूँ । जब मैं घर छोड़ कर यहाँ आ गई, तो पहले से ही बदलने की कोशिश की हूँ । जैसा उम्मीद रखा जाता अपने लोगों के साथ मैं उनके जैसे अब नहीं रह सकती ।
You are like me and you are able to live here so maybe I can also live here with my values and learn to live like people here...I can change myself so I can live somehow, I already made a change when I left. I don't have to be perfect like my people expect and I know I can be strong like other women. I pray to Godess Kali to give me power so I can be strong. I care for my husband but I want him to also die. This is bad to say but I feel this...

LIST OF GLOSSARY

Agni-Pariksha: Witness by fire to attest to purity as a devoted wife (Mookerjee, 1988).

Arranged marriage: A tradition in which parents or the elders in the family, propose and settle the marriage of their son or daughter within their specific caste or ethnic community.

Brahmans: Highest caste within the hierarchy of the caste system; commonly identified with priests and individuals engaged in scriptural education and teaching.

Caste: A social hierarchy that dictates status, marriage, and occupation in the Indian culture.

Cultural Hybridity: The abandonment of an identity defined by an individual's prescribed race, and the embodiment of a pluralistic identity encompassing elements of both.

Culture of honor: A culture in which the actions (positive or negative) govern the behavior of its men and women.

Custom: Traditions taught by one generation to the next; practices maintained by societies.

Dalits: See Harijan.

Dowry: Is a custom in which the brides parent's offer, money and gifts to her husband and his family in marriage.

Duppate: Traditional scarf worn by women.

Durga: In Hinduism she is the Goddess who can redeem during situations of extreme distress. She is depicted as having ten arms, sitting on a lion or a tiger, carrying weapons and a lotus flower, maintaining a smile, and displays symbolic hand gestures (Mookerjee, 1988).

Funeral pyre: Is a structure made of wood, for burning a body as part of a funeral rite. The body is placed on top of the pyre that is set on fire.

Ghoonghat: The veiling of one's face.

Gujarati: An individual from the state of Gujarat in India.

Guru: A spiritual leader

Harijan: Known as the *"children of God"* by Mahatma Gandhi. Previously referred to as the untouchable caste and associated with jobs such as toilet cleaning or garbage removal.

Henna: Is used to stain the skin with designs and is used in rituals for weddings. Traditionally in India, brides henna is known to be the lasting love between a husband and wife.

Hindi: The official language of India.

Hindu: An individual whose religion is Hinduism; relating to Hindus or their culture.

Hindu-Punjabi: A Hindu person who is from the state of Punjab in India.

Hybridity: Is referred to a cross between two separate races or cultures.

Izzat: Translates to honour; it has multiple connotations and overlapping meanings, relating to respect, honour, esteem, dignity, and reputation. Inherent in the code of honour is a constant striving by individuals and groups to maintain honour and at all costs to avoid shame [*sharam*] (Gill, 2004).

Kali: Kali is the fearful and ferocious powerful mother goddess (Mookerjee, 1988).

Karma: The force generated by a person's actions held in Hinduism and Buddhism to determine the nature of the individual's next existence.

Kathak kali: A famous dance from the south part of India.

Kaurva Chauth: A traditional ritual fast ceremony in India that is meant to prolong the lives of husbands.

Kshatriyas: Second highest caste in the caste system in India; associated with rulers, warriors, property owners.

Laxmi: Hindu Goddess of wealth.

Mahabharata: The Indian national epic about the Great War in northern India.

Maternal holding: A term referred to as the mother or caregivers, ability to physically and emotionally hold the client through containing, receiving, and giving (Slochower, 1996).

Nazar: Evil eye.

Parihas: See Harijan.

Parvati: A Hindu Goddess; the kind, giving companion (Mookerjee, 1988).

Pativrata: Translates to husband worshipper.

Pundit: Spiritual leader.

Punjabi: The official language of Punjab, India.

Purdah System: Translates to "curtain or veil." It is the system of gender segregation, practiced by keeping women in seclusion (separate from men and strangers).

Rama: Hindu God; known as a model of reason, virtue, and right action (Mookerjee, 1988).

Ramayana: Hindu epic of the Hindu religion and of classical Sanskrit literature that tells of the adventures of Rama, an incarnation avatar of the god Vishnu (Mookerjee, 1988).

Sada suhaagan raho: Translates to "always remain married."

Saree: Traditional South Asian Indian women's clothing that consists of several yards of cloth draped around the body.

Sati: The self-immolation of a wife on her husband's funeral pyre.

Satyavana: Husband of Savitri the Hindu Goddess (Mookerjee, 1988).

Savitri: Hindu Goddess; portrayed as the dedicated, unselfish and loyal wife (Mookerjee, 1988).

Self-sacrificing: The act of being unselfish; the act of giving up personal needs or desires, as a sense of duty or to benefit others.

Shakti: Translates to power; it is the principle underlying feminine energy that is necessary and complementary to the masculine principle. Both are co-dependent and have comparatively equal status. Shakti is embodied in several Hindu goddesses.

Sharam: Translates to shame; A feeling of being exposed, scrutinized, and judged negatively by others (Tangney & Fischer, 1995).

Shiva: In Hinduism, Shiva is a deity, worshipped as the god of destruction (Mookerjee, 1988).

Shudras: Fourth caste in Indian caste system; linked to the semi-skilled and unskilled labourers.

Sikh: Member of Indian religion.

Sita: Devoted wife of Lord Shiva; portrayed as the ideal Hindu wife in Hindu mythology (Mookerjee, 1988).

South Asian women: Immigrants from the Indian subcontinents that identify themselves as Indian who have their traditional roots from India.

Spiritual belief: Relating to the spirit; to religious or sacred things instead of worldly things.

Therapeutic Container: The experience of therapy in which the therapist serves as a container for the client's emotions (Gabbard, 1990).

Therapeutic holding: The therapist's ability to emotionally hold the client through containing, receiving, and giving.

Therapeutic space: A protective and safe space that allows the client to heal and grow.

Tulsi: A plant worshiped by Hindus and a significant symbol in the Hindu religious tradition.

Urdu: Official language of Pakistan; also used in India.

Vaishyas: Third caste in the Indian caste system; engaged in commercial activity (businessmen).

Varna(s): Translates to "class" within India's caste system, i.e. the caste system has four main classes (varnas).

Yama: Is known as the Hindu lord of death (Mookerjee, 1998).

Yogi: A guru or spiritual teacher.