TRANSFORMING THE POSTTRAUMATIC SELF: A HEURISTIC ARTS-BASED UNDERSTANDING OF IDENTITY AFTER CHILDHOOD MEDICAL TRAUMA

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ABSTRACT

TRANSFORMING THE POSTTRAUMATIC SELF: A HEURISTIC ARTS-BASED UNDERSTANDING OF IDENTITY AFTER CHILDHOOD MEDICAL TRAUMA

JADE ANNE WILLSHAW

This research paper investigates how visual symbolic forms in an arts-based self-inquiry can help redefine identity in a posttraumatic self, from childhood medical trauma. There is little research on childhood medical trauma's impact on identity, especially in creative arts therapies. The researcher used Moustakas (1990), six-phase model to explore her childhood medical trauma through an arts-based process. She created arts-based data for an intensive seven-day period, using imaginative dialogue, art, and body awareness to explore her medical trauma. The analysis brought surfacing imagery, such as; hands, infant, womb, and medical spaces. The themes found in the dialogue were identified as follows: imagination, transformation, connection, inner and outer dialogue. A creative synthesis was generated, highlighting the process and change through new connections. The outcome was a transformative process, changing the researcher's awareness concerning her identity and her experience of childhood medical trauma.

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Introduction

This topic of research has been fueled by my experience of childhood medical trauma. When I was nine months old, I had a stroke causing physical impairment to the right side of my body, leaving me with a movement disorder. As a child, I spent countless hours in hospitals and rehabilitation centers, which reinforced my traumatic body and medical trauma. It was in these medical spaces, that I felt most conflicted about my traumatic body, as it was often an object of intrigue and at the same time was violated with testing. However, I remained resilient and determined to do what others did, adapting, taking on the challenges that life brought. It had often occurred to me that this perceived negative event may have shaped my identity.

I questioned who was I in relation to the childhood medical trauma. Did I integrate it or did I repress it from my identity? What role does trauma play in the formation of identity in individuals who have had medical trauma in childhood? These thoughts formulated my research question*: How can visual symbolic forms in an arts-based self-inquiry help redefine identity in a posttraumatic self, from childhood medical trauma?* Ganzevoort (2008) states that "the disrupting power of traumatic experiences calls for profound reflection on the meaning of trauma for identity" (p.19).

For years, I have been exploring my posttraumatic self in my private art practice as a form of introspection and self-discovery. The posttraumatic self or, posttraumatic identity is considered a symbolic term, defined by the rebirth of identity, with movement towards wholeness after trauma (Wilson, 2007). As Wilson (2007) further describes, "The transformation of traumatized internal psychic states is a symbolizing process that balances the polarities of self dimensions" (p.69). Art has always served as a means to safely confront unaccepted aspects of myself, particularly my medical trauma through artistic body representations. The images in my artworks continuously brought discomfort and an element of introspective symbolic

representation, of living in my posttraumatic body. In this research, artistic processes will be utilized to further my inner dialogue with my post-traumatic self. This is the basis of the fact that art has always been positioned to offer a form of reparation, integration, and mastery of even the most disturbing traumas. It is through imaginative transformations, that change can occur on a conscious level. I am using Jung's active imagination method as a means of transforming the self through art, though I am calling it imaginative transformation.

This research's foundation lies in my passion to help others overcome their difficulties with trauma. Through this, I hope to inspire others in their own exploration of trauma, redefining identity through symbolic representations of a posttraumatic self. This heuristic arts-based research was to investigate how medical trauma in childhood shaped my identity and how imaginative transformations through art therapy can help redefine concepts of the self.

Literature Review

Theoretical contributions in psychology focusing on these key terms: trauma, identity, imaginative transformation, fragmented kinesphere, and creative arts therapies, are defined and explored in this literature review. The research was gathered using these terms, including peer-reviewed articles written within the past ten years, and some foundational texts.

Childhood Medical Trauma

Trauma is defined as "exposure to actual or threatened death, serious injury or sexual violation" (American Psychiatric Association [APA], 2013, p. 143). Medical trauma is an invasive medical procedure or a severe medical condition where frequent testing occurred in a medical institution. When these highly invasive procedures occur at a young age, the memory of the potentially traumatic experiences can impact psychological constructs of identity. Neurological disorders have significant emotional and physical effects through traumatic

experiences, such as experiencing changes in lifestyle, physiology, and quality of life (King, 2016). Most of the research illustrates that medical trauma in childhood creates many psychological issues for individuals in their developmental processes. Throughout the literature, there seems to be an overall agreement that medical trauma in childhood causes dissociation and possible dissociative amnesia (DA), post-traumatic stress disorder (PTSD), dependency, stigma, and loss of self-image impacting identity (Staniloiu et al., 2020; Bronfman et al., 1998; Chapman et al., 2001; Crawford, 2010).

In a study about how trauma affects autobiographical memory, Staniloiu et al. (2020) outline several models that describe the impact of trauma on individuals with dissociative amnesia (DA). One model of dissociation is *motivated forgetting* where there is a purposeful consciousness to forget, a process of going fully into the trauma, to the point where they actively forget (Staniloiu et al., 2020). This is a state that serves as a protective fight mode to maintain normality, but these individuals who actively forget often then feel something is missing and unresolved in their life. Another model identified by these authors is what they call *impairment in the emotional colorization model*, which is directly linked to the individual's lack of ability to integrate new experiences of the self that are emotionally charged (Staniloiu et al., 2020). Moreover, the *fantasy proneness model* suggests that individuals may use extreme fantastical recalls of the event (Staniloiu et al., 2020). Fantasy proneness refers to a personal trait that involves a profound participation in fantasy and imagination, a natural ability to act, and even sometimes having difficulty distinguishing images from real events (Lynn & Rhue, 1988; Wilson & Barber,1982). Although this model outlined by Staniloiu et al (2020) is viewed strictly as misinterpreting memory, there is power in the use of fantasy proneness as a strategy for dealing with trauma, especially childhood trauma. It has been argued that fantasy proneness may be

considered a coping skill for traumatized persons to escape from their reality (Näring & Nijenhuis, 2005). This fantastical aspect of dissociation may also be beneficial in the procedure of imaginative transformation, where the imaginative aspects are predominant in coping and processing. These three models could be applied to those with childhood medical trauma during therapeutic interventions to better understand their relationship with identity, and the gaps in treatment that may exist due to dissociative tendencies.

Those with severe trauma may use these dissociative schemes, though not all individuals with childhood medical trauma will have such severity to cause full dissociation. In this regard, Staniloiu and Markowitsch (2014) argue that "usually dissociative amnesia occurs in patients with a labile personality; frequently the occurrence of stressful or traumatic events starts already in childhood or youth" (p.2). Therefore, trauma occurring in childhood could have serious effects on the formation of identity, as dissociative fragments of memory impact the normal psycho-development, but also the physical relationship with the body. As an aspect of bodily dissociation, there are often missing fragments of the traumatized body, creating a form of disconnection. This form of disconnection renders the individual of whole-body awareness. This pertinent link to the body will be further expanded upon in the Creative Arts and Trauma section of this literature review.

In general, disconnection, commonly known as dissociation, refers to a compartmentalization of experience: elements of the experience are not integrated into a unitary whole, but are stored in memory as isolated fragments consisting of sensory perceptions or affective states (Nemiah, 1995; van der Kolk & van der Hart, 1989, 1991). Staniloiu et al. (2020) point out that there is a link between emotions and the retrieval of memory; indeed, if the individual is in a similar stress induced state due to similar stimulus experienced in their trauma,

they are more likely to recall the original traumatic event. This ability to recall the original traumatic event is due to the similarity to the way that it was encoded in the brain (Staniloiu et al. 2020; van der Kolk & Fisler, 1995). In these cases, "affect seems to be a critical cue for the retrieval of information along these associative pathways" (van der Kolk & Fisler, 1995, p.509).

Cole & Putnam (1992) suggests that the combination of gaps in autobiographical memory and continued dependence on dissociation, makes it difficult for these individuals to reconstruct an accurate account of their past or in severe cases, their current reality. It has been found that the failure to formulate the traumatic memory into a narrative, leads to intrusive elements of the trauma into consciousness in the form of frightening perceptions, fixated concerns, and anxious somatic re-experiences (Janet, 1909; van der Kolk & van der Hart, 1991).

As a stress induced phenomenon, "it's useful to consider posttraumatic impacts to the self as a complex set of factors that alter the integrated structural and functional components of personality processes as a whole" (Wilson, 2006, p.12). Trauma creates significant change to a person's representation's and modifies their adaptive patterns of relational behaviour (Horowitz, 2015), ultimately shaping their identity.

Identity

Identity is a complex and evolving concept. It can best be understood through the lens of self in relation to others. Identity is generally defined as "referring to a psychological rather than a physical being, and is one that contains thoughts, feelings, and attitudes, one that is socially validated and holds down multiple places in the matrix of social relationships" (Baumeister, 1999, p.2). However, identity and the "…self starts with body" (Baumeister,1999, p.2). Epstein (1973) found that, "If one recognizes that people have stable patterns of underlying personality

attributes inferred from their repetitive behaviour, then there is as much reason to assume that people have a personality identity as that they have a body identity" (p. 413). The concept of self and identity would have no meaning without self-awareness (Baumeister, 1999).

In recent history, identity was generally defined by stability within various social roles and attributes, including age, gender and origin of birth (Baumeister, 1999). However, a more modern concept of identity is defined by its fluidity and constantly changing ability in fast-moving society. Identity in a "modern self-definition has come to depend on a changing, uncertain mixture of choices and accomplishments, and the self is assumed to contain the values and other bases on which these choices are made" (Baumeister, 1999 p.4).

The self is seen an integral structural aspect of personality, establishing self-worth and an overall sense of unique identity. Identity is thoroughly linked with self-esteem (Adler, 2015). Self-esteem is an individual's idiosyncratic value of their own worth. How one thinks about oneself determines the formation of identity through childhood. Erikson (1968) conceptualized that identity development has both conscious and unconscious components. Both these inner and outer workings effect the trajectory and development of identity formation. Leary & Tangney (2012) contend that "the self is often viewed as playing a consciously active role in making meaning, implementing choices, pursuing goals, and initiating action" (p.155).

Identity is inextricably linked to the course of a lifespan, using narrative and memories to build a sense of self through integrated lived experiences. Erik Erikson (Mohr, 1960;1968) wrote tirelessly on how identity forms a blueprint for how we conduct, plan, and live. Identity is formed through one's own story about the self (Ganzevoort, 2008). It is an ever changing and evolving concept throughout life, events contributing to it along the way. Burke & Stets (2009) outline that identity is formed from a person's use of symbolic interaction for themselves and

with others. Identity "supposes an uninterrupted continuance of existence" (Perry, 2008, p.108), therefore can be extricability altered from a traumatic event.

Identity and Trauma

Research has only recently started to recognize that trauma in childhood can cause fractures and disruptions to the functioning and development of an individual's identity (Kirk & Madden, 2003; Scott et al., 2014). Erickson (Mohr, 1960; 1968) proposed that an important challenge in childhood is identity formation, which involves an internal struggle to develop a sense of personal identity. Waterman (2020) conceptualized that traumatic events can create different forms of identity functioning, such as; identity delay, trauma-shaped identity, and trauma-centered identity.

Identity delay is defined by Waterman (2020) as "the emotional distress engendered by the trauma whether or not it reaches the intensity of PTSD, creates an immediate priority to deal with that stress rather than continuing along the pathways in place before the event" (p.61). It has been reasoned that traumatic experiences encourage questioning and re-evaluation of current identity commitments and may foster identity diffusion (Berman et al., 2020). Trauma shaped identity, identified by Waterman (2020), is when the traumatic events form the life path and the aspects of a person's identity, defined by the very characteristics of the traumatic event itself.

Trauma-centered identity, as seen by Waterman (2020), is an identity that is highly influenced by the trauma, causing it to become the core of the person. Trauma-centered identity has been referred to as trauma-induced identity. When the traumatic event is central to the role in a person's life, it can bring both negative and positive outcomes for identity, including posttraumatic growth (Schuettler & Boals, 2011). Trauma-centered identity concerning

posttraumatic growth occurs when the individual has been able to integrate the trauma in productive ways, having found new insights from the experience (Waterman 2020). However, trauma-centered identity can also be negative, where the traumatic events are ever present and intense, often resulting in the exploration of identity to the point of hindrance in life (Waterman, 2020), extending into social aspects, goals and trajectories. These differing forms of identity functioning suggest the impact of childhood medical trauma's influence on identity, as Knox (2003) describes, since trauma alters the individual's self-perception.

Wilson (2006), in a model of posttraumatic self, contends that there are altered systems and processes involved that are impacted by trauma, such as identity types, and aspects of the self. With early disruptions to fundamental developmental stages of identity, there is a severe risk to the formation of maladaptive traits and feelings of disconnection from the self (Kalsched, 1996; Wilson, 2006). Some of these maladaptive traits have been identified as; hopelessness, helplessness, post-traumatic stress disorder, avoidance, dissociation, anxiety, low self-esteem (Wilson, 2006).

Having defined identity, trauma, and certain aspects of the complex connection between them, therein lies strength and coping through creative and protective measures. The importance of transformation through artistic means, such as imagination and creative arts, are highlighted below.

Imaginative Transformation

The term imaginative transformation can be understood through the lens of Jung's notions of active imagination and transformation. Active imagination is a method of accessing the unconscious while simultaneously acting as a function of shaping the existing symbols of the

person (Jung 1983; Jung & Chodorow, 2015). Transformation is understood as a process of inner and outer change.

Imaginative transformation involves active use of creative imagination (Winnicott, 2017) applying its "transitional space" to transform oneself through symbolic representations and play. Imagination is a powerful tool that is used throughout childhood as a means to express different aspects of the self. The child utilizes it trying to gain mastery over emotions and behavior while building identity. It is often exhibited in play and is a vital element in accessing the medical trauma from childhood and expressing it actively in the art. Children will most often replay their trauma as a form of processing through imaginative play (Bronfman et al., 1998). Nabros et al. (2013) demonstrated the importance of imagination, finding that "medical play was a mechanism for imaginal coping and working through stress related to medical experiences" (p.212). Within play, there are elements of both fantasy and imagination. Imagination is an active process, where fantasy is generated from unconscious responses to psychological need or distress. Kalsched (1996) describes fantasy as a compulsive self-protecting unconscious choice that causes psychological determents as the individual refuses to live in reality. However, Bacon & Charlesford (2018) found evidence to suggest that fantasy proneness has many facets, not all are maladaptive or linked to negative emotions.

In adulthood, imagination is often present in creative endeavors. Yet imaginative thinking can be an important aspect for accessing the forgotten, repressed inner-child. Imaginative qualities allow for a means of safely accessing traumatic material, as it brings play and childlike aspects to the process of redefining identity. This can be further extended through art-making to realize and transform painful and provocative thoughts. As Miller (2012) wrote,

"Jung conceived of fantasy as that terrain of psyche where the shekels of preconceived limits could be discarded and psyche could actually transform itself" (p.43).

Creative Arts Therapies and Trauma

In this section of the literature review, I'm focusing on highlighting the main aspects of creative arts therapies that pertain to my research question; therefore, focusing on Art Therapy and Dance Movement Therapy. Music therapy and trauma literature is a vast research field, though too extensive for this limited research paper. This research merely nods at the use of music and sound benefits as an additional sensorial aspect, rather than the main focus of the exploration. In the following, I explore certain areas within Art Therapy and Dance Movement Therapy that support creative uses in healing trauma. Therefore, aiding in my own self-exploration of inner healing through their creative applications in this research.

Art Therapy

Art therapy is a synthesis of creativity, imagination, and unconscious processes as a way of intuitively seeing oneself within a therapeutic framework, in the presence of the art therapist. In the context of a traumatic experience, it can be seen as providing a safe distance from the trauma, acting as containment in the physical materials of the art for the imaginative and verbal aspects that are intangible.

Art therapy in recent years is acknowledged as a valuable method for treating trauma (Avrahmi, 2006; Crenshaw, 2006; Gantt & Tinnin, 2009; Johnson, 1987; Talwar, 2007; Tripp, 2007). Within psychology and art therapy literature concerning the therapeutic treatment of trauma, there is overwhelming evidence for pictorial narrative therapy, and neuroscience-based approaches (Chapman, 2014; Gannt & Tinnin 2000, 2013; Tripp, 2007). Narrative art therapy

allows for a structured reflection process of the lived trauma, emphasizing the emotional state, creating a new way of integrating the trauma and understanding of the self (Carpenter et al., 2016; Gantt &Tinnin, 2007). There is often a dysregulation in emotions where significant trauma has occurred, resulting in a lack of personal insight but also a dissociation due to its severity. The Chapman Art Therapy Treatment Intervention (CATTI) is specifically intended to treat the precise medical trauma, giving the opportunity to sequentially revisit the trauma through perceptual and verbal means (Chapman et al., 2001). The CATTI is a drawing intervention that was created by Chapman (2001), as a means to resolve trauma or reduce its impacts.

There are also strong foundations in art therapy to suggest that symbolic representations are a powerful means of investigating the trauma. Ganzevoort (2008) found that one catholic individual who experienced trauma as a child used religious symbolization as an imperative element in coping with the trauma. Carr & Hancock (2017) found that within portrait therapy, symbolic representations increased the understanding of self-identity and the integration of the trauma. As van der Kolk (2006, 2014) contends, traumatic memory is encoded through visual imagery and bodily sensation, rather than through language or cognition, thus unresolved traumatic memory can severely compromise cognitive functioning. There are also the physical elements of the body within the act of art therapy to consider, the kinesthetics of the process. Within the Expressive Therapies Continuum (ETC), the kinesthetic component highlights bringing awareness into the body, as an embodied experience where change can occur through this form of knowing (Hinz, 2020). Therefore, by highlighting this aspect of using art materials through body attunement, the integration process of the fragmented kinesphere can occur, enabling a less disjointed sense of self.

Dance Movement Therapy

The body is an important aspect of identity, and more especially if trauma has occurred. It is said that "the body remembers" (van der Kolk, 2006). There is a physical aspect that lingers, a reminder of the medical trauma. In many ways, people who have experienced trauma will often struggle within their own bodies (van der Kolk, 2006).

The body is one's own, it belongs entirely to the individual who inhabits it in their kinesphere. The kinesphere, according to Laban (1974), is the space one uses in a grounded stance, an inner and personal space that surrounds the body (Fernandes, 2014). In the kinesphere of a medically traumatized individual, there is fragmentation. This often renders the whole into a disjointed body, known as a fragmented kinesphere within the language of Dance Movement Therapy (DMT). There is a power to dance movement therapy that is subtitle, as it is a raw form and medium that is used to interact within the world. DMT can assist with healing trauma, as it generates a pre-verbal mind body connection (Serlin, 2020).

According to Levy (1999), DMT theory believes "…that body movement reflects inner emotional states and that changes in movement behavior can lead to changes in the psyche, thus promoting health and growth" (p.1). Throughout the years DMT has promoted this vital connection, with the use of movement to reconnect these pathways to the mind. For those who have suffered medical trauma, such as a stroke or neurological dysfunction, reintegrating these pathways to the traumatic loss in the body is a vital component for dance and movement therapy, often being the main goal. It is in the fragmentation of the kinesphere, the trauma that resides in the body, that needs to be accepted and integrated into the whole body. Doidge (2007) outlines Taub's belief that "…brains of some stroke patients with minimal damage went into an equivalent of spinal shock, 'cortical shock'" (p.142), that can lead to nonuse from attempted and repeated failure of the traumatic body part. Cortical shock and spinal shock are a shock-like

phenomenon that is at differing levels, the spine or brain (Taub et. al, 1998), causing differing disturbances to the body. This type of shock to the system is in itself a trauma that resides in the body, resulting in a fragmentation of the kinesphere.

As Doidge (2007) supports Taub's findings, stating, "…people who had had strokes or other kinds of brain damage, even in earlier years, might be suffering from learned nonuse" (p.142). This learned nonuse generates further imbalance in the body, tilting and fragmenting the whole kinesphere. The learned nonuse only reinforces the strong and unaffected parts of the body, creating further imbalance.

Through DMT techniques and theories of reintegration of the trauma, the use of kinesthetics in art therapy enables an integrative approach, exploring identity through the body in the process of art-making (Tripp, 2007; Talwar, 2007; Elbrecht 2012; Elkis-Abuhoff et al., 2013; Lusebrink, 2010). Bodily processes are stimulated through creative processes that are intrinsic to repair and healing connections (Rancour & Barrett, 2010).

Methodology: Heuristic Arts-Based Approach

Heuristic research requires oneself to dig deep into the unknown, a process of courage and intense introspection. As Sela Smith (2002) describes heuristic analysis as, "… making new awareness and connections or seeing things from a different perspective, and thus reinterpreting their meaning and significance" (p.17). Art-based practices in art therapy research create an intimate way of presenting research, yet is systematic enough to hold validity in its basis, that can be expanded upon. "Art is a way of knowing", as Allen contends (1995), of seeing an externalized aspect of the self-being inquired, and presenting itself as a valid means for research (Allen, 1995, 2005; McNiff, 2019; Fish, 2012). Since this research paper is a highly personal topic involving my lived experience, a heuristic research method was chosen, focusing on the art

processes as a means to gather new insight into my posttraumatic self. There was a new unearthing of the lived experience, a knowledge known, yet unknown.

The heuristic approach gives the lived experience a unique yet relatable voice in research and is a model that was introduced by Moustakas (1990). This methodology is well suited since it concentrates on gathering data from an introspective lens on the topic of a lived experience. Moustakas (1990) proposed a six-phase model for heuristic research, which was implemented for a systematic approach to the methods. It is through this process that "one seeks to obtain qualitative depictions that are at the heart and depths of a person's experience-depictions of situations, events, conversations, relationships…" (Moustakas, 1990, p.38) and in my case, deepening the understanding of the lived experience of the childhood medical trauma. This six-phase model will be described below in the data collection procedure.

Ethical Consideration and Potential Biases

Honesty with the process and myself was an important measure to maintain. Implementing open and intimate dialogues with myself, the artwork, and my body concerning the lived phenomenon was carried out through the research as an integrative yet preventative process. I attempted to ensure that there was minimal harm to myself through the process of the research by implementing self-care practices. Self-care routines included: attending weekly art therapy sessions, taking baths, stretching, practicing meditation, and yoga to increase bodily awareness. Though reflexivity was strived for, there is potential implicit biases within this research. The biases shaped by my gender expression, sex, background, socioeconomic status, and relationship with trauma implicitly informed the interpretation of the findings and overall outcome of the research.

Data Collection Procedure

First, the research question and phenomenon took over my thoughts: *How can visual symbolic forms in an arts-based self-inquiry help redefine identity in a posttraumatic self, from childhood medical trauma?* It is everywhere, including my living space in pervious artworks that adorn the walls. My posttraumatic self is confronting me at all sides. It has been for years. It was time for me to go to the source once again: the childhood medical trauma. Because I have engaged with my posttraumatic self through other artistic means, the initial phase was sparked by the desire to revisit my medical trauma in a new form of engagement. I needed to go deeper, to go directly to the traumatic event. According to Moustakas (1990), it is here that the researcher begins a dialogue with the self to discover, through an intense willingness to the topic. This was the first ember of phase one*, initial engagement* (Moustakas, 1990), and a formulation of the research question began. I prepared myself to become fully aware, "to be alert to the signs or expressions of the phenomenon, willing to enter a moment of the experience timelessly and live the moment fully" (Moustakas, 1990, pg.44).

In the second phase, the *immersion phase* (Moustakas, 1990) there is a deepening of the topic, on both a conscious and unconscious level. For me, this began in the research class of 2020, formulating questions around the topic of medical trauma. Moustakas (1990) writes: "The immersion process enables the researcher to come to be on intimate terms with the question-to live it and grow in knowledge and understanding of it" (p. 28). As the phase is titled *immersion*, it goes beyond activity, the researcher dives into their research in every aspect of their being (Douglas and Moustakas, 1985). In this phase, I followed where the research question was leading me through artistic responses that were done daily for a week. Art-making occurred from 20 minutes to an hour. The art method was using my dominant hand, to dialogue with my right hand that is affected by my stroke as a means of accessing my childhood medical trauma.

Externalized dialogue (ED) technique was also used. ED is meant to foster an exchange between an individual and an imagined entity, the two parts being different aspects of the same individual (King, 2016). The imagined entity is a certain aspect of the self, that is illusory in nature. In this technique, the person uses both hands to dialogue with different parts (Schwartz, 1995). I checked in with my body before the art creation, with a mindfulness body scan. Then a dialogue occurred back and forth between each of my hands. They represented different parts of myself, the right one being my childhood traumatic self, and the left one being my present posttraumatic self. The Intention Witness Process developed by Pat Allen (1995, 2005) was utilized to explore the imagery and dialogue with my traumatic self. This procedure is used to help artists decipher their artistic works without judgment, through a process of description and noticing. Finally, I also integrated DMT theory into the dialogues with my post-traumatic self. Body movement theory, combines somatic awareness and physical sensations, bringing new awareness to my physical self, placing words to bodily sensations. I also maintained notes from my art therapy and physical activity for the duration of my research process once a day for a week.

In the *incubation phase*, Moustakas' third phase, there is a pause in the intensity of the depth in the research. This letting up, will give way to the unconscious processes and allow for the illumination phase to occur more naturally within. Moustakas (1990) describes incubation as a "process in which the researcher retreats from the intense, concentrated focus of the question" (p. 28). In these brief periods of incubation, I continued to attend my weekly art therapy, maintained stretching, and taking extra time to check in with my body. Though in these times of pause, I was still reminded of my research and my post-traumatic body in previous symbolic artworks on my walls. It was also present with the daily challenges that come with living in a

posttraumatic body. These moments of pause were welcome in a very heavy year of personal change and current global instability due to the pandemic. My body was at its limits in many ways, so these breaks from intensive research were vital. It was in my art therapy sessions and dreamscapes that my medical trauma emerged. Words came to my mind: "Help me". They began to haunt me, resurfacing again and again. I needed to know how to help myself.

In the *illumination phase* (Moustakas, 1990), there is an awakening of knowledge. There is a new awareness of the phenomenon. As Sela-Smith (2002) describes, "It occurs of its own, a major reorganization of knowing happens and transformation takes place on a deep level" (p.17). Exploration occurred on three levels of communication for an intensive week of creation. It included a dialogue with the child self. This dialogue integrated; written, visual, movement, and body attunement as differing forms of communication. Dialoguing with the child self through the written word was a direct way to communicate readily with the traumatic self, while the visual depictions were a form of engaging with the trauma on an imaginative level. As Malchiodi (2020) suggests, "with increased understanding of the embodied nature of trauma, working with trauma narratives often calls for a multimodal approach, including the pacing and communication of trauma memories" (p.253). Imagination plays a large role in this process. As described above, imagination is necessary for accessing the traumatic body, and that aspect of myself. Each day, I utilized my imagination to picture my younger self, and the felt experiences that may have been embodied. I also relied upon using the collective narrative from my family members who were present during the initial medical trauma. The active imagination was used to increase the embodiment and integration. Imaginative activation was necessary to access my internal child.

Through the *Explication Phase* (Moustakas,1990), there is a deepening through further self-examination. The researcher compiles together "… discoveries of meaning and organizes them into a comprehensive depiction of the essences of the experience" (Moustakas, 1990, p.31), concerning others. In this stage, a deep reflection of the created art data and its patterns were observed. I noticed several themes, such as imaginal spaces, artistic rendering, transformation, connection, light and dark, opposites, inner and outer dialogue. The reoccurring images in the artwork were hands, infant, medical, sound, and body. These will be further explored in the Findings. And lastly, I coded the patterns that emerged in the dialogue: help, save, me, she, how, sound, scared.

The *Creative synthesis* is the final stage where the realization of the research comes together. In this process "the creative synthesis can only be achieved through tacit and intuitive powers" (Moustakas, 1990, p.31). This is when the phenomenon was fully realized in a final art response (Figure 15). In this last stage, I followed where the dialogues were intersecting, bringing together a final piece through a visual, and bodily representation of the post traumatic self. In this artwork both hands were used to simultaneously draw a self-portrait, while confronting myself in the mirror. This piece embodies the essence of the personal and challenging process of the research.

Validity and Reliability

It is important to note that within this self-inquiry heuristic arts-based research, there are many complexities and limitations. Being the nature of the research design, I'm the sole participant, therefore the research is only valid as far as it relates to my own personal experience. Its reliability is dependent upon the participant to be vulnerable, with an ability to engage authentically with the process (Cresswell & Cresswell, 2018). There is an inward cascade into

the unknown unconscious areas of the self, that is not yet solidified until the end of the research process. This is where the synthesis of the material can be explored more clearly. Therefore, the process is personal, a journey of knowing that is illustrated in an efficient transformative process of gaining new insights. Moustakas (1990) points out that, "every method or procedure, however, must relate to the research question and facilitate a collection of data that will disclose the nature, meaning and essence of the phenomenon being investigated" (p.44). Also keeping focus within myself during the second phase was important to maintain, as Sela-Smith (2002) argues that if the focus is on something outside of the research, then the researcher is not conducting a heuristic self-inquiry and validity can be lost. There is also the limitation of time, as, within Moustakas's framework for heuristic research, it is suggested that there be no time restraints and that there is a natural flow and end. However due to the parameters of the program, a timeline and frame were withheld, and a sense of pressure was felt to complete the research on time.

Findings

In this section, I will discuss the repeated themes that emerged from the data, beginning with the visual imagery and then the dialogues. I will also note the bodily sensations that were recorded.

The reoccurring images in the art were clear. Hands were the most common symbol surfacing in 6 of the 9 drawings (see Figures 1, 3, 7, 10, 11, 14). The hands are represented independently, attached to the infant in an outward reaching gesture, and joined. Throughout the research, I was asking myself where were these hands? What were they reaching for? My hands often joined together while doing a body scan before or during the art creation. As seen in Figure 1, the hands are separate, as I attempted to connect to my traumatic self through mirroring my

right hand in the drawing method. Before beginning this process, I did mindful breathing and positioned the pencil in my right hand. I noted at the time, “The right side was feeling tight, a resistance to the process already” (Personal note, Willshaw, 2021).

The infant or baby was the most powerful image to encounter on an emotional level. This symbol occurred in three of the 9 drawn images (see Figures 3, 5, 7). This infant appears cradled in a soft “U” shape repeatedly. This encompassed space holds and protects, like the womb. This symbol evoked a physical and emotional reaction. My body often cascading into a fetal position to self-regulate, mirroring the “U” and weeping. In the first occurrence (see Figure 3), the womb-like sensations were entirely felt. I had the desire to retreat to my mother. Other complex and personal memories flooded me, reflecting on this quest for safety of my mother. For context, she was always present with me when I was in the hospital, and remained steadfast in my rehabilitation. She was sick for most of my childhood with cancer and died when I was eighteen. Longing for a womb that is no more, is a painful realization. I needed to feel safe to revisit this. I took a bath after this artwork, attempting to return to the womb symbolically. The infant resurfaced again, but in the medical atmosphere (see Figures 5 and 7) posing new questions to this “medicalized womb”, where the infant is in pain. It was evident that this was an unsafe environment to revisit and re-imagine. The traumatic-self writes, “The sound hurts me, I’m crying. THREAT” (Figure 6), when remembering being in the tube of the MRI. My body remained uncomfortable, feeling strangely exposed and unsafe during the creation of these two drawings. Was my body remembering its former infant self? There was a particular sadness for the infant in these images. I felt a desire to care for its fragile, yet willful little body. With direction from my art therapist, I created an imaginal safe space. Constructed partially from childhood memories, it’s pictured as follows; my living room with beige carpet, the fire is

burning, I'm warm. I can hear the Def Leppard tape playing, with smells of wood and breakfast mingling in the air. I also bought a weighted blanket to mimic the comfort of a womb, using it after each intensive art session.

Another reoccurring image is the medical equipment, and medical spaces in two of the drawings (see Figures 5 and 7). The strange void-like spaces evoked questions of memory, time, and sensory information from my posttraumatic body. My body was very tight when these images were drawn, and regulation through breath and stretching was necessary. Specifically, the MRI machine (see Figure 5), where the infant is also in the image, a gesture and a hint of a body inside the tube brought me anxious physical responses. "My body is so tense, pulse-quickening. I have to remind myself to breathe" (Personal note, Willshaw, 2021). With this knowledge, I intended to heighten and soothe my felt experiences with the images. I also found the rhythm of breath an important aspect to add when encountering these strange medical spaces, as Aldridge (1989a, 1989b, 2002), throughout his research, found that the control of breath was an important aspect of incorporation in the process. Controlling my breath intentionally allowed me to feel grounded, and less anxious.

I also discovered emerging patterns in the recorded dialogues and personal notes. Most of these repeated words intertwined with the themes of imagination (see Figures 1, 3 ,4, 5, 6, 7, 8 ,9 13, 14), transformation (see Figures 8, 9, 10, 11, 13, 14, 15), connection (see figures 1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 14, 15), and inner and outer dialogue (see Figures 1, 2, 4, 6, 8, 10, 11, 12, 14). Specifically, the words "help me" and "save me", reoccurred in the dialogues and personal notes on 5 separate occasions. The words related heavily to the recorded bodily sensations, and the necessary step to create an imaginative safe space. In each moment of visual and textual dialogue, there was a transformation, a connection, as well as a repair of the body through a

witnessing process. When these words appeared to me, it was through touch that I was able to connect to the traumatic self on a somatic level, as seen in Figure 5's dialogue and personal notes: "Scared, tired". (I pause, sitting with this response. I hold my hands together). Another internal response followed: "Just hold me". When this response came to me, I wept. I continued to hold my right hand (Figure 5, Personal notes, Willshaw, 2021). It was the drawing of the MRI machine that encompassed the entirety of symbolic imagery and the trauma with the posttraumatic body.

Transformations in my muscle tone transcended to the image, the line and movement were less challenging post stretch. The pain was still present, but the movement flowed and control of the line was increasingly easier. Specifically, I noticed an increase of connection when breathing consciously and with the movement of my right hand; as I noted, "…I can feel my muscles softening with each slow exhale" (Personal note, Willshaw, 2021), performing a stretching routine.

Discussion

This research was a challenging pursuit of self-discovery through symbolic art, imagination, and bodily awareness. Through this integrative art and bodily process, I was able to directly begin to heal fragmented pieces of myself. "A connection has been made that will remain forever unbroken and that will serve as a reminder of a lifelong process of knowing and being" (Moustakas, 1990, p.55-56). The dialogue and surprisingly confrontational images transported me to the medical trauma, demanding all of me. My self-care routine was essential to maintain equilibrium for other daily activities.

The symbols that surfaced in the art were almost all familiar and have been explored previously in my art practice. Living within this posttraumatic body is challenging, bringing

anxiety, depressive thoughts, physical pain, and fatigue. It makes sense that hands would arise in the symbols and that there would be an intense sensation of pain and fatigue after each session of creation and dialogue. I encountered frustration with my affected right hand, struggling to accept its spastic motor functioning during artistic rendering. For example, I noted, "assistance with positioning the pencil in my right hand was tedious, and my muscles strained and tensed, my mind concentrating on holding it" (Personal note, Willshaw, 2021). Over the extent of the research process, I was able to connect these present symptoms to the artwork. I attempted this each time, connecting the imaginative or memory source of the trauma, to my bodily sensations. The symbol of the hand evoked this connection over the others through its literal struggle to execute fine motor functioning.

In contrast, it was the infant symbol that was the most confrontational. The infant symbol has only surfaced in one previous artwork prior to this research. However, its resurgence in this research demonstrates its rich and complex nature. In my pre-research artwork the infant symbol appeared as an invisible body; its form is only observable from the drawn contours of the medical braces. In that artwork my body is not acknowledged, it is invisible. It is only the braces that are visible, outlining a bodily form. However, in this heuristic self-inquiry, the infant appears fully present, visible (see Figure 3). It was drawn with my right hand, a direct acknowledgment to my fragmented kinesphere. This infant was fragile, vulnerable, and yet, resilient. The infant's reach and cradled position within the womb-like "U" shape embodies a state of vulnerability and a need for care. It represents seeking acceptance and love of the traumatic self who resides within. Perhaps this symbol was also evoking a regressive state to transform from these traumatic origins. When confronted with this symbol, I would often have to pause, using touch and movement to comfort and soothe myself.

The medical trauma was present in all the images, but it was the medical spaces and devices that conjured anxiety and intense tightening in my body. These drawings are strange, proposing questions related to emptiness, 'void-scapes', and lack of clarity. There is an overwhelming sense of uncertainty and anxiety, an ungrounded nature in these evocative drawings. Yet in their lack of information, the symbolic medicalized atmosphere is entirely felt within my body. These drawings allowed me to reconstruct my posttraumatic body and revisit the medical spaces. As Thompson (2011) states, "The architecture of this personal space of interiority, combined with metaphor, is a powerful force for accessing buried and dissociated traumas—creating a "breathing space" for significant relief" (p.39). It was during these drawings that the alternating sounds of the MRI machine, and Def Leppard were playing. As Baker (2001) demonstrated, people experiencing post-traumatic amnesia are often able to access the events with familiar music in therapy. Aldridge (1989) also contends that since "the processing strategies for the perception of music are distributed over both hemispheres, it is possible to infer that this holistic strategy is closer in developmental terms to physiological processes and autonomic activity than language" (p.96).

These themes and connections evolved and transformed over my intensive week of artmaking. In light of the research parameters, the images were able to surface without direct conscious awareness and take me where it was both necessary and challenging. In this sense, new knowledge and discoveries of the self were possible. Wix (2003) emphasizes that art-making is a beneficial process as a means of creating knowledge, and through this new meaning, self. Wix (2003) states, "constructing a reality is constructing a world is constructing a self. Selfing through art has to do with giving form to matter and in so doing giving form to self" (p. 45).

In the creative synthesis, I engaged in joining the posttraumatic body and the traumatic body, through a mirroring of movement and line, such as seen in several of my created drawings, the joining of hands and body (see Figures 10, 11, 12, 13, 14). This theme extended further with a direct call for connection. The dialogue between the traumatic self and the posttraumatic self-reinforced the body's desire to integrate. Here are examples, "Come with me. *Where?* Togetherness" (see Figure 13); "Pieces, Fragments to come one. *Join together*" (Figure 14). Here, it was the traumatic self that was leading the posttraumatic body toward togetherness. It felt complete in this drawing, hence the title "Whole". It was with this final piece that I felt a sense of calm, release, and inner harmony. I noted, "My body is calm, though is still restless in movement" (Personal note, Willshaw, 2021). I also noticed that during the process, my breath was "slow and steady, synching with the movement" (Personal note, Willshaw, 2021), as I looked into the mirror, fully confronting my body.

Implications and Limitations of the Findings for the Application in Art Therapy

There are many limitations to this research, firstly being the design. Heuristic arts-based research is a subjective experience of the lived phenomenon. That being said, it is evident that the process of ED and symbolic imagery of the trauma surfaced through the experience. It is entirely subjective to those who view the creative synthesis, to judge the communicated symbolic form of the research. These findings simply emphasize the effectiveness of using symbolic representations, kinesthetic, and other creative arts modalities to address trauma, concerning identity.

Conclusion

With the scarce literature for childhood medical trauma, it was important to use an integrative approach in this personal exploration. The literature on trauma suggested that

rendering a narrative-based progression would benefit the self's integration of the trauma. Ultimately, the creation of a clear figurative narrative of the trauma may be required for symbolic processing and trauma resolution to occur (Collie, Backos, Malchiodi, & Spiegel, 2006). The other creative arts modalities using movement, and music suggested strategies of integration and immersion. Movement and bodily awareness of my fragmented body was a vital aspect of transformation that extended from the visual forms. The music of Def Leppard and MRI medical sounds were used to heighten my imagination and creativity. The music brought comfort and the MRI sounds mimicked medical trauma, and the medical spaces. Within all these aspects, it was possible to transform and understand my traumatic body and how it shaped my identity. Erickson's (1968) theory of identity formation suggests that reintegration and transformation of inadequate unresolved stages are possible at any time.

This research project has been an intensive investigation into my childhood medical trauma through the use of imagination, artmaking, and bodily experiences. I intended to reconnect and heal certain aspects of the medical trauma in an integrated manner, gaining new knowledge of this lived experience. The journey thus far has taught me that I need to accept and nurture this still unresolved trauma, that resides in myself as an inner child. I learned that this trauma positively changed my development of self, giving me reliance, patience, and empathy for both myself and others. Despite the challenges faced with body image, and social anxiety over the years, my traumatic body has given more than taken from my development of identity. It's unclear if these resilient qualities would be present without the medical trauma, however, I believe that they have been heightened by it.

Though parts of myself remain fragmented in this post-traumatic body, I have formed new connections, acknowledging, and moving towards acceptance of this aspect of my identity. I

hope that this research will enlighten a way of knowing for others faced with similar disjoined traumatized parts so that they can explore and accept these aspects as well.

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Appendix

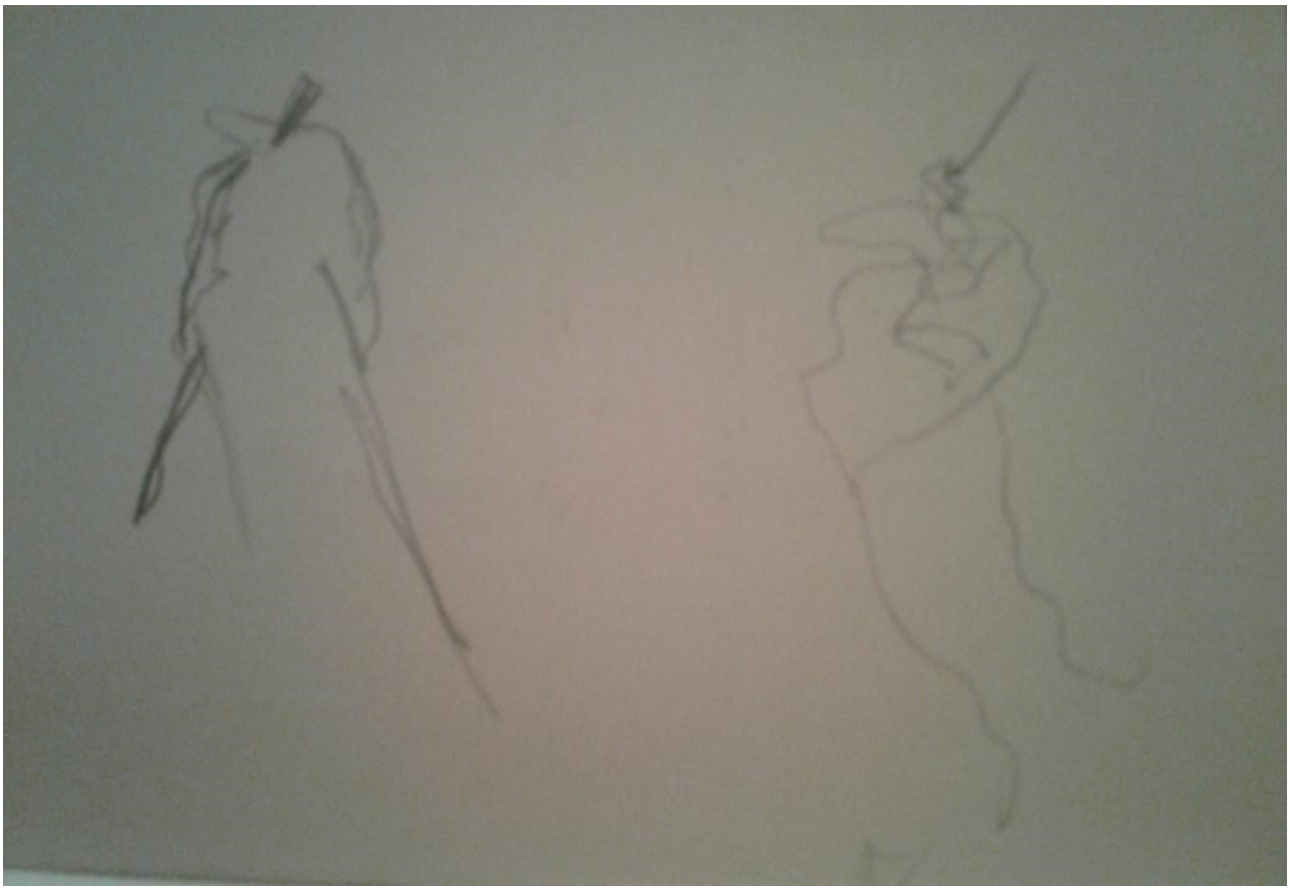

Figure 1. Simultaneous drawing of right hand, while it is drawing itself. Pencil on paper.

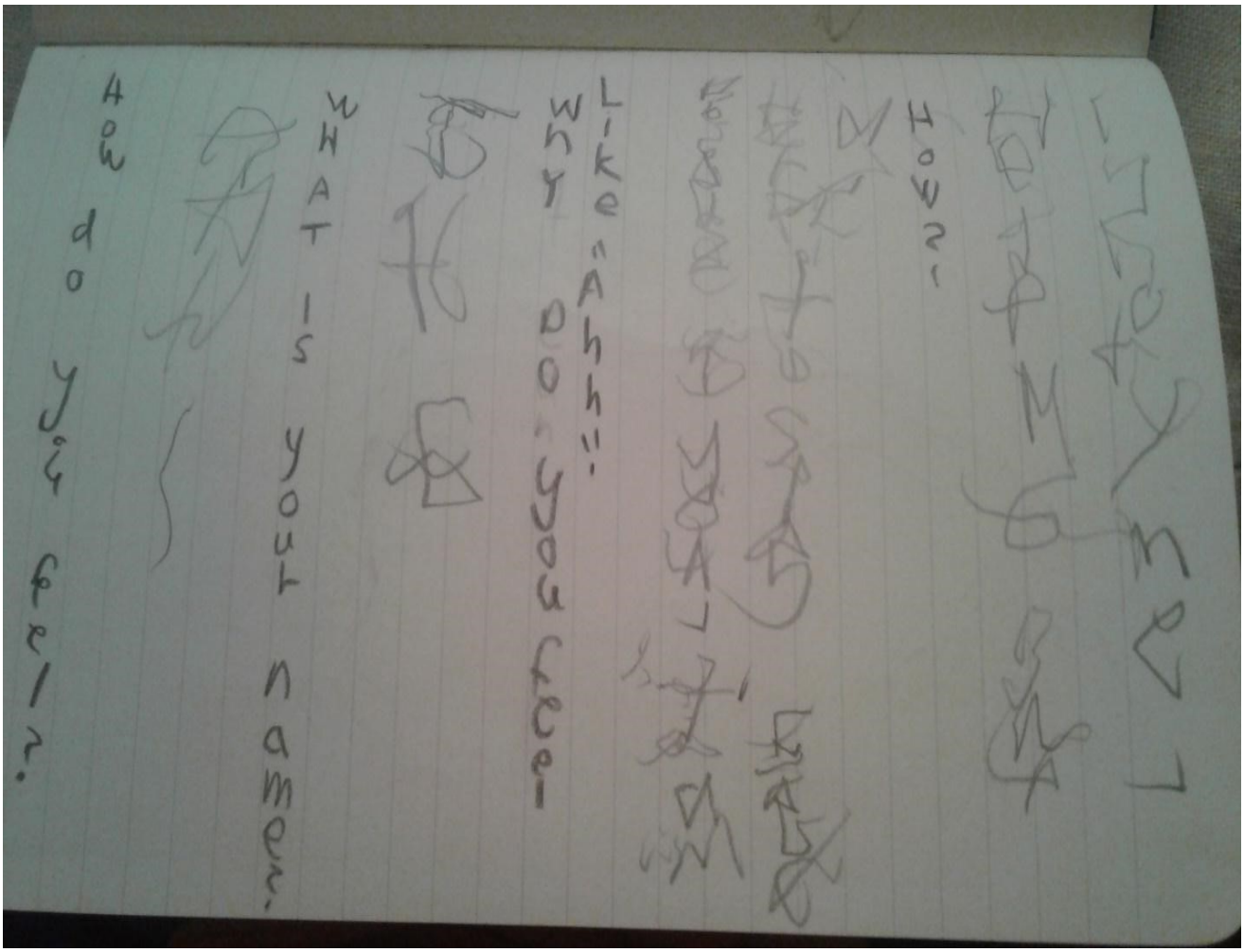

Figure 2. Dialogue with traumatic self, named "She". "Help me". Pencil on paper.

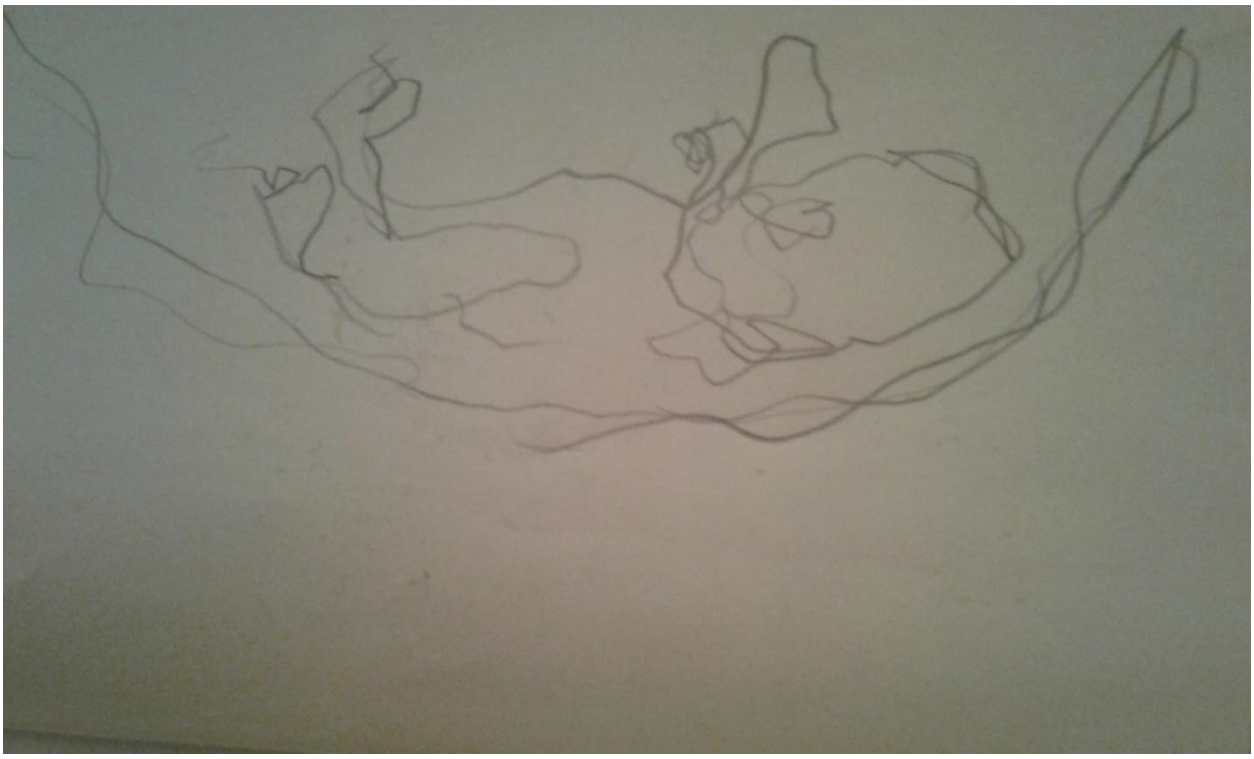

Figure 3. Infant in 'U'. Pencil on paper. Drawn with right hand.

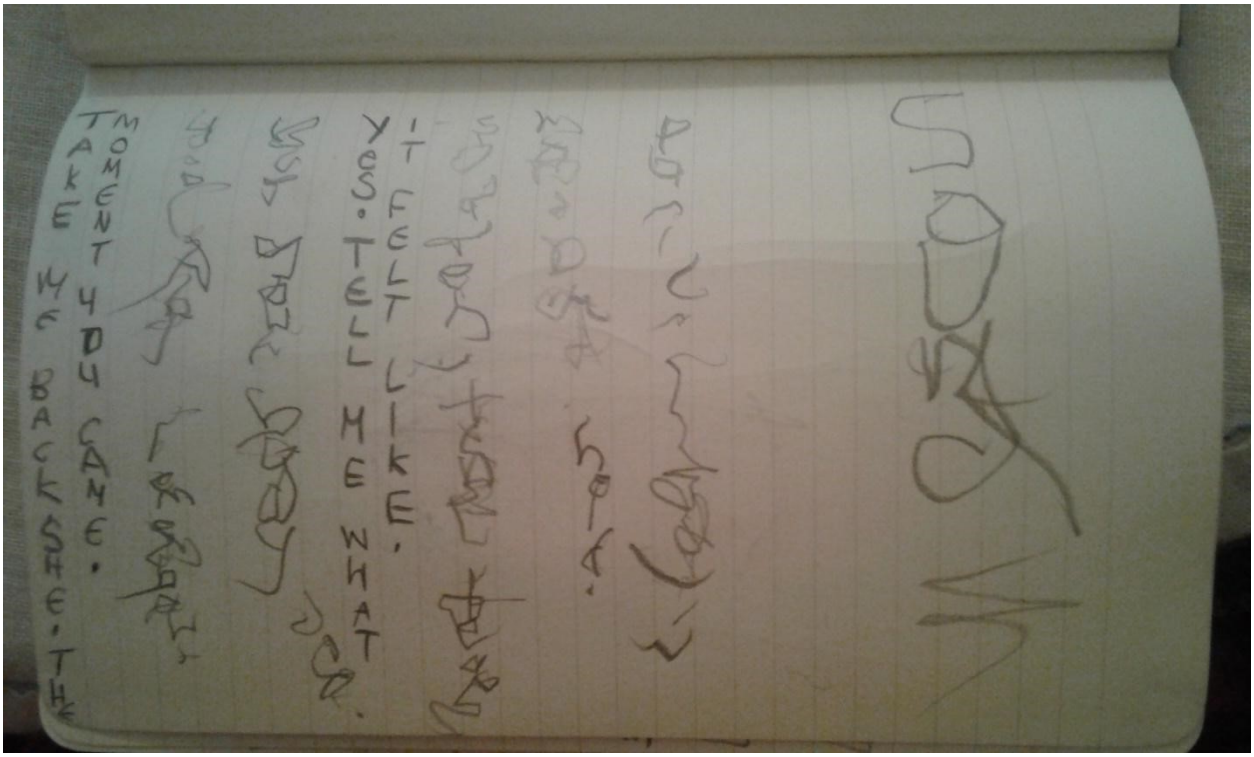

Figure 4. Dialogue; "body remembers", "Mom, Dad", "panic, sound". Pencil on paper.

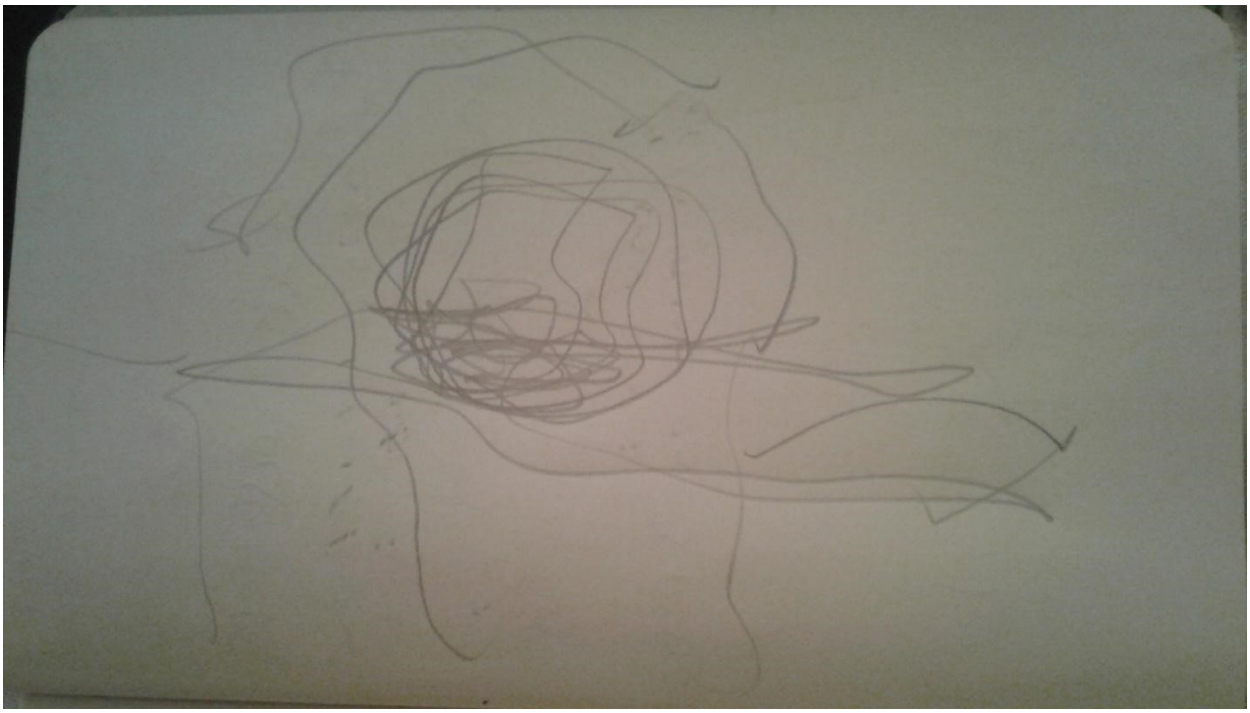

Figure 5. MRI Machine with Infant. Pencil on paper, drawn with right hand.

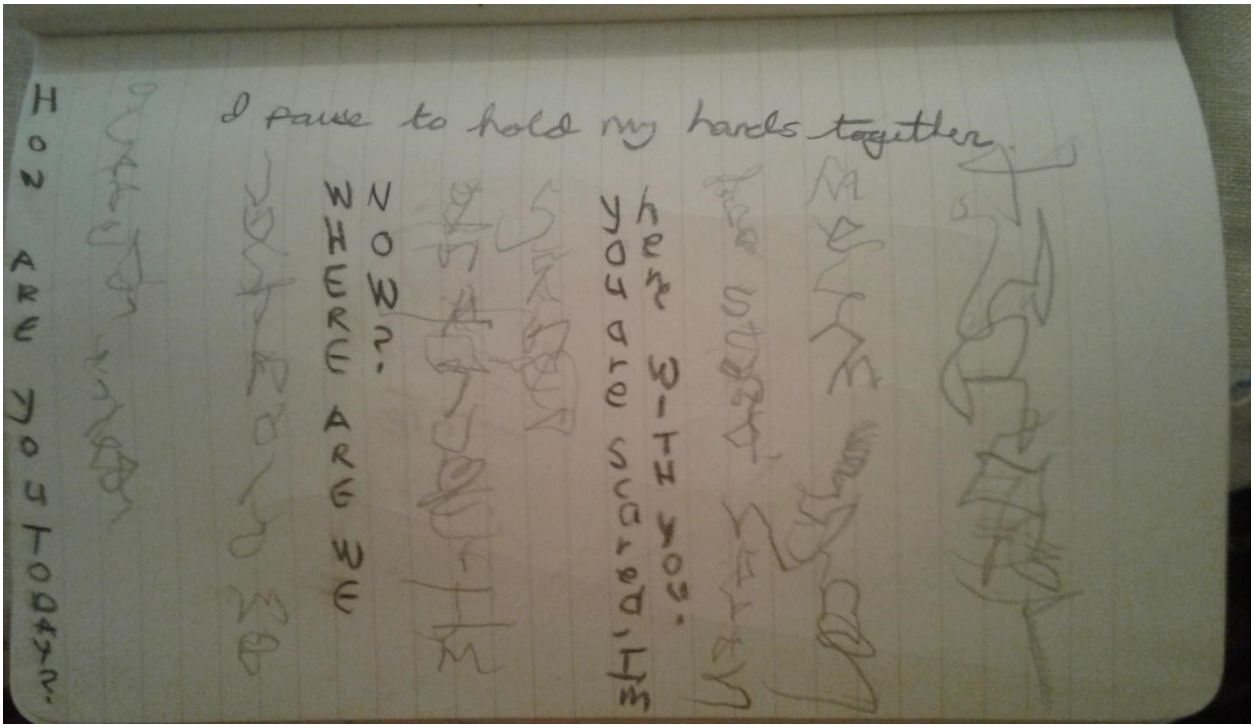

Figure 6. Dialogue with traumatic self concerning MRI machine drawing, "Hold me", "The sound hurts me. I'm scared"

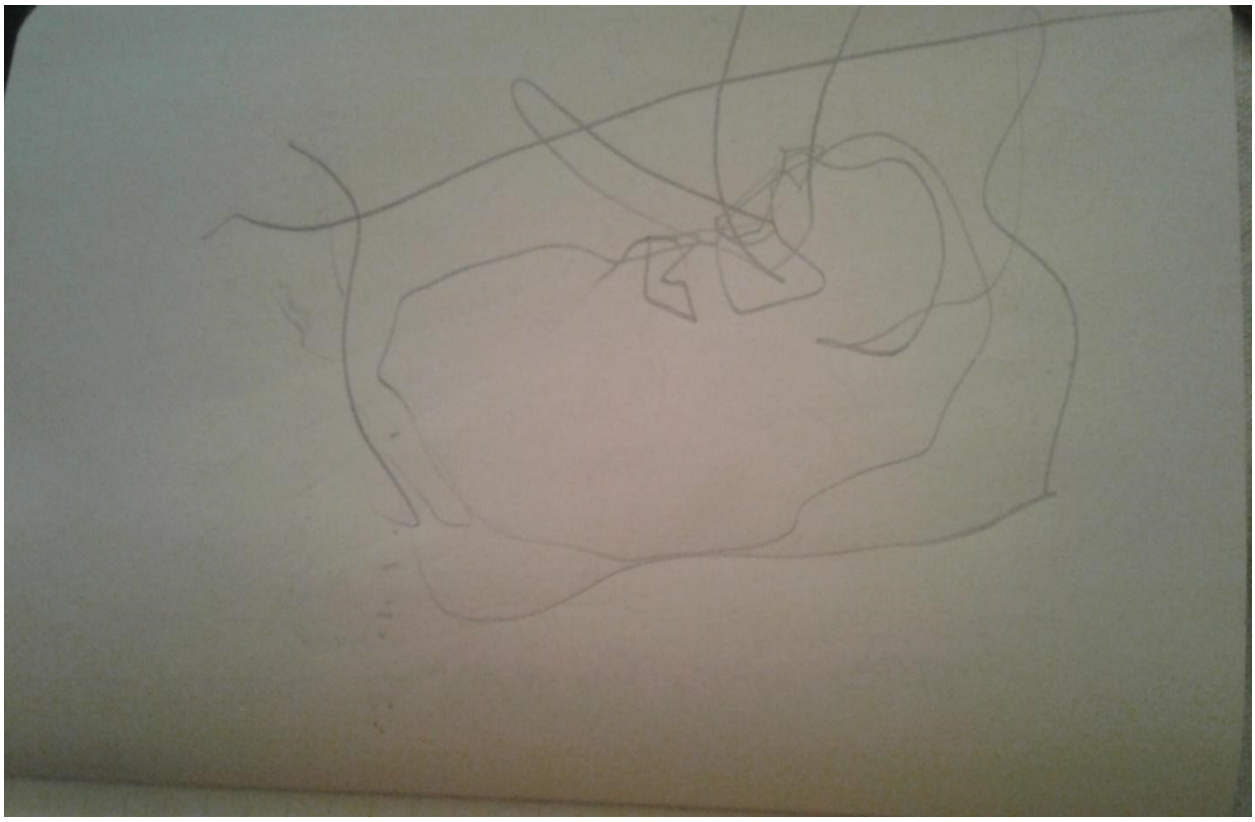

Figure 7. Infant in box. Another medicalized 'Womb'. Drawing with right hand. Pencil on paper.

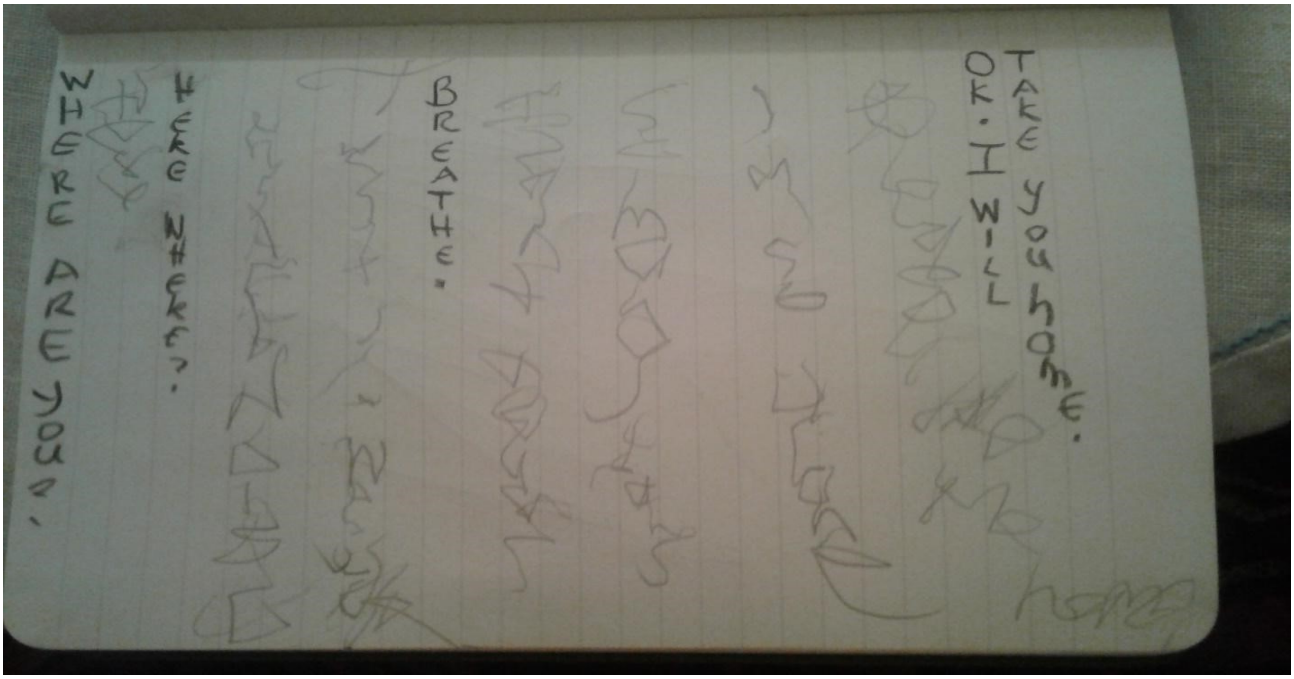

Figure 8. Dialogue with traumatic self. "Unsafe noise. Test. Needles.", "I can't, tears, so many tears. I'm alone. Please take me home".

Figure 9. Torso, rejected part. Drawing with right hand. Pencil on paper.

*Figure 10. Dialogue with traumatic self. "*I'm here. In you. *How do I help you?* Accept me.*",*

Portrait. *Drawing with both hands.*

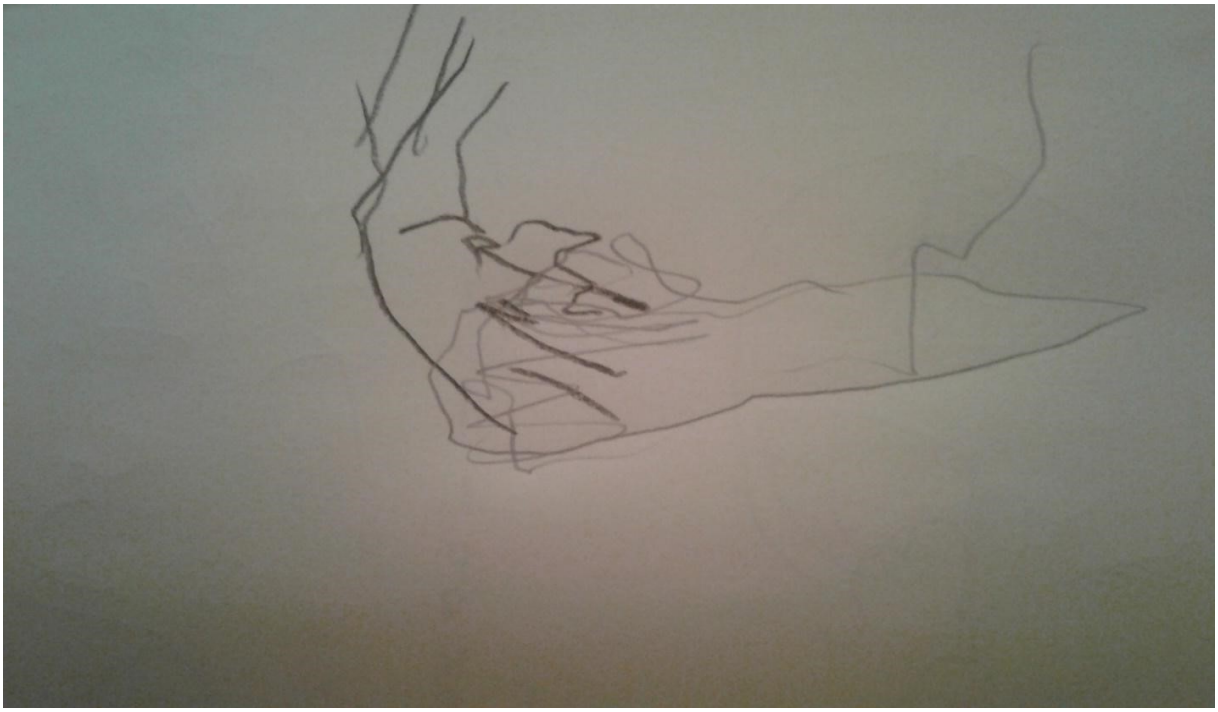

Figure 11. "Connected". Simultaneous drawing with both hands. Pencil on paper.

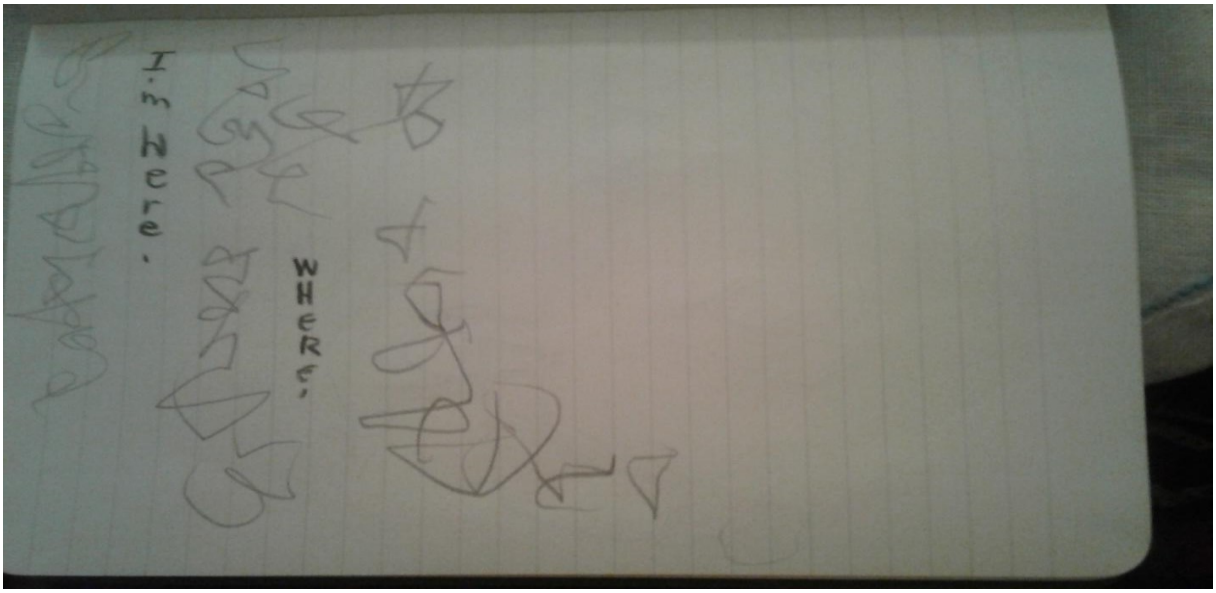

Figure 12. Dialogue with traumatic self. "Togetherness". Drawing with right hand. Pencil on paper.

Figure 13. Simultaneous drawing with both hands. Portrait. Pencil on paper.

Figure 14. Dialogue with traumatic self, "pieces, fragments, join together". Simultaneous drawing with right hand, "Arms". Pencil on paper.

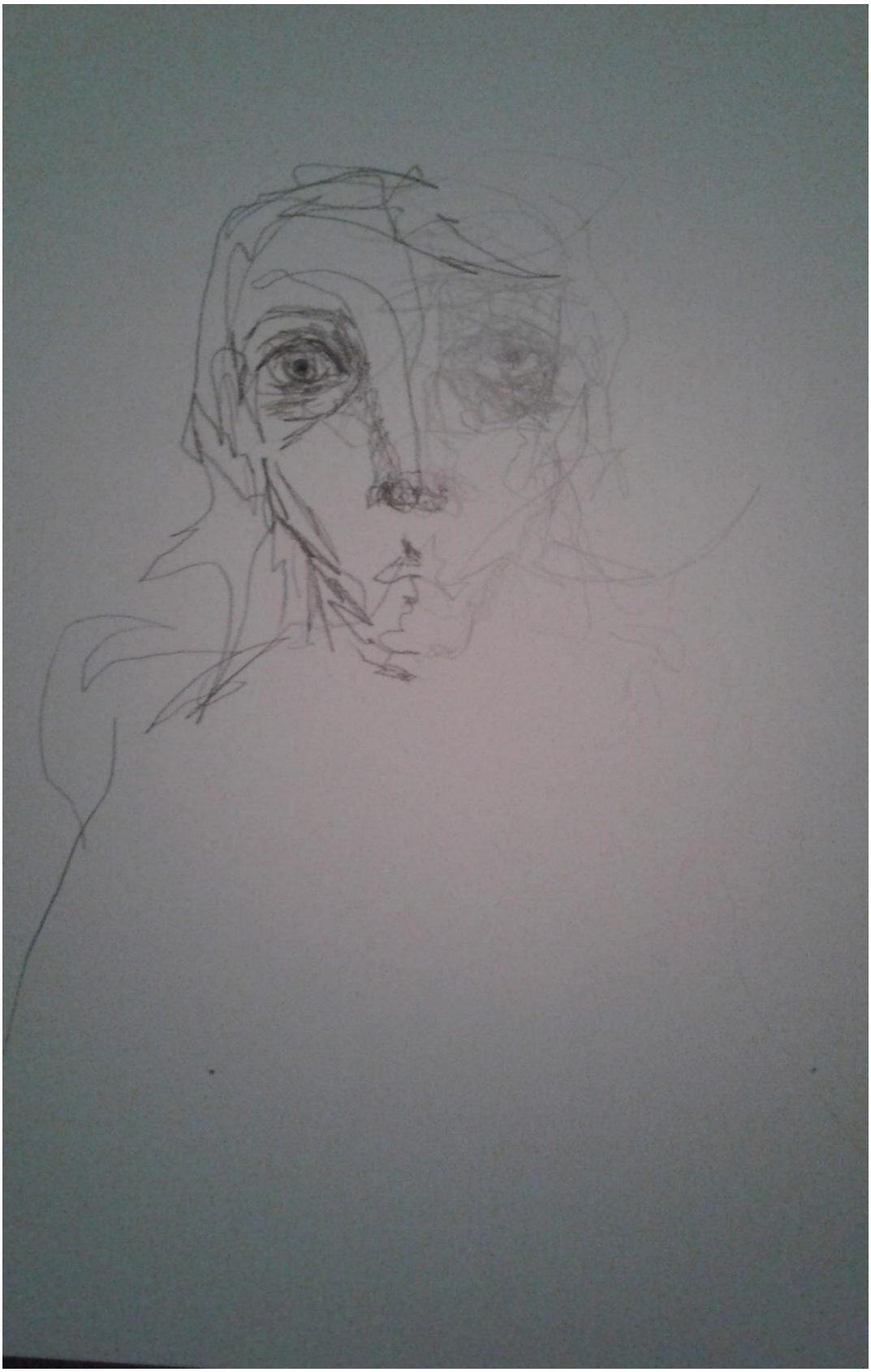

Figure 15. Creative Synthesis portrait, "Whole". Simultaneous drawing with both hands. Pencil on Paper.