POPULAR EDUCATION IN COLLECTIVE RECOVERY AND RECONSTRUCTION FROM CONTINUING COMPLEX TRAUMATIC STRESS: A COLLABORATIVE PSYCHOEDUCATION APPROACH

by

MOISES U. ESCUETA, JR.

B.S.S.W., University of the Philippines. 1989
M.S.W., San Francisco State University. 2001

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ABSTRACT

This participatory action-research project explores the contributions that popular education, particularly using visual-arts based methods, makes to collective recovery and reconstruction efforts being undertaken by a group of individuals living in contexts of chronic, acute, and continuing trauma and related mental health issues. Towards this end, a psychoeducation group I called Trauma Recovery and Reconstruction Group (TRRG) was created and conducted with clients of the Centre for Concurrent Disorders (CCD) in Vancouver.

This study was undertaken over three phases. The first phase focused on informing the CCD staff of the project, recruitment of clients, and individual interviews of participants. The second phase included the twelve group sessions where data was collected through field notes, observations, and creation of visual images. The final phase involved interviews with each of the participants. The method created for this project was called Trauma Recovery-Focused Participatory Research (TRFPR) which forges a partnership between the researcher and participants through the various phases of research. The resulting data illustrates theoretical, methodological, and practical contributions that popular education makes to psychoeducation initiatives in a clinical setting. Theoretical contributions include the extension of popular education theories and application in trauma psychoeducation, identifying processes to ensure continuing context assessment, and the translation of pedagogy into united action for collective recovery and reconstruction. Methodologically, it provides a model for employing collective, participatory, visual arts-based and capacity-building approaches. This model includes identifying visual arts-based methods which enhance collective expression of distress and recovery, critical analysis of systemic and structural origins of collective (re)traumatization, and the identification and actualization of concrete steps.
through united action. This project also outlines a new research method, Trauma Recovery-Focused Participatory Research (TRFPR), which simultaneously involves processes that contribute to trauma recovery and reconstruction. Practically, it contributes to recovery and reconstruction efforts of a group through the actual conduct of the Trauma Recovery and Reconstruction Group (TRRG), a twelve-week collaborative psychoeducation group. At the end of the twelve weeks, participants outlined a number of action steps including advocating for the continuation of the TRRG to sustain the community of mutual learning and support they created.
# TABLE OF CONTENTS

ABSTRACT .......................................................................................................................... ii

TABLE OF CONTENTS......................................................................................................... iv

LIST OF TABLES.................................................................................................................. vii

LIST OF FIGURES................................................................................................................ viii

GLOSSARY OF TERMS......................................................................................................... ix

ACKNOWLEDGEMENTS....................................................................................................... x

CHAPTER ONE: INTRODUCTION AND PROJECT OVERVIEW........................................... 1
  Problem Statement and Purpose of the Study .................................................................... 1
  Why Popular Education in Trauma Work: My Own Story ............................................. 3
  Defining Key Concepts..................................................................................................... 5
  A Collective Popular Education Approach...................................................................... 7
  Significance of this Project.............................................................................................. 8
  Dissertation Outline....................................................................................................... 9

CHAPTER TWO: LITERATURE REVIEW ON TRAUMA....................................................... 12
  Trauma ............................................................................................................................ 12
  Embodied Effects.......................................................................................................... 14
  Trauma Recovery and Reconstruction: Varying but Integrated Views ....................... 17
    Post Traumatic Stress Disorder (PTSD)......................................................................... 17
  Trauma as Suffering, Trauma is Suffering...................................................................... 22
  Integrating (Buddhist) Suffering and Liberation to Trauma and Collective Recovery and Reconstruction........................................................................................................... 25
  The Dominance of Individual-Based Approaches......................................................... 27
  Trauma as a Complex Continuing Experience ................................................................ 31
  The Need for Collective Approaches............................................................................ 34
    Psychoeducation ......................................................................................................... 35
  Summary ......................................................................................................................... 38

CHAPTER THREE: THEORETICAL FRAMEWORK: POPULAR EDUCATION..................... 39
  Freire’s Popular Education Theory and Methodology..................................................... 39
    A Humanizing Pedagogy ............................................................................................. 40
    Liberating Processes .................................................................................................. 43
    Translating Pedagogy into Action.............................................................................. 49
  Reflections, Reactions, and Criticisms of Freire......................................................... 52
    Inaccessible, Sexist, and Paternalistic Language....................................................... 52
    The Popular Educator as Colonizer ........................................................................... 54
    A ‘Western’ Approach ................................................................................................. 56
  We Continue to Learn................................................................................................... 58
  From My Standpoint: A Liberating, Not Colonizing, Practice .................................... 59
CHAPTER EIGHT: PROJECT SUMMARY AND IMPLICATIONS......................................................... 191
Project Summary .................................................................................................................. 191
TRFPR – A New CBPR-Oriented Approach Towards Recovery and Reconstruction........... 198
Project Implications .............................................................................................................. 200
Changes in Individual Treatment Plans .............................................................................. 201
New Trauma-Related Services ............................................................................................ 202
Applications in Other Contexts .......................................................................................... 202
Establishing a Network of TRRGs ....................................................................................... 203
Policy Changes ...................................................................................................................... 203
Towards a New Diagnosis: ‘Continuing Complex Traumatic Stress Disorder’ (CCTSD) .... 204
Undertaking this Project: My Experience ........................................................................... 208
Context .................................................................................................................................. 209
Content .................................................................................................................................. 211
Methodology .......................................................................................................................... 212
Suggestions for Future Research .......................................................................................... 213
Limitations of the Study ......................................................................................................... 218
‘ASAP’ ................................................................................................................................... 219

REFERENCES ......................................................................................................................... 221

APPENDICES .......................................................................................................................... 230
Appendices B, C, D – BREB and VCHRI Certificates of Approval ....................................... 232
Appendix E – Therapists’ Orientation Protocol .................................................................... 234
Appendix F – TRRG Inclusion and Exclusion Criteria ............................................................ 244
Appendix G – Participants’ Project Orientation Protocol ........................................................ 246
Appendix H – Consent Form .................................................................................................. 251
Appendix I – First Individual Interview Protocol .................................................................. 255
Appendix J – First Group Discussion Protocol ...................................................................... 256
Appendix K – Second Group Discussion Protocol ................................................................. 258
Appendix L – Second Individual Interview Protocol ............................................................... 259
Appendix M – TRRG Group Guidelines ............................................................................... 261
Appendix N – Coping Skills Self-Inventory ......................................................................... 262
Appendix O – Examples of Cognitive Distortions ................................................................. 268
Appendix P – Action Discussion Document ......................................................................... 270
Appendix Q – Participatory Visual Appraisal: Processing ................................................... 273
Appendix R – Context Mapping of Distress: Processing ...................................................... 274
Appendix S – Vancouver Coastal Health Adult Team Mandate ........................................... 273
LIST OF TABLES

Table 1. Outline of the Conduct of the TRRG..........................................................90
LIST OF FIGURES

Figure 1. Individual Illustrations of Shifting Levels of Distress and Well-being ............115
Figure 2. Participatory Visual Appraisal of Trauma and the Effects of Trauma..............140
Figure 3. Participatory Visual Appraisal of Depression and Effects of Depression .......142
Figure 4. Participatory Visual Appraisal of Substance Abuse.......................................144
Figure 5. APA Diagnostic Criteria for PTSD............................................................151
Figure 6. Individual Illustrations of Varying Spiritual Dimensions of Trauma ..............156
Figure 7. Context Maps of Distress and Recovery..........................................................160
GLOSSARY OF TERMS

CCD – Centre for Concurrent Disorders - a community-based, outpatient mental health service funded by Vancouver Coastal Health which provides services to individuals with both a chemical dependency and serious psychiatric illness, such as anxiety or depression.

CBPR – Community-Based Participatory Research – a research method which emphasizes the equitable participation of community members and researchers in all aspects of the research process (De Koning & Martin, 1996).

CCTSD – Continuing Complex Traumatic Stress ‘Disorder’ – a proposed new diagnosis to expand PTSD which includes criteria for when a person, group, or community has been, is, and continues to be exposed or subjected to traumatic experiences including those facilitated by other individuals or groups or unjust and oppressive systems and structures.

Context Mapping of Distress – a visual arts-based method where participants create comprehensive maps of their contexts to comprehensively articulate individual and collective distress in the context of systems and structures that facilitate (re)traumatization.

Meaning-Making - critical reexamination of systems and patterns of thinking that are based on internalized oppression which reinforces negative thoughts and feelings which, in turn, can sustain systems of distress. The search for and creation of new personal philosophies, cognitive structurings, and patterns of behavior.

Participatory Visual Appraisal - a visual arts-based method for individual visual rendering of various concepts, experiences, or realities, to facilitate collective critical analysis.

Popular Education - a liberative approach to education that emphasizes context-based, people-centered, dialogical, and transformative processes where a group or a community works together to develop critical consciousness to identify root causes of their problems and undertake collective action towards meaningful social change (Freire, 1998).

Psychoeducation - initiatives that provide access to information and facts about mental health topics in a systematic way in order to enhance strategies to deal with the latter effects (Royal Brisbane and Women’s Hospital, 2007).

PTSD - Post-Traumatic Stress Disorder - a set of symptoms developed after exposure to, witnessing of, or learning about a traumatic incident involving intense fear, helplessness, or horror (APA, 2000).

Recovery and Reconstruction - responses to the shared needs of individuals who have come together as a group to collectively address distress from similar trauma in terms of symptoms and their systems- and structures-based sources.
Social Suffering - human problems that have their origins and consequences in the devastating injuries that social forces can inflict on human experience (Kleinman, Das, and Lock, 1997).

Trauma - defined based on one’s worldview, predominantly understood in ‘Western’ societies to be an incident of grave threat to life or one’s personal integrity, or unexpected or violent death of others (APA, 2000).

TRFPR – Trauma Recovery-Focused Participatory Research - the research method designed for and used in this project. TRFPR is oriented in CBPR which forges a partnership between the researcher and participants to contribute to the latter’s efforts at developing or enhancing capacities to address trauma-related needs for recovery and reconstruction through the various phases of this study.

TRRG – Trauma Recovery and Reconstruction Group - the twelve-week trauma psychoeducation group created and conducted in this project using popular education as a framework.
ACKNOWLEDGEMENTS

This project is a culmination of over twenty-five years of invaluable learning, experience, and involvement in social justice work in the Philippines, San Francisco, and Vancouver. It is the convergence of the many aspects of who I am and what I have been blessed with being able to do as a contribution to other people’s efforts at actualizing change. It has been shaped by the individuals, groups, and organizations I have encountered and has been facilitated by the caring and nurturing forces of the universe that sustain all of us. As such, it is difficult to acknowledge everyone, everything, and every force, that has contributed to this undertaking, through naming. For how can I adequately acknowledge the many individuals, families, and groups in small Indigenous Peoples’ villages, peasant communities, urban poor neighborhoods, upland farming areas, schools, non-profit organizations, medical and mental health care settings, on the streets, and makeshift homes. The numerous members of community-based and people’s organizations, advocacy and support groups, youth formations, development projects, and other people that one typically encounters by being involved in efforts for meaningful social change, particularly in the Philippines. I acknowledge all of these people with whom I share a similar vision of a more just world by humbly extending my deepest gratitude with collective blessings of loving kindness. Thank you.

I do acknowledge, however, that there are individuals and groups that have been concretely involved in this project that need to be mentioned. The members of the TRRG, the staff of CCD, my Supervisory Committee (Drs. Shauna Butterwick, Pilar Riano-Alcala, and Amy Metcalfe), my friends, my family (especially Mom and Dad), and my dearest husband, Graham, for their caring generosity, precious contributions, and loving support. Blessings of peace, plenty, and warm light are as generously extended to all of you.
Problem Statement and Purpose of the Study

The devastating effects of the prevalence and legacy of trauma are well-documented: traumatic experiences can result in significantly disempowering distress and physical, emotional, psychological, and spiritual impairment (The American Psychiatric Association (APA), 2000). This is particularly true and is experienced in more severe ways in contexts of chronic, acute, and continuing trauma. Most approaches to address traumatic distress, however, are individual-based (e.g., one-on-one psychotherapy) in response to individual needs, and are mainly focused on symptom management to help a person cope with their situation. These approaches are not oriented toward the structural and systemic forces such as exploitation, marginalization, and cultural imperialism (Young, 1990) that lead to trauma. This individualistic approach is unfortunately also used with groups: neither do most interventions address collective and structural dimensions of trauma or collective needs for recovery, nor do they use group-based methodologies.

This study will explore, using an action-oriented and participatory methodology, an alternative approach – popular education. Popular education, using visual arts-based methodologies, is an empowering orientation in that it provides venues for people to come together to collectively develop critical consciousness by engaging in problem-posing dialogue to identify root causes of their problems and organize to effect meaningful social change (Freire, 1973). Collective approaches to recovery are made more essential by the fact that no traumatic experience is ever really individual: a group or community is usually affected by these experiences (Martin-Baro, 1989). There is, therefore, a crucial need for more empowering interventions that contribute to the collective efforts of groups in addressing not just individual symptoms but the systemic and structural roots of trauma.
The research into visual arts-based methods illustrates how they enhance learning and empowerment processes through collective visualization of ideas and feelings and the power of visual images for self-expression and healing in specific cultural contexts (Curtis, 2005; Eisner, 2004). Research and theories of coping in the context of trauma have shown collective interventions are particularly effective not only for healing (Chester, 1992; Drees, 2000), but for helping groups develop capabilities in addressing trauma-related distress collectively, as well (Hubbard & Pearson, 2004).

The purpose of this study, therefore, was to explore how a popular education approach, including the use of visual arts, contributed to collective efforts at trauma recovery to address not just individual symptoms, but the systemic and structural roots that have and continue to facilitate retraumatization. The main research questions which guided this study are as follows:

1. What contributions can popular education (particularly using visual arts-based methods) make to efforts being undertaken by a group collectively experiencing the effects of chronic, acute, and continuing trauma including the oppressive forces of poverty, violence, and mental health challenges, towards collective recovery and reconstruction, in a clinical setting?

2. How can popular education theory and approaches be extended to inform psychoeducation initiatives for recovery and reconstruction?

3. What methods can be employed to facilitate collective expression and critical analysis towards united action in these undertakings?

4. What particular considerations would a framework for psychoeducation using popular education as framework take into account?
Why Popular Education in Trauma Work: My Own Story

My interest in this project comes from my own experience as popular educator in the context of community and organizational development initiatives spanning over twelve years in the Philippines with various not-for-profit organizations, over five years as a clinical social worker in the context of individual and group trauma psychotherapy in San Francisco, California with the Trauma Recovery Center, and my present occupation as a trauma psychotherapist with the British Columbia Operational Stress Injury (BC-OSI) Clinic in Vancouver working with soldiers returning from Afghanistan, Regular and Reserve members of the Canadian Forces (CF), members of the Royal Canadian Mounted Police (RCMP), their partners, and their families.

I lived the first twenty-two years of my life and my first years as a professional working also as a popular educator under the Marcos dictatorship and later under similarly repressive regimes in the Philippines. As popular educator, I contributed to the efforts of various groups and communities at empowering themselves by conducting learning needs assessments, designing, facilitating, and evaluating learning initiatives in partnership with them. These learning initiatives included topics in community organizing, community development work, organizational development/visioning, ancestral domain defense, team-building, facilitation skills for popular education, orientation to the visual arts, paralegal skills, orientation to Philippine social realities, upland farming technologies, care and support for people living with HIV/AIDS, and other topics, in the context of the Philippine progressive movement, the radical left. I worked with numerous communities including peasants, landless farmworkers, factory workers, urban poor communities, indigenous peoples, youth and students, and indigenous people’s rights advocates. In addition to these, I also worked with upland (mountainous farming areas) peasant youth, progressive visual artists, community
development workers, developmental lawyers, paralegals, environmental groups, youth organizers, people living with HIV/AIDS (PLWHAs), caregivers of PLWHAs, government employees, human rights advocates, and other development workers.

I attended graduate school in 1999 in San Francisco, California, and worked as a trauma psychotherapist with individuals and groups suffering from trauma-related anxiety, depression, substance abuse, and other mental health challenges. I facilitated groups using popular education as framework with individuals experiencing the effects of acute, chronic, and, in most cases, continuing traumatic distress. I acquired valuable competencies not just in cognitive-behavioural and other interventions to trauma to help in the management of individual symptoms, but also the use of popular education in a clinical context of psychoeducation to contribute to collective efforts at addressing systems and structures that facilitate (re)traumatization.

This action-research project is the culmination of the lessons, experiences, attitudes, knowledge, and competencies I have gained from a combined total of over twenty years of my involvement in popular education initiatives (particularly using visual arts-based methods), trauma psychotherapy, and participation in social justice and change work, with numerous groups/organizations in the Philippines, San Francisco, and Vancouver. It facilitates the translation of significant aspects of my life’s work thus far into a relevant contribution to the practice of popular education in the context of the efforts undertaken, in terms of this project, by the project participants.

Of great influence to my work is Paulo Freire, a Brazilian theorist and practitioner of popular education. His pedagogy for community-based, dialogical, and participatory education to bring about meaningful social change has been the basis of my own contributions to people’s efforts in my own work. The particular way I have come to define and practice popular education, however, has been based on my own
experiences in relation to the broader context of the groups and communities I have been fortunate enough to have worked with.

In this project, I bring various aspects of myself and my experience together as my own significant contribution to the practice of critical pedagogy by way of a new approach in its use in the particularly difficult circumstances of trauma.

Defining Key Concepts

A more thorough review of the literature on trauma and recovery follows in chapter two. Similarly, in chapter three, I provide a more detailed discussion of popular education. An introduction to the key concepts of trauma, collective recovery and popular education is outlined here.

Trauma is defined by an individual, group, or community, in a number of ways based on various considerations including but not limited to: ethnicity, culture, history, values, socialization, and, as will be discussed in greater detail later, worldview. These definitions are varied and, in many cases, contradictory. People do not usually have only one specific way of defining trauma, evidenced by how people draw on various sources of healing for recovery, including medical science, psychotherapy, spirituality, reason, alternative healing arts, the spirits of the natural world, or the divine forces of the universe, just to name a few. One definition of trauma is that it is a “serious injury or shock to the body, as from violence or an accident; an emotional wound or shock that creates substantial, lasting damage to the psychological development of a person, often leading to neuroses; an event or situation that causes great distress and disruption” (The American Heritage Dictionary, 2006). Other communities, on the other hand, define trauma in more spiritual terms: as a form of suffering, an experience that is integral and essential to life and living. In Buddhism, suffering is necessary so that we may realize liberation through the exploration of the roots of our anguish,
the prevention of its further creation, and the undertaking of efforts to sustain its non-existence (Hanh, 1999). Native American communities define trauma also in the context of suffering as “soul wound,” which may involve the intrusion of a diseased object into the body (Duran & Duran, 1995). Duran and Duran (1995) also state that it may be in the form of “loss of soul,” or the departure of the soul from the body or the theft or abduction of the soul from the body by ghosts or spirits.

Herman (1997, p.33) defines traumatic events as “those which overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.” Such events can result in long-term alterations in people’s physiological arousal, emotion, cognition, and memory. Individual members of a community or nation who may be far away from the site of traumatic events may also experience hypervigilance, a compromised sense of safety, and altered views of their lives and futures (Ursano, Fullerton, & Norwood, 2003; Fullerton, Ursano, Norwood, & Holloway, 2003). Van der Kolk (1996) describes how lack of predictability and controllability are main themes of trauma-related distress and that it is the persistent and intrusive reliving of the event that results in complex changes in people’s cognitions, behaviors, relationships, and view of their future lives.

*Post-Traumatic Stress Disorder (PTSD)* is defined by the APA (2000, p. 463) “a set of symptoms developed after exposure to, witnessing of, or learning about an incident of grave threat to life or one’s personal integrity, or unexpected or violent death of others, involving intense fear, helplessness, or horror.”

*Collective recovery and reconstruction* is concerned with responding to the shared needs of individuals who have come together as a group to collectively respond to distress from similar trauma. These traumatic experiences may include long-term childhood physical and sexual abuse, domestic violence, community violence or organized terror. Collective recovery and reconstruction involve contributing to the capability of group members to together
analyze and address social systems and structures (e.g., family, community, or mental health systems) that have and continue to facilitate trauma. These undertakings support the reconstruction of networks (e.g., identity, support, advocacy, learning, or community) to decrease the sense of isolation and address collective needs for healing (Miller & Rasco, 2004). For the purposes of this study, one aspect of recovery that will be focused on is meaning-making which involves the naming of new and more healing personal philosophies and ways we regard history, emotion, behavior, and ideals to integrate trauma-related-distress into our concrete reality (Carlsen, 1988).

*Popular education* is a liberative approach to education that emphasizes context-based, people-centered, dialogical, and transformative processes where a group or a community works together to develop critical consciousness to identify root causes of their problems and undertake collective action towards meaningful social change (Freire, 1998). Pedagogies used are participatory and are based on specific cultural contexts and indigenous methods of learning. These may include oral traditions, song, dance, games, local symbols/materials, myth and lore, and traditions of theater arts and visual arts. In contexts of chronic, acute, and continuing trauma, popular education can significantly contribute to the process of critically analyzing the systems and structures of (re)traumatization to identify its origins as basis for determining relevant courses of unified action for recovery and reconstruction. This project focuses on visual arts-based methods used in popular education which have significant contributions to recovery and reconstruction efforts by helping facilitate the expression of individual and collective distress for collective analysis towards united action.

**A Collective Popular Education Approach**

This participatory action-research project explores the contributions that popular education makes to efforts being undertaken by a group of individuals experiencing the
effects of chronic, acute, and continuing trauma (and related mental health challenges) towards collective recovery and reconstruction, in a clinical setting. These contributions were determined through the creation and implementation of the Trauma Recovery and Reconstruction Group (TRRG), a twelve-week psychoeducation group using popular education as framework, at and with clients of the Centre for Concurrent Disorders (CCD), in Vancouver, British Columbia, a community-based, outpatient service funded by Vancouver Coastal Health which provides services to individuals with both a chemical dependency and serious psychiatric illness (such as anxiety or depression). I will discuss this project in greater detail in chapter four.

This project was undertaken in three stages. Stage One included the conduct of a project orientation session with referring therapists and individual orientation sessions with prospective participants. Stage Two included individual interviews with those who agreed to participate, a group project orientation, and the conduct of the twelve-week TRRG. Stage Three involved a group evaluation session and a final round of individual interviews also for evaluation.

For this study, I designed a research method, Trauma Recovery-Focused Participatory Research (TRFPR), which involves participatory research processes and activities that also contribute to or facilitate trauma recovery and reconstruction. I will discuss TRFPR in greater detail also in chapter four.

**Significance of this Project**

This project makes theoretical, methodological, as well as practical contributions to the practice of popular education, particularly using visual arts-based methodologies, in the efforts of a group at collective trauma recovery and reconstruction in a clinical setting in Vancouver, British Columbia, Canada.
These theoretical contributions include the extension of popular education theories and application in trauma psychoeducation work in contexts of chronic, acute, and continuing trauma and how these significantly enhance collective initiatives at recovery and reconstruction. This includes efforts at addressing not just individual symptoms but systems and structures that facilitate (re)traumatization, particularly by individuals who have and continue to negotiate the mental health system. These efforts, therefore, take clinical considerations into account.

Methodologically, this project provides a model for employing participatory, visual arts-based, and capacity-building approaches. These approaches involve processes for collective expression of trauma-related distress and recovery towards developing skills in critical analysis of systemic and structural origins of collective (re)traumatization, and the identification and actualization of approaches to collective recovery and reconstruction through united action. This project also outlines a new research method, Trauma Recovery-Focused Participatory Research (TRFPR).

Practically, this project contributes to recovery and reconstruction efforts of a group in contexts of chronic, acute and continuing trauma through the actual conduct of the TRRG, a twelve-week collaborative psychoeducation group. The TRRG provides a venue for the participants to create a community of support and learning in the context of effecting systems- and structures-based change.

**Dissertation Outline**

This dissertation has eight chapters. This Introduction and Project Overview followed by Chapter Two - Literature Review on Trauma, in which I explore the current literature on trauma to a significant extent. In Chapter Three - Theoretical Framework: Popular Education, I discuss the set of theories that inform this project including some
of the principles and processes of popular education, trauma and trauma recovery and reconstruction, visual arts-based methods and meaning-making, and insights I gained from my involvement in education initiatives using popular education as framework.

In Chapter Four – Community-Based Participatory Research (CBPR) I discuss methods used in the conduct of this research both in terms of this dissertation and the TRRG. For this project I designed a method I call Trauma Recovery-Focused Participatory Research (TRFPR) which is oriented in Community-Based Participatory Research (CBPR); I describe the use of TRFPR in the context of popular education.

Thematic analyses follow in the next three chapters, beginning with Chapter Five – Towards a Grounded Theory on Trauma, where I outline particular theoretical contributions from the TRRG including participants’ perspectives and viewpoints on the nature of trauma and various ways that dialogic, participatory, and transformative processes can inform collective recovery and reconstruction.

In Chapter Six – Visual Arts-Based Methods and Collective Expression, I focus on the visual arts-based methods used in relation to contributions made to the practice of popular education in contexts of trauma.

I present A Framework for Popular Education and Collective Trauma Recovery and Reconstruction in Chapter Seven. In this chapter, I discuss aspects of Freire’s popular education theories that pertain to this study and aspects that have been extended to define a framework appropriate to psychoeducation initiatives for collective trauma recovery and reconstruction.

In the final chapter, I present the Project Summary and Implications. I begin this chapter with a review of the main research questions and objectives in terms of this project’s outcomes. I then discuss project implications in terms of individual treatment plans to routinely include client participation in a psychoeducational group, programs of
mental health agencies to ensure delivery of trauma-related services, the conduct of psychoeducation initiatives in contexts other than mental health agencies (e.g., community-based organizations and other formations), the establishment of a network of groups for trauma psychoeducation initiatives in contexts other than mental health agencies (e.g., community-based organizations and other formations), and the establishment of a network of groups for trauma psychoeducation and support. I also discuss how there is a need for changes in policies involving mental health, the limitations of the study, and considerations for Continuing Complex Traumatic Stress Disorder (CCTSD) as a contribution to the current discussions on revising or expanding Post-Traumatic Stress Disorder (PTSD) as a diagnosis.
CHAPTER TWO
LITERATURE REVIEW ON TRAUMA

In this chapter, I explore the current literature on trauma in the context of this study. These discussions include exploring trauma as an embodied experience and considerations for recovery and reconstruction. I then explore trauma as outlined in the diagnostic canon (i.e., PTSD) and the prevalence of how individuals regard this experience in these terms but integrate aspects of other ways of knowing and believing in their lives and living. I note the dominance of the individualistic approach, the ongoing nature of trauma, and conclude the chapter by outlining the contributions that a more collective orientation can bring to understanding and healing from trauma.

Trauma

Discussions of trauma in Western societies abound in the context of psychiatry, psychology, psychotherapy, clinical social work, and counseling, largely based on the diagnostic canon as articulated by the American Psychiatric Association (2000) (please see discussion later in this chapter).

It is essential to first clarify that not everyone who experiences a traumatic incident develops trauma-related symptoms or clinically-significant distress. The Canadian Mental Health Association (2009) estimates the prevalence of clinically-significant trauma symptoms (e.g., PTSD) at 10% of those who have experienced a traumatic incident. The American Psychiatric Association (2000) states that PTSD affects approximately 8% of the adult population in the United States. The National Center for PTSD (2006) pegs this number at 7.8% among adult Americans with women twice as likely, at 10.4%, than men, at 5%. This represents a small proportion of those
who have experienced a traumatic event at some point in their lives: 60.7% of men and 51.2% of women reported experiencing at least one traumatic event.

Intimate details of trauma including various aspects of PTSD and treatment have been explored (Van der Kolk & McFarlane, 1996; Ursano, Grieger, & McCaroll, 1996; Rothbaum & Foa, 1996) including acute preventive interventions (Raphael, Wilson, Meldrum, & McFarlane, 1996), trauma and its challenges to societal structures like the church, media, and community (McFarlane & Van der Kolk, 1996), and discussions on trauma history (Van der Kolk, Weisath, & Van der Hart, 1996), adaptation (Brett, 1996; Van der Kolk, 1996), and memory (Van der Kolk, 1996) which have provided valuable information in undertaking this project. Work with families and children has also been written about identifying particular needs for healing in the context of the family, school, group, and community using debriefing techniques, murals, maps, music, art, and drawing (Webb, 2004), which also provide a basis for the work with and use of various methods in groups.

Early interventions to traumatic experiences can enhance chances for recovery. Innovations in early intervention have been explored and many of these uncover vital information in the care of traumatized populations. These innovations come from a variety of discussions including: crisis, crisis theory, debriefing, psychobiological considerations, learning theory, communities affected by organized violence, psychodynamic interventions, cognitive-behavioral therapy, interventions with populations affected by war, and competence-building, among others (Orner & Schnyder, 2003). Refugee communities have experienced various forms of trauma and retraumatization necessitating particular approaches to deal with the unique aspects of mental health and recovery in these contexts (Miller & Rasco, 2004). Refugees from Angola, Sierra Leone, Cambodia, Sri Lanka, East Timor, Colombia, Bosnia, Kosovar,
and Vietnam each have particular contexts, means of adaptation, and approaches to recovery. Recovery is also discussed in terms of establishing healing relationships, working on safety, remembrance and mourning, and reconnection towards healing (Herman, 1997).

Ethnocultural aspects of trauma have been researched in various communities including African American, Native American, Asian, and Asian American. Research into various themes and dimensions of trauma and recovery have likewise been undertaken including: emotions, cross-national issues, domestic captivity, trauma in children and adolescents of various ethnocultural groups, issues in the community of veterans, service delivery and ethnopsychopharmacology (Marsella, Friedman, Gerrity, & Scurfield, 1996). These discussions provide valuable lessons in understanding the various ways that trauma is experienced by different groups and communities.

Although these texts take important aspects of trauma into account, including acknowledging how different communities define, manifest, and heal from trauma, they are very limited in considering continuing collective trauma-related distress and responses undertaken through dialogic, participatory, and transformative education to address systems-based needs for recovery.

**Embodied Effects**

Before going any further into the discussion on trauma in the diagnostic canon it is important to first establish that, unlike what is commonly perceived, traumatic experiences, even those that do not involve actual physical harm (e.g. witnessing mass deaths, long-term emotional abuse, imminent threat to one’s life) can result in actual physical injury, at the outset, to the brain. This is to say that traumatic experiences, if severe enough, can actually result in physical damage to the brain. Such injuries can then lead to other physical impairments such as chronic pain, specific illnesses related
to anxiety, problems with vision, among others. In addition, trauma-related distress facilitates other mental health challenges which can further complicate physical impairments. Trauma, therefore, does not just affect cognition, it is oftentimes embodied.

It is beyond the scope of this dissertation to extensively discuss how trauma affects the brain but a basic understanding of this is necessary. Although laid in out in the simplest of terms, it is hoped that this discussion will provide the reader with an overview of how trauma can result in physical alterations/damage to the brain.

The brain is essentially made up of three main parts: the forebrain, the midbrain, and the hindbrain (Britannica, 2008). These contain the structures known as the cerebrum, the brainstem, and the cerebellum. The cerebrum, the massive pair of heavily wrinkled matter at the front part of the brain, is the ‘youngest’ and most highly developed part. This part controls, among others, cognition, speech, planning, problem-solving, reason, judgment, self-control, abstract thought, appropriate communication, and sense perceptions (e.g., touch, pressure, and our ability to judge size and shape). In addition to these, the cerebrum also controls visual and verbal memory, personal identity, learning, and olfactory and visual perception. Within this structure is found the more primitive part of the brain, the sympathetic nervous system, including the hypothalamus. The hypothalamus controls the more basic survival functions common to mammals, including that which is most relevant to this discussion, our ‘fight or flight’ response. The brainstem connects the brain to the spinal cord and within this system is found the parts that are responsible for basic life functions including heartbeat, blood pressure, visual and auditory systems, and breathing. The cerebellum, for its part, regulates and coordinates nerve impulses to control our limbs, posture, and balance (Britannica, 2008).
When a person experiences trauma, the brain recognizes the threat or danger and sends signals to the part of the brain that controls our response to such, the sympathetic nervous system. Typically, the hypothalamus regulates our ‘fight or flight’ response so that we are able to help identify and actualize appropriate coping and self-defense strategies; we usually respond to threat or danger according to the degree of peril based on our analysis of the situation and the best course of action to take. This process of coping and self-defense ordinarily involves a complex system of responses involving both the body and mind (Herman, 1997).

Unfortunately, we sometimes experience some incidents that overwhelm and disorganize these systems of reaction which can result in anxiety disorders such as post-traumatic stress disorder (PTSD). I will discuss PTSD in greater detail later in this dissertation. In simple terms, a traumatic experience can essentially ‘hijack’ the brain and shut down the brain centers that control its higher level functions, including our ability to use adaptive reactions to danger. When these systems are overwhelmed over an extended period of time, the brain experiences physical alterations: the brain can be physically damaged.

Kardiner (1947, as cited in Herman, 1997, p. 35) states:

When a person is overwhelmed by terror and helplessness, the whole apparatus for concerted, coordinated, and purposeful activity is smashed. The perceptions become inaccurate and pervaded with terror, the coordinative functions of judgment and discrimination fail . . . the sense organs even cease to function . . . the aggressive impulses become disorganized and unrelated to the situation in hand . . . The functions of the autonomic nervous system may also become disassociated with the rest of the organism.

As PTSD goes untreated the effects become even more complicated as the brain continues to function in this ‘hijacked’ state. Typically, other mental health challenges are experienced including depression and substance abuse. In these
situations, more and more aspects of one’s life and functioning are adversely affected, characterizing what is more and more becoming accepted as complex traumatization.

Presently, however, there are inadequacies in the clinical definition of trauma in terms of people’s actual experiences which serve as the bases for a new diagnosis, particularly considering complex trauma. Complex trauma (Herman, 1997) may include multiple experiences of traumatization including unresolved effects of long-term childhood abuse and neglect, lifelong exposure to violence (e.g., domestic, state-sponsored terror) and other such devastating incidents throughout the lifespan.

Trauma as an embodied, and not just a cognitive experience, informs any and all efforts undertaken towards recovery and reconstruction.

### Trauma Recovery and Reconstruction: Varying but Integrated Views

**Post Traumatic Stress Disorder (PTSD)**

As briefly described earlier, an individual (or community for that matter) defines trauma based on their worldview. For many who live in ‘Western’ societies, trauma and recovery are typically viewed in more individualistic, medicalized, and regulative terms. It is a ‘disorder’ experienced by an individual (or group) whose recovery is evidenced by regulated behavior based on a social contract of what it means to have ‘order’ in the context of the system in which it is located.

Many, however, regard trauma and recovery beyond these terms. Aspects of varying worldviews are usually integrated into one’s own creating a broader framework by which the world is negotiated and recovery and reconstruction are realized. This is an important consideration in realizing a more comprehensive understanding of what trauma and recovery truly are based on people’s lived experiences.
To explain further, let us take a closer look at the ‘Western’ worldview and how trauma is defined.

‘Western’ worldview is fundamentally individual-centered, compartmentalized, linear, sequential, and emphasizes values around meritocracy, consumption, accumulation, material wealth, conquest, colonization, and domination (Duran & Duran, 1995). Many of these values inform how trauma is regarded. In this worldview, trauma-related distress is seen as an experience by an individual on a continuum anywhere from having hardly any detectable effects to the demolition of entire lives. It is regarded as the result of the sequence of events (which is how recovery happens, as well), and is an experience that can be distinguished or separated from other aspects of one’s life. In medical/psychotherapeutic discourse, there is a point in this distress continuum when trauma is gravely concerning and diagnosable as a disorder. One such point of ‘clinically significant distress or impairment in important areas of functioning’ is referred to as Post-Traumatic Stress Disorder or PTSD (APA, 2000).

The APA (2000, p. 467) describes PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), the basic clinical guide, as:

A set of symptoms developed after exposure to, witnessing of, or learning about an incident of grave threat to life or one’s personal integrity, or unexpected or violent death of others, involving intense fear, helplessness, or horror. The exposure to trauma results in clinically-significant distress or impairment including symptoms of persistent re-experiencing of the event, persistent avoidance of trauma-related stimuli, and persistent numbing of general responsiveness lasting more than one month.

A diagnosis of Acute Stress Disorder (ASD) can be given for less than one month of clinically significant distress (with slight variation in symptom criteria.) The APA (2000) diagnostic criteria for PTSD are outlined in Appendix A.

It is important to note that it is not solely the direct traumatic experience of an individual that may result in clinically diagnosable trauma-related anxiety. A person may
have also ‘witnessed’ or were ‘confronted with’ these incidents that happened to others (APA, 2000), particularly significant people in their lives.

The characteristic symptom picture of an individual suffering from PTSD includes persistent re-experiencing in the form of intrusive memories, agonizing dreams, a sense of reliving the event, and distress at reminders/triggers of the incident, which may include nearly anything present or associated with the event: a person’s own body, specific objects, the site, time of day, scents, certain types of people, reminders of the perpetrator in cases of assault, etc. (APA, 2000). This may mean that an individual goes through their day with a greatly diminished or total lack of control over their thoughts (and therefore their emotions and behaviors) experiencing distress whenever and however often memories come. They may experience anguish for no apparent reason, sometimes not knowing that they are being triggered by seemingly neutral objects: a cup, flowers in a vase, or a chair present during the incident, or the temperature in a room, dawn, or soft music playing that is somehow associated with the traumatic experience.

In addition, the APA (2000) describes how the individual persistently engages in psychological, emotional, and behavioral avoidance in the form of actively avoiding thoughts, feelings, discussions, activities, places, contexts, and people that remind them of the trauma. They may ‘numb out,’ feeling significantly detached from others (even those they are very close to) and disinterested in interactions and undertakings that used to be pleasurable (relaxing walks on the beach, watching movies, playing sports). In cases of compromised personal integrity such as in cases of physical or sexual assault, the capacity for close physical and sexual contact, intimacy, affection, or feelings of connection to others may be greatly diminished (Herman, 1992). These feelings of detachment may manifest in intimate relationships with partners, family
members and friends, and in relating with members of one’s community or organization (Bar-on, 1999). It is also common that traumatized individuals may not remember significant aspects of their traumatic experience (Janik, 2005) or may have a sense that their future has been foreshortened (Herman, 1997). Many are not able to think of longer-term plans in terms of a career or a long and happy life post-incident. In fact, for many young African-American men I worked with in San Francisco, life after 21 was simply not a likelihood; they expect, or rather, they know, that they will be killed just like the majority of their friends and other members of their community in the context of ongoing gang or drug-related violence. Many individuals engage in avoidance by denying their pain (trivializing the incident and its effects) by making things seem ‘fine’ or ‘as they were before.’ This is a fairly common form of this maladaptive coping strategy.

The traumatized individual may also endorse persistent symptoms of hyper-arousal, feeling a disturbing sense of anxiety and hypervigilance (there is constant threat of assault or danger from most everyone/everywhere), oftentimes more pronounced in public settings (Herman, 1997). An individual might experience distress simply by being in public spaces, unable to leave their home or even their bedroom, sometimes for days or months on end. These symptoms may also be manifest in difficulty falling or staying asleep due to distressing dreams or the anticipation of such dreams. They may also have an exaggerated startle response, irritability, and problems with managing anger (APA, 2000). Many experience difficulty concentrating or completing simple tasks, for example, reading the newspaper, writing a letter, or just sitting and watching television.

One way of understanding trauma is in terms of various categories to describe its symptoms. These may include the particular characteristics of individuals, groups, communities (physical, cognitive, emotional, psychological, developmental, relational,
occupational, and spiritual) and contexts (geographic, economic, political, social, and cultural), which also serve as bases for defining trauma and recovery and reconstruction. The nature of the traumatic experience itself (individual or collective; chronic, acute, or continuing; unexpected or not), intensity (mild, moderate, or severe), frequency (single, multiple, or recurring), location (occurring in contexts of safety or enhanced risk), timing (when such incidents happen in people’s lives), impact (temporary or permanent damage/injury), and other related factors, also affect how people experience the typically adverse effects of these experiences (APA, 2000).

These factors determine the extent to which people experience trauma-related distress as manifested in the three main symptom clusters of re-experiencing, avoidance, and hyperarousal. The management of these symptoms is the focus of treatment in order that those affected may be able to function based on how they need or are expected to. This may be accomplished in the most effective way through a combination of interventions including psychotherapy (evaluation, diagnosis, and treatment of mental health disorders), medication support (provision of psychiatric care as needed), psychoeducation (individual and group - providing information and facts about one’s condition and healing), case management (ensuring access to needed services including housing, food, medical/social/legal services, etc.), advocacy (support for the promotion of patient rights and welfare), and community outreach (Okin & Boccellari, 2004).

The reality, however, is that although many people ascribe to this individualistic, medicalized, and regulative definition of trauma (APA, 2000), aspects of other worldviews inform their actual lived experience. For example, many who live in the ‘Western’ societies ascribe to the tenets of a ‘Western’ worldview, but have incorporated aspects of other worldviews. This is so even though these may contradict
each other. To illustrate, many individuals in ‘Western’ societies live their lives in the context of free market economies, work in institutions that promote values of capitalism, accumulation, and consumerism, and also believe in holistic healing and other practices that advance notions of oneness with all creation. It is important to understand this reality if relevant responses are to be realized. For many, integrating these aspects help in making sense of these seemingly permanently chaotic experiences and provide other viable sources of meaning and hope, particularly when one fails or falls short. This is true for the numerous spiritual belief and faith systems. I explore one such belief system, Buddhism, to provide the reader with a glimpse of a seemingly convergent way of regarding trauma and recovery which many people in ‘Western’ societies ascribe to and heal by.

**Trauma as Suffering, Trauma is Suffering**

The worldview that Buddhism is based on is related to notions of collective- (as opposed to individual-) centeredness, spiritual (versus material) advancement, unity and compassion (in contrast to segregation or supremacist thinking), holistic (not compartmentalized) view of reality, non-linear/non-sequential (as opposed to linear/sequential) regard for the order of things, harmony with others and the environment (versus conquest, colonization, domination, and the destruction of the environment for human beings), non-separation (in contrast to disconnectedness from others), and other related values (Siddharta, 2005). These are also reflected in how trauma is regarded, subscribing to principles around spiritual advancement through holy convictions and acts to attain enlightenment through difficult human experiences (Thera, 1999).

Hanh (1998) explains how Buddha taught that suffering is holy as it facilitates the knowing of truth in the context of silence (defined as the peace that comes from the
quieting of the body, mind, and spirit) towards liberation. Through the lens of inter-being (the notion that nothing can itself stand alone, is separate, or non-continuous) traumatic experiences and other forms of suffering are integrated with well-being; they are one, not two separate phenomena (Siddharta, 2005). Suffering, therefore, is an essential component of existence, a reality of life that needs to be acknowledged and reflected upon in order that one may be able to identify ways to prevent its causes towards living an existence characterized by peace and joy in the principal realms of life (Hanh, 1997). This is articulated in Buddhism’s Four Noble Truths (Hanh, 1997, pp. 9, 11):

1. Suffering (Dukkha) – all beings suffer to some extent.

2. Arising of Suffering (Samudaya) – our suffering has a knowable nature, origin, and root causes, borne of spiritual and material things we ingest.

3. Cessation of Suffering (Nirodha) - we have the capability to cease the creation of suffering by preventing ourselves from doing things that cause us to suffer.

4. The Path (Marga) - we can live our lives in well-being by following the Path of Eight Right Practices: Right View, Right Thinking, Right Speech, Right Action, Right Livelihood, Right Diligence, Right Mindfulness, and Right Concentration.

In the tradition of inter-being, it is of great consequence to note how the elements of the eightfold path are interrelated. Thera (1999) describes how Right View, for example, is integral to the other elements; it is impossible to actualize this without all the others. It is vital to our existence to have the right view of suffering in order that we may actualize liberation in our lives. One of the processes in attaining this is articulated in the Twelve Turnings of the Wheels of Dharma three for each of the Four Noble Truths (Hanh, 1997).

It is important to note the way in which the Twelve Turnings of the Dharma Wheel articulate the processes of recognition, encouragement, and realization throughout. These are consistent with popular education processes of critical analysis,
conscientization, and united action. This will be discussed further later in this dissertation.

For each noble truth, Hanh (1997, p. 30) outlines three turnings of the dharma wheel involving recognizing the nature of or potential in what we experience, encouraging what could be, and realizing or actualizing meaningful change. The processes under the first noble truth, Suffering, include recognizing that what we are "experiencing is suffering, encouraging that suffering should be understood, and realizing that suffering is understood." Under the second noble truth, Arising of Suffering, processes include recognizing that “there is an ignoble way that has led to suffering, encouraging that that ignoble way should be understood, and realizing that that ignoble way is understood.” For the third noble truth, Cessation of Suffering, such processes include recognizing that “well-being is possible, encouraging that well-being should be obtained, until well-being is obtained.” The fourth noble truth, The Path, includes recognizing that “there is a noble path to well-being, encouraging that this noble path should be lived, until this noble path is being lived.”

But what causes suffering? Hanh (1997) talks about how suffering is, for the most part, the result of our misattribution of the quality of permanence to people, objects, and experiences and our attaching to these misattributions. He illustrates this by explaining how we regard composite entities (and by being composite he means things that will eventually break apart) like people and things to be permanent; we affix ourselves to them and consequently experience distress when we are faced with their loss (Salzberg, 1995). No one and nothing is ever permanently in our lives; to expect to have people, own things, or be a certain way (e.g., healthy, young) forever is a source of human distress. In terms of traumatic experiences, our misattribution of permanence to aspects of living that are inherently impermanent (e.g., our physical, emotional, and
psychological health and well-being, our lives and control over them) causes or exacerbates the resultant anguish that comes from their loss. In addition to this, Hanh (1997) describes how our sense of separation from each other facilitates emotional states like craving, desire, anger, ignorance, suspicion, arrogance, and wrong perceptions, which can likewise cause great suffering in our lives.

Such misattributions prevent us from acknowledging and deeply analyzing the origins and root causes of our suffering, and understanding it. This then leads us to not undertake meaningful efforts to resolve the causes of our suffering and therefore will likewise prevent us from ascertaining well-being (Thera, 1999). These acts characterize ignoble truths which will likely lead to an ignoble path: wrong view, wrong thinking, wrong speech, wrong action, wrong livelihood, wrong diligence, wrong mindfulness, and wrong concentration (Hanh, 1997).

Hawkins (2006) describes different levels of consciousness and ways to transcend these through processes of spiritual advancement. This can be achieved through meditation/prayer, surrender/acceptance, and loving kindness/compassion, among others. These processes involve overcoming the levels of falsehood including shame, guilt, apathy/hatred, grief, fear, desire, anger, and pride towards levels of truth including courage, neutrality, willingness, acceptance, reason, love, joy, peace and enlightenment. This relates to aspects of a worldview and processes of learning and spiritual development that many people and communities across the world ascribe to.

**Integrating (Buddhist) Suffering and Liberation to Trauma and Collective Recovery and Reconstruction**

It may seem that since Buddhism regards trauma (i.e., suffering) as a necessary component of spiritual advancement that it is simply accepted and not seen as something that needs to be addressed. Furthermore, it may seem that Buddhism is
focused only on the individual and not on systemic and structural injustices. In one sense, it is. Many of the ways that Buddhists experience liberation from suffering is by doing internal work through the eight right practices: in view, thinking, speech, action, livelihood, diligence, mindfulness, and concentration, which seem divergent from systems- and structures-based work that this dissertation advances. In another sense, it is not. Like any religious belief system, one’s interpretation can be on one end of the spectrum, individualistic (considering only self and one’s well-being) and conservative (working on individual change within a system), or at the other end, collective (considering others in the context of systems and structures) and progressive (participating in efforts to actualize meaningful social change); it is a range.

Those who have an awareness of social suffering can regard Buddhist notions of collective-centeredness, holistic thinking, harmony with all creation, and non-separation, as basis for undertaking work to advance collective well-being in terms of social justice. This is what I have encountered in my work in the past. Many merge what seem as divergent aspects of various worldviews to help make sense and meaning of difficult experiences. This broader framework by which people live accommodates the various beliefs that are seamlessly integrated to create a sense of being whole where their predominant worldview does not allow for the full expression of their faith, hope, a sense of community with others, or the need for compassion expressed in striving for collective justice, other worldviews do.

As an example, The Four Noble Truths (Hanh, 1997) can be interpreted as parallel processes of systems- and structures-based work. The Recognition of Suffering is contextual analysis which goes beyond the individual toward acknowledging more systems- and structures-based distress. The Arising of Suffering involves the recognition of the roots or sources of this suffering which can include the ways that
systems and structures facilitate (re)traumatization. The Cessation of Suffering is the actualizing of alternatives to collective suffering through social action. And the Eightfold Path serves as basis for sustaining a more just and humane society. And all this starts with the self, by developing competencies to first be able to address one’s individual needs while remaining in the context of addressing the collective needs of one’s community. This is the significance of the integration of these aspects as far as this dissertation is concerned. It is contextualized in one’s reality and the complex workings of one’s view of the world.

One truth about Buddhism, or any other religious belief system for that matter, is that as long as there is injustice in one’s immediate context (e.g., family, community), and by extension, the world, principles of spiritual growth, enlightenment, or salvation can not become real. We can not move toward the divine if we allow for injustice to prevail because denying justice to others as long as we have it for ourselves is precisely the opposite of being divine.

One’s worldview informs how one defines trauma and recovery and reconstruction. As well, it is clear that cognitive processes involving education and learning play a key part in recovery and reconstruction. These processes include assessing context and needs, defining content and methods of learning initiatives, unifying for, and undertaking collective action, among others. It is vital that people experiencing trauma-related distress acquire or enhance competencies in engaging these processes towards meaningful change, in life as well as in education.

The Dominance of Individual-Based Approaches

However trauma is regarded or experienced, it is unfortunate that the most common response to addressing the resultant distress is through individual-focused
approaches. This is particularly so in the ‘Western’ world, where most people believe that this is an individual concern. Many simply endure their pain and cope with the anguish by themselves, receiving no assistance at all. Many deny it even exists. Professional interventions if and when accessed, are mostly individual-focused, usually in the context of psychotherapeutic interventions. These interventions are based on approaches that deal with trauma as manifested in the three main cluster symptoms of re-experiencing, avoidance, and hyperarousal (APA, 2000) and may be in the form of crisis counseling, psychotherapy, psychoanalysis, psychiatric care, or one of the alternative healing arts. Even in contexts where trauma is experienced by large numbers of people, as in communities in contexts of gang or drug-related hostility, organized terror, state-sponsored violence, or war, it is more typical that people’s distress is addressed individually, especially in ‘Western’ societies. These interventions are designed to help individuals cope with their distress as individuals in their context, usually in ways that are defined solely by the therapist. In addition to this, hardly any efforts are undertaken to connect the trauma to or transform the systems and structures that facilitate these distressing experiences (Herman, 1997). Kaye (1999, p. 21) describes how individual-based psychotherapeutic approaches involve the “exploration and examination of an individual’s experience to engage the other actively in the process of reinterpreting their narrative within the therapist’s frame, developing new behaviours in accord with it.” People are basically assisted in enhancing or developing their individual ability to deal with distress until this is reduced to manageable levels, in most cases, without any efforts undertaken to change the contexts in which these traumatic experiences are located.

Kaye (1999, p. 20) argues that the individualizing of people’s distressing experiences while disregarding their possible social contexts
must lead us to question whether the enterprise of psychotherapy is largely trapped in a limiting paradigm by virtue of its focus on intrapsychic causation of problems to the relative exclusion of a concern with the loss of certainty wrought by a changing world or by structurally ingrained inequities – of class, race, gender, economic deprivation, and unfavourable living conditions.

Disregarding contexts of social inequities that have facilitated traumatization may result in us assisting individuals to adjust to the unjust (Cross, as cited in Kaye, 1994).

Some initiatives to help groups or communities respond to trauma in professional psychotherapeutic approaches in ‘Western’ societies seem collective but a closer look at these will reveal that these are usually also designed to help individual members cope with their distress as individuals in a group setting, not together as a group or community to address collective needs. Klein and Schermer (2000) note how there are a large number of group therapists who are merely doing individual therapy in groups. An example of this in the category of early intervention strategies is Critical Incident Stress Management (CISM), a form of ‘psychological first aid’ (Spiritwood Ambulance Care, Ltd., n.d.) that is undertaken in the acute/crisis stage of trauma, usually only within 24-72 hours up to four weeks post-incident (Everly & Mitchell, 1997). Young (2006, p. 139) describes psychological first aid as a strategy “to address individual needs for safety and basic support, the reduction of extreme stress reactions, and connection with restorative resources through referral.” CISM is usually conducted through discussions with affected groups about what happened, what the effects are of these events, ways to immediately manage these effects, and referral to continuing care, if necessary (Everly & Mitchell, 1997; Wilson & McFarlane, 1996).

Another example of these presumably collective responses is group therapy. These are designed to help members deal with trauma-related anxiety, depression, substance abuse/dependence or other mental health challenges. The focus of these, too, however, is usually on the individual and how s/he can more effectively cope with her/his psychological
and emotional pain in a group setting; relationships in the group are the contexts of exploration and examination. Group therapy falls in the category of longer-term interventions as opposed to early intervention strategies, such as CISM. Although undertaken with larger numbers of people, these approaches use mostly individual-focused treatment modalities including cognitive-behavioral therapy (CBT), medications (e.g., selective serotonin reuptake inhibitors or SSRIs), and alternative therapies like eye movement desensitization and reprocessing (EMDR) (Raphael & Wooding, 2006). These interventions are usually limited to the group system and are not designed to address collective needs for collective recovery in the context of larger social systems and structures that adversely impact participants.

Another group approach to trauma-related distress is family therapy. Family therapy, however, has its emphasis on how the individual is affected by and can cope better with trauma specifically in the context of her/his family; thus, the work is usually limited to the family system. Klorer (2006, p. 118) enumerates the issues explored in family trauma therapy:

1. helping the family to explore the individual reactions to the trauma;
2. exploring the role that each person plays;
3. helping each other family member to communicate needs; and,
4. helping the family to find support, either from one another or outside of the family system.

To complicate matters, Waller (1993) states how there continues to be a lack of awareness and appreciation among mental health and other providers of the value of group psychotherapy. Most people feel anxiety about groups, particularly those who have experienced trauma, experiencing the need to be isolated from and avoid contact with others, especially strangers. Many people, then, who could benefit from group psychotherapy are referred only to individual services (Waller, 1993).
Trauma as a Complex Continuing Experience

In my experience working with poor and oppressed individuals, groups, and communities for over twenty years, many have described how, aside from being a collective experience, trauma is also very much a continuing one. Many have experienced (re)traumatization across their lifespan beginning with indescribable long-term childhood abuse and neglect leading to multiple adulthood traumas, many quite severe. For many, this is on-going. These experiences result in chronic trauma-related anxiety and unremitting depression, two emotional states that usually pave the way for substance abuse/dependence which, in many cases, complete a three-pronged assault ensuring devastation and continuing traumatization throughout most of people’s lives.

As is typical In such contexts, many individuals deal with systems- and structures-based issues such as poverty, ill-health, lack of opportunities, grief and recurring loss, lack of power over decisions that affect them, and other similarly severely difficult life circumstances. Kleinman, Das, and Lock (1997, p. ix) use the term ‘social suffering’ to describe ‘human problems that have their origins and consequences in the devastating injuries that social forces can inflict on human experience.’ It is common that traumatizing experiences from social systems and structures have relentlessly damaging effects on people’s physical, psychological, emotional, academic, interpersonal, social, relational, occupational, and spiritual lives. These distressing experiences impinge upon entire community systems and their networks of social arrangements (Martin-Baro, 1989): family, community, social, political, economic, and cultural systems are affected by these acts of violence. This is not more evident than in cases of chronic, acute, and continuing trauma when people are experiencing distress from past trauma while being confronted with the effects of on-going trauma in the context of unfolding retraumatization which also affects their families, friends,
communities, networks of support, other mental health service consumers, and society in general.

Kleinman, Das, and Lock (1997, p. x) state that:

Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems. Included under the category of social suffering are conditions that are usually divided among separate fields, conditions that simultaneously involve health, welfare, legal, moral, and religious issues. They destabilize established categories. For example, trauma, pain, and disorders to which atrocity gives rise are health conditions; yet they are also political and cultural matters. Similarly, poverty is the major risk factor for ill health and death; yet this is only another way of saying that health is a social indicator and indeed a social process.

Many who have experienced trauma across their lifespan end up in traditionally-disadvantaged, poor, oppressed, and stigmatized urban neighborhoods. Many live in decrepit and filthy single occupancy hotel rooms, needing to use substances all day to cope, and are exposed to constant threat of and actual violence on the streets, practically on a daily basis. Some are homeless for periods of time which further intensifies these risks and threats, signifying the absolute worst that their lives can be. Many face continuing retraumatization in ways that may otherwise be mildly or moderately distressing to others but not to those who are in heightened states of anxiety and depression due to trauma-related distress. For those who are housed, many are in housing facilities with other individuals who are also dealing with complicated mental health challenges which can represent increased risks of recurring distress. They describe continuing retraumatization in problematic interactions and relationships and constant encounters with countless triggers in such living situations. Most continue to receive services from providers also located in these neighborhoods or find themselves needing to go back there. Many report involvement in unhealthy (i.e., harmful) relationships with other individuals facing similar life issues and getting
enmeshed in ‘co-dependent’ or ‘violent’ relationships where there is increased risk for relapse and injury. They describe continuing traumatic distress also from mental health and emergency service providers in community clinics and hospitals with stories of severe physical abuse in emergency rooms and even cases of sexual assault by mental health providers.

For every individual affected by trauma, people close to that person are also affected and, in cases of childhood abuse and neglect, may most likely be implicated. For every life characterized by chronic mental health issues due to trauma from childhood, the risk of devastation of lives in adulthood is significantly enhanced; in most cases, the likelihood of (re)traumatization is undeniable. In these situations, families, schools, communities, social services, government, and the general public are not only affected; they, too, may be implicated. This is not only so in that these acts of violence are allowed to happen, particularly to children, but also that those who are victimized are further retraumatized by stigmatization by these same systems and structures.

Stigmatization adds another layer of distress which in some cases can be more enduring and have more intense effects that the original incident. Wahl (1999, pp. xvii, 12) argues that stigma greatly affects individuals in that:

Such misconceptions contribute to highly unfavorable views of the people who experience such disorders; these views, in turn, create a countertherapeutic environment that undermines efforts to cope with and recover from mental illness. Stigma is the term that represents these negative and inaccurate views of mental illness, and, just as mental illness affects millions of us and our friends and loved ones, so too does mental illness stigma . . . the stigmatized attribute becomes, in the eyes of others, the most important characteristic in judging and responding to the person; it thus pervades all social interactions.

Many consumers of mental health services talk about being labeled and treated as ‘mentally ill,’ and nothing else but ‘mentally ill,’ in whatever social interaction, relation, or role (Wahl, 1999) they found themselves in: daughter or son, sister or
brother, student, employee, significant other, tenant, customer, teaching assistant, church member, mother or father, patient, volunteer, pedestrian, client, shopper, patron, user, buyer, and most significantly, mental health consumer. Every instance when this happens, social systems and structures are implicated as this represents the harmful ways that belief and value systems as a society (re)traumatize the already traumatized.

Clearly, for those who have experienced lifelong and on-going distress which continues to affect their physical, interpersonal, social, occupational, academic, and spiritual lives, among others, trauma is collective complex, and continuing.

**The Need for Collective Approaches**

Herman (1997) states how traumatic incidents have a primary effect on systems of community linkage and attachment that bears upon the fabric of social relations and interactions (Herman, 1997). Jenkins (1996) states that it is crucial to regard individual trauma in the context of its collective experience to fully understand the nature of traumatic distress and respond to it appropriately. As stated earlier, trauma is a collective experience both in instances when it is seemingly individual (e.g., domestic violence, sexual assault, torture) and when it is obviously collective (gang-related community violence, state-sponsored terror, war). The effects of such events impact more than just the individual victim; society is implicated when its members are injured by the systems and structures it entrenches.

Herman (1997, p. 121) advances the need to address collective traumatic distress with groups of people who have been subjected to

. . . totalitarian control over a prolonged period (months to years) including hostages, prisoners of war, concentration camp survivors, and survivors of some religious cults and those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse and organized sexual exploitation.
These groups of people may endorse traumatic distress in the form of “collective alterations in affect regulation, consciousness, self-perception, perceptions of the perpetrator, relations with others, and systems of meaning” (Herman, 1997, p. 121). Traumatized groups (e.g., survivors of the Holocaust, wars in Rwanda, Darfur, Nicaragua, Colombia, Vietnam, The Philippines, among others) experience collective suffering in the form of massive psychic trauma (i.e., collective affect ‘lameness,’ anxiety, depression, and somatization) due to organized violence/terror or cultural and ethnic genocide (Jenkins, 1996).

In the case of refugees from political violence, Miller and Rasco (2004, p. 26) enumerate displacement-related stressors which affect:

1. loss of social networks leading to social isolation;
2. loss of social roles and role-related activities;
3. unemployment, poverty-related stressors;
4. lack of environmental mastery;
5. discrimination;
6. separation from loved ones, concern for their survival; and,
7. intergenerational differences in rates of acculturation.

In contexts where trauma is experienced collectively, distress shared by a group or community needs to be responded to through collective responses (Hubbard & Pearson, 2004). It is simply not possible, for example, to work on political and economic inequality, suffering collectively experienced by large numbers of people, damaged social networks, shared discrimination, loss of social roles, unemployment, and other similar injuries to collective life, unless members of that community do so together.

**Psychoeducation**

Addressing trauma-related distress (or any other mental health challenge) is not simply a matter of receiving psychotherapy/psychiatric care which deals with the evaluation, diagnosis, and treatment, of individuals suffering from various mental health issues. An equally important aspect of mental health work is psychoeducation which concerns itself with providing people who are affected by mental health challenges vital
information and facts about their diagnosis and recovery. Psychoeducation initiatives, particularly in group contexts, reflect a shift from psychotherapeutic/psychiatric interventions in that they are based on approaches that are more holistic, emphasizing health, partnership, coping, and to a certain extent, empowerment (Dixon, 1999).

Psychoeducation initiatives provide access to information and facts about mental health topics in a systematic way in order to enhance strategies to deal with its effects; it is technically not treatment in itself but is designed to be part of an over-all treatment plan (Royal Brisbane and Women’s Hospital, 2007). Psychoeducation “integrates and synergizes psychotherapeutic interventions” (Lukens & McFarlane, 2004, p. 204). In the case of trauma, psychoeducation initiatives provide venues for discussing the nature, manifestations, effects of, and information on recovery from trauma-related distress. Topics may include how trauma as a mental health concern is defined, what one may expect to experience because of it, and what interventions may work for one to heal from their distress (Najavits, 2002).

Lukens and McFarlane (2004, p. 205) state that:

Psychoeducation is among the most effective of the evidence-based practices that have emerged in both clinical trials and community settings. Because of the flexibility of the model, which incorporates both illness-specific information and tools for managing related circumstances, psychoeducation has broad potential for many forms of illnesses and varied life challenges. To prepare participants for this partnership, psychoeducational techniques are used to help remove barriers to comprehending and digesting complex and emotionally loaded information and to develop strategies to use the information in a proactive fashion.

Unfortunately, most psychoeducation initiatives are limited in their scope. Most deal with the concerns of the individual. There are rarely any sustained efforts aimed at responding to traumatic experiences not just collectively but in the context of the systems and structures in which they are laden. Collective responses to shared trauma are necessary to respond to group needs for recovery which is only possible if the members of
the group/community work together (Miller and Rasco, 2004; Najavits, 2000). There is a need, therefore, for collective initiatives in psychoeducation that are group- or community-based, structurally-oriented, culturally-sensitive, and responsive to retraumatization. One framework for such interventions is popular education.

Kaye (1999) argues for a reframing of approaches to psychotherapy, and psychoeducation from one that is regulative (seeking to manage a person’s thoughts, behaviors, and relationships to maintain a normalizing social order) to one that is discursive (critical of the systems and structures that people’s experiences are located in). He states that these regulative initiatives may

. . . position individuals to become complicit in their own subordination by implicitly inducing them to conform to specifications of personhood derived from dominant assumptions of normality, limiting role prescriptions or moral codes governing exemplary ways of being –discursive formations which problematized their positions in the first place (p. 28).

Based on my over five years of experience facilitating psychoeducation groups, such initiatives using popular education as framework can significantly enhance trauma recovery and reconstruction efforts as people go beyond merely learning about their experience and actually undertake action to bring about meaningful change.

From my review of the literature, however, there is currently no empirical basis for initiatives such as these. There is, therefore, a need to examine the ways that the use of popular education in psychoeducation initiatives can contribute to collective trauma recovery and reconstruction. I am exploring these kinds of initiatives in a clinical setting because part of my background, as outlined in chapter one, is full-time work as a trauma psychotherapist. Although I am also very much interested in exploring the use of this framework in other contexts (e.g., with community-based or people’s organizations), this study is contextualized in a clinical setting. Popular education, most particularly the approach outlined by Freire is explored in the next chapter.
Summary

In this literature review I explored trauma and the nature of the kinds of experiences which can involve some form of devastation not just in the cognitive but very much in the physical. Trauma as an embodied experience can result in extensive injury, particularly in contexts where this isn’t or cannot be addressed. Indeed, for many, trauma recurs through the lifespan and may be a continuing reality. It is crucial that these experiences are regarded in their larger contexts within the systems and structures that oftentimes facilitate (re)traumatization. Such distressing situations require responsive approaches which can help address the need to not just understand what is going on but to identify meaningful strategies to address these difficult circumstances. This need is not simply at the level of the individual and their symptoms but at the level of the collective and the systems and structures that bear upon or facilitate these forms of suffering.

One such responsive approach is popular education, a framework for identifying systemic and structural sources of (re)traumatization towards utilizing collective strength to bring about meaningful change. Freire’s theorizing and articulation of popular education is outlined in the next chapter, as is the use and power of visualization and visual images in meaning-making towards recovery and reconstruction.
CHAPTER THREE
THEORETICAL FRAMEWORK: POPULAR EDUCATION

In this chapter, I discuss the principles, approaches, and processes of popular education, the framework used in the TRRG, as well as some reflections and criticisms from popular education practitioners about these ideas. In the first part of this chapter, I explicate Paulo Freire’s framework for popular education in great detail to provide the reader with an understanding of the theoretical basis for the implementation of the TRRG. I then advance how visual arts can deepen the pedagogic power of popular education. Freire’s ideas about popular education also informed the methodological approach for this research which is discussed in chapter four.

Freire’s Popular Education Theory and Methodology

Paulo Freire is one of the most influential educator/s of our time. His most celebrated and best-known piece of work, ‘Pedagogy of the Oppressed’ (1973), has greatly inspired the practice of education on a global scale in the context of critical dialogical pedagogy. This book, originally banned in his native Brazil, has been translated into numerous languages. His philosophy and framework has been, and continues to be, used in various contexts including academic/institutional and community-based/informal settings, in many countries. Freire has been described as “one of this Century’s greatest voices of human emancipation” (Mayo, 1997).

Garvin, Gutierrez, and Galinsky (2004) point out that most of the current literature which takes up Freire’s ideas, centres on the use of popular education in community organizing and group work. Very little Freirean research has been focused on the use of popular education in recovery and reconstruction efforts in contexts of trauma.
Freire’s framework is grounded in three key practices: critical context analyses, use of participatory/dialogical approaches that are appropriate to people’s realities and needs, and the addressing of systemic and structural roots of oppression through united action. Freire also advanced the notion of education as the practice of freedom, including his view on shifting historical cultural contexts resulting in new forms of dehumanization. Challenging such forms of colonization requires the development of critical consciousness, conscientization, which I shall discuss later. He talked about his work with ‘culture circles’ which facilitated community empowerment processes concretely undertaken through progressive literacy programs, articulating concrete steps to undertaking such initiatives (Kreider, A., n.d.).

**A Humanizing Pedagogy**

In Pedagogy of the Oppressed, Freire (1970) articulated his theory of education ‘with’ people who were experiencing the profoundly adverse effects of illiteracy in the context of poverty and powerlessness including exploitation, injustice, violence and oppression. His analysis of reality was based on Marxist thought which recognizes the concrete economic, political, and cultural conditions of the oppressed masses as the backdrop for class struggle towards systemic change (Allman, 2001). He argued for the need for people to exist in conditions that respect and advance humanity and against ones that negate this (e.g., oppression). He justified a pedagogy of the oppressed by problematizing illiteracy in relation to dehumanization in the larger context of systemic oppression. He regarded illiteracy as a ‘cultural artefact’ of oppression (Freire, 1973), a dehumanizing expression of unjust and violent systemic relationships. It was, therefore, crucial for people to learn to read and write not simply for the sake of doing so but, more importantly, to be able to begin to address their oppression (literacy facilitated participation in democratic processes, particularly voting). It was in this sense, among
many, that Freire made a great contribution to education work: he politicized it (da Silva & McLaren, 1997). Allman (2001, p. 91) explains this further:

One of the basic tenets of Freire’s approach, then, is that cultural action for socialism is about developing a critical (dialectical) consciousness, a critical praxis, but this pertains to the leaders or the educators as it does to the people, even if the former have a theoretical, conceptual, and analytical head start . . . Freire understands revolution to be a process with an important and essential educational component (Freire, 1973). However, he also understands education to be a thoroughly political process – not just his approach to education but all education and every aspect of it.

Freire’s approach critiques not just immediate oppressive systems (the classroom, the educational system), but extends it to larger structures and systems of society. Shor (1997) elaborated on Freire’s notion of the political nature of education as it was manifested in the student-teacher relationship, in how content is chosen, and in the nature of the discourse in the classroom. In addition to these, the nature of education was also manifest in silences (when students simply sit and listen, unable/not permitted to express themselves), in the imposition of standardized tests, in the physical conditions of the classroom, the attitude of the curriculum towards the language actually used by the students, in the devaluing of the arts, in unequal funding, and in the power held by an unelected bureaucratic leadership (Shor, 1997).

Freire (1970) discussed the process of dehumanization, describing the consciousness of the oppressed as determined by their experience of oppression. The oppressed “identify with their oppressor; they are at the same time themselves and their oppressor” (Freire, 1973, p. 30). This is in recognition of the reality that people are tied to oppression, not just in terms of the systems and structures they are in, but also by their psychological being as oppressed peoples (Aronowitz, 1997); one of the main features of oppression is the control of the consciousness of the oppressed by the oppressor.
This identification with their oppressor can afflict the oppressed with the ‘fear of freedom,’ the desire to take on the role of the oppressor, or the need to remain oppressed (Freire, 1998). This can, in turn, result in the oppressed defining that the way to address powerlessness/oppression is the (re)gaining of power for themselves to become powerful (and oppress others) and not necessarily in the dismantling of oppressive systems. An example of this, in the context of agrarian reform, is how ‘freedom’ has been defined in terms of acquiring land or taking land back (the peasant becomes a landowner) and not necessarily in the more essential terms of both the landless peasant and landowner both being free from the systems of unjust land ownership. This is what Freire (1998) refers to as ‘humanization.’

Humanization is not simply a matter of the oppressed taking over power and ‘becoming oppressors of their oppressors’ (Freire, 1973). This only leads to the reproduction of the dehumanization of both, a return to the first relationship by a simple shift in roles. Freire advanced a discourse in humanization as the people’s vocation for the liberation of those who are oppressed and dehumanized by injustice, and the oppressor, who is likewise dehumanized by committing injustice.

Despite this theoretical turn that allows for the dehumanization of the oppressor, it is the oppressed, not the oppressors, who can advance and actualize a pedagogy for liberation. This pedagogy needs to address the problem of the consciousness of both the oppressor and the oppressed. It begins with a critical analysis of the systems of violence, exploitation, tyranny and the negation of humanity, to facilitate the identification of their root causes. This convergence of analyzing reality based on concrete conditions and identification of oppressive systems and structures is the foundation for the development of critical consciousness (Freire, 1970).
For Freire, the development of critical consciousness is necessary for social transformation. It is imperative that the oppressed have the opportunity to examine their consciousness in relation to their reality in order to identify the root causes of oppression, to “extroject the slave consciousness which has been introjected by oppressors into the deepest recesses of their being” (Freire, 1973, viii).

This process involves critical analysis one’s context to facilitate the realization that it is necessary to undertake action towards meaningful change (Freire, 1973). It is not sufficient to develop critical consciousness; it is also necessary to translate this into action. Efforts need to be undertaken to respond to people’s physical, economic, political, and cultural needs, based on what they define these needs to be. This is then followed by serious reflection. Freire refers to this as ‘praxis:’ the process involving critical consciousness, action, and reflection. This is one of the foundations of Freire’s framework for liberative education which he translated into concrete community-based programs of action. This concrete set of practices is an aspect of Freire’s pedagogy that sets it apart from others (Aronowitz, 1997). I will discuss this in further detail later in this dissertation.

**Liberating Processes**

The process of liberation involves the two distinct stages. First, the oppressed uncovers oppression in the world and engages in its transformation through praxis, a stage Freire refers to as ‘cultural action.’ Second, this pedagogy becomes a pedagogy for all people for permanent liberation in the stage he calls ‘cultural revolution’ (Allman, 2001).

The process of critical consciousness/awareness building can only be realized through dialogue in the context of ‘co-intentional education’ (Freire, 1970). It is the only effective humanizing approach which does not allow for the manipulation of the
students (the oppressed) by the teachers (the revolutionary leadership). Co-intentional education recognizes the need of both the students and the teachers to engage in social change work based on the notion of both being in the world, critically knowing reality, and re-creating knowledge for their mutual liberation (Freire, 1970). This pedagogy dismantles the false notion that the educator has over her/his own authority and transfers it to the authority of knowledge, shifting the power to the student (Aronowitz, 1997).

Freire (1973) also differentiated between the ‘banking’ and ‘problem-posing’ concepts to discuss liberative approaches to education work. The banking method, in which the students are regarded as empty repositories for knowledge to be ‘deposited’ by the teacher (like a bank), domesticates students into inaction and renders them incapacitated from transforming the world. He thus describes a ‘culture of silence’ that many oppressed people live in, entrenched by oppressive social systems and structures, including education. The banking method likewise sabotages critical thought, fosters authority-dependence in both students and teachers, and entrenches the certainty that teachers are the source of knowledge through lectures (Shor, 1997). Problem-posing education, on the other hand, presupposes the reconciliation of the teacher-student relation in the context of co-intentionality, recognizing that the teacher is also a student and the student is also a teacher. The content of this educational approach regards people in their context – they are ‘with the world’ and ‘with others’ – rather than simply being ‘in the world’ (Freire & Macedo, 2000). Through dialogue, teacher-students and student-teachers become jointly responsible for all aspects of education initiatives.

Allman (2001) explains how Freire’s description of the banking teacher was a criticism, not of the method, but of the teacher’s regard for knowledge which
informs the method utilized. As such, even in seemingly participatory methods of learning, like discussions, the regard for knowledge as an object to be acquired is likewise ‘banking education.’ Allman (2001, pp. 99-100) states that:

The gist of what Freire says is that the teacher goes to her study of the library and researches the topic for a lecture. She prepares her notes and organizes the appropriate order of presentation, and in this process her ‘act of knowing’ is completed. She has only now to transmit the results to the learners. . . . I would argue that the same ‘banking’ relations to knowledge pertain in most discussions as well as the vast majority of experience of progressive pedagogy. For example, let us look at what takes place in a discussion. People enter into discussion in order to articulate what they already know or think. If the discussion takes place in an educational context, the teacher will want to use the discussion method to be sure that the students have understood and can express or apply what they have already learned prior to the discussion. Discussion is an ordered and managed communication of monologues.

Kaye (1999, p. 28) explains how, in the context of psychoeducation, one who regards her/himself as the authority on knowledge uses a ‘regulative’ approach which

. . . may position individuals to become complicit in their own subordination by implicitly inducing them to conform to specifications of personhood derived from dominant assumptions of normality, limiting role prescriptions or moral codes governing exemplary ways of being – discursive formations that problematized their experience in the first place.’

It is likewise necessary that the educator is aware that her/his role is not as an ‘expert,’ as this is a role that most likely disempowers. As mentioned earlier, an educator works in co-intentional partnership with the people (Horton & Freire, 1987). S/he may have contributions, yes, but these need to be regarded as one among those that people bring into the space of learning and just as valid; no educator has a monopoly on education or has superior knowledge.

It is important therefore in educational contexts to use dialogue as a method for participatory learning, to ensure that knowledge is not treated as an object to be learned and simply regurgitated in class. In addition, it is vital that the focus of sharing is the
‘relevance’ or ‘application’ of this knowledge to a ‘student’s’ context, not just to what has been read.

It is important to be critical not just of ‘what’ we know but ‘why’ and ‘how’ we know what we know (Allman, 2001). In terms of our process of thinking, it is not merely about ‘what’ we think, but about ‘why’ we and others think what we do and ‘how’ we come to this knowledge. Dialogue “is a collaborative form of communication and learning which involves challenge and the building of trust . . . enabling people to dialectically conceptualize their reality” (Allman, 2001, p. 101). In addition to this, there is mutual affirmation of the teacher and student; neither experiences disaffirmation in the affirmation of the other (Shor, 1997).

**Collective Content Analysis: The ‘Word’ and the ‘World,’ ‘Text’ and ‘Context’**

Freire advanced the imperative of reading the ‘word’ and the ‘world’ or ‘text’ and ‘context’ (Freire, 1998), of always contextualizing what is learned in the participants’ concrete reality. He stated that it is not enough to learn words, ideas, or things, but to do so in their context. Following from this, trauma, in the case of my research, must not simply be defined but done so in the context of the participants’ concrete realities. Also, Freire described the importance of bringing people together to facilitate collective reflection towards critical analysis through the creation of appropriate venues where participants can feel safe and trusting of each other in order that skills in self-expression and critical analysis can develop. As an example of this, Gonzales, Lejano, Vidales, and Conner (2007) used Freire’s framework for environmental health research in California, engaging community-based processes of collective critical analysis. Participants’ concrete environmental health issues were the context of the research agenda.

Of particular importance to these initiatives, and a focus of this study, is the use of visual arts-based methodologies for social change (I will discuss visual arts-based
methods in greater detail later in the next chapter). These methods allow for collective expression and critical analysis towards united action. The use of visual arts-based methods in popular education is extensive, with many such efforts undertaken in contexts of but not about trauma-related distress as a mental health concern. It is both impossible and is beyond the scope of this paper to discuss these initiatives but some examples would be helpful here.

The use of visual arts-based methods has been described in the context of popular education initiatives with various oppressed communities (Arnold, Burke, James, Martin, & Thomas, 1991); immigrant women (Brandt, Cristall, & Marino, 1983); in South Africa with numerous communities in the context of liberation theology (Hope, Timmel, & Hodzi, 1984); and with disadvantaged communities in Canada (Gatt-Fly, 1983). These methods have also been used for discussion towards action (Marino, 1981); in the context of organizing (Nadeau, 1996); in popular theatre initiatives (Boal, 1992); and countless others.

Discussions using visual arts-based methods in popular education allow for collective contextual analysis since common threads relate to common systems (i.e., widespread crime can correspond to systemic problems of poverty, powerlessness, and hegemony; organized terror to oppressive political, economic, and cultural structures). Popular education emphasizes collective and creative inquiry into the concrete situations of participants to identify root causes of social ills. In situations of collective trauma, these inquiries are aimed at identifying root causes of problems in the context of existing systems and structures. It is in this respect that the use of visual-arts based methods in the TRRG differs in that they identify the systemic and structural sources of traumatic distress. These methods facilitate individual and collective expression for collective analysis up to the level of systems and structures of (re)traumatization.
There have been numerous projects that have used Freire’s popular education framework to facilitate dialogue to critically analyze community contexts to identify needs and strategies for change. Several projects have been undertaken with groups and communities using art therapy for social action, involving collective initiatives such as mask-making with a community of homeless people in Illinois for greater public awareness-building (Allen, 2007), using illustrations to depict and deal with conflict (Wiselogle, 2007), art for anger management for individuals in the mental health system in the United Kingdom (Liebman, 2007), a ‘paper people project’ on gun violence in Oregon (O’Rourke, 2007), and puppet- and mask-making for community-building in Nova Scotia and New Brunswick (Gerity & Bear, 2007), among others (Kaplan, 2007).

In relation to the use of visual arts-based methods in the context of collective action, Kaplan (2007, p. 22) states that:

One way in which social action and art therapy are linked is through the versatility and power of the image. Social action is ultimately predicated on the relationship between personal and collective suffering, and the image has the unique ability to bring to consciousness the reality of a current collective predicament, as well as the universality and timelessness of an individual’s suffering. Moreover, images can concurrently heal personal-collective wounds while demanding a response to injustice.

In the context of popular education, visual arts-based and other methods are used to address collective needs for meaningful change. In the context of trauma, the analysis of visual materials is not just meant to identify and address individual symptoms but to also respond to collective needs in the context of the systems and structures which facilitate trauma-related distress. This is an important feature of the use of these methods in this study. The analysis of distress does not end at common themes that the group experiences, but at how systems and structures are implicated in these experiences, and how the group can unite to undertake action to address more systems- and structures-based (re)traumatization.
This is why it was necessary to conduct needs assessments sessions with each and every participant and why discussions always began with and were based on the participants’ lived experiences. Furthermore, this is also why visual representation and collective analysis needs to go beyond symptoms to reach the deeper levels of systems to determine root causes of trauma-related distress to facilitate the identification of the sources of these from the community, to national, and even international levels. This is particularly helpful in crisis situations when most people may only by paying attention only to surface-level issues and not systemic or structural origins.

Members of the affected group/community need to determine not just how to visually represent their distress (and recovery/reconstruction) but also how to analyze these images together. This collective process of actualizing recovery and reconstruction can be an empowering experience in that group/community members take control of articulating their own thoughts and feelings not just as individuals but together. They work with each other and do not rely on an ‘expert’ to provide data they themselves are living. This data no longer just includes information based on their individual knowledge and experiences but also on aspects of their shared processes in the context of addressing (re)traumatizing systems and structures as they collectively undertake popular education initiatives collectively.

**Translating Pedagogy into Action**

Freire’s framework for liberative education was based on his work (particularly, literacy work) with oppressed peoples in his native Brazil in the 1950s and early 1960s. He was involved in other programs while in exile, but continued his work in Brazil when he was able to return in the 1980s. The literacy programs in which he was initially involved were not merely educational undertakings meant to help people read and
write. They were essentially empowerment initiatives meant to help people participate in democratic processes as literacy was a requirement in voting.

The basic components of Freire’s literacy method (1973, p. viii) are as follows:

- participant observation by educators who are ‘tuning in’ to the vocabular universe of the people;
- their arduous search for generative words at two levels: syllabic richness and a high charge of experiential involvement;
- a first codification of these words into visual images which stimulate people ‘submerged’ in the culture of silence to ‘emerge’ as conscious makers of their own culture;
- the decodification by a ‘culture circle’ under the self-effacing stimulus of a coordinator who is no ‘teacher’ in the conventional sense, but who has become and educator-educatee – in dialogue with educatee-educators too often treated by formal educators as passive recipients of knowledge;
- a creative new codification, this one explicitly critical and aimed at action, where those who were formerly illiterate now begin to reject their role as mere ‘objects’ in nature and social history and undertake to become ‘subjects’ of their own destiny.

Freire (1973) also discussed experiences that people’s movements go through in undertaking empowerment initiatives. He stated how these experiences have included initially seeking solutions from outside which are not based on a critical analysis of these people’s context. This resulted in the alienation of those participating in these movements and the experience of alternating between hopefulness and hopelessness. People then realized that these transplanted solutions are inappropriate. Freire described this process as a transition of the consciousness from intransitivity (dominated, fatally-lived, static) to semi-transitivity (partial change through partial empowerment as problems are seen in parts and not as a whole system, change will come from a strong person and not themselves), to transitivity (holistic, the highest development of critical thought and action, relates concrete conditions to larger societal context) (Shor, 1997).
Freire emphasized the importance of praxis (action-reflection) by making the important distinction between verbalism and activism. He stated that without action, undertaking empowerment initiatives (particularly involving education) is verbalism; without reflection, this is merely activism. To engage in verbalism is to engage in idle chatter, which cannot transform the world; to engage in activism, on the other hand, is to negate dialogue and reflection (Freire, 1973, p. 68). In either case, there is disempowerment. Only in praxis can there be meaningful transformation, only can life be lived as a process of ‘becoming’ (Aronowitz, 1997).

Freire described the process of critical analysis, action and reflection as ‘conscientization.’ It is important to note, however, that he stopped using this term later on in his work in much the same way that he stopped using the term ‘training,’ in the spirit of not using directive/educator-centered terminology. Freire later used the word ‘formation’ to recognize the permanent process of growth that people undergo, of being critical, of being continuously shaped and reshaped (Horton & Freire, 1990).

Shor (1997, pp. 32-33) describes critical consciousness as having four qualities:

1. Power Awareness – realizing that people possess the power to transform their reality;
2. Critical Literacy – deeper understanding of social realities and applying the meaning of these to one’s own in the context of analyzing ways people think, read, write, speak, or discuss;
3. Desocialization – challenging what is learned through mainstream culture, including internalized regressive values (racism, sexism, classism, homophobia, etc.); and,

Freire’s framework for popular education is a pedagogy for working in dialogic partnership with oppressed communities to identify and address root causes of their problems. It uses appropriate, empowering, creative, critical, and culturally-sensitive methodologies which are respectful of the indigenous ways that people learn. This learning translates into action and reflection in praxis undertaken by the participants to
bring about meaningful social transformation which is characterized by the liberation of both the oppressed and oppressor in a genuinely humanizing context for all.

**Reflections, Reactions, and Criticisms of Freire**

For the most part, Freire’s framework and approaches have been and continues to be used in two main arenas: the academe (in theoretical discourse) and the community (in practice) in innumerable and highly diverse contexts all over the world. It is thus not surprising that Freire’s work has drawn these reactions, both positive and otherwise. Following are some of the more critical views about the limitations, mostly of ‘Pedagogy of the Oppressed,’ particularly in the context of community praxis. (I found very little criticism written about Freire’s other works in my research which may indicate how most people have probably only considered and read ‘The Pedagogy of the Oppressed.’)

**Inaccessible, Sexist, and Paternalistic Language**

An immediate criticism of ‘Pedagogy of the Oppressed’ is one that is most obvious: the text is inaccessible to most. Although it is a text about liberation using a popular pedagogy, it is not written in a popular way. It uses language that is alienating and not easily understood by most, least of all oppressed peoples who do not have the experience with text and dense theoretical discourse, and has been described as ‘pompous and elitist’ (Freire, 1992). Although it serves the purpose of articulating a rigorous theory for critical radical pedagogy for the academe, it is unable to accommodate popular discourse (Hendriks, n.d.). Furthermore, Hendriks (n.d.) observes how the language used in this book is sexist and paternalistic, inconsistent with the message of liberation of oppressed people that the book advances.
Freire’s works, particularly ‘Pedagogy of the Oppressed,’ was not easily comprehensible by many members of groups and communities I worked with. This proved to be a significant limitation as the use of his framework relied heavily on educators who had access to and value of the language, concepts, and approaches used in the book.

Freire had earlier responded to criticisms about the sexist language of his book in ‘A Dialogue with Paulo Freire’ (Freire & Macedo, 1997) by first explaining the context in which he grew up. He described growing up in a highly patriarchal, male-dominated society. He recalled witnessing and experiencing discrimination in his country in the form of blatant and violent racism, classism, and sexism. It was oppression based on class and race, according to Freire, however, that was most striking to him. He stated how he, too, was a victim of the systems of gender oppression as it was within this framework of sexism that his understanding about oppression were formed along the lines of his class background and race. He admitted to not having been able to escape the power of this highly sexist culture in his formative years. He also recalled how he was most influenced by and preoccupied with Marxist analysis of oppression based on class and that he regarded the struggle of women to be a class-based issue. He continued by stating how he appreciated how feminists called his attention to gender issues and consequently engaged with the feminist movement and later insisted on the avoidance of sexist language in his work (Freire & Macedo, 1997).

In ‘Pedagogy of Hope,’ Freire (1992) addressed this criticism once again by expressing his apologizes for the sexist language in his book reiterating his commitment to more inclusive language. The Twentieth Anniversary Edition of Pedagogy of the Oppressed has been rewritten to address this.
The Popular Educator as Colonizer

Esteva, Stuchul and Prakash (2005) discuss how Freire’s framework serves the purpose of the educator, and not the oppressed as it intends to, as this is a pedagogy for ‘educators’ who work in the capacity of ‘liberators.’ This is to say that many popular educators erroneously believe that they ‘liberate’ oppressed people in their work. Freire (1970) advanced the notion that the oppressed are dual and inauthentic human beings who ‘host’ the oppressor within themselves. While surely there have been many educators who have co-opted the discourse of popular education to further their own agenda, many still believe that it is their task to ‘liberate’ the oppressed. This dismisses or negates the reality that the consciousness of oppressed people does not merely contain the experience of oppression or a slave consciousness but that it also contains a consciousness of resistance and rebellion; many oppressed peoples have, in fact, risen against their oppressors without outside intervention. Sanchez-Bejarano (2005) argues that Freire’s pedagogy is a prescription for how to regard the world and to what extent transformation needed to be actualized in it, which is colonizing. This prescribed approach negates other more culturally-sensitive ways that many communities posses with respect to thinking about and realizing liberation. This pedagogy, therefore, serves to legitimize the role of the individuals engaged in critical education, revolutionary leadership, community development, and intellectual pursuits (Esteva, Stuchul and Prakash, 2005).

Freire’s identification of generative themes is an important contribution to critical pedagogy, particularly in politicizing the process of education/literacy work for social transformation. These themes, along with other aspects of popular education initiatives, are based on a Marxist analysis of reality which is based on people concrete conditions. Most popular educators thus purposefully exclude perceptions or analyses of reality that
are not based on these concrete conditions. This includes perceptions that might promote superstition or other notions of idealism although these can be very much within the realm of the people’s reality and consciousness. Siddharta (2005) cited an as example of this, how some indigenous people’s communities believe that problems such famine, drought, or even war, occur because they have angered the spirits. When these ‘false beliefs’ are articulated, many educators dismiss them and discussions are redirected into more ‘appropriate’ analysis of people’s problem situations based on material and historical conditions, particularly class oppression. This dismissal by educators, too, is colonizing.

Another critique is that popular education uses a framework that is also based on European leftist notions of power and powerlessness, which the educator imposes upon people who may not necessarily regard themselves as powerless or may not desire the power as defined (Blackburn, 2000). Siddharta (2005) states how regarding individual critical reflection as the only valid approach to awareness for social change negates other traditions that exist in many different communities. There are other ways that people create and recreate knowledge for transformation and ‘liberative education’ discourse does not include these. One example of this is inter-existence or inter-being, the notion that we are part of a whole and that we, as human beings, do not occupy a special place and are the only inhabitants of this planet who are capable of having consciousness. A paradigm that respects the earth addresses the error of believing that any kind of human development is at all possible if it is detached from the very source of its sustenance (Siddharta, 2005).

In response to this, Freire (1992) reaffirmed his commitment to an anti-authoritarian and liberating pedagogy in ‘Pedagogy of Hope’ that needs to be undertaken in ways that are appropriate to people’s realities and needs. This is to
recognize that what an educator brings is ‘partial’ to the totality of knowledge which includes what people already know (Freire, 1973). It has always been important to Freire that the educator, although holding a special form of leadership, possesses the appropriate attitude and commitment to co-intentionality, reciprocity, equality, dialogue and the abolition of privilege and elitism (Freire, 1997).

Freire extends his definition of oppression to include other dimensions like race and gender but continues to emphasize the importance of class analysis stating how he finds this to be crucial in comprehending social reality (Freire, 1973). Freire restates how the major themes of his work remain very relevant: contextualizing the person in their concrete, social reality, critical consciousness translated into action, use of dialogical and empowering methodologies, participating in the process of creating more humanizing processes, engaging in reflection in the context of praxis, addressing root causes of people’s problems, to recount a few.

A ‘Western’ Approach

Teran (2005) and Siddharta (2005) talk about how Freire’s definitions of being human, consciousness, change, spirituality and development are based on ‘Western’ worldviews in the context of individualism, competition, consumerism (progress defined in terms of material gain), human-centeredness, and development in linear terms, within the context of globalization. The notion of the holistic nature of existence is argued to have been neglected in Freire’s narrative, overlooking important social and ecological factors (Teran, 2005). This is argued/questions as anthropocentric notion of liberation overlooking the relationship of human beings to the biosphere (Siddharta, 2005). Some advance that this makes Freire’s pedagogy inappropriate to many communities who do not subscribe to such a Western worldview, particularly but not exclusively, indigenous peoples.
Freire is criticized for regarding indigenous culture and consciousness in much the same way that the Western world does. He regarded indigenous worldview as backward, undeveloped, fatalistic, and superstitious requiring extraction from people’s consciousness or a shifting to accommodate more ‘empowering’ mainstream notions of human development. For Freire (1970) how this is achieved is through the imperative of literacy, to enable participation in democratic processes.

It is important to state, however, that many oppressed communities do not view development in linear terms measured through material gain. Many communities all over the world believe in notions of human advancement based on a holistic, non-linear, and interconnected nature of existence within the context of spiritual growth/enlightenment. They believe in cooperation, not competition, collective, not individual, and ecologically-based, not market-driven existence, among others (Siddharta, 2005). Robinson (2005) states how Freire’s pedagogy defines oppression and liberation which is limited to a construction of ‘self’ in Western historical conditioning. It is argued that this does not allow for other ways of regarding the nature of the self that is not distinct from the rest of creation and the divine, and that material reality is not what is truly essential in life. These are the bases of the faiths of many people all over the world.

It is likewise important to note that Freire’s framework is articulated in binaries: oppressor and the oppressed; oppression versus liberation; text and context; ‘man’ and animal; banking versus problem-posing education; educator and educatee. This divided view of social reality is in part informed by Marxist thought which has proven inadequate in understanding more complex social systems (Siddharta, 2005). An example of this is India’s caste system, where the horizontal divisions of and oppression based on class are somewhat defused by vertical connections based on ethnicity (Siddharta, 2005).
In addition to these, the fact that a specific language needs to be chosen in literacy work (in Freire’s case, Portuguese), speaks to an ethnocentric worldview. Who gets to choose which language communities should be literate in? What if this is not their native language or one they have not been able to make an informed decision about to learn? What impact does this have on a people’s way of communicating, on their culture? At its most essential level, Siddharta asks who decides that literacy/language/knowledge production is a superior, desirable, and liberating state.

Rasmussen (2005) argues we need to prioritize creating a context that allows for liberation first, to prepare a ground where empowerment efforts that people themselves undertake can actually be meaningful. He emphasized the need to rethink before we continue to engage in ‘liberative’ education work that really serves only to educate people into becoming participants in seemingly democratic processes in decidedly undemocratic contexts. Rasmussen (2005, p. 127) writes:

As long as we need 80% of the world’s stuff, we are going to end up having to go next door and bully people to get it. Rushing around the world thinking we’re being neighbourly, proselytizing our alpha-numeric fetishism, and narrowing down rich physical-oral-mental cultures into lonely consumers and dazed human ‘leasees’ only burdens the planet with people like us.

Paradoxically, for his critics, Freire’s discourse in critical analysis of social reality sought to address root causes of problems of oppression but failed to perceive the possible effects of reproducing these systems in implementing his liberative pedagogy.

We Continue to Learn

Criticisms about Freire’s work will continue to be made. A significant number of these are valid while others may be based on misinterpretations of his work by those who have read only the ‘Pedagogy of the Oppressed’ and not his other works, or who have simply misread him. Freire’s thought, theory and practice certainly developed from
and responded to these criticisms, as shown in his later writings, discussions, and presentations.

It is unfortunate that many educators have not really understood Freire’s pedagogy by not meaningfully contextualizing popular education efforts, disregarding Freire’s own belief that his pedagogy needs to be based on people’s concrete realities and needs, including aspects of it that may not be necessarily consistent with his analytical framework (e.g. animist or superstitious beliefs). Freire always stressed the importance of context and how content is vital as the basis for all these initiatives. It is important to identify what ideas are universal in his framework and use these as basis for initiatives in other settings; paradigm shifts need to be made where they are needed and this is abundantly allowed for and encouraged in Freire’s work.

It is even more unfortunate that the blame for the adverse effects of the inappropriate use of Freire’s framework is put on exclusively on Freire himself. However, as Freire often responded to such criticisms, learning and change are the nature of praxis, and praxis occurs in multiple unique yet connected contexts. Thus, criticizing his work from the multiple perspectives of individual and collective contexts allowed his theory and practice the room and opportunity to develop and grow.

**From My Standpoint: A Liberating, Not Colonizing, Practice**

In undertaking popular education initiatives, I have found that it is necessary to ensure that, as a popular educator, one is conscious and vigilant about the processes of disempowerment that comes through believing that one has a monopoly on knowledge. Moreover, it is vital to remember that what one knows is never more valid than what others know. I found that one way to ensure this is to make certain that the processes involved in popular education initiatives (e.g., learning needs assessment,
design, facilitation, and evaluation) are participatory in truly relevant ways. This is to say that people are not simply consulted about these undertakings, which was something that tended to happen quite often when educators regarded themselves to be the ‘experts.’ I have also come to realize that it is important that one does not simply know that one is not an ‘expert,’ but that one develops the appropriate attitude for this. This is translated into how one presents oneself and treats others, both of which can communicate superiority, authority, or ascendance, such that people will regard one and one’s knowledge as dominant. These are some of the ways that being a popular educator can be colonizing.

Along these lines, it may be helpful to share the following particular learning points which may illustrate other aspects of being ‘colonizing:' First, the organization the educator belongs to along with the services that organization provides may actually be the basis for what problems people identify in their community. For example, if one is working with a health service agency, the problems people will define will be about health; if it is a legal services provider, the problems will be legal in nature; and so on. It is important to be aware of the effects of organizational affiliation and do everything possible to not allow this to dictate to people what they need in terms of services. An organization’s services needs to fit into people’s agenda for meaningful social change and do so on the latter’s terms, not the other way around. Second, people will treat one another based on their class and role in their agency including ascribing authority to individuals simply by virtue of their affiliations. In many cases, this creates an unequal relationship which may result in service providers unwittingly dictating the content and direction of learning and other development objectives.

Third, methodologies need to be truly popular. It is extremely easy to believe that methodologies are appropriate for popular education initiatives simple because they are
participatory. One needs to be critical of this. There are many traditions and features of participatory methodologies used that are simply alien to many communities. I am reminded of instances when I truly believed that illustrating people’s realities was a popular and liberating methodology; it is creative, it is not text-based, and visual expression is familiar and a common facet of communication, it facilitates individual expression and collective critical analysis, and so on and so forth. In some communities I worked with, however, paper and markers were foreign objects. For many, visualization using paper and markers is not an indigenous method of learning, much less of expressing social ills for critical analysis. In those situations, a shift to indigenous method of communication and transmission of knowledge and ideas was undertaken: oral stories by chanting. Fourth, one needs to be aware of one’s perceptions about oneself, others, and one’s work. There are many popular educators/development workers who see their role as empowering in that they ‘empower’ people. This reflects the notion that one possesses the power to make people powerful or give them power, which is, in itself, a disempowering and arrogant position to hold. As popular educators, we need to be aware of how our own exercise of power may be disempowering of others, even if supposedly in the interests of empowerment. Fifth, we need to respect that people are where they are in their process. We may not agree with their analysis and courses of action all the time but we need to realize that we can not impose our values on them (Freire, 1998). To do so is to simply replace those who have made decisions for people, disempowering them. That said, if we are in a dialogic relationship, then challenges can and should be made about how some worldviews, our own included, can enforce and maintain oppressive situations.

There are numerous other lessons that I have learned but I feel that it is
necessary to limit my discussion to the above. In the tradition of praxis, I continue to learn as I reflect on new experiences, always acquiring new lessons. As a popular educator who has used Paulo Freire’s framework, I realize the value of reflecting on my experiences and forging ahead with replenished inspiration from the continuing reality of oppression and injustice, undertaking action this time in the form of this action-research project.

Visual Arts-Based Methods for Collective Expression and Critical Analysis

In this section I focus on the use of visual arts-based methods as part of popular education and a methodology that was a significant dimension of this research. As a visual artist, I am more familiar with the elements, principles, and processes of design in the visual arts than of any of the other forms of creative expression (e.g., literature, dance, music, film poetry, etc.) and therefore feel more confident in using it in initiatives such as this.

In my own experience of more than twenty years working with groups who have and continue to experience traumatic distress, I have found that the use of visual arts-based methods can provide a means of expression that is beneficial in many ways.

The act of rendering distress in visual form creates a sense of separation of the cognitions and emotional states from the individual who is thinking and feeling them (Wadeson, 2000). A sense of detachment arises from what is embodied through the process of translating these thoughts and emotions externally. Many have found this very helpful in talking about significantly distressing thoughts and emotions as the focus of the discussion is extracted from the physical person facilitating a decrease in internal stimulation.
This disembodiment of trauma-related distress when it is translated into visual work provides the individual with a sense of relief from their anguish (Waller, 1993). For many, this feeling of relief from possibly persistent distress signifies a crucial first step in managing these emotions towards recovery.

A crucial sense of control arises in the process of visual expression as loss or lack of power over a person’s thoughts and feelings is persistent in trauma (Herman, 1997). In depicting trauma-related distress visually, the individual decides its form, shape, color, texture, size, or general appearance which is helpful in taking the power out of these distressing experiences. The individual can decide what to do with these visual representations: they can display, discuss, store, burn, tear, or dispose of them in ways that are helpful to them. This gaining of control is essential in the process of recovery as one of the main themes of trauma is the lack of a person’s ability to manage the effects of such disorganizing and disempowering experiences.

Creative expression, particularly and especially in group settings, allows for the discussion of otherwise extremely difficult subject matter such as long-term childhood sexual abuse by multiple relatives, abduction and gang rape, prolonged community violence and daily shootings, and political torture (Waller, 1993). In the same vein, such a form of expression facilitates conversations about the commonly-endorsed negative feelings associated with these experiences including guilt, shame, self-blame, negative self-regard, identification as victim, and immobilizing powerlessness. This process facilitates a redirecting of the focus of these discussions on the experiences and the emotions rather than the person in a way that provides for helpful distancing.

Use of creative forms of expression in therapeutic group settings enhances interaction between members, helps build a sense of community, and consequently increases the chances for recovery. Unity is built through collective expression as
commonalities are realized and mutual goals for recovery are identified. As well, expression through visual art forms is fun and engaging for some. This helps the recovery process remarkably as it is simply human nature to participate activities that we enjoy.

Collie (1998, p.5) describes how the visual arts can help facilitate a distressed person’s expression of problems, internal strengths, and recovery through narrative processes:

Art making can facilitate the narrative processes in the following way: (a) the externalization is aided by the fact that problems are expressed as images that are visibly external to the person; (b) art making brings the personal resource of creativity clearly into the foreground; (c) the client’s involvement in a creative process facilitates the imagining of new narratives and art images can be used to give form to these narratives; and (d) art is meant to be looked at by others, and therefore, therapeutic change represented in a client’s images can be witnessed easily.

This increased awareness of these elements and their meanings facilitates a deeper understanding of how these may impact a person’s perception of and relationship with reality as represented through these images. There is a deepening of the understanding of one’s context in these meaning-making initiatives, and an increasing of one’s awareness of one’s circumstances, with respect to how the different aspects of one’s world relate to each other. In addition, it is important to point out how this relating is subject to constant change with the passage of time thereby making it imperative to consider on-going meaning-making; people are affected by the same things differently on different occasions in the changing context of living their lives.

**Beyond Art Therapy**

The use of visual arts-based methodologies in this study reflects the principles and approaches of art therapy. The difference in how these approaches were used, however, lies in its use in popular education as framework.
Simply put, art therapy advances and utilizes the power not just of visual images/artworks but also of art activity in ‘healing’ (Waller, 1993). The use of the visual arts in therapy involves the production and analysis of visual materials which can represent embodied thoughts and feelings. This oftentimes facilitates the articulation of ideas and emotions that can otherwise be exceptionally difficult to express (Case & Dalley, 2006). Waller (1993) states how image production in a group setting can facilitate the reenactment of forgotten or repressed memories/events in a way that is powerful and cathartic and, when undertaken in group contexts, can hopefully help in the transcendence of the power of these distressing experiences. These visual images can provide important information about the group and help in understanding their present contexts. Group members can reflect on how visual materials relates to an individual and to the group. This exercise can “be very helpful in revealing group themes or issues, particularly since the nature of visual arts production in group settings is usually less threatening than verbal, is more fun, rewarding, and can stimulate learning” (Waller, 1993, pp. 38-40).

Groups or communities have their own ways of dealing with trauma-related experiences as a collective. When these ways of coping become overwhelmed, “expressive therapy approaches may be the most appropriate because they allow persons at multiple developmental levels to be involved simultaneously, and they can bypass the censors and defenses that may have evolved due to post-traumatic stress responses (Klorer, 2006, p. 115).

**Meaning-Making as an Aspect of Recovery and Reconstruction**

As earlier stated, this project involves identifying contributions to the participants’ efforts at helping themselves manage their individual symptoms through psychoeducation in context of addressing significant aspects of systemic and structural sources of (re)traumatization. One aspect of recovery and reconstruction that was explored in this study is meaning-making. Meaning-making involves critical reexamination of systems and patterns of thinking that are based on internalized
oppression which reinforces negative thoughts and feelings which, in turn, can sustain systems of distress. Examples of this include false beliefs that one is inadequate, worthless, unlovable, undeserving, or hopeless. These can also be manifested in individual and collective consciousness which may result in belief of deserving to be poor, deserving to be oppressed, or deserving to be slaves (Freire, 1998). Alternatives to these systems and patterns of thinking are considered in order that new ‘ecologies’ may emerge. In collective contexts, these negative such belief systems can sustain oppression and (re)traumatization. Meaning-making is not necessarily a challenge to particular beliefs more than it is to particular ways of thinking which interfere with new and more appropriate ways of regarding and relating with the world (Carlsen, 1988). Carlsen (1988, p. 92) identifies ‘steps’ to meaning-making in therapy:

1. The establishment of a holding environment which includes the supportive qualities of confirmation, continuity, and creative, constructive contradiction.
2. The gathering of data in the joining with client meaning as individuals. This can include therapeutic techniques and many ways of looking at the data.
3. The search for patterns and process in the understanding of the old meanings in the creation of the new. This includes the naming of personal philosophies and cognitive structurings, as well as patterns of history, of emotion, of image and ideal, of behavior, of stimulus and response.
4. Reinforcement of new abilities to think about one’s own thinking – to stand outside and look in. This is the time to integrate and reconcile new insights with past history, understandings, and experience. This is the time of therapeutic closure.

Herman (1997) advances the importance of remembrance in trauma recovery towards meaning-making. Reconstructing the traumatic experience provides those affected with the opportunity to review their lives in the context of acute and chronic trauma which provides a contact for uncovering the meaning of the event. This may occur in discussions about the past, relationships, identities and roles, ideals and dreams, and adversities and personal battles, particularly those that have been won. In these processes, visualization may be of significant benefit, facilitating the articulation
of the unmentionable or indescribable, including what and how sensations are felt in
the body. It is important that feelings related to what is told are expressed to also allow
for addressing the physical manifestations of lived distress.

Kaye (1999) advances the notion of recontextualizing approaches to
psychotherapy to facilitate the emergence of new meanings and possibilities. This may
happen in a context which:

1. brings those involved to a process of reexamining their beliefs and
   presuppositions rather than just living by them;
2. have them explore their assumptive world from a new perspective; and,
3. prompt the emergence of new ways of construing experience and change
   interpersonal attributions (pp. 24-25).

These same considerations apply in psychoeducation initiatives that seek to
depart from an ‘individualizing focus’ that may result in those involved being ‘oblivious
to the socio-cultural constitution of the difficulty or its location in adverse social
conditions’ (p. 24). Collective initiatives involve, among others, context assessment to
identify root causes of problems (involving the development of the capability for
collective critical thought), efforts to actualize meaningful change together (including the
development or enhancement of skills for collective action), and initiatives for assessing
these efforts to identify more effective ways of continuing them (implying acquiring the
ability to engage in collective reflection) (Freire, 1992.)

The dialogical processes and activities employed in each of these sessions are
elaborated upon in the next chapter.

Summary

In this chapter, I discussed the theoretical framework of this dissertation
including popular education in terms of its framework, principles, and approaches. The
use of popular education as framework in trauma psychoeducation for collective
recovery and reconstruction addresses the need to not just consider but to address systemic and structural sources of (re)traumatization. Trauma is very much a systems- and structures-based experience yet efforts at healing from trauma usually fall short of considering these contexts. As such, psychoeducation efforts are typically limited to understanding trauma, the ‘word,’ but not its context, the ‘world.’ In addition, approaches regard the participants as recipients of knowledge solely possessed by mental health professionals.

It is imperative that psychoeducation initiatives aimed at trauma recovery use dialogic, participatory, and transformative approaches in order to avoid the further retraumatization of the already traumatized. This retraumatization takes the form of rendering participants into inaction and inability to meaningfully change their situations because they are simply taught how to cope with their symptoms without considering efforts to alter the contexts which facilitate and perpetuate these symptoms in the first place.

The goals of these undertakings include the need to regard those affected as central to the learning process, building on their capabilities to come together to collectively analyze systemic and structural sources of their distress, and translate this new learning into united action. The use of Freire’s popular education framework in trauma psychoeducation for collective recovery and reconstruction entrenches these necessary processes for meaningful change by beginning where people are, contextualizing efforts in their concrete realities, and facilitating collective critical analysis using creative methods, towards the translation of new knowledge and experiences into collective steps that address the needs of the group for relevant change. I also outlined how visual arts-based methods extend the power of popular
education processes that enable collective understanding, analysis, and meaning-making.
In this chapter, I begin by outlining the methodological approach for the collection of data which reflect the principles of community-based participatory research (CBPR), an approach that fits well with the pedagogical orientation of popular education. The phases of the study and the recruitment of participants are discussed. In the latter part of the chapter I turn to an explanation of the TRRG and the twelve sessions before making some remarks about ethical considerations.

Community-Based Participatory Research (CBPR)

This study is oriented in community-based participatory research (CBPR) which emphasizes the equitable participation of community members and researchers in all aspects of the research process (De Koning & Martin, 1996). I have honored much of the spirit of CBPR in the conduct of this research but, as key researcher, acknowledge how I was responsible for some key decisions throughout the project and was the main person involved in the data analysis.

There are a number of terms used to describe CBPR including ‘action research’ (as is commonly used in the UK, Australia, and New Zealand), ‘community-based research’ (often used in Canada), participatory action research and participatory research (used widely in numerous developing countries), mutual inquiry, feminist participatory research, and maybe most recently, ‘community-partnered participatory research’ (Minkler & Wallerstein, 2008).

Variations exist in these research approaches but they share common principles (Israel, Shulz, Parker, Becker, Allen, & Guzman, 2008, pp 49-52):
1. CBPR recognizes community as a unit of identity – community is based on 'socially constructed dimensions of identity created and recreated through social interactions (e.g., family, support network, neighborhood).’ It is characterized by the ‘identification with and emotional connection to other members, common symbol systems, shared values and norms, mutual (although not necessarily equal) influence, common interests, and joint commitment to meeting shared needs’ but may also involve ‘outside individuals and groups who benefit the community through their skills and resources’ (p. 49).

2. CBPR builds on strengths and resources within the community – community strengths, resources, and relationships are identified and utilized to address community needs.

3. CBPR facilitates collaborative and equitable partnership in all research phases and involves an empowering and power-sharing process that attends to social inequalities – including acknowledging the inequalities between researchers and participants and emphasizing empowering processes of decision-making and mutual support, among others.

4. CBPR promotes co-learning and capacity-building among all partners – includes processes involving the development or enhancement of the ability of all partners to use acquired competencies for other undertakings.

5. CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners – efforts to build a ‘broad body of knowledge about health and well-being’ in the context of efforts to bring about change (p. 50).

6. CBPR emphasizes public health problems of local relevance and also ecological perspectives that recognize and attend to the multiple determinants of health and disease.

7. CBPR involves systems development through a cyclical and iterative process – involves the development of systems aimed at developing competencies in establishing and sustaining partnerships, community assessment, problem-definition, defining research methodology, the collection, analysis, and interpretation of data, the identification of action and policy implications and impact, the dissemination of results, and undertaking action.

8. CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process.

9. CBPR requires a long-term process and commitment to sustainability – involving efforts beyond a single project in the context of addressing community needs in the long term.

Consistent with popular education, CBPR ensures processes of dialogue, critical analysis, and participation by group or community members in all phases of research.
Thus participants are not merely ‘consulted’ on the various aspects of the research but are in a meaningful partnership with the researcher. They help in defining the research problem, gathering and interpreting data, and application of findings (Leung, Yen, & Minkler, 2004).

Minkler (2004) states how the outside researcher is confronted with issues around ensuring that (a) the research agenda is genuinely "community-driven;" (b) tensions that may arise from insider-outsider collaboration are identified and addressed; (c) issues around possible discrimination are also identified and addressed (d) the limitations of ‘participation’ are clarified and addressed and (e) issues involving the sharing, ownership, and use of findings for action are clarified and resolved.

The nature of collaboration in CBPR involves

. . . the negotiation of information and capacities in mutual directions: researchers transferring tools for community members to use to analyze conditions and make informed decisions on actions to improve their lives, and community members transferring their expert content and meaning to researchers in the pursuit of mutual knowledge to their communities (Hatch, Moss, Saran, Presley-Cantrell, & Mallory, 1993, as cited in Wallerstein & Duran, 2008, pp. 26-27).

Cargo and Mercer (2008) point out that one of the most important aspects of participatory research is the "integration of the researcher’s theoretical and methodological expertise with nonacademic participants’ real-world knowledge and experiences in a mutually reinforcing partnership" (p. 327). It is important to state at this point, however, that these principles may not be fully translated into the actual activities and processes of some community-based participatory research initiatives. In a number of cases, there are limitations that hinder the full participation of participants in some of the aspects of the research study. This was the case in this project as certain requirements needed to be met in order for it to
be implemented. This does not, however, necessarily compromise the spirit of CBPR as was the case in this project. I shall discuss this later in further detail.

**Roots and Traditions of CBPR**

Minkler and Wallerstein (2008) explain how CBPR has two main traditions: Southern and Northern. Kurt Lewin was the first to use the term ‘action research’ in the Northern tradition, challenging the “gap between theory and practice seeking to solve practical problems through a research cycle involving planning, action, and investigating the results of the action” (p. 27). In this tradition, social progress is based on rational decisions made by the application of scientific knowledge to real-world problems with practitioners and researchers acting as coequals. The Southern tradition arose within Latin America, Asia, and Africa, in the 1970s, “receiving much of its impetus from the structural crises of underdevelopment, Marxist critiques by social scientists, liberation theology, and the search for new practice by adult educators and community developers among populations vulnerable to globalization” (p. 28). Among those who advanced this tradition are Jose Ortega and Paulo Freire, academics who worked with land movements and community-based organizations, learning people’s experiences towards developing critical consciousness, emancipation, and social justice.

CBPR identifies its roots in health research, exploring the causes of health concerns from the individual, to the community, and to social systems. Although more of an orientation to research than a method, CBPR broadens methodologies used and brings together people's knowledge and scientific know-how (Leung et al., 2004). This requires “working with people to define variables, design instruments, and collect data (qualitative and quantitative) that reflect ecological reality in that population, as people experience it” (Schwab & Syme, 1997, p. 2050.). Schwab and Syme (1997) argue for cultural sensitivity and competence in this undertaking, necessarily addressing
differences around various categories (e.g. age, class, gender, culture), and the sharing of power between the researcher and research participants. They describe how community participation – the involvement of people in designing and implementing research and intervention intended to benefit them – emerges from the need for a new paradigm to consider the numerous potentially relevant variables in collaborative research with communities.

Developing a CBPR Approach in the Context of Trauma: Trauma Recovery-Focused Participatory Research (TRFPR)

There is not one way to conduct research using CBPR as orientation. Israel, Schulz, Parker, Becker, Allen and Guzman (2008) state that there is no one design and method appropriate for all CBPR efforts. Instead, each partnership has to decide what works best for its research question and intervention goal in its particular community context. They also describe how not every single participant is involved in the same way in all the project activities considering variables like the skills that participants desire to acquire, time demands, and technical aspects of the project. It is, however, important that the level of involvement is determined by all participants in meaningful dialogue and not just by a few who possess more power.

As this project was conducted with individuals dealing with trauma-related distress, it was essential to position these efforts in a clinical context. This means that it was important to consider, while undertaking these participatory, dialogic, and transformative initiatives, how participants were dealing with mental health concerns and were consumers of mental health services.

Thus, for this study, I designed and used a research method oriented in CBPR which took the above-mentioned into consideration while positioning it in a clinical context. I refer to this as Trauma Recovery-Focused Participatory Research (TRFPR).
TRFPR is a method of CBPR that forges a partnership between the researcher and participants to contribute to the latter’s efforts at developing or enhancing capacities to address trauma-related needs for recovery and reconstruction through the various phases of the research. These initiatives seek to contribute to the body of knowledge on trauma psychoeducation for recovery and reconstruction through the sharing of resources, knowledge, competencies, and experiences between and among those involved.

**Conducting the Research through TRFPR**

The use of TRFPR includes the processes described below (some components of the research part of TRFPR are based on works by Israel, Shulz, Parker, Becker, Allen, and Guzman (2008) and Israel, Eng, Schulz, and Parker (2005)). Each of these processes contains parallel sub-processes undergone simultaneously to address the two intertwined components of this study: conducting the research (TRFPR) and conducting the group (TRRG). As such, the TRFPR also contributes to efforts towards recovery and reconstruction. Brief descriptions of each process are provided below.

1. Identifying Research Partners/TRRG Participants

The first step involves identification and building of a community of individuals who share common values and experiences. These individuals are interested in establishing connections and interactions in the context of meaningful partnership towards the pursuit of mutual goals for trauma recovery and reconstruction. This was accomplished in Stage One through recruitment of participants to whom the TRRG was clinically-indicated. This means that the participants are not simply research partners but that their participation in this project is deemed beneficial by them and their individual therapists in terms of clinical goals towards recovery and reconstruction.
Data collected in this initial stage includes descriptions of the processes of recruitment, orientation, needs assessment, and setting-up of the TRRG using popular education as framework. Beginning the group in this manner emphasized the participatory nature of undertaking this research which is consistent with that of the TRRG. These descriptions include data on the conduct, participant’s reactions to, observations, and output of the various activities.

Individual interviews with each and every participant followed by the first group discussion served as needs assessment sessions which were designed to lay the groundwork for dialogic, participatory, and transformative processes. These sessions contribute to recovery and reconstruction in terms of enhancing control the participants have over what they undergo in terms of mental health services, the contextualization of these efforts in their concrete realities, and the identification of their actual needs and goals. The participation of mental health consumers in the analysis of their own context towards identifying the content of a recovery group significantly addresses themes around lack of control, possible retraumatization, and relevance of mental health services to their concrete needs. In terms of popular education, this process ensures the contextualization of content in participants’ realities while entrenching participatory processes necessary for conscientization (Freire, 1995).

2. Establishing and Conducting the Group

Various activities are necessary in establishing the group. The needs of the participants are a primary consideration in ensuring safety and trust-building, creation of safe spaces for learning, symptom management, and prevention of retriggering. In addition, the establishment of links between individual symptomatology and systemic and structural origins of trauma, while respecting, building on, and utilizing participants’
strengths and competencies, are important considerations. This was accomplished beginning Stage Two and built-in throughout the conduct of the TRRG.

Data collected during this stage include descriptions of popular education processes of facilitating collective expression and critical analysis towards developing a sense of community. Visual arts-based methods are used to create venues for analysis of individual and collective contexts, identification of needs and issues, and forging of a sense of unity between and among the participants. During the TRRG, discussions, exercises, and activities were conducted which allowed for individual and collective discussion of long-standing unarticulated distress necessary for recovery (Foa, Keane, Friedman, & Cohen, 2009).

These undertakings likewise contribute to the participants’ need to address issues related to isolation, learning, skills development, analysis of systems and structures of (re)traumatization, and the development of systems of support. In relation to popular education, these processes facilitate the development of skills in critical analysis of participants’ contexts and needs using dialogic, creative, and capacity-building approaches (Freire, 1998).

3. Establishing Necessary Relational Processes

The development of partnerships between and among the participants and with the researcher is another key process of this study. This is contextualized in efforts to address individual and collective needs for recovery and reconstruction. The collaboration between the participants and the researcher ensures equitable partnership in the various project phases and processes of decision-making, education and learning, capacity-building, and mutual support, among others.

A focus on group relations and interactions ensures the relevance and appropriate functioning of the group. It is important to address needs related to
sustaining group cohesion with respect to safety, trust, comfort, creative expression, and united action. The use of popular education as framework goes beyond the study of the ‘word’ or the ‘text’ to extend dialogue to the ‘world’ or ‘context.’ Such is possible when education initiatives consider unifying people’s consciousness towards building community for later translation into united action.

4. Ensuring Relevant Content and Theoretical Foundations/Theorizing

Another key aspect of TRFPR involves the exploration of theories related to the various aspects of the study (in this case, popular education, trauma psychoeducation, the use of visual arts-based methods, meaning-making, and recovery and reconstruction). These all contribute toward united action, to address more systems- and structures-based issues and needs; social inequalities are acknowledged and ways to address these are identified.

In this study, data was gathered from transcripts of discussions and workshops, visual materials produced, videos taken, observation data gathered from sessions, and information from reflection and evaluation sessions analyzed. Data from collective steps undertaken, field notes, as well as other sources of information, were used as basis for thematic analysis, articulation and extension of theories, and discussions about the other aspects of this project.

In the TRRG sessions, the content of discussions and group processes were contextualized in people’s lived experiences and informed by theories to determine the contributions that these initiatives make to collective recovery and reconstruction. Theories were extended to the particular realities and needs of the participants and these initiatives. These included theories about trauma, critical analysis, recovery and reconstruction, and collective action, informed by the participants’ lived experiences, not the other way around.
The use of popular education as framework is necessary to ensure sound theoretical foundations of these undertakings and to inform how theories can be extended in the conduct of the TRRG in a clinical setting. Research data adds to the knowledge base of participatory, dialogic, and transformative approaches to health and well-being.

5. Contextual Clinical Framing

The actualization of dialogic, participatory, and transformative processes in consideration of both the clinical and social change contexts of this group is another key dimension of TRFPR. This includes undertaking individual and collective context assessment and identification of needs, determination of research design, and the conduct of group sessions. In addition, it is necessary to identify the identification of action steps to be undertaken and united action to be realized (Israel, et al, 2005). These are framed in clinical considerations particular to this group towards contributing to recovery and reconstruction efforts.

It is important, again, to emphasize that this particular study was conducted in a clinical setting and was informed by clinical considerations. Differing sites will necessitate variations in the conduct of the research. Clinical considerations arise in terms of recruitment, appropriateness for group, the use of best practices/evidenced-based psychoeducational interventions, particular group processes (ensuring safety and confidentiality, trust-building, prevention of retraumatization, enhancement of symptom management strategies, addressing collective needs for recovery, and systems- and structures-based focus also on the mental health institutions), among others.
6. Undertaking Action

Project activities are determined in relation to finding a balance between research and action. TRFPR is consistent with popular education in terms of employing dialogic, participatory, and transformative processes in efforts towards meaningful social change. Its conduct mirrors the processes of undertaking the TRRG in that its processes, although for the purposes of research, also contribute to the efforts of the participants in collective recovery and reconstruction. With these above elements in mind, the project’s objectives were developed.

Project Objectives

Since popular education approaches involve participatory processes which include the participants in the initial design including its objectives, this project’s objectives were finalized through discussions with the participants. The following are the objectives of this project, initially based on the draft objectives I prepared and finalized through discussions with the participants based on their self-assessed needs and goals for recovery and reconstruction:

General Objective:

The general objective of this action-research project is to explore the contributions that popular education (particularly using visual arts-based methodologies) can make to efforts being undertaken by a group collectively experiencing the effects of chronic, acute, and continuing trauma, towards collective recovery and reconstruction, through the conduct of a twelve-week trauma psychoeducation group.

Specific Objectives:

For the Participants
This study seeks to contribute to the efforts of its partner group or community towards collective recovery and reconstruction from trauma-related distress in the context of psychoeducation using popular education as a framework.

In particular, it is hoped that by the end of this study, the participants will be able to:

1. explain effective strategies in ensuring safety and stabilization when experiencing trauma-related distress or when they are retriggered;
2. explain post-traumatic stress disorder (PTSD), depression, substance abuse symptoms and the links between and among these;
3. enumerate and explain some cognitive and behavioral factors that inform trauma-related distress with respect to negative patterns of thinking and unhealthy relationships and alternatives to these;
4. critically explain the individual and collective effects and systemic and structural sources of trauma and related mental health and other issues;
5. enumerate and explain some ways to actualize individual and collective recovery and reconstruction also using visual-arts based methods;
6. identify collective action steps to contribute to recovery and reconstruction; and,
7. display more manageable levels of trauma-related distress in the context of reconstructed systems and structures of group support and community.

For the Researcher

This study seeks to identify popular education approaches using visual arts-based methodologies that can contribute to efforts of groups/communities at recovery/reconstruction in the context of collective distress due to chronic, acute, and continuing trauma.

In particular, it is hoped that the researcher will be able to:
1. articulate theoretical foundations of initiatives that contribute to efforts of groups at collective trauma recovery and reconstruction in the context of popular education;

2. identify methodologies that are relevant to group/community needs for collective recovery and reconstruction in relation to the objectives of this study; and,

3. design a twelve-week group psychoeducation approach in the context of this research the framework of which may be replicated by other groups/communities experiencing collective trauma-related distress.

**Preparatory Activities**

It was necessary to draft an initial design of this project, prior to working with a group of participants and to propose the same to a partner organization. This draft was submitted for approval by my Supervisory Committee, for ethical review by the UBC Behavioural Review and Ethics Board (BREB). I drafted an initial design for this project with the understanding that this would serve as a road map for continuing discussions with the participants about its various aspects (objectives, content, methodology, implementation, facilitation, evaluation). Changes and alterations to this project were made rooted in continuous dialogue with the participants and occasional inquiry into the relevance of subsequent steps throughout the project.

To identify a site for this project, I approached several agencies to explore the possibility of working in partnership. For one reason or another, I did not hear back from any of these organizations, even after several follow-ups. This was quite frustrating for me as I had no idea why I was not hearing back from these organizations, not even to
be told that they were declining my request or were unable to consider working with me on this project at that point in time. But such was the case.

I was finally able to identify a partner organization, the Centre for Concurrent Disorders (CCD). This was upon the recommendation of the Coordinator of the ACT/Bridging Program of Vancouver Coastal Health (VCH), an agency I did contractual work with over the summer. I set a meeting to discuss this project with the CCD Coordinator who was very open and supportive. After several consultations, we reached an agreement. This project was undertaken at and with clients of the Centre for Concurrent Disorders (CCD) of Vancouver Coastal Health (VCH) in Vancouver, British Columbia.

CCD is a community-based, outpatient service funded by VCH which provides leadership in treatment, education, and research through integrated community partnerships. The program supports those individuals who present with both a chemical dependency disorder and a serious psychiatric illness (such as clinical depression, anxiety, or thought disorders) though programs for youth, adults, aftercare/maintenance, alumni, and families. The CCD team includes professionals from counseling psychology, nursing, rehabilitation, addiction medicine, psychiatry, and support services (Vancouver Coastal Health, 2008).

It was necessary to obtain approval for this research study from the UBC Behavioural Research and Ethics Board (BREB) and Vancouver Coastal Health Research Institute (VCHRI) (please see Appendices B, C, and D). This was a two-part process for this project and required a significant amount of work. An application for approval of Stage One was first filed, minor revisions required, and was approved. Discussions to determine the content of Stages Two and Three, particularly the design of the TRRG, were conducted in Stage One. Approval for an amendment was then filed
for Stages Two and Three, again with minor revisions required, with approval granted within a month. I was then able to proceed with the project.

**Project Stages**

Once a site for this study was secured this project was undertaken in three stages:

Stage One which included a Project Orientation Session with CCD therapists (please see Appendix E) to facilitate the process of referring clients to the TRRG. An Inclusion and Exclusion Criteria was used as guide for these referrals (please see Appendix F). I then met with each of these interested clients for a Individual Project Orientation to discuss the project, answer questions, and address concerns they may have regarding participation (please see Appendix G). The project Consent Form (please see Appendix H) was also discussed and a copy provided to each participant for their further review. They were asked to return for a First Individual Interview (needs assessment) two weeks after this initial meeting if they felt that they were interested in participating in the project.

Stage Two included First Individual Interviews (please see Appendix I) with those who agreed to participate to discuss needs and expectations they may have had in relation to the nature and content of the project. After these Individual Interviews, a First Group Discussion (please see Appendix J) lasting two hours was conducted to discuss and agree on the details of this project. Stage Two likewise included the conduct of the twelve-week TRRG.

Stage Three involved a Second Group Discussion (please see Appendix K) and the Second Individual Interviews (please see Appendix L) to gather data on the impact of the activities and processes undertaken in this project as well as participants’ learnings and insights based on their experience.
Data was collected from discussions and visual and other materials produced from these activities. Data was also collected from observation data by a CCD staff member present in some sessions, the writer’s field notes, audio recordings, video (which included only participants who gave consent to being videographed), and analyses of interactions between participants and between participants and researcher/facilitator.

The Participants

There were fifteen individuals who were initially referred to this group by their individual therapists. Thirteen were able to make it to the individual orientation and interview sessions. This was composed of six women, six men, and one transperson. The age range of the group was from early twenties to early eighties, with diverse cultural and religious backgrounds including one who was a member of a First Nations band. Almost everyone alluded to coming from resource-constrained and disadvantaged contexts. Most described coming from middle- to lower-income families described as “okay,” “we got by,” “we never went hungry,” and “we were provided for,” and “we were your average Canadian family.” All of the participants attended school with two having attended University. Ten came when they could for the first five groups, until the regular group of six, who finished the twelve weeks, was formed. Attrition is common in groups, particularly for ones dealing with trauma, and I had expected this to happen.

The group of six who ended up as the TRRG members until the end was composed of four women and two men whose age range was from early twenties to early fifties. They were from the socio-economic backgrounds described above. All of them had been involved in the mental health system as clients of CCD for varying lengths of time. One participant had just started seeing a psychotherapist at CCD when
this group began, four had been involved in mental health services for three to six years prior, while the sixth participant first saw a mental health professional over twenty years ago and had since been involved in mental health care in one way or another since.

Three of the participants described living in a housing facility for individuals at varying stages of recovery from various mental health challenges. One participant rents a room with her partner, one lives in an apartment she can no longer afford since she has needed to stop working due to mental health difficulties, while the sixth one lives in a small apartment with her mother and her son who is developmentally-delayed. All of the participants receive financial assistance from the government.

The participants reported various intensities of traumatization, presenting with diverse levels of severity and frequency of symptoms. Most were symptomatic, stating how they had chronically felt anxious and depressed, many for two or more decades. Almost everyone reported substance abuse/dependence. As agreed upon, trauma stories were not discussed but most of the participants alluded to moderate to severe trauma beginning in childhood and throughout their lives. Most of these early experiences were with family and other relatives, schoolmates, people in authority, and those charged with their care. Early adulthood and adulthood trauma were mostly in the form of interpersonal, small group, and/or systemic and structural violence by significant others, neighborhood or community members (particularly the Downtown Eastside (DTES), Vancouver’s traditionally-poor, disadvantaged, stigmatized community), mental health and other social service providers, government institutions, and society in general. These contexts excluded situations of war.

Many had experienced immobilizing trauma-related distress, particularly depression, at some point in their lives. Substances were used to cope with the pain and anguish with most of the participants reporting great losses (e.g., their home, job,
family, cars, savings) and now living in marginal or transitional housing. Some had health problems including such ailments as angina, knee problems, sleep apnea, and vision and weight problems. Additional ‘vulnerabilities’ mentioned by the participants included sleep problems, unhealthy appetite and diet, physical complaints (e.g., chronic physical pain), and constant lethargy, among others.

Beyond these vulnerabilities, however, the participants also possessed remarkable resilience, as a result of living through decades of trauma-related distress and other mental health issues. Every one of the participants had managed to cope with these at times extremely difficult life circumstances through their hopefulness, intelligence, street smarts, resourcefulness, humor, and creativity. In addition to these, they also possessed skills in the use of available supports, strength of faith, inspiration, persistence, ability to detach, honest self-expression, and letting go of harmful relationships. The participants likewise stated that they had developed a keen sense for danger in some situations, expecting to feel distress in certain places and preparing for this, learning from past experiences, positive self-talk, and attendance in individual therapy and group sessions. They also mentioned how they engaged in rethinking things when harm is possible, asking for help, reaching out, not ignoring red flags, noticing the cost of harmful behaviors, prioritizing healing, and finding healthy ways of self-reward. These vulnerabilities and strategies, among still others, were also tapped into in the course of this project to enhance recovery and reconstruction.

In the final part of this chapter, I turn to a more detailed outline of the TRRG.

The Trauma Recovery and Reconstruction Group (TRRG)

The TRRG was a psychoeducation group conducted in twelve weeks in the tradition of brief, time-limited, and structured models (Klein and Schermer, 2000;
Najavits, 2000). These are regarded as viable strategies in addressing a particular set of objectives for a specific time period in the context of an over-all treatment plan. The twelve weeks was also in consideration of time constraints in terms of participants’ availability and the length of time for groups that they could usually commit to (O. Lim, in conversation, November 3, 2008), as well as the limitations of my academic program.

One of the most essential and distinguishing features of this project was ensuring dialogic, participatory, and transformative processes in the context of psychoeducation initiatives. It is not common that such participatory processes are ensured with participants who are consumers of mental health services. Oftentimes it is only the psychotherapists, educational psychologists, or whoever the ‘expert’ is, who determines the design (objectives, topics, methodology, resources, and evaluation) of these undertakings; participants simply attend the sessions. This ‘top-down’ approach is what Freire (1978) refers to as the ‘banking’ method of education. Participants are regarded as empty receptacles of knowledge, mere recipients of information or knowledge which can only come from ‘experts.’ The participants have nothing to teach, only everything to learn; the reverse being true for the ‘expert’ who believes that s/he holds the only true and valid knowledge.

In general, groups to address mental health challenges are advantageous for various reasons: they are cost-efficient, they provide support systems with others in similar life circumstances, they facilitate the development of skills in relating with others, and they provide venues for acquiring new information and mutual learning. In addition to these, they also provide feedback and knowledge not from authority figures but from peers which may be easier for some to hear. They provide a sense of identity and community, and promote individual and collective growth (Klein & Schermer, 2000).
Najavits (2002) describes the importance of discussing safety in the beginning stages of group as this serves as the foundation of efforts towards recovery. It is very difficult, at times impossible, to realize one’s goals for change unless there is sense of enhanced control over one’s situation. This is particularly true in contexts of substance use, self-harm, trust issues, lack of self-care, and unmanageable symptoms. Herman (1992, pp. 159-60) states that

no other therapeutic work can possibly succeed if safety has not been adequately addressed. No other therapeutic work should be attempted until a reasonable degree of safety has been achieved . . . Establishing safety begins by focusing on control of the body and gradually moves outward toward control of the environment . . . Because no one can establish a safe environment alone, the task of developing an adequate safety plan always includes a component of social support.

The outline of the activities in the conduct of the TRRG follows (Table 1). The content of the TRRG itself was finalized in the First Group Discussion based on topics identified by the participants in the First Individual Interviews. As stated above, it was necessary to begin the TRRG with sessions on Safety and Stabilization and sessions on PTSD, Depression, and Substance Abuse (Najavits, 2000). It was also necessary to dedicate the final sessions to discussions on Systems and Structures that Facilitate (Re)Traumatization and Action Planning as these were essential components of the TRRG. These sessions were non-negotiable and not to require these would not have been good clinical judgment.

In the interest of keeping this dissertation reader-friendly, I will now discuss the TRRG twelve sessions briefly. The analysis of themes and project contributions of this study are discussed in the following chapters.
<table>
<thead>
<tr>
<th>Dates</th>
<th>Activity</th>
<th>Activity/Session Title</th>
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<tbody>
<tr>
<td>September 3 to October 3, 2008</td>
<td>First Round of Individual Interviews</td>
<td>First Introductions, Discussion of Consent Form, Needs Assessment</td>
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<tr>
<td>October 6</td>
<td>First Group Discussion</td>
<td>Discussion About and Designing of the Group and the Research</td>
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<tr>
<td>October 13</td>
<td>THANKSGIVING</td>
<td>No Group</td>
</tr>
<tr>
<td>October 20</td>
<td>Session 1</td>
<td>Orientation to the Group Safety and Stabilization Part 1</td>
</tr>
<tr>
<td>October 27</td>
<td>Session 2</td>
<td>Safety and Stabilization Part 2</td>
</tr>
<tr>
<td>November 3</td>
<td>Session 3</td>
<td>Trauma, Depression, and Substance Use, and the Links Between Them Part 1</td>
</tr>
<tr>
<td>November 10</td>
<td>Session 4</td>
<td>Trauma, Depression, and Substance Use, and the Links Between Them Part 2</td>
</tr>
<tr>
<td>November 17</td>
<td>Session 5</td>
<td>Changing Negative Patterns of Thinking and Behaving</td>
</tr>
<tr>
<td>November 24</td>
<td>Session 6</td>
<td>Establishing Healthy Relationships Part 1</td>
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<tr>
<td>December 1</td>
<td>Session 7</td>
<td>Establishing Healthy Relationships Part 1</td>
</tr>
<tr>
<td>December 8</td>
<td>Session 8</td>
<td>Systems and Structures that Facilitate (Re)Traumatization Part 1</td>
</tr>
<tr>
<td>December 15</td>
<td>Session 9</td>
<td>Systems and Structures that Facilitate (Re)Traumatization Part 2</td>
</tr>
<tr>
<td>December 22</td>
<td>HOLIDAY BREAK</td>
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<tr>
<td>December 29</td>
<td>HOLIDAY BREAK</td>
<td>No Group</td>
</tr>
<tr>
<td>January 5, 2009</td>
<td>Session 10</td>
<td>Building Community and Ensuring a Sense of Belonging</td>
</tr>
<tr>
<td>January 12</td>
<td>Session 11</td>
<td>Action Planning</td>
</tr>
<tr>
<td>January 19</td>
<td>Session 12: Last Day of Group</td>
<td>Synthesis/Termination/Evaluation</td>
</tr>
<tr>
<td>January 26</td>
<td>Second Group Discussion</td>
<td>Lessons and Insights from Group; Recommendations</td>
</tr>
<tr>
<td>January 20 to January 30</td>
<td>Second Round of Individual Interviews</td>
<td>Lessons and Insights from Group; Recommendations</td>
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Table 1. Outline of the Conduct of the TRRG.

Each of the twelve sessions began with a welcome, statement of objectives, and check-in using individual illustrations to represent how the participants’ past weeks had been. The session topics were then discussed using dialogic and participatory methods including visual arts-based ones. Although I had initially planned to use more visual
arts-based methods, there were sessions when these were not viable due to time constraints (participants checked-in longer than usual which was an indication of increasingly enhanced inter-connectedness) or shifts in the direction of the group’s discussion. Each group ended with a check-in as to how the participants were doing at that point, a brief discussion of take-home exercises (if any), a synthesis of the session, and a quick reminder of the following week’s topic.

Session 1 was on Safety and Stabilization. The participants talked about trauma-related challenges and coping strategies. The need to be critical of the coping strategies they used was stressed as some which may seem to be adaptive (e.g., exercise, meditation) may be abused and cause more harm than good. Some may exercise much more than is required, spending endless hours in the gym every day. Meditation may be used to the extent that the individual dissociates from reality to a significant level. Still other strategies may be replacements for previous maladaptive ones (e.g., addiction to food or relationships in place of substances), among others. This was the beginning of an important aspect of this project which was to contribute to the process of developing critical thought necessary for identifying and addressing sources of (re)traumatization.

In Session 2, the discussion on healthy and unhealthy coping strategies was continued using the Coping Skills Self-Inventory (please see Appendix M) based on a list of coping skills (Najavits, 2000). The participants discussed what they learned while doing this exercise. The participants stated that they learned about “numerous other alternatives to unhealthy coping,” “being more conscious of reacting through emotions,” “noticing automatic reactions,” “having reactions that are not really valid,” “being more aware now of being retraumatized,” and “repeating maladaptive coping strategies.”
Session 3 was the first part of the discussion on Trauma, Depression, and Substance Use and Links Between Them. An exercise I call Participatory Visual Appraisal was used to discuss the participants’ definitions of trauma, depression, substance abuse, their effects, and the links between them. Six pieces of flip chart papers each containing the word or phrase for discussion: ‘Trauma;’ ‘The Effects of Trauma;’ ‘Depression;’ ‘The Effects of Depression;’ ‘Substance Use;’ and ‘The Links Between Trauma, Depression and Substance Use’ (Najavits, 2000) were posted around the room. I had identified these terms in consideration of the need to discuss these topics for the purposes of the TRRG, as well as the self-identified needs of the participants. The method used facilitated the provision of immediate responses to each term when the participants were asked to draw on each piece of paper a symbol or image of what first comes to mind in relation to what is written. A discussion followed after everyone finished. Each participant was asked to briefly explain what they drew and the space was opened for dialogue. This exercise provided the group with the opportunity to articulate and analyze their individual responses in the context of the group’s responses. It was quite effective in facilitating not just the exchange of ideas and the collective analysis of these, but also in the expression of validation and support. The critical analysis component of the method allowed the group to come up with a collective understanding of the concepts discussed (e.g., what is trauma, depression, substance abuse, and the links between these) and reinforced the process of unifying the group for the project’s later activities.

A discussion on the DSM-IV (APA, 2000) diagnostic criteria for PTSD, Major Depressive Disorder, and Substance Abuse/Dependence, followed this exercise. These criteria were presented as a set of ways of defining these mental health challenges and in no way carried more weight than any other definition, particularly, the meanings of
these ideas provided by the participants. The systematized and organized presentation of what had been an entangled mess of mental health issues and devastated lives helped the participants make more sense of their experiences. They expressed relief over learning that what they had gone through was within the range of human experience: they were not “crazy,” “damaged,” “worthless,” or “bad.”

Session 4 was the second part of the discussion on Trauma, Depression, and Substance Use and Links Between Them. The discussion on depression was continued with the participants describing the various aspects of these problems in greater detail. They talked about death and dying, of thinking about “finally experiencing an end to long-standing distress,” “living with unending pain,” “having no source of hope,” and the self-harmful ways they had dealt with these in the past. They described how social systems and structures exacerbated their depression in the form of stigma and discrimination, in how they were regarded or treated, or in how they were neglected or ignored. Substance abuse was also discussed and how these substances have been used to cope, providing an artificial sense of self and false perception of desired positive feelings (e.g., joy, painlessness, happiness). Towards the end of the session, the links between trauma, depression, and substance abuse were discussed. Most of the participants stated how they came to a first understanding of the inter-relatedness of these three mental health concerns (Najavits, 2000) in this session and how it was truly helpful to discuss this with others in similar life circumstances. Providing a new context for talking about what may have once been considered undiscussable helps participants reframe and work through their experiences (Bar-on, 1999).

The discussion in Session 5 was on cognitive distortions, particularly, distorted automatic thoughts. Distorted automatic thoughts significantly inform how we relate to ourselves, others and the world. Although these distorted automatic thoughts seem
sensible, they “can cause or exacerbate dysfunctional emotions and behaviors” (Leahy & Holland, 2000, p. 296). For example, if a person has been socialized into believing that they are “worthless,” “stupid,” or “will never amount to anything,” this may affect how they regard themselves, how they relate with a partner, or function in a job. To a person who has been traumatized, such experiences may be regarded as something they deserved or they are to blame for. This may, in turn, affect a person’s efforts at recovery; believing that they are “useless,” “dumb,” or “a loser,” and may prevent them from persevering or even attempting to recover.

The participants provided examples of cognitive distortions including “avoiding conflict at all cost,” “pushing people away before they let me down,” “avoiding healthy people,” “letting situations build to a boiling point,” “not being smart enough,” and constantly “replaying past failure,” among others. A handout (please see Appendix N) was provided containing a list of negative patterns of thinking and used to add to the discussion, deepening the sharing on the effects of past experiences.

A continuing thread in the sessions thus far, as mentioned earlier, is the development of skills in critical analysis by exploring origins of traumatization related to cognitive distortions, the validity or invalidity of assumptions and knowledge, and the identification of alternatives to existing beliefs, feelings, and behaviors. In addition to these, questions around systemic and structural origins of (re)traumatization were also always posed. Freire (1997) advanced the necessity of critically analyzing social contexts and identifying root causes of social ills in order that these can be addressed in relevant ways.

Session 6 was the first part of the discussion on Establishing Healthy Relationships. We began this session with each participant drawing a relationship map on a piece of paper that was divided into two. The map showed every single person or
groups of people the participants had in their lives: family, friends, acquaintances, fellow residents in housing, providers, mental health and other groups, co-workers, and other people they interact with. The participant was at the centre of the paper and the upper portion contained the names of people they regarded as ones with whom they have positive/healthy relationships, the lower part with the opposite. The closer the person is to the participant, the closer their name was written to the participants’ name: the upper portion for people who are the closest and have the most positive influence and the lower portion for people who are also the closest and have the most negative influence. Some participants wrote the names of the same persons on both parts of the paper, stating how these were both positive/healthy and negative/unhealthy influences in their lives.

This mapping provided the participants with an over-all view of their relationships and the qualities of each of these. This was used to analyze these relationships in terms of their nature, ways to sustain and increase the number of healthy relationships, and ways to decrease or transform unhealthy ones into positive influences. These analyses provided the participants with lessons and insights on their interpersonal landscape necessary for recovery and reconstruction efforts, particularly with respect to systems of support and constructive influence. This exercise, like the ones in past sessions, was also designed to contribute to the participants’ efforts at developing skills in critical analysis in the context of conscientization.

The discussion about establishing healthy relationships from the previous week was continued in Session 7 using the participatory appraisal technique described earlier but with the use of text and not visual images. Large pieces of paper were posted around the group room with questions written on them including ‘What is a healthy relationship?’, ‘What is an unhealthy relationship?’, ‘How can you get out of unhealthy
relationships?’, ‘What kind of help do you need to get out of unhealthy relationships?’, ‘Why is it important to establish healthy relationships?’, ‘How do trauma, depression, and substance use affect relationships?‘

The participants also talked about needs in terms of support towards establishing healthy (or at least, healthier) relationships including “creating a network of support,” “learning how to be grounded in reality,” “learning how to help family members also affected by PTSD,” “learning to be open and honest,” and “setting boundaries.”

In Session 8 on Systems and Structures that Facilitate (Re)Traumatization, the participants took turns talking about the systems and structures that have and continue not just to traumatize, but also to retraumatize them. These included family and home life, school and community systems and structures, mental health services, social services and service delivery systems, and society in general. This analysis of broader contexts and contextualizing of symptoms in systems proved to be greatly beneficial to the participants in terms of identifying sources of (re)traumatization which would have otherwise remained disregarded and therefore not addressed.

A discussion of systems and structures that facilitated recovery and reconstruction followed in order that these may be identified and acknowledged. It was necessary for the participants’ recovery and reconstruction efforts to include the supporting and reinforcing of already existing systems and structures and to be able to create what the participants need where no systems and structures previously existed.

Session 9 was the second part of the discussion on Systems and Structures that Facilitate (Re)Traumatization. The past week’s conversation was continued with the participants sharing more concrete experiences in terms of systemic and structural (re)traumatization. They talked about particular experiences with institutions including being treated unfairly in emergency rooms, community mental health clinics, social
insurance offices, doctor’s offices, blood work clinics, banks, buses, hospitals, and other places where care or customer service is supposed to be provided. They discussed the various forms of stigmatization and discrimination they have experienced particularly from mental health and other social service providers because of their mental health status. They also discussed their new insights into how these experiences speak of policies and practices that they now regarded as oppressive or unjust. The participants also talked about how, before the TRRG, they had no awareness that these were forms of injustice or that anything could be done about them. The identification of the need to collectively do something about these situations punctuated the exchanges, with the members identifying possible ways that their unity could be translated into action for change.

In Session 10, further details of the group’s ideas and experiences about and ways of responding to systemic and structural sources of (re)traumatization were discussed. The participants also identified the need to educate those involved in other systems and structures (e.g., medical, political) and, eventually, the general public, about trauma and how best to work with individuals and groups suffering from trauma-related distress. They felt that many do not understand what trauma and trauma-related distress are and the complex ways that these are experienced in relation to other mental health challenges (e.g., depression and substance abuse). This is especially true in cases when these challenges are lived throughout the lifespan. Some possible activities proposed to actualize responses to these needs included: meeting with heads of various city, provincial, and national institutions and commissions; conducting a panel discussion with service providers and others in positions of authority; producing of visual materials to be presented and discussed also in a panel discussion; going on
CBC radio to discuss their experiences and needs; writing letters to city, provincial, and national officials; and producing of a short skit/play.

The participants also stated how one of the courses of action that they could take was to advocate for the continuation of the TRRG at CCD. They felt very strongly that continuing the group would be greatly beneficial to them and to others who are experiencing similar trauma-related difficulties and may be interested in participating in the group. This was a way to effect systemic and structural changes in terms of ensuring delivery of a needed service to consumers of mental health at CCD.

The collective experience of mutual learning and critical analysis of systemic and structural sources of (re)traumatization leading to united action was one of the most essential processes of the use of popular education as framework in the context of the TRRG. To continue the process of identifying and agreeing on the group’s action steps through further discussion and reflection, a planning session was scheduled for the following week.

Session 11 was dedicated to Action Planning. The participants discussed all considerations of undertaking collective action based on the previous week’s discussion. After careful analysis of their individual, group, larger social contexts, and their needs, they decided that their priority was to advocate for the continuation of the TRRG. This was to further establish the community of learning and support they had created, expand it, and deal with the other identified collective responses later. Some of the participants did not feel like they were in a place where they were able to go public with what they had and were going through at that point in time. Others needed more time to experience increased stability before engaging in more extensive efforts. The entire group agreed then to schedule a meeting with CCD, to present their proposal for the continuation of the TRRG, and advocate for the provision of funds, staff, resources,
and institutional support. All of the participants felt that this was the most appropriate course of action at that point.

This was articulated in the Action Discussion Document (please see Appendix P).

Session 12 was on Project Synthesis and Evaluation which began with a brief review of everything that had happened in the TRRG using all the visual materials, handouts, and other documents produced and used in the group. This provided the participants with the opportunity to review and to reflect upon what we had experienced and learned.

The participants discussed the various aspects of what they hoped to actualize in terms of continuing the TRRG. They agreed that it was important to sustain the gains acquired from this experience in the context of continuing the community of mutual learning and support that they had reconstructed.

The session ended with a reminder of final project activities including a Second Group Discussion to talk about the participants’ experiences participating in this project and to conduct a more thorough evaluation. A second round of individual interviews was conducted as well, to provide the opportunity for more in-depth discussions about and evaluation of the group on a one-on-one basis. Finally, as agreed upon by the participants, a meeting with CCD had been scheduled to advocate for the continuation of the TRRG.

Analyzing the Data

The analysis of both textual and visual data from the TRRG processes is informed by Wolcott’s (1994, p.10) approach which includes the following categories: description, analysis, and interpretation of data. (Analysis as used by Wolcott in this approach differs from the broad sense of analysis and “refers quite specifically and
narrowly to systematic procedures followed in order to identify essential features and relationships consonant with identified descriptors” (ibid., p. 24)).

Wolcott (1994, p. 12) explains that description addresses the question, “What is going on here?” Staying as close to the original data as recorded lets the data ‘speak for themselves’ and that data “consist of observations made by the researcher and/or reported to the researcher by others” (ibid, p. 12).

The observations elaborated upon in this dissertation are from session transcripts, visual materials produced, field notes, and observation data from the CCD staff present at some of the sessions. Some of the conversations between the participants are presented in the dissertation in their entirety. In addition, visual materials produced in some workshops are presented, along with the dialogue that occurred in relation to these.

The presentation of both conversations and visual materials illuminates group interaction, which Wolcott (1994) states is one way to organize and present data based on actual experiences. Group interaction is a format that focuses on the participants themselves as change agents and emphasizes ways in which members of a group relate with one another. Pink (2007, p. 120) explains how visual images do not simply serve as evidence of written knowledge but “contextualize each other . . . and form a set of different representations and strands” of these forms of information. This is true for the TRRG, as the textual and visual materials produced provide a mutual understanding of each other.

I undertook the process of data analysis by identifying key words (in the text) and relevant elements (in the visual images) that were significant to the concerns of the project. These included key words and visual elements that signified participants’ common experiences, previous and modified meanings, shared processes, and other
significant information relevant to the research questions and objectives of this study. Some examples of these key words and visual elements included definitions of trauma, depression, substance use, trauma-related distress, recovery and reconstruction, and forms of united action.

*Analysis*, addresses the question, “How do these things relate with each other?” and involves “the identification of essential features and the systematic description of interrelationships among them” (Wolcott, 1994, p. 12). It is in this category that the relationships between the various elements are explored. The initial descriptions are “expanded and extended beyond a purely descriptive account proceeding in some careful and systematic way to identify relationships among them” (ibid, p. 10). Pink (2007, p. 167) describes how visual images “interact with, cross-reference, and produce meanings in relation to other elements in the text.”

From the observations in the *description* phase, I undertook *analysis* by identifying themes that indicated theoretical and practical contributions that popular education makes to trauma psychoeducation. In addition, I also identified themes that involved the use of participatory and dialogic methods in the context of popular education, processes that advanced collective recovery and reconstruction, and contributions made by the use of visual arts-based methods in these initiatives, among others. An important consideration in the analysis of the data in this particular project was that it was undertaken in a clinical setting. This informed my decisions as to which data were to be highlighted and which were not. Not all themes identified were included in the discussions in this dissertation; only the most relevant in terms of responding to the research questions were included. Significant effort was undertaken, however, to incorporate some aspects of those themes that were not thoroughly discussed in other parts of this dissertation.
It is important to state that, although participatory approaches upon which this study is based often includes thematic analyses of the data with the participants, given the participatory nature not just of the study but also its research method, it was not clinically appropriate to do so. Thematic analyses served the purpose of this project in terms of its research component but not in terms of its clinical objectives. Discussions involving thematic analysis, were they to include the participants, would have been in the realm of theorizing and conceptualizing, thus not directly relevant nor responsive to the participants’ needs. I believe that undertaking this activity with the participants would not have contributed to their efforts at collective recovery and reconstruction.

*Interpretation*, for its part, is concerned with “processual questions of meanings and contexts” in response to the question, “What is to be made of it all?” (Wolcott, 1994, p. 12). This phase involves going beyond the factual data to extend the analysis, “to reach out for understanding or explanation beyond the limits of what can be explained with the degree of certainty usually associated with analysis” (ibid, p.11). Wang (2003) describes how the interpretation of data from learning initiatives using visual images extends understanding of participants’ contexts in terms of facilitating action through ingenuity and imagination, fostering mutual support, and ensuring reciprocal assistance through shared learning.

The interpretations I made of the data of this study are presented beginning in the next chapter of this dissertation. These interpretations are based on the particular realities of the participants; the individual and collective contexts of the group members and the particular setting of these initiatives served as the contexts for the interpretations of research data. The themes were linked back to the research questions and objectives in a more in-depth way which considered the interrelation of the various aspects of this dissertation: trauma psychoeducation using popular
education as a framework; collective recovery and reconstruction in a clinical setting; the use of participatory, dialogic, and transformative processes; and visual arts-based methods.

A Brief Word on Ethics

It is very important that participants in initiatives such as these, particularly those who are experiencing vulnerabilities due to trauma, are able to give informed consent. This does not simply mean that they agree to participate in the activities of the study but that they are fully aware of the consequences of their participation. The researcher needs to be aware of a person’s capacity to give informed consent as there are instances when it is not fully apparent that an individual is not able to fully grasp the consequences of giving consent to studies of this nature. Of particular importance is an awareness of the risks of participation, including possible retraumatization and how this can be effectively responded to. Consent is likewise qualified; it is defined by what is agreed upon in the beginning of the study which is to say that participants can expect only the activities they have given consent to to be undertaken; any variations in the conduct of the study does not come with implied consent. Participants also reserve the right to change their minds about their participation in all the activities/aspects of the study and need to feel that they have the ability to state this when the need arises, with no questions asked.

In this research, these issues were addressed through discussions of these points in the individual and group orientation and individual interview sessions. This was emphasized several times over the course of the TRRG. I also considered my own expertise in being able to identify possible difficulties or barriers individuals may have had in giving informed consent including the possibility of non-comprehension due to
compromised functioning as a result of trauma-related distress. This may have been present in the form of dissociation as evidenced by ‘zoning out’ and not being able to repeat back what was just discussed. Some may also have been experiencing significant levels of distress, which could compromise understanding of the context, content, and consequences of what was discussed.

Although it is beyond the scope of this paper to comprehensively discuss ethical considerations, it is also vital to state their importance not just in the use of visual materials, but more so with the use of visual materials of or produced by individuals with increased vulnerabilities due to trauma. Banks (2001) talks about various ethical considerations including ensuring that participants give permission for the use of such materials understood in a socially- or culturally-appropriate context; written consent for release may be used with groups/communities that value such documents, other forms of consent for others. Informed consent is important in that individuals, particularly in contexts of crisis due to trauma, may not fully understand the short- and long-term implications of giving permission to the use of visual materials. These materials may either depict them or are produced by them to represent their thoughts, emotions, etc. It is vital that individuals understand exactly what these images are going to be used for, when they will be used (i.e., consent is not automatically ‘in perpetuity’ unless stated), who will view them, and that they can withdraw their consent for such use at any time. Needless to say, the researcher is bound by this agreement and should not use these visual materials for purposes other than what is given permission for, in the time period stated, and so on. In many instances, it is not necessary either to identify individuals, groups, or communities depicted in or with the images they produce; unless absolutely necessary, people’s real names need not be used. This is important to remember, particularly in cases where there are enhanced safety or retraumatization risks.
Ethical considerations also need to be construed in the context of legal and moral concerns. What may be legal may not necessarily be ethical or moral. For example, it may be legal to use visual materials that young male offenders signed releases for when they were in detention but it is not necessarily ethical or moral to use these materials many years later when some of these individuals are living different lives as husbands or fathers (Banks, 2001). Banks (2001) also states that although one can claim legal ownership of most (but not all) visual images by those who created them, many feel that the people depicted in these images still retain moral ownership of these materials.

Unfortunately, there are limits to how group participants can be held accountable in terms of ethical considerations. For the most part, an understanding can be forged based on trust that group or community members will abide by agreements and guidelines of the group. This is true in most group settings where participants can only rely on each other to ensure confidentiality; there is no professional regulating body that addresses these issues.

It is likewise important to be aware of copyright laws in the use of images. One should be aware of the laws that govern the use of visual materials. Credit should be given where it is due and every effort needs to be undertaken to obtain permission for the use of visual materials. Evans and Hall (1999, as cited in Banks, 2001, p. 170), in cases when copyright holders of images can not be located, suggest writing something along the lines of the following in the introduction, “Every effort has been made to trace all the copyright holders [of the images in this paper], but if any have been overlooked, or if any additional information can be given, the publishers will be pleased to make the necessary amendments at the first opportunity.”
In addition to these, for the purposes and particular needs of this project, important considerations were given to ensuring the least possible harm or adverse effects on the participants of project activities. This included having systems and structures in place to address emergent distress, setting limits as to the nature and scope of what could be discussed given the psychoeducational nature of this research project, and making sure that each participant had a clear and comprehensive understanding of the risks and benefits of participating in all of the activities.

For the TRRG, a Therapists’ Orientation was conducted to ensure that the referring clinicians understood the project, particularly the inclusion and exclusion criteria. The nature, scope, and objectives of the project were clarified so there would be no confusion about these and only appropriate referrals were made. Each participant was referred by their individual therapist based on a determination of the participants’ appropriateness to be part of the group; the referral needed to be clinically-indicated.

Each participant was then invited to an Individual Orientation Session and an Individual Interview so that they had a clear understanding of the project, particularly its risks and benefits, and the safeguards and requirements for consent, confidentiality, and safety. The participants were given a minimum of three weeks to decide whether they wanted to be part of this research project and knew that they could leave the group anytime, with no questions asked. They were also asked if they were coerced into participating so that this could be addressed if they were. It was ascertained that each participant had an individual therapist and that they agreed to see their therapist when needs arose, particularly if there was retriggering or ideation of self-harm or harm to others; there was also a clinician available at CCD in case the need arose.

All the participants agreed to not discuss any details of their traumatic experiences in order to avoid retriggering. The focus of the discussions was on learning
to deal with the effects, the individual and collective symptoms in the context of systems and structures that facilitate (re)traumatization, and not on the distressing experiences themselves. It was also agreed upon that no one was allowed to be under the influence of any substances during group sessions, to behave inappropriately, or harm the other participants, to avoid retriggering.

Each session was conducted with utmost consideration for each participant’s well-being in the context of their constantly changing circumstances. Every effort was undertaken to ensure their safety and well-being in the context of meeting the goals and objectives of this research project.

**Summary**

In the first part of this chapter, I described the CBPR orientation which was foundational to creating my approach to this research. I then outlined six key considerations that were central to creating the TRFPR and the objectives of this study, for both the researcher and the participants. The phases of the project and a description of the participants followed. The latter part of the chapter focused on the TRRG in terms of its conduct and content. The TRRG differs from other psychoeducation approaches largely due to the use of popular education as framework. This involved processes including collective critical analysis of concrete realities to address systems- and structures-based sources of (re)traumatization through united action by the participants.

The processes undertaken in the implementation of the TRRG were the research processes, as well. The use of TFRPR as a research method allowed for the needs for recovery and reconstruction to be addressed in the conduct of project activities. Needs assessments did not just provide data for the content of the group but also provided research data in terms of identifying processes by which popular
education can contribute to trauma recovery and reconstruction. Sessions conducted utilized methods and approaches that were also at the same time research data for determining the aforementioned contributions.

Finally, I briefly explored about some ethical considerations in relation to the activities of this project highlighting the particular needs of individuals who are affected by chronic, acute and continuing trauma. Such needs can not be understated particularly in consideration of trauma experienced throughout the lifespan. Vulnerabilities may exist such that unethical actions on the part of services providers can bear upon those already suffering from continuing traumatization to be experienced with severity that can further exacerbate existing long-term unbearable anguish.
CHAPTER FIVE

TOWARDS A GROUNDED THEORY ON TRAUMA

In this chapter, the participants’ perspectives and lived experiences of trauma, as discussed through their participation in the TRRG, are outlined. The popular education processes honored in the TRRG sessions, which always began with participants’ lived experience, created a space for participants to articulate their knowledge of trauma recovery and reconstruction. These contributions emphasize some of the ways that popular education theory and approaches can be extended to trauma psychoeducation towards collective recovery and reconstruction in a clinical setting. I have included some transcriptions of the actual exchanges between the participants (represented by letters - myself as the letter ‘M’) for a more substantial understanding of these contributions.

There are a number of theoretical contributions coming from the TRRG but, for the purposes of this dissertation, I will limit my discussion to five. First, I will outline the collective complex, and continuing nature of trauma and how this requires continuing needs assessment and contextualization of education initiatives which need to take clinical considerations into account. Second, I focus on how silencing can be retraumatizing which can also be addressed through ensuring dialogic, participatory, and transformative processes in the context of popular education. Third, I discuss how dialogic processes towards the development of critical thought can contribute significantly to efforts at trauma recovery and reconstruction. Fourth, I outline how trauma-related vulnerabilities can facilitate trauma-related strengths and capacities essential to recovery and reconstruction efforts. Fifth, I outline how participatory processes can facilitate deeper levels of connection and identification of more intimate
details of trauma-related distress which can enhance the building of systems of learning and support.

**The Collective, Complex, and Continuing Nature of Trauma**

One of the primary positions I take in this paper is that the nature of trauma is collective even when it seemingly bears upon only one individual. The TRRG participants recounted an abundance of devastating ‘individual’ experiences of trauma that occurred in the context of family, community (including church and school), mental health and social services, and society in general, across their lifespan. These ranged from repeated physical, emotional, and psychological abuse and long-term sexual assault in childhood to decades-long physical and sexual assault and continuing retraumatization (including by mental health and other social service providers) in adulthood. These were described in the group only in general terms. Most of these experiences were in contexts of disadvantage based on class/socio-economic status, gender, faith, and health/mental health status, among others.

For most of their lives, most of the participants of the TRRG firmly believed that the effects of trauma, including systemic and structural (re)traumatization, were only on them as individuals. Many have and continue to live with self-blame, shame, guilt, and an overwhelming sense of being “damaged” all their lives. Here is some of what the participants said about this:

S: When I meet a guy who’s great, who’s really nice, really comfortable, I always feel like I’m damaged. You know.

I: What happens? What do you do?

S: I’m stupid, I get very introverted, I guess. Like this weekend, this really nice guy started talking to me and I didn’t feel like I was good enough to talk to him. So I walked away.

P: Are you good enough? Do you believe you are good enough to talk to him?
S: I guess so.

P: Well then you are. And you need to invalidate the idea that you are not.

S: But that's not how I felt. Like I said, I've always felt like I'm too damaged for a relationship.

A: I have a sense of what that's like. I felt like that for so long but the boyfriend I currently have, he wanted a relationship. Before I felt like I was stupid, but he was so persistent and I said 'ok' even though my life was so painful to even think about. But he's been supportive and we're still together. I was totally closed off before.

M: So are those past thoughts still valid? Do you think they were valid in the first place?

K: No, not anymore. Uhmm, in a sense. I mean depending on the person. I mean I wouldn't want to share that with a person who . . . but now, I guess, I don't know. I just feel like I have a grasp on things now so that it's not so caustic, toxic I guess, affecting me.

M: We talked about those thoughts being problematic if they are automatic. You meet a person and you automatically think you're not worth it. That's why it's important to ask if those perceptions are still valid.

R: In a way they are. But it's good to really be sure and to think about why.

A: Someone talked to me in the grocery and I asked myself should I tell her I was an alcoholic, depressed, everything?. Should I talk, leave, or . . . And when it got nicer, I thought I should leave. And there was truth to it, too. Having had experience with schizophrenia, bankruptcy . . . I can't do that to anyone.

P: I guess it's problematic when you regard this as something that can be taken only one way. That it's an absolute.

L: I guess if they really like you then they should have a say in whether they are fine with all that or not. We can't just automatically assume.

A: Yeah, I agree. Like I said, that's what happened with me and my boyfriend. And things are going great.

And in another session:

I: I can't be in a relationship now because I feel that I'm damaged goods. I've always thought this after what I went through as a child. At home, I was always blamed. For everything. My sister was the golden child. I thought I was the only one who went through this. I always believed it was my fault.
L: That was my experience, too. I was always beat up by my father for everything everyone else did. Even if somebody else did it, I was the only one who was beat up. My father came into my room late at night to punch me repeatedly in bed to satisfy my mother. He beat me up. This happened for years. It was only last year, last year, that I found out that it happened to my brother, too. Blonde, blue-eyed golden boy. My relationship with my entire family, with all of my relatives has been affected by all that. I never wanted to talk to them. That’s why I left and went as far away as I possible could. I could never keep a job as I always sabotaged it. Never had a relationship. I’ve gone through daytox many times, received services for years, and still can’t work. Been an addict, been homeless and now I live in housing and getting cheques. It’s only now, after almost 40 years, that I realize how everything and everyone has been affected by all that. I thought it was just me.

The participants described experiences which revolved around a number of themes. Many had experiences of various forms of abuse beginning early in life entrenching negative and disparaging self-regard in the form of self-blame, shame, and guilt. At times these facilitated prohibitive or self-destructive feelings of inadequacy and being a failure. This entrenchment led to a lifelong self-perception of being “damaged,” “stupid,” and “inadequate” resulting in negative effects on their physical, psychological, emotional, academic, social, relational, occupational, and spiritual lives. These perceptions often meant automatic rejection of any possibility of intimate connection particularly with others who are perceived to be ‘healthy’ or ‘normal’ (i.e., not mentally ill). As a result, the participants spoke of continuing to lead lives that are deemed to be too painful, ‘toxic,’ or ‘caustic’ to share with others, rendering their selves unworthy of being in a relationship. The participants struggled with how to regard systems and structures (e.g., family, school, church, community, society) as they are implicated in such experiences.

It became evident through the group discussions that these distressing experiences were collective in nature. They affected other people in their lives, were
interpersonal in nature, or group- or community-based. Their effects are reflected in (and reflective of) social systems and structures.

The themes enumerated above not only informed the participants’ cognitions and behaviors with respect to their intimate relationships, they also affected their other relationships, interactions, and social roles and functions resulting in enduring anguish and misery. Various aspects of these themes, along with others from previous discussions, served as bases for identifying strategies to deal with the effects of these ‘embedded injuries’ including ones involving the systems and structures that facilitated these distressing experiences and possible ways that these, too, can be addressed.

The collective process of analyzing the linking of symptoms to systems and structures of (re)traumatization in the TRRG revealed the following. First, participants came to understand that no trauma is ever really only individual; we are all affected by any act of violence inflicted upon another human being. Second, they came to understand how trauma across the lifespan represents complex trauma-related distress in the form of continuing (re)traumatization through various forms of violence including stigmatization and discrimination. Third, that the TRRG process highlighted the importance of trauma being regarded in its context, particularly in terms of the systems and structures in which these experiences are located, and not limited only to discussions about its individual effects that manifest in symptoms.

What does it look like when one is experiencing trauma-related distress from chronic, acute, and continuing traumatization? The participants discussed this:

S: We have good days and bad days, peaks and valleys all the time. There are highs and lows and we just have to deal with it.

A: Yeah, that’s true. It’s like a roller coaster ride. Up and down, up and down, usually it’s terrifying.

K: It’s like having a wet blanket over you all the time.
J: I agree. You live it every minute of everyday. There are days when I feel okay and days when I can’t get out of bed. Some days things will go bad and I am fine, other days, the smallest thing will set me off. Back to being anxious, depressed, and fragmented thinking. It’s been like that for decades.

I: You just never know. Last week I was feeling depressed and hopeless. Yesterday was a little better. But it just won’t go away. I don’t think it will ever go away.

R: Sometimes I can be so indecisive, feeling worthless, feeling depressed, nothing helps, nothing changes, nothing shifts.

A: That’s how it felt for me for years. It was just endless yet I had to fight to survive. It’s tiring!

R: I’ve had that experience that I’ve had everything I could have and lost everything. Because of my brother and husband defrauding the government in my name. You give-up and just let things be. Then I get over it and try to make it work but lose everything again. Success for me is now fear-based. I’m not happy but I can’t lose what I don’t have. I saved up to get this camera but if I lose this, then oh, well. The only thing I have in this world is this camera but if it’s stolen, I don’t care anymore.

K: Mine is like just having convoluted thoughts. Feel more directed than this same time last year. Just been having bouts of depression when I don’t think that there are really reasons to. It’s just like that.

This and other conversations in the TRRG revealed lifelong struggles with the adverse effects of trauma: years, even decades, of misery in the form of anxiety, trauma-related depression, and substance abuse. These manifested in difficulties with being able to live lives worth living due to problematic and violent relationships, inability to perform important roles and functions, and recurrent episodes (at times lasting years) of immobilizing distress from anxiety, depressed mood, and the effects of substances. This was experienced in the everyday usually in the form of instability, disorganization, dysregulation, and frequent shifts in levels of distress and well-being.

This experience I refer to as the ‘distressing persistence of variability’ was also represented in visual images drawn for the session check-ins (fig. 1). Every week,
participants described having “good days and bad days,” with good days being “okay” but bad days being “really bad.” Here are some of the images and conversations:

Figure 1. Individual Illustrations of Shifting Levels of Distress and Well-being. Photos by Mok Escueta.
S: Uphill, uphill, uphill, then everything just becomes difficult, but smiley face. Once you're on the ride, you're on the ride. Don't know if I want to be in front or the back.

P: Overwhelmed. Looking forward to things slowing down a bit, like they usually do.

I: Same as yesterday. Things are quite difficult. Things were better a few days ago but not today.

R: I'm ok today but something happened yesterday that affected my thinking, I felt hypervigilant. I came out of it because of something external. I came through and am coming out of it and had a really it good day on Saturday.

L: Starting to function better but have been up down; down side is needing a picture ID but told we don't do that, and things like that that prevent me from doing things. But a person who called me who I 'helped' made me feel good about that. Our lesson about how to nurture oneself has also been helpful.

S: I feel great 'cause I got a job! It's only for one to two days a week but it's the first time in about ten years! I'm really excited. On the other hand, my relationship with my boyfriend has gotten me down. That's really depressing!

J: Noticed some hard times these past weeks. Was worried that I was going into another relapse but there was a shift, turnaround. A handout I have helped for a turnaround last Friday at the CCD field trip. Yesterday was hard but today is good. So I am on an up. Things will be rough again. I'm only now starting to recognize that the down times are not permanent.

Common elements in the visual images above include erratic, toothed, or wavy lines which represented unpredictability in levels of distress and wellness. The peaks in these lines typically stood for increased levels of anxiety, depression, or substance use but have also been used to signify “good days” when the individual was feeling “up.” The valleys usually symbolized a regression in symptoms, a calming down and decrease in distress. For some, these meant “bad days” when the individual was feeling “down.” The first image represents a roller coaster signifying the feeling of dread associated with the moments right before the “big fall” and then “it's just roller coaster ride.” In the last four images the horizontal line stood for the individual's baseline, when things felt at a level. Above this line represented PTSD flaring up, when there was
significant anxiety, while below it signified a state of depression. Note how two individuals reported not experiencing being above their baseline, feeling “down” the entire time, some days more so than others. This was due to trauma-related anxiety, depression, or substance use. These visual images represented frequently shifting levels of “good” and “bad” states of being which could be experienced during the course of the day, several days, weeks, or months.

It was also crucial that these experiences with instability, disorganization dysregulation (the inability to regulate one’s mood or affect), and frequent shifts in levels of distress and well-being were considered in the design and conduct of the group as it is the reality in which people live their lives. Any and all initiatives in recovery and reconstruction need to also be informed by and based on these constantly changing levels of anguish and ease. This meant that it was necessary to conduct continuing needs assessments throughout the twelve weeks in order for this project to remain relevant; it was fundamental that the conduct of the TRRG be adaptive to contexts that are dynamic and changing. Freire (1973) stressed the importance of contextualizing education initiatives in people’s concrete realities and recognized how these realities are never static; they constantly change as people act upon them making it vital to reflect upon these changes as basis for consequent undertakings. It is important for efforts to be consistently based on emergent realities.

Needs assessments were undertaken during the course of the TRRG when it seemed appropriate and necessary. It was agreed upon that we would conduct these when the sessions were not as meaningful as was originally thought or when there were more pressing needs that required more time than what was originally scheduled. These were identified in the course of check-ins or during the discussions and were conducted by asking the participants about content of and methods used in group and
whether needs were or were not being met. Needs assessments were also conducted from observation data on group processes involving participants’ behaviors and interactions during the session and the content of discussions outside of group.

There were several occasions when shifts in how the group was to be conducted occurred due to significant distress. Some participants reported experiencing distress from what was going on that particular day, anniversaries occurring, or due to unforeseen events taking place. One such incident involved news about one participant’s partner attempting suicide which the group spent some time discussing. The group provided support and suggested possible courses of action, particularly to assist the participant in ensuring safety and no self-harm. Another incident involved one participant repeatedly making rather sexist comments and eventually walking out which the other participants also spent some time discussing. In these situations, it was crucial to not only acknowledge what was going on but to have systems established for continuing needs assessment, dialogue, and participatory processes in determining appropriate next steps. In consideration of the nature of this project, it was important for these decisions not to be made solely by the therapist. Some examples of what the participants said were:

L: Things are the same as last week. Today, though, marks the anniversary of the death of my father and it marks half my age and am contemplating on that so I’m just pensive.

S: 1981 was 27 years ago and in three years is my 30th High School reunion. Well, this dip is for the bad times but I worked a couple of days last week, so that’s good. Yeah, it’s an easy job but it was busy last week with a lot of people buying books and calendars and everything but it had to be done on the cash register, I know the first part but the second part is really hard. The down part is with the boyfriend thing. Seems like there’s a black cloud hanging over him. I felt bad for him. Someone broke into his place and stole all his equipment. He filed a police report but they said that the chances of getting those things back are nil. I feel bad. I’m trying not to let that affect me, try to stay positive but I have not heard form him though he did email in response to a picture of me I sent. So that’s the down, brings me down but for the most part, last week was good, tried to get things done.
R: My aunt passed away this morning, my dad told me, finally. She had liver cancer, she’s in Kelowna. Also the amount of weight I get for the two days visiting them. My jeans don’t fit me and I wear sweats all the time. As my counselor pointed out, I’m an emotional eater, so I came here today so I wouldn’t spend the day at home just eating.

J: I have a smile but there are dark clouds. I’m feeling good, not really tumultuous. Last week I talked about something that happened with a counselor here. I set my boundaries and I’m feeling good about that. When I find that something is destructive and not constructive and that’s good for me, it’s really good to be in a place like this where they hear it. Not like other institutions who don’t and despite what I say continue what they do so I’m grateful about that. I’m trying to find ways to have a friendship going. First time I’ve let someone in my life for 17 years and I’m trying to find ways so that this friendship will not be co-dependent. That’s where I am.

It was vital that continuing needs assessment was conducted in order that the frequent shifts in the participants’ disposition be reflected in and addressed by the content and methods of the TRRG. It was equally important that all decisions about shifting course content and methods be a collective undertaking as it was necessary to not compromise group needs and make changes without group consent.

This component of unpredictability required adaptability and adaptability not just on the part of the facilitator but also the participants working in partnership to sustain the group’s relevance. It was important for people in the group, particularly the facilitator, to possess skills in de-escalation, crisis management, group processing in the context of psychoeducation (not group psychotherapy), and a broad knowledge of various topics and interventions that may come up or may be needed (e.g., helping address safety concerns, assisting with dealing with self-esteem issues, helping manage retriggering).

Retraumatization through Silencing and the Shattering of the Self

A number of participants stated how silencing has been and continues to be very distressing to them. They recounted many instances of feeling invalidated,
disregarded, trivialized, discriminated against, or otherwise considered invisible, by being silenced. This was manifested in various ways. They described not being included in decision-making processes about matters that affected them, particularly with their treatment and efforts for their well-being. One way this occurred was in moments when they were not being asked for information on or their ideas about important issues that relate to their condition or situation (e.g., ‘Do you agree with my diagnosis of you of Borderline Personality Disorder?’ or ‘What do you think may be good to do at this point?’) in ways that are truly relevant and not just lip service. They also described being ignored in their presence as if they could not comprehend what is going on because of their mental health problems. They frequently experienced being talked about in the third person in their presence as if they weren’t there or could not have possibly had any input in the conversation. Other ways they were silenced included automatically not being believed particularly when their stories seemed improbable (e.g., “My psychiatrist sexually abused me” or “I was not able to make my housing appointment because I was dealing with PTSD”). In addition to these, they also talked about being disrespectfully cut off or interrupted either verbally, through gestures, or by body language, when they were “rambling on” or were “repeating their stories.” Many participants related incidents of being allowed to ‘speak’ but not really being ‘heard.’ Sometimes they also experienced being threatened with serious injury to themselves or people they loved, if they said something, as well as being threatened with not receiving services or benefits if they complained or were non-compliant. A few of the participants recounted past experiences when they were publicly silenced (e.g., in therapy groups, emergency room, and clinics) which was significantly distressing resulting in staying in bed at home for weeks due to anxiety and depressive symptoms.
In broad terms, silencing was perpetuated by the non-existence of systemic and structural venues for self-expression. The participants talked about how being silenced represented another form of 'shattering of the self' which, for individuals already dealing with trauma-related distress, can be thoroughly devastating. Some participants talked about walking out of individual or group sessions after feeling like they were 'silenced' because they were 'interrupted,' 'asked to stop talking,' 'were not acknowledged,' or 'were negated.' Other experiences included never going back for treatment with psychiatrists and other mental health providers who thought that the participants were essentially lying about what had been and what was currently going on.

It is in these and numerous other ways did participants felt silenced which oftentimes was significantly distressing.

Morris (1997, p. 27) shows how silencing is reveals a basic level of suffering in that:

Suffering is voiceless in the metaphorical sense that silence becomes a sign of something unknowable. It implies an experience not just disturbing or repugnant but inaccessible to understanding. In this sense, suffering encompasses an irreducible nonverbal dimension that we cannot know – not at least in any normal mode of knowing – because it happens in a realm beyond language.

The anguish that comes from not being able to describe one’s internal landscape of agonizing pain, and therefore begin to understand it, makes that torment even more unbearable.

For many, because this pain happens in “a realm beyond language,” it is important to access other modes of knowing which are achieved through the collective efforts of individuals who speak the in the same voice. This, for the purposes of this group, included articulating through visualization. As stated earlier, the use of visual arts-based methods, which is discussed in more detail in the next chapter, allows for the articulation of thoughts and emotions that, for the most part, have been difficult to
express. This ‘voice’ is vital to recovery and reconstruction. Morris (1997, p. 29) continues:

Voice matters precisely because suffering remains, to some degree, inaccessible, voice is what gets silenced, repressed, preempted, denied, or at best translated into an alien dialect, much as clinicians translate a patient’s pain into a series of units on a grid of audio-visual descriptors. Indeed, voice ranks among the most precious human endowments that suffering normally deprives us of, removing far more than a hope that others will understand or assist us. Silence and the loss of voice may eventually constitute or represent for some who suffer a complete shattering of the self.

Retriggering by silencing is consistent with the themes of trauma around lack of control. It brings up cognitions and emotions around being subjected to abuse, violence, or neglect by another and the helplessness and horror that is associated not just with these but also with being threatened if they said anything about these atrocities (Herman, 1994).

Freire (1970, p. 70) talked about the “culture of silence” of the oppressed (i.e., traumatized) who have internalized their oppression and have been rendered inarticulate. This is why it is necessary to engage dialogic processes because being denied the right to speak is being subjected to ‘dehumanizing aggression.’ Freire (1970, pp. 70-73) commenting on dialogue, writes:

If it is in speaking their word that people, by naming the world, transform it, dialogue imposes itself as the way by which they achieve significance as human beings. Dialogue is thus an existential necessity. And since dialogue is the encounter in which the united reflection and action of the dialoguers are addressed to the world that is to be transformed and humanized, this dialogue cannot be reduced to the act of one person’s ‘depositing’ ideas in another, nor can it become a simple exchange of ideas to be ‘consumed’ by the discussants . . . Only dialogue, which requires critical thinking, is also capable of general critical thinking. Without dialogue there is no communication and without communication there can be no true education.

It is imperative that the participants’ ability to engage in dialogic processes, to silence silencing, and use their voice (or produce one), is entrenched in efforts toward recovery and reconstruction. This is in recognition of the power they posses not just
despite of, but also because of, trauma. In the TRRG, this was accomplished through various means. A key aspect of the group process was to create a safe space for individual and collective expression of what once were considered undiscussable topics taking clinical considerations in mind. Such considerations included the use of sound clinical judgment in finding the balance (in partnership with the participants) between making sure that people are able to express themselves and feel heard and managing retriggering and the possibility of retraumatizing other participants in the context of learning using popular education as framework. The use of visual arts-based methods enhanced the participants’ ability to articulate difficult thoughts and emotions. It was important to ensure that group processes were co-intentional and directed towards addressing not just individual needs but systems- and structures-based needs for meaningful change.

It is in these ways that voice replaced the participants’ silence leading to opportunities for meaningful change.

**Dialogic Processes Towards the Development of Critical Thought Contributes Significantly to Efforts at Trauma Recovery and Reconstruction**

It was immediately clear how valuable it was to establish dialogic processes in the TRRG. Each participant was regarded as possessing of pertinent knowledge and experience to share with each other which facilitated collective learning towards collective recovery and reconstruction. This entrenched the popular education principles that all participants are co-learners in co-intentional education which facilitated the development of critical thought (Freire, 1998). The following discussion illustrates co-intentionality:

**S:** For me, I had to learn that it does not have anything to do with me. Before I would always think whether it has something to do with me and it has made me decide to ask myself whether it is necessary to respond.
M: We need to be very critical about how much the danger really is and not interpret a situation padded with past trauma. We need to contextualize, need to be critical about what the danger level really is where we are. We think the danger is at a '9' when it’s a '4.' Need to ground myself in concrete reality. In many situations, we have to be aware that there is danger. Some places are dangerous, but we can’t walk around thinking that it’s a ‘9’ all the time when it’s actually a ‘4.’ And we can’t allow ourselves to feel that it’s a ‘9’ everywhere because it simply isn’t. That is no way to live,

L: Are we going to talk about why we’re anxious?

I: We have to ask ourselves what is causing this anxiety. We start with asking if it is because of physical issues. There are illnesses that cause us anxiety.

M: Or if there is something emotional, psychological, or other things going on. A lot of anxiety is due to perceived fear or perceived loss. Looking at what you’re thinking about, including all the other things in the past that have not been resolved, padding things with a lot of things that have happened in the past.

L: How can I help myself keep my anxiety low. What strategies can be used to keep these?

J: I can work on my cognitions and realize that I am reacting more than I should and can use all these cognitive approaches to what’s going on but these don’t work all the time.

M: You are talking about grounding. Of being aware of what your real situation is and what is really going so that our minds are not somewhere else in a context of trauma. That can be difficult sometimes, specially if we are not dealing with the deeper issues. We can use different strategies but these won’t be effective if we are not dealing with the our real issues, the deep, core issues like unloveability, abandonment, undesirability . . .

S: I wouldn’t know how to get at underlying issues. That scares the hell out of me.

L: Well, it’s Important to set boundaries if we are not ready to do deeper work now. Safety is important. But we have to recognize that it will need to happen at some point. We also can’t limit our discussions to these symptoms as we have to look at the big picture and what systems have done.

J: The very efforts of finding a community like this have been difficult. You think some communities are supportive but many people just expect you to ‘suck it up.’ Not think about it. Which is very dangerous because you don’t work on deeper issues and larger systems.

K: I’m totally outraged by people who say they don’t need to deal with things.
J: You’re still the best person to know what works best for you. That’s what does not help trauma victims: ‘Suck it up’ does not help. We need to find support and community that really responds to our needs. And build it if we don’t find it.

M: We need to really find appropriate ways to respond to our needs, the way we need the kind of support we need. We also need to be critical about how we form communities. Many trauma victims are not able to form the community of support they need. That’s why we need to be critical and see if what we have is really what we need.

The rest of the conversation touched on retraumatization and how this happens, particularly when we lose grounding in our context. The importance of using critical thought all the time was restated, as it is important to consistently know what is really happening and whether or not we are using appropriate (i.e., adaptive) coping strategies. The importance of possessing or acquiring competencies in using healthy coping strategies was also stressed again, particularly as far as the activities of this project were concerned. The participants agreed that they needed to have numerous strategies to deal with emergent trauma-related distress especially when situations make it hardest to use them. At the same time, it was essential to undertake efforts to address systems and structures that entrench trauma-related distress.

Some of these strategies involved critically analyzing cognitions to identify distortions and resultant adverse effects on the various aspects of life and living, learning to set boundaries, and enhancing capabilities to manage anxiety and depressed mood. In addition to these, opportunities for examining adverse effects on open and honest self-expression, creating a community of support and identifying ways to connect individual issues and undertaking collective efforts to address more systems- and structures-based issues, were also important to realize. These processes likewise helped enhance the functioning of the brain by facilitating higher level cognitive process such as grounding, analysis, sound reasoning, and even creativity, with the use of
methods that are visual arts-based. This in turn helped to enhance one’s ability to manage trauma-related symptoms.

The above conversation illustrates one example of Freire’s (1998) concept of praxis which involves the development of critical consciousness, action, and reflection. It was evident that the opportunity for dialogue about the aspects of trauma-related distress and efforts at recovery and reconstruction facilitated reflection. Analysis points including why, how, what are the effects, and what can we do, all speak to a process by which the participants collectively identified not just manifestations of problem situations and the contexts of these, but also other important considerations necessary for identifying next steps that are even more appropriate and relevant to recovery and reconstruction.

Not a Deficit Model: Trauma-Related Vulnerabilities can Facilitate Trauma-Related Strengths and Capacities

At the same time that this project acknowledged the participants’ trauma-related vulnerabilities and all of their aspects, it also described the participants’ trauma-related strengths and capacities. In fact, the first appears to have helped facilitate the second, to a certain extent. For most of the TRRG participants, traumatic experiences also helped in developing extraordinary ways of dealing with extraordinary situations and events. Not very many people can survive years of trauma-related distress, difficult life circumstances, chronic pain, long-term despair, year after year after year.

These initiatives not only contributed to the efforts that the participants were undertaking towards recovery and reconstruction, it also capitalized on and advanced participants’ strengths and capacities.
Horsman (2000) argues for a valuing of learners’ strengths and knowledge and not to regard the learner as the problem in literacy programs. This holds true in psychoeducation initiatives such as this project. She defines how in the deficit model:

. . . only the individual learner needs change to acquire the lacking –hence, deficit – skills. Society can be left unaltered. Analogies of literacy as a sickness or disease to be eradicated often signal this deficit approach. It is an approach that suggests that the learner simply needs to improve her literacy skills to fit into society; the problems will be solved and she will have access to social mobility in meritocracy (p. 20).

Some of the strengths and capacities that the participants revealed include:

1. Motivation to learn and teach what they know about complex trauma, depression, substance abuse/dependence, and survival.

2. Motivation to give and receive support for long-term and current issues and concerns.

3. Resilience from surviving decades of trauma, depression, and substance abuse/dependence and strength of character that comes with enduring.

4. Knowledge about the intimate details of complex trauma from living and learning about it.

5. Knowledge about and use of adaptive coping strategies.

6. Ability to model some desirable behaviors in the context of distress including setting boundaries, self-advocacy, asking for help, self-activation, and persistence with recovery efforts.

7. Possessing streetsmarts from surviving years of living on or being otherwise involved in neighborhoods where there are enhanced risks for traumatization.

8. Resourcefulness and knowledge of resources and extraordinary ways of navigating these.

9. Intelligence, articulation, and analytical skills.

10. The ability to manage distress and move forward with this group.


12. Openness and honesty which proved helpful in dealing with denial, grounding, and keeping self safe in relationships.
13. Kindness, empathy, and caring for other participants and the robust longing to live these in healthier relationships.

14. The ability to provide validation, support, and affirmation to others.

15. The interest in and ability to participate in building a community of support and learning and the desire to include even more people in these initiatives.

16. Willingness to share lessons from past experiences to advocate for patient’s rights and other similar efforts to support others.

17. The longing to change their life circumstances with vigor.

18. Faith in faith. Particularly when all other sources of hope have emptied.

19. The capacity and yearning to express caring for others in similar life circumstances with a sense of genuine immediacy.

20. Humor. Particularly when things are at their absolute worst, there is nothing one can do but laugh.

All of these strengths and capacities, and more, contributed significantly to the accomplishments of the group in forging their unity to bring about more systems- and structures-based change at CCD. It is thus vital that these are identified through and used as foundation for group processes.

**Participatory Processes can Facilitate Deeper Levels of Connection: The Illuminating Exchange about Cemeteries**

One of the more telling exchanges among the participants about trauma happened during a TRRG discussion about various forms and sources of distress and recovery. In this discussion some new issues emerged:

**A:** One thing new that has come up lately that’s added stress is heights. Watching skydiving now gives me heebie-jeebies. I used to work in construction and heights did not bother me, Maybe I couldn’t justify fearing it cause I was getting paid. One false move and you’re dead. Now watching TV when there are heights, or being in the 28th floor balcony is distressing for me. I don’t know what happened. Why is that?
L: That's happened to me, too! Yes, it's very distressing, it's not something that I would have thought of but it started last year. Who would have thought? Very interesting phenomenon, I used to not be afraid of heights.

S: Oh, I love heights, I'd love to try skydiving, and my dad pulled my out of hang gliding class in high school. Didn’t allow me to do it. But anything like that, fast cars, man, I love ‘em.

J: I like cemeteries. Love them.

L: Oh, me, too! Very peaceful.

J: My apartment looks across to a huge cemetery. I really, really like having that!

L: Uh-huh. That would be great!

I: Yes! I totally agree!

K: I like cemeteries, too. I’ll be staying with friends on Christmas in Europe and I plan to walk cemeteries there. It’s like a morbid sense of fun. It’s one of the biggest reasons why I’m going on my trip to Europe. To visit cemeteries everywhere!

S: You know where I grew up. We used to ride our bikes way out and walk through all the old stakes, old gravestones. We rode our bikes all the way out there and spent lots and lots of time in the cemeteries.

I: We used to walk to cemeteries, one close by, near highway, walk. Just be There. I like being with the dead.

P: If you ever get to Halifax check out the cemetery there. 4000 dead from the Halifax explosion in 1917. And 125 from the Titanic. Not all taken to NY. Have only been there once. I’m not really into cemeteries but those ones are really interesting.

J: When I was a kid, since there was a lot of abuse in my home, was very introverted and was abused a lot in school, and cemeteries was very safe since kids did not go to cemeteries. I found it very safe place to be. Where I am is very interesting since it’s very diverse, it’s beautiful, with different areas for different communities. It's gorgeous.

I: You have to see the cemetery in Louisiana.

A: Oh, yeah. Yes, that one’s just beautiful

R: We lived 2 blocks away from a cemetery. Grandma died before I was born and I liked going around her grave but it was too far for me to travel. Two years ago, I drove up to a cemetery at 33rd and Fraser. I was there to
commune with nature, meditate. It was a full moon. There was a fresh grave nearby. Police car came up. I told them I was meditating. They thought I was an axe murderer or something; did not believe. Fresh grave they made mention of but I did not engage. Two other cop cars came and they asked if I was on drugs. It was hard to explain why I was three. It’s just too complex. Anyway, they eventually left.

S: We should all go up to your place and go to the cemetery near you! That would be so interesting!

L: I used to walk through that cemetery. That’s a good one to walk a cross through.

I: I used to spend a lot of time in cemeteries when I was a kid. Growing up, I used to always be treated badly at home and in school. Kids bullied me and called me names. It was just horrible. It was only in cemeteries where I found peace and calmness. I felt happy when I was there. No one was around to treat me badly. No one judged me there.

This was the first time that I had ever known a group of people where all but one really liked cemeteries. I have had some experience facilitating trauma groups, and extensive experience facilitating groups of traumatized individuals working on social change, but I had never come across a conversation such as this. The enthusiasm with which this conversation was conducted was gripping; it seemed like the participants chanced upon a long-lost friend or family member.

For most of the participants, it seemed like going to cemeteries continually reminded them, in the most graphic way possible, that there was an end to their suffering; there was relief and a release from it all. The participants were simultaneously elated not just about finding out that almost all of them liked cemeteries but that these had been a significant feature of their childhood, of their consciousness. Cemeteries served as a refuge from judgment, abuse, maltreatment, and violence. It was truly interesting, to say the least, to witness that while the participants were thrilled to have made this connection between and among each other, they were also not surprised at all; to them, all this made sense.
This collective connection with cemeteries revealed significant features of a shared emotional landscape shared by the participants. For many people, cemeteries are, to say the least, not a place they would typically go to feel peace, peaceful, or calm. On the contrary, these places are often associated with sadness, loss, and dread; cemeteries can be a vexation to the spirit. As the participants ascertained, however, they really found acceptance, serenity, and the calming of spirits that have otherwise been in chronic chaos, in cemeteries.

What does a person have to go through to yearn for solace in a place that is so enormously akin to death? Quite a significant quantity of repeated trauma, one would imagine. If we consider the participants of the TRRG, one would most likely have to have gone though a rather massive and unimaginable amount of trauma-related distress characterized by seemingly severely limited sources of tranquility for one’s being.

On the other hand, there are other ways of regarding death that are more life affirming. Eastern thought views death as a natural conclusion of life. It is accepted with grace and greatly anticipated as an opportunity to go through a rebirth when the lessons of the present life have been learned and one is ready to live a new life to learn greater lessons in the context of spiritual advancement.

For some participants, it seemed to me that different ways of viewing death made cemeteries a positive place for healing, finding peace in the knowledge that there is a divine purpose to life’s extremely agonizing experiences. For others it was the intermingling of these differing perceptions about cemeteries: the somber reminder that there is an end to suffering and the spiritually uplifting symbol of hope for renewal and rebirth, a place free from judgment.
Langer (1997, p. 58) explains how traumatic experiences can signify a dying of parts of the self which fuse life and death, described by many survivors of severe trauma as “the condition of having missed one’s intended destiny by surviving one’s own death.” The continuing to live this reality, he further stated, cannot be described by any word – certainly “not a word as tame as suffering.”

With respect to Langer’s notion, I can’t help but think about what it is like to live a life with many parts of you having died, to live with this reality, for the anguish to remain unexpressed, and face only the prospect of even more parts of you dying, while struggling to live a life worth living? “You wonder if it will ever end,” expressed one participant, “it feels like it will never end.”

My sense is that one will yearn to be in places where there is an affirmation of this paradox: the living with the deep sorrow of living through one’s own multiple deaths while struggling for the living in being alive. In this context, physical presence where there is a completely quieting calming of the exasperated spirit in the abundance of death stands to good reason.

This exchange highlights a number of the important aspects and processes of popular education. The creation of this venue for what Freire (1995) refers to as co-intentional learning facilitated feelings of trust, safety, and shared identity, which allowed the participants to express themselves freely and explore their experiences together. The giving of voice to lifelong-silenced experiences that they discovered they mostly all shared raised the level of unity, in terms of consciousness and community, to a new level. This moment of revealing a ‘shared past’ contributed to later processes of unified action; participants felt that they ‘knew’ each other in more substantial and deeper ways which made collective efforts for collective change much more relevant. This relates to what was stated earlier as a process of facilitating the surfacing of new
meanings and possibilities through the collective re-exploration of past beliefs and presuppositions rather than just accepting them, and exploring these from a new and shared perspective, to create new ways of understanding (Kaye, 1999) towards engaging in more adaptive strategies in living.

For most of the participants, there was a process of humanization in this exchange. A sense of taking back control over the parts of themselves that had been dehumanized by their shared experience of engaging in behaviors that they thought many would find ‘odd,’ ‘bizarre,’ or ‘crazy.’ It was liberating for them to critically analyze these experiences in the context of systems and structures that facilitated them: neglectful and abusive families, violent forces in schools, oppressive systems in the community, among others. This process facilitated humanization in many respects.

Indeed, it took a significant amount of courage for the participant who first admitted to spending considerable amounts of time beginning in childhood among the dead in cemeteries to feel alive, accepted, and not judged. The same holds true for the other participants who seemed like they could not wait to finally share their experiences. Once they did, they expressed feeling all the more human for it.

This exchange also speaks to the further development of critical consciousness in the participants, a process involving the identification of the root causes of their trauma-related anguish, which is necessary for transformation through collective action (Freire, 1973). This falls under the first of the two distinct stages of liberation advanced by Freire: the uncovering of oppression and engaging in efforts leading to united action for meaningful change (Allman, 2001), as described earlier in this chapter.

The participants described themes involving the need for nurturing, quiet (not just in external terms as in the lack of noise, but internally, as in the absence of turmoil), protection, and calmness of the spirit, which they spoke about needing for most of their
adult lives and mostly finding in the most difficult life circumstances. Such contexts for these spaces were paradoxically found in the very poor, traditionally-disadvantaged, and stigmatized Vancouver neighborhood, the DTES. Although the DTES is in constant turmoil and is tragic in many respects, there is at least a sense of acceptance, non-judgment, and 'protection' by being with the familiar, almost familial.

It is in these ways that the contributions that popular education can make to efforts at collective recovery and reconstruction are at their most definitive. In the moments when the participants’ individual consciousness converged with the group’s in a process of dialogue, critical analysis, and community-building, the decision for collective action took on the most momentum.

**Summary**

In this chapter, I discussed how the popular education approach underlying the TRRG led to participants collectively mapping their lived experiences of trauma. Such collective explorations of the nature, internal processes, and intimate details of (re)traumatization provided a deeper understanding of its devastating effects. The reality for most people of the collective, continuing, and complex nature of trauma was discussed, emphasizing the importance of sustained efforts at needs assessment in psychoeducation initiatives of this nature. As such, efforts at recovery and reconstruction need to be responsive to continuously changing contexts; trauma-related distress is a dynamic and constantly varying experience.

The participants’ anguish with the persistent sense of being shattered and silenced throughout their lives was explored, for many for the first time. These experiences, which were chronically retraumatizing to most, needed to be expressed and addressed. The use of visual arts-based methods for collective expression and
critical analysis of these initially undiscussable forms of anguish proved essential in moving towards enhanced well-being as individuals and as a group.

Recovery and reconstruction from continuing trauma in the TRRG involved work based on participants' strengths. For many, such strengths have been buried by seemingly limitless suffering made worse by systemic and structural (re)traumatization, particularly by the mental health profession. From the TRRG group’s experience, the process of building the knowledge base about and use of collective strength to address trauma recovery and reconstruction helped begin the shift towards recovery and reconstruction.
CHAPTER SIX

VISUAL ARTS-BASED METHODS AND COLLECTIVE EXPRESSION

In this chapter I focus on contributions that the visual methods used in this study made to the practice of popular education in contexts of trauma, illustrating how they further enabled participants’ collective expression and analysis.

Visual Arts-Based Methods in Collective Expression and Critical Analysis of Trauma-Related Distress: Participatory Visual Appraisal

As stated earlier, the act of rendering distress in visual form creates a sense of separation of the cognitions and emotional states from the individual who is thinking and feeling them (Wadeson, 2000). This was expressed by more than one participant in appreciation of the sense of detachment achieved by externalizing of what were, in many instances, lifelong internalized distresses. The relief that comes from the disembodying of these difficult thoughts and emotions provides opportunities for learning and mutual support (Waller, 1993). For many participants, this served as an additional adaptive coping strategy and helped fortify critical consciousness-building efforts. It has been discussed how control is a central theme in trauma and any experience of enhanced influence over aspects of one’s life contributes to recovery and reconstruction. Creative expression, particularly and especially in group settings, allows not just for dialogue about extremely difficult subject matters but also intensifies other group members’ desire to express themselves. In the TRRG, these creative forms of collective expression helped enhance interaction between members and helped build a sense of community through the identification of common themes and mutual goals for recovery and reconstruction.
One of the objectives of this project is to illustrate the power of visual arts-based methods in facilitating collective expression and critical analysis of trauma-related distress leading to united action. “Participatory Visual Appraisal,” as described earlier in this dissertation, provided a tool to explore the participants’ individual definitions and collective analyses of trauma, depression, substance abuse, their effects, and the links between them. These terms needed to be discussed for the purposes of the TRRG; this was non-negotiable. The materials produced included visual images in response to ‘Trauma;’ and ‘The Effects of Trauma;’ (fig. 2) ‘Depression;’ and ‘The Effects of Depression;’ (fig. 3) ‘Substance Use;’ (fig.4) and ‘The Links Between Trauma, Depression and Substance Use’ (Najavits, 2000). As related earlier, these large pieces of paper were initially folded so that the participants only saw right before the exercise what was written on them. This facilitated the provision of spontaneous responses when the participants were asked to “draw on each piece of paper a symbol or image of what first comes to mind in relation to what was written.” Each participant was given about one minute each to go to each piece of paper and illustrate their responses. It was essential that the participants drew the immediate ideas that came to mind as it was important that these not be too well-thought and therefore been based on previous interpretations rather than more organic and experienced-based conceptions. (Please see appendix Q for a more detailed discussion on this process.)

All but one participant proceeded without hesitation. This participant stated how he “did not know how to draw” and felt “a bit shy.” I had encountered this many times in the past and I found that the best way to proceed is to not make a big deal out of it. I told the participant that, “yes, it makes sense to feel shy but we are not looking for beautiful drawings just your response,” and left it at that. After a few minutes of seeing
what the others were doing, this participant got up and drew on all the pieces of paper quite enthusiastically.

This way of dealing with this situation has proven helpful and effective in facilitating participants’ processes of self-activation and encouraging them to give themselves permission to freely express.

A discussion followed after everyone had finished. Each participant was asked to briefly explain what they had drawn and the space was opened for dialogue. This exercise provided the group with the opportunity to express and analyze their individual responses in relation to the group’s responses. It was quite effective in facilitating not just the exchange of ideas, and collective analysis of these, but also the expression of validation and support. The critical analysis component of the method allowed the group to come up with a collective understanding of the concepts discussed and reinforced the process of unifying the group for the project’s later activities.

The dialogical process of this activity facilitated critical analysis which provided information on the impact of these mental health challenges not just on the individual but on the collective, as well. This, in turn, facilitated deeper understanding of people’s relationships with their realities and how the realities of other group members related to theirs. This knowledge and process also served as a basis for aspects of recovery and reconstruction efforts in the TRRG as they contributed to determining a common language and shared notions of mental health issues, and the identification of more forms and sources of (re)traumatization to later be addressed collectively. In addition, discussions also included other elements of the visual world from the built environment, material culture, use of space, structures and meanings, among others (Emmison and Smith, 2000). To further analyze their circumstances, people described
traumatizing contexts such as the DTES, the emergency room at St. Paul's Hospital, various mental health and social service agencies.

It is important to state that a discussion like this can be very difficult, retriggering, or distressing, to some participants. It was important to not go deeply into detail, particularly in consideration of the content of the entire session which was quite intense. Care was taken in monitoring the participants’ non-verbal reactions (e.g., body language, facial expression, interactions).

Here are images created by participants followed by the discussion:

Figure 2. Participatory Visual Appraisal of Trauma and the Effects of Trauma. Photo by Mok Escueta.
Occasional inquiry into how people were doing discussing this was also undertaken, to help ensure continuing safety and well-being.

The images above contain the participants’ responses to the ideas of trauma and the effects of trauma. Below is the dialogue these images (I added the participants’ descriptions of each image in red).

S: One of the experiences I have with trauma is smashing my head in the windshield of a car and its effects are like I am being strangled, experience of broken heart. This happened when I was homeless and using drugs all the time, out for a drive with someone driving who was also high on drugs.

J: I agree. External stressors are traumatizing for me, too, they have shattered me. There are bits and pieces of me, just broken apart. Effects of trauma to me is being encased walking around in pieces. And that’s all of me.

S: Yes, it is physical, emotional, and mental. Everything is traumatized. Your entire body is shattered, your mind, your emotions. Everything.

L: Mine is the stick figure going towards the shadowy stick figure. Trauma is for me . . . well. I just leave my body and go somewhere else. The effects, well, I just put a straight line, cause I am there but I am not present. If I’m not there then what am I really doing? Are these interventions I’m using effective?

R: I drew an X for trauma. It’s like a mark on my life. What’s the quality of my life if it is marked? Trauma to me represents no entrances, no exits. Effects of trauma, my head is broken and all the good things are leaving it. And false sense of happiness at the bottom.

I: I drew the bones, and broken bones and broken spirit is the effect. Like what you are talking about.

L: The effects of trauma? It takes away all your ability to feel, to love, to want. It takes away all your emotional states from you.

Below are the drawings generated in response to the notions of depression and effects of depression followed by the dialogue.
Figure 3. Participatory Visual Appraisal of Depression and Effects of Depression. Photo by Mok Escueta

K: I drew the black hole 'cause there's no way out.

L: I saw what you drew and I feel that, too. And I drew the tears beside it which represent the pain that comes from going down the black hole.

I: I drew that volcano. 'Cause a lot of depression comes from a lot of rage. So much is overwhelming with what goes on at home, in the community. They just make me feel rage sometimes. It's traumatizing.

S: Oh, God, okay. This is what depression feels for me. Being in a coffin, being slowly covered by earth. Sun is shining, then slowly earth covers me, the sun no longer shining. You're six feet under, shovel of earth keeps coming on you, and earth keeps coming and you can't do anything about it. Can't claw your way out of it. You can't move, can't do anything
about it, can't see the light. That's depression. That's the best analogy I have for depression.

J: That's how I experience it, too. Like something closing in on itself, turning in on itself, like some kind of death, no air, very much like that black hole. Really no other way to describe it.


L: What are the effects of depression? It can kill you. For me, I just overeat. That causes me to not lose control. But that's not good at all.

K: We do that because eating releases serotonin and you feel good doing it until you finish eating then you feel bad. I do that.

A: Mine is the zombie. Like the living dead. That's the effect of depression to me.

J: Falling out of touch, out of reality.

I: Mine is a lot of misery and a lot of tears.

R: Mine is that I turn into a lump of molasses. Feeling of blah.

J: I feel depression everywhere. It's cellular.

K: It's real physical pain.

L: Yeah, in the muscles. It is painful everywhere now that I think about it.

P: Yeah, like having a wet blanket over you.

K: Yes, it's cellular, everywhere. You feel the physical pain. You are on your couch for days and your body is telling you that you're not moving and there's pain.

P: Looks like common threads are being in an endless and bottomless pit, having no way out, no exits, being in a black hole, tears and sadness, rage, feeling of being in a place that you can't get out of, death and dying, pain in every cell, being out of touch with reality, suffocating, endless sadness.

Below are the visual images generated by the participants in response to their ideas about substance abuse followed by the dialogue.
S: With substance abuse, you don't really feel anything. It feels shitty.

L: Substance abuse with trauma and depression, I feel overwhelmed. And it’s not just one feeling, right?

R: Substance abuse makes me feel broken but connected somehow, a false sense of being whole, encased but still shattered.

J: So much has been going on for so long. Substances give you a false sense of happiness. Substances used to make things go away.

I: Substances made you feel like you were okay.

K: Let’s face it. We did it because it helped. I had fun doing it,
J: Yeah but it gave me a shattered sense of self.

S: Yeah, in the beginning. But then stopping it they tell me that it might take months when I would feel better again. But after taking that shit, your natural pleasure sensors no longer work. So, I want to feel better but I don’t. But maybe I’m used to being traumatized all my life. So I try to be happy but I am not doing that, I try to be happy but it feels insurmountable.

J: Yeah, your natural pleasure sensors are shot.

A: I did feel better, it helped me.

K: It let me forget stuff, it helped at the time.

R: I went through psych depression, I remember feelings of hopelessness and not wanting to move and I can’t imagine where I’d be without help but I am not happy. Now I’m bloody scared.

P: It’s a slow going process. I’ve been depressed and traumatized and I’m still working on things now, decades later.

M: What is it like hearing other people describing trauma, depression, and substance use?

J: I can relate to everyone one of them, specially that I can feel my body leaving me, If I’m leaving my body, but I’m just not there.

S: It’s interesting and helpful to see what other people think. I thought I was alone.

L: I can’t figure our whether I am coping when it feels like I am not overreacting but then I overanalyze. Really, I’m not there. I can’t come back to that place.

These visual images and discussions substantiate how there is not one definition (or experience) of trauma, depression, or substance abuse, although there are recurring themes. In the TRRG, these themes involve various manifestations of trauma-related distress.

Most of the individuals in the TRRG described a sense of a “shattered self,” “broken apart,” in “bits and pieces.” Many talked about “a broken spirit” to signify deep anguish to their core. One participant described her distress as the experience of “my
head being broken and all good things coming out.” Everyone spoke of a lack of control over the different aspects of their person and their life (e.g. thoughts, emotions, behaviors, events, relationships, and the systems and structures that impacted their well-being). It was commonplace that individuals had the sense that their lives were in constant chaos due to dysregulated affect and disorganized existence.

Many verbalized a sense of being trapped, “encased,” and “finding no way out.” This is congruent with the persistence of hopelessness which also involved repeated failure of efforts at healing. Most of the participants found themselves “caught in a downward spiral without any indication of relief” and, where there was, had always seemed short-lived. Most of them likewise expressed feeling a sense of “falsehood” or “not being in touch with reality.” They did not “feel like they were living in the real world.” They also recounted continuing struggles with dissociation and zoning out. Moreover, they described a pervasive feeling of “disconnectedness with their self and with the world.” This involved artificial feelings of happiness, intimacy, wholeness, and other positive and affirming emotions.

Almost all of the participants experienced being “branded” or “marked for life.” For many, “everything was trauma,” describing having led lives with a sense of inescapable distress despite countless attempts to lead a life worth living.

In addition to these, the participants talked about persistent and recurring torment “also due to encounters with systems and structures” (e.g., “external stressors”) that have entrenched (re)traumatizing methods of dealing with and treating consumers of mental health services.

The ways that the participants illuminated the realities of trauma based on how they actually experienced it uncovers additional ways that trauma-related distress may be regarded. Not only is there not one definition of trauma, there is ‘no absolute
measure of how traumatic an event is; rather, the judge is the person experiencing it’ (Horsman, 2000, p. 33).

Several ways of perceiving trauma emerged from the creation of visual images and the participants’ subsequent discussion. One involved a shared sense of the inevitability of plunging into a dark, bottomless, inescapable void which represented enduring and immobilizing despair with no way out. This is descriptive of a very common experience of despondency throughout the lifespan.

The participants likewise discussed experiences that involved a sense of witnessing an ultimate ending of life and living. This was described as a feeling of being “buried alive.” Most talked about significant distress at the prospect of endless despair.

In addition, the participants described a persistent feeling like they were being subjected to ceaseless and overwhelming pain “in every cell” of the body. This involved anguish that came from being totally physically depleted described as “melting like molasses” all the time.

Finally, most shared the experience of dealing with explosive anger and rage due to countless losses and difficulties with tolerating distress not just from internal cues but from unrelenting struggle with systems and institutions.

These led to the establishment of common themes.

In terms of substance abuse, the themes included a sense of inability to feel anything positive and pleasurable and a feeling of distress over being numbed out (i.e. deadened) all the time. They found that most of them perceived of their brains as severely damaged including having seemingly permanently impaired pleasure centers.

The participants recognized how substances helped them feel ‘better’ and ‘pain-free.’ They experienced ‘ease,’ and ‘forgot’ distress but also knew that it was all artificial. It was important to validate that substances can make one feel these desired
emotional states but that healthier and more adaptive alternatives to acquiring drugs states need to be actualized to experience genuine happiness, ease, intimacy, and connectedness.

Lastly, they talked about a shared sense of being disengaged from one’s body while being simultaneously overwhelmed, which speaks to a shattered sense of self in chaos.

These themes formed part of the basis for identifying the aforementioned action steps in terms of continuing support and psychoeducation as well as future initiatives to collectively address more systems- and structures-based needs collectively. In addition to identifying action steps, popular education approaches were useful and effective as they enabled the participants to articulate the nature of trauma as not merely cognitive but embodied in nature.

The use of this visual arts-based method actualizes several popular education principles. First, this project revealed the centrality of recognizing the knowledge generated through the participants’ concrete realities/experiences. Secondly, co-learning happens when participants are involved in co-intentional education where dialogue provides exchange of ideas towards an analysis of the whole. Third, creative methodologies are processes that deeply enhance participants’ learning towards collective action (Freire, 1998).

Following these group discussions, I presented the DSM-IV (APA, 2000) diagnostic criteria for PTSD (fig. 5), Major Depressive Disorder, and Substance Abuse/Dependence. This was conducted following the above exercise to provide additional information on these mental health challenges. These diagnostic criteria were presented as a set of ways of defining these mental health challenges as found in the diagnostic canon and in no way carried more weight than any other definition,
particularly, the meaning and understanding provided by the participants. I chose to provide this medical diagnostic information for several reasons.

First, I felt it might be beneficial to add a systematized way of understanding trauma-related distress to the discussion of these mental health challenges to help in making some sense of what is otherwise a chaotic experience. Second, the presentation of diagnostic criteria provided a sense that these symptoms were typical and predictable; learning that what one has been chronically struggling with, confused about and agonized by, many for decades, is evidently a ‘natural’ human experience provides a sense of relief. Most of the participants in past groups I facilitated felt “understood for the first time in their lives” and many stated their disbelief at this uncovering. Not a few participants said, “I am not crazy after all!” Third, all of the participants were receiving mental health services through clinicians who were using the DSM-IV. The language, framework, and context in which these diagnostic criteria are stated were familiar as many have been (mis)diagnosed before and learning these diagnoses helps provide significant clarity. Fourth, part of the process of making this learning experience a transformative one is to assist with the participants’ ability to gain access to information and knowledge that has been previously inaccessible. This enhances the participants’ control over more aspects of their recovery and reconstruction.

It is important to state that, for this project, the discussion about these mental health challenges as defined by the diagnostic canon was contextualized through the identification of this kind of discourse or language as a component of the systems and structures that facilitate (re)traumatization. In a similar vein, Horsman (2000) advances the need to not ‘medicalize’ trauma. She states:

Medical approaches show trauma as creating individual and health problems that need to be addressed through medical and therapeutic means.
The demands that the violent nature of society must be changed and the revelation of the presence of the aftermath of violence as a public issue in educational settings are silenced as an emphasis on medical approaches to trauma. Although medical categories can reveal impacts of violence, they also conceal. This contradictory potential creates pitfalls for educators who, as they draw on medical conceptions that support their process of recognizing impacts of trauma on learning, may become complicit in the mechanisms that frame trauma as an individual health problem and obscure the issue that must also be addressed by social change (p. 32).

The diagnostic criteria for these mental health challenges were written on flip chart paper as illustrated below in figure 6; participants took turns in reading these.
Figure 5. APA Diagnostic Criteria for PTSD.
Photo by Mok Escueta
The room fell silent during the reading of these materials. The impact of beholding large pieces of flip chart paper containing lifelong distressing symptoms, presented in a systematized and comprehensive way seemed to be paradoxically healing and agonizing at the same time. After each statement, there was a palpable sense of increased tension mixed with anticipation, discovery, clarity, and profound relief. I related each symptom to what was discussed earlier, the feeling increased that things were making more and more sense.

Some aspects of trauma were discussed more in-depth when participants asked questions to clarify, provided examples, and shared thoughts. There was constant exchange of ideas and experiences throughout the discussion and everyone seemed excited about this new knowledge.

I validated how intense this conversation was and reminded the participants again to be aware of what was going on in their bodies, with themselves. I asked how they were doing and restated that it was fine if they did what they needed to do to feel safe, including stepping out of the room. The conversation about participants’ reactions to this session reveals the importance of these kinds of dialogical process in collective learning:

K: For me retriggering happens if someone touches me, I feel it in my body

M: And it does not have to be a person. A trigger can be coffee or a song, a cup, the time of day, a scent. Basically anything, every single thing present during the incident. That makes things more difficult after.

J: As far as what happened to me is concerned, just how someone moves, a person moving a certain way. You associate it. Even when it does not really have anything to do with the event. There is no malice. It retriggers me.

P: What if you always see or even talk to the perpetrator? That can be very distressing. That’s one way that my trauma keeps repeating.

K: I was in denial a lot in my childhood but when I was in Edmonton, there was a lot of triggers. I am reminded now by things that I encounter.
L: It is good to know that this is going on. Good to be aware of what our triggers are so we can maybe prepare for them. For example, go through your house in your minds right now. Think of things that might be a trigger. Why do we have these things in our homes? Maybe we can less things that distress us and more things that make us feel well.

S: I feel overwhelmed. But it’s okay. It’s good to learn about this.

J: How can a person like me know these things? You’re working on this with providers and you don’t know. They don’t even know!

A: Which is further traumatizing. I remember my experience that other providers don’t know. They don’t know what I’m going through and what they need to be doing!

J: It’s important to know these. Not many providers know this. Many of us are misdiagnosed and mistreated.

L: I broke my back and I didn’t know that I was dissociating and I was being asked questions and at one point I said, ‘No I did not know that,’ and they did not know that I was dissociating. Knowing now helps in the future.

S: What does hypervigilance mean?

K: When you are super aware of your surroundings

S: I have lived in fear for so long. I used to go to places that really scared me. I left my counselor’s office once, saying ‘I can’t stay here anymore’ and now, seeing that, it’s clicking in me that that’s why. We just made arrangements for her to come to my home.

M: We need to know the appropriate level of vigilance. If it needs to be a ‘4’ in some neighborhoods, let’s work on it not being a ‘9’ all the time which is what hypervigilance can feel like.

S: I’ve needed to manage my anxiety by standing for myself. Sometimes I just write it off! Different levels is what I’m saying. I’m more scared of getting blood work done now rather than being at Main and Hastings.

K: I would be more afraid and hypervigilant being on Granville St. on a Saturday night rather than being on Hastings.

S: If you really don’t look the part. If you do, then people at Hastings will talk to you. So it’s good to know what the level is exactly.

M: Good point, if you know what’s going to happen, plan on ways to manage those before you experience it. Practice it before you go there.
P: I’ve never feared anyone downtown except my brother. I’ve chased 250 lb. guys down shoot-up alley but if I meet my brother, I’ll shit myself.

J: I don’t like it there but I know the rules at Main and Hastings so I don’t feel as much distress. I know the rules.

S: You know what though it’s different when you’re a woman. Different, too, if you’re looking at it through sober eyes. I have to go there and I can’t change that. Trauma can be really complicated.

K: It’s easy to read it but feeling it is different.

L: It helps but talking about this now makes me remember. Going over it is triggering in itself. It helps that we are doing this to learn about it, though. Doing it this way helps me be more objective about it, not too emotionally attached.

S: It makes me remember now that I am going to be facing this person who assaulted me when I go back to court and I just don’t know what I’ll do.

K: It helps to do this exercise ’cause we can read this anytime but it helps that we have visualized it, that we made our drawings and talked about them. If you just read this by yourself, this would be very, very difficult. I don’t know if I’ll finish reading these things if I was doing it by myself.

I: Which is why it is helpful as knowing is empowering.

This discussion was conducted in the third session when a certain level of safety, trust, and mutual comfort had already been established in the group. It was also important that this discussion was clinically-indicated at this time, which meant that it was beneficial to the participants in terms of their goals for recovery.

It was vital to clarify during this discussion that the diagnostic criteria from the APA contained only how mental health challenges are manifested in the form of symptoms. Beyond these symptoms are the systems and structures in which these experiences are contextualized and which facilitate (re)traumatization (this was discussed in later sessions). In discussing the effects of trauma, Horsman (2000, p. 33) advances the need to not disregard social agents of trauma, and that “societally, we need to focus on who and what violates and who is traumatized.” This point of clarification emphasized this project’s objectives of contributing to recovery and
reconstruction efforts being undertaken by the participants for themselves by helping address not just individual and collective effects but also more systems- and structures-based sources of (re)traumatization.

The above process of discussing trauma was likewise used with depression, substance abuse, and the links between these three mental health issues.

**In Terms of Freire**

This undertaking parallels some of the basic components of Freire’s literacy method as discussed earlier in this dissertation. The ‘tuning in’ to each other not just in terms of ‘words’ but of ‘worlds’ facilitated the identification of common experiences which possessed a shared emotional charge for the participants: trauma/retraumatization, depression, substance abuse, etc. These were ‘codified’ into visual images by the individuals and analyzed by the group in dialogue, giving voice to what had been silenced, many for most of their lives. This ‘giving of voice’ to what was previously regarded as undiscussable is what Freire (1973) refers to as an emergence into a consciousness of being free, of “extrojecting” the slave (or in this case, the “sick” and “helpless mental health patient). The collective analysis undertaken by the group involved a process of decodification which lead to a new codification of these experiences contextualized in the systems and structures with which they are laden in order that these may eventually be addressed. This was a process through which the participants forged their unity to later undertake collective action. For those who had simply been ‘consumers’ of mental health services, this process allowed for the possibility of creating a new and more meaningful destiny as ‘decision-makers.’ lives.

**Integrating Aspects of Other Worldviews**

There were several occasions when the participants talked about trauma and recovery based on other worldviews, including spiritual dimensions. Based on these
discussions and visual materials produced, it was evident through most of the
participants ascribed to the aforementioned APA definition, they also had personal and
sometimes different definitions of trauma and recovery. It is equally important to
acknowledge these realities as they inform additional ways that a person can
experience healing. Participants in the TRRG described trauma in terms of ‘a broken
spirit’ and talked about healing in faith-based contexts such as the synagogue and other
places of divine connection. At the same time that some of the participants regarded
that their distress was due to objective realities (e.g., interpersonal or systemic and
structural violence, stigma, discrimination, and oppression), there was also a parallel
sense that it was spiritual in nature. This means that they also regarded healing not just
in terms of altering the physical/material world (e.g., utilizing effective interventions,
managing symptoms, using psychotropic medications, addressing systemic and
structural sources of (re)traumatization) but healing the spirit, strengthening one’s faith,
and reconnecting with divine forces. Elements of visual images (fig. 6) produced in
check-in sessions in the TRRG below also provide information about this.

Figure 6. Individual Illustrations of Varying Spiritual Dimensions of Trauma.
Photos by Mok Escueta
In my view, the use of such symbols as the cross, the mind’s eye, radiating energy, wholeness, energy centers, speak to spirituality-based ways that trauma and recovery are defined. This image of the “head broken open and all good leaving” speaks to a sense of depletion of positive energy through the head which in Eastern thought is the location of the crown energy center, the site of our connection with our divine selves.

Concepts around wholeness of spirit and non-separation can help individuals have hope when there seems to be none as trauma-related distress is framed as necessary for growth and advancement (Siddharta, 2005). "It helps you know yourself
more, helps you grow,” is a fairly common expression of faith in situations of great difficulty and near hopelessness. The participants described building a community of support towards establishing non-separation or connectedness as an important aspect of recovery and reconstruction.

Most of the participants have, in the past, used strategies that are more spiritual in nature like meditation, yoga, mindfulness, vision quests, journeying, and the like. Such strategies are also suggested by some psychotherapists as effective means to manage symptoms although many may not be all that familiar with the philosophical foundations of these undertakings. Drewery and McKenzie (1999, p. 139) state that “difference is a condition of human existence and every client is, in some sense, a mystery.” Also, “we cannot assume anything much about the ways in which the discursive world of another is knit together.” It is necessary for the therapist to be “curiously interested in the presuppositions, usually unstated, which enable the person whom they are working with to make this sense rather than some other kind of sense of their life at this time” (p. 140).

In the TRRG, participants were not only encouraged to express the differing ways they perceive the world and their experiences with it and with others; it was vital to do so.

**Comprehensive Analysis of Contexts of Distress and Recovery Towards Meaning-Making**

As stated earlier, the visual arts-based methods used in this project are rooted in the traditions of art therapy which involves the production of images for expression of difficult ideas and emotions (Case & Dalley, 2006) and, in a group setting, can facilitate catharsis to transcend distress (Waller, 1993). Aside from contributing to identifying shared issues or themes, these methods allow for the visible externalization
of problems which promote the imagining of new narratives that are advanced through creativity (Collie, 1998).

Kaplan (2007) explains the link between art therapy and social action in terms of how visual materials are capable of bringing individual and collective predicaments into people’s consciousness to advance healing while demanding responses to injustices. In this project, the analysis of visual images is not limited to individual and collective distress but also includes analysis of the systems and structures that are implicated by these experiences and how the group can unite to undertake action to address systems- and structures-based (re)traumatization.

I created ‘Context Mapping of Distress and Recovery’ as another method to continue to comprehensively articulating individual and collective distress in the context of systems and structures that facilitate (re)traumatization. This exercise was also used as basis for identifying action steps to address systemic and structural issues. However, in addition to this, however, this activity (among and in relation to others undertaken in this project) involved meaning-making processes. This included the critical reexamination of systems and patterns of thinking and relating with one’s context. This, in turn, contributed to reconstruction efforts in that one’s context was analyzed as comprehensively as possible. Distress and recovery were located in these contexts in order that these were brought into individual and collective consciousness and addressed (in the case of distress) or reinforced (in the case of recovery). Herman (1997, pp. 178-79) explains:

Reconstructing the trauma story also includes a systematic review of the meaning of the event, both to the patient and to the important people in her life. The survivor is called upon to articulate the values and beliefs that she once held and that the trauma destroyed. She stands mute before the emptiness of evil, feeling the insufficiency of any known system of explanation. Survivors of atrocity of every age and every culture come to a point in their testimony where all questions are reduced to one spoken more in bewilderment than in outrage: Why? The answer is beyond human understanding. Beyond this unfathomable
question, the survivor confronts another equally incomprehensible question: Why me? The arbitrary, random quality of her fate defies the basic human faith in a just or even predictable world order. In order to develop a full understanding of the trauma story, the survivor must examine the moral questions of guilt and responsibility and reconstruct a system of belief that makes sense of her undeserved suffering. Finally, the survivor cannot reconstruct a sense of meaning by the exercise of thought alone. The remedy for injustice also requires action. The survivor must decide what is to be done.

Participants were asked to illustrate every single location or context they find themselves in presently (fig. 7). This may include their home, neighborhoods, mental health and social service agencies, streets, institutions, parks and other public spaces, etc. Beside each they were asked to rate on a scale of 1-10 (10 being the highest) the level of trauma-related distress (including those involving depression and substance abuse) and recovery they experience. The discussion that followed included the sharing of experiences identifying not just individual but also collective locations of (re)traumatization and recovery, and the systems and structures that facilitated both of these. (Please see appendix R for a more detailed discussion on this process.)

Figure 7. Context Maps of Distress and Recovery.
Photos by Mok Escueta.
P: My distress comes from family back in Halifax. I try my best not to think about past sources of depression anymore but stress comes from where I’m living now. But instead of making up excuses, I don’t. The places I go around here Vancouver like the bowling alley, bars, or clubs. Very little distress level from here but if I were in Halifax, it would be different. Having support and knowing that I’m not alone. The more people I see, processes are working and they go on. Something’s working. It’s more about the housing facility and why it’s hard to find a place to live where I can recover.

L: Looking at this drawing I realize that my distress comes from interacting with institutions. Social services, disability, housing. Also financial. I’m covered as far as disability goes but with my accounting background and with the financial global crisis, I’m concerned about it. I’m not on edge but it causes me grave concern. I’m not taking things for granted as far as benefits are concerned. These institutions distress me, though, and sometimes I just let myself suffer rather than deal with these. What can we do about these? We have to talk about these things and try to do something cause we can be so alone. Walking is one source of recovery, being on the computer where I require focus which helps me not experience pain. Keep doing something else I can focus on. Help also comes from my doctor and psychiatrist.

I: Most of my trauma is between my home and my son’s home. Home because I have to deal with family and my son because of his disability. Stress comes from my son’s autism, he can’t speak, there is no communication. So it’s in my face all the time. The care that he’s not getting. My son and I have a great relationship but dealing with social services, I can’t handle that anymore. Recovery I feel in the synagogue. It helps to be there.

S: Distress for me comes from being out in public. The grocery store, being out. My home is not exactly how I want it. Dark scares me. Going to meeting during the day helps but I can’t do it at night. My life is a big circle, pretty simple. Recovery sometimes at meetings, going out to an agency in Surrey where they try to help you, empower you. Any place that’s really big, malls, grocery stores, with a lot of people, I can’t take it. Streets and neighbourhoods, same beaten path, but now will try to choose different ways that are less distressing. Sometimes I have to go to downtown and that’s hard. It’s not just the location, the people I encounter who are in my face all the time when I am there, but some services just don’t work and there’s no other choice.

K: I agree with M as I am also from a different place, Calgary, and I have not been here long. I don’t like downtown, try to avoid it. The atmosphere, the people. Some areas are half and half for me, They cause distress not because of the place but because I am distressed when I am there. I feel recovery at my friend’s place, a studio space.

J: I get distress from the psychiatric community, which is the source of my PTSD to begin with. Hospitals, psych wards, doctors, too, because every time I turn to these, there is denial about what happened. I feel unsafe right now here because of something that happened here last Wednesday but I
also know that I get obsessive about things. Buses, parks are not distressing for me. Malls and parks for me feel safe due to the anonymity, as if I don’t exist. It feels safe because I am anonymous. Places I go to to feel safe are the library, Carnegie, Harbor Light, my church. They are all in an area I find most unsafe, DTES. Its interesting cause it’s a triangle where I see distressing things but things I do there make me feel safe, like playing chess. But sometimes to the point that it’s an addiction cause it’s a way for me to get out of my head. But the biggest stress is from big institutions, church, psychotherapeutic environment.

In relation to other discussions in the TRRG, this activity facilitated the visible externalization of participants’ contexts to promote the imagining of new narratives, particularly in terms of addressing more systems- and structures-based sources of (re)traumatization (Collie, 1998). The participants stated how they appreciated not only visualizing and analyzing their contexts (for everyone for the first time) but also undertaking these with others in similar life circumstances. This stitching together of individual stories created a collective image which helped build a sense of identity and community through common themes of traumatized lives and (re)traumatizing contexts.

As Kaplan (2007) states, this approach facilitates the recognition of injustices towards collective action, and, in the case of the TRRG, included distressing experiences with family, school and community, mental health service providers, medical service providers, and provincial and federal government agencies. Alternative meanings were articulated in the critical reexamination of systems and patterns of thinking and behaving in relation to systems and structures. These were enumerated in the TRRG discussion on action steps and in meeting with CCD staff to actualize changes in service delivery at the agency.

A Community of Learning and Support

One of the most important contributions of this project is the TRRG, the twelve-week psychoeducation group which involved contributing to participants' efforts at
addressing their individual and collective needs for recovery and reconstruction
including undertaking united action to sustain a community of continuing learning and support. The TRRG was not only the first service of its kind conducted at CCD but also in the Vancouver Coastal Health system. The participants enumerated numerous benefits from the group including acquiring perceptions, experiences, attitudes, knowledge, and skills in trauma recovery and reconstruction. The participants stated that they acquired additional competencies in ensuring safety, managing distress, life planning, receiving and giving support, strengthening motivation, establishing healthy relationships, increasing objectivity, setting and keeping boundaries, learning and practicing active listening, using the visual arts for expression and critical analysis, contextualizing symptoms in systems and structures of (re)traumatization. In their words:

J: I have been searching for a group just like this for over twenty years! One about trauma that is psychoeducational and supportive. I got a lot out of the group. It would be good to continue the group. I have nothing to say but good things about the group. It helped me in life planning and setting myself up for support. I now understand the process I went through when everything was laid out. Structuring information was extremely helpful for me, it gave me a vocabulary and a lot of motivation. It’s wonderful. I’m also really glad we talked about systems and structures as a lot of my trauma came from the mental health community.

L: I did not know what to expect. I was pleasantly surprised. It helped me with learning better strategies to deal with things and everyone was supportive though we were all in different points in our recovery. I used to get emotional when I talked about these things but the method we used helped me feel more comfortable. It was safer. I like that we focused on what we can do and not just that we’re all depressed and stuff. In some group that’s all they talk about. How they’re so depressed that you leave the group and you feel more depressed.

R: I learned how to ‘listen twice, talk once.’ I like that I had the chance to be listened to especially since I am not very talkative. It helped me look at relationships and people, look at trauma-related, family, and systemic things more objectively. My needs that were met include needing to be heard. Need to not feel oppressed or victimized. I was quite young in comparison to the others but that was never a big deal. Need to have a support network specially what I’ve learned from this group.
S: I learned what trauma was, why I react the way I do, and why I react to certain things and not to others. That was helpful.

K: Drawing helped me add my piece to the discussion. I found the doing the pictures fascinating. It forced me to think and participate and that was good. I learned how to interact respectfully again. We really came together as a group, boundaries were respected. The materials brought me good insight that I did not expect to get. I was here to participate and it was really positive. I got some really good stuff.

The final comments made by K in this discussion illustrate the power of these approaches in facilitating the reconstruction of systems of support and community using dialogic and participatory methodologies.

The TRRG provided the participants with the venue and opportunity to address individual and collective needs together after going through processes involving critical analyses of various aspects of their contexts. One of the facets of this group experience is the process of ‘transition of consciousness based’ on Freire’s popular education framework as described by Shor (1997). As stated earlier, this process involves shifts from intransitivity (dominated, fatalistically-lived, static) to semi-transitivity (partial change through partial empowerment as problems are seen in parts and not as a whole system, change will come from a strong person and not themselves), to transitivity (holistic, the highest development of critical thought and action, relates concrete conditions to larger societal context).

The TRRG contributed to the participants’ efforts at moving from a consciousness of intransitivity to transitivity through the critical analyses of their concrete situations in relation to systems and structures that affected them.

Below is part of the discussions during the meeting with CCD staff where the participants talked about continuing the TRRG:

A: I attend two other groups here and this group encompasses all three groups into one and I thought it went pretty well.
L: Having done a little bit of group before, it was a refresher for me to get back into this kind of space. But K is a fabulous artist and was able, through art, she was able to articulate our feelings and just to look at that, I found that melded into what was happening with me. And trauma, all I thought about was the trauma center, the hospital, where you go when you’re broken. But as far as my mind, I didn’t really get that until we studied it here a lot. And with people being supportive, the structure was helpful.

D (CCD staff): I am curious about what you said M, with what you said. Out of all the groups we do here, do you think that this group was what got to the root of what you’re dealing with?

J: Yes, that’s kinda what I was coming from. It gave me a better perspective of what I was going through and the process I was going through. What I was saying at the depression management group last week about getting at core beliefs and core values, some of those things are based almost all on abuse and so when I start to deal with those core beliefs, it brings up a lot of trauma, a lot of pain. So it’s not just core beliefs, it’s all the trauma. But when I got a better perspective like I did here, then it was easier to work on the other stuff.

S (CCD Staff): My understanding of this group was that you didn’t go into people’s experiences but more the cultural and political context of it. I guess you did not go into personal trauma?

J: In some sense we did. It was kind of what worked, too, to use one’s own personal experience. To try to use our personal experience and relate it to psychoeducation, to try to apply what we learn.

S (CCD staff): It seems like if this was to continue, other clients with trauma histories would benefit from coming into this group if they wanted to and are ready to.

K: Yeah, I think so. It would be good. I guess before I didn’t think I experienced trauma or that it happened to everyone else. I was in denial for so long. It was only after being hospitalized that I was like, ‘Oh, really?’ and just going through all the steps and everything in this group. I just like the educational aspect of it. I just had a case meeting this morning and I was saying to my three people that I see, it really helped detach the emotional aspect and just be able to look at everything really objectively.

D (CCD staff): Good for you.

K: Which is really comfortable without being like, it’s not, cause especially when you’ve experienced trauma, you know, like kids, you end up with problems. Your brain just kinda stops. So if you’re kinda put in that situation when you’re hyped up emotionally and you just lock it with stuff but then you have to like go on, it’s kind of like, you’re getting into trouble basically. Or you’re just worse off that when you started, basically.
S (CCD staff): That’s good.

P: About what you said about not really getting into a lot of the stories. So we each had an idea of what we went through but we didn’t talk about that but we had a good sense of how these affected us. So we didn’t need to know about the details, it was just sort of in the room. And we lifted what the effects were and looked at those instead of looking at the stories. So it was very personal, very individual in a sense, but we also looked at big picture matters.

L: The facilitator was really good at keeping us focused on ‘we’re not going to be doing the therapy to the trauma’ but we didn’t go into it but can’t not talk about that either.

S (CCD staff): I was going to say that it is skillful to be able to do that.

L: What was really good was how the facilitator did that.

A: Basically every exercise that we used we each had our own stories as background. Now it was a lot of information to take in. A lot. Maybe too much and we did not spend a lot of time on expanding on a lot of things. And there are 6 of us here so you did not have like 18 people with 18 different stories talking about 18 different things. We would have had even less time.

S (CCD staff): Yeah, so it needs to be contained in terms of size.

J: And I can see that as being problematic, too, because on the one hand, it is a trauma group. Because of the nature of trauma, there is a building of trust. So on one level, the group is somewhat closed unlike the other groups when members are recommended and that come and go. There needs to be some continuity with a trauma group. The other side of it is that it is open to referral, that’s the other thing. So I can see that that may be a problem.

J: I’ve been dealing with trauma since ’82 and have not made much progress. The process I’ve gone through here at CCD has been good and I found that the kinds of things we talked about in groups merged really well with cognitive-behavioral therapy (CBT). When you start talking about, say being retriggered by an authority figure and I go through the flashbacks and retraumatization. I’m learning slowly, to use these techniques to deal with the trauma. To make new friendships as I have not made a friend in the last 20 years. There are sorts of things that come up just using sing CBT. Here we learned about the structure of relationships that we kind of get into. What is my pattern of thinking? Why do I think like this? This is a trauma-related thing I’m bringing in as opposed to an actual thing. Sometimes sorting that out is very difficult. I found what we did here to be very helpful.
Advocating for the continuation of the TRRG underscored how the participants valued the community of mutual learning and support, as well as the community itself, that they had reconstructed.

Entrenching Transformative Processes

From all indications, this project planted the seeds of transformative processes in the participants towards a culture of more sustained liberation as advanced by Freire (1998). This means that a pedagogy of critical consciousness in the context of trauma recovery and reconstruction has been developed (i.e., that the ‘oppressed’ uncovers ‘oppression’ in the world and engages in its transformation through praxis (Allman, 2001)) and will hopefully become a pedagogy for continued engagement in recovery and reconstruction (i.e., social change work).

One aspect of this is the desired shift in the participants’ relation to knowledge about mental health issues (e.g., trauma, depression, substance use) recovery and reconstruction in the context of systems and structures. Allman states (2001) how

. . . a transformed relation to knowledge involves constantly scrutinizing what we know and constantly testing its adequacy as a tool for illuminating our real conditions and informing our action. Knowledge, therefore, cannot be conceived as a static possession but only as a mediation or tool between people and the world which either helps or hinders a critical perception of reality (pp. 97-98).

Horsman (2000, p. 23) states that:

Rather than dwelling on individual harm or seeing the aftermath of violence as an individual problem, educators must recognize violence against women as a social inequity. Healing is not an individual problem. The goal of education with those who have experienced trauma should not be to simply support their healing – to help them become ‘normal.’ The responsibility of educators, funders, and others in the field is to recognize that all learning must be carried out in recognition of the needs of trauma survivors. It is needs of trauma survivors that should be normalized as an everyday part of education.

Freire (1998) advanced the need for dialogue for the development of critical consciousness. Co-intentional education recognizes the need of both the students and
the teachers to engage in social change work based on the notion of both being in the world, critically knowing reality, and re-creating knowledge, for their mutual liberation.

Kaye (1999, p. 28) explains how an educator who regards her/himself as the authority on knowledge can be regarded as ‘regulative’ in approach which may position individuals to become complicit in their own subordination by implicitly inducing them to conform to specifications of personhood derived from dominant assumptions of normality, limiting role prescriptions or moral codes governing exemplary ways of being – discursive formations that problematized their experience in the first place.’

It is likewise necessary that the educator is aware that her/his role is not as an ‘expert,’ as this is a role that disempowers. As mentioned earlier, an educator works in co-intentional partnership with the people (Horton & Freire, 1987). S/he may have contributions, yes, but these need to be regarded as one among those that people bring and just as valid; no educator has a monopoly on education or has superior knowledge.

How will all these look like in actuality? It appears that as a result of the TRRG, participants have developed some foundational skills to be critical of what they come to know and how they come to know it. That knowledge they receive from this point on will hopefully be constantly analyzed in terms of whether it contributes to meaningful change or whether it furthers their suffering. This form of critical consciousness will hopefully mean that trauma-related problems that emerge in their future will be analyzed differently; they will be regarded not as a function of the participants’ ‘deficits’ as traumatized individuals, but will be contextualized in systems and structures that reproduce trauma. Furthermore, it is hoped the unjust ways the participants are treated will not be construed simply as personal but also in relation to social suffering due to system- and structure based (re) traumatization.

Hopefully, when there are discussions about symptoms, whether these are intrusive memories, avoidance behavior, hypervigilance, depressed mood, or substance abuse relapse, that participants will not simply settle for discussing these as individual reactions to difficult life circumstances which they need to manage. They have
developed an appreciation for how their symptoms are linked to systems- and structures-based sources of (re)traumatization and that these structures must be addressed. Furthermore, I believe that the participants of the TRRG have reached a place where they understand that they have a collective responsibility to work for our shared humanization. Indeed, we all have that responsibility.

As Allman (2001, p. 101) states “the struggle to transform antagonistic relations and to keep then transformed demands the constant unity of action and critical reflection.” We cannot “think, then act and turn off our critical reflection, nor can we think critically without an active struggle.”

Summary

In this chapter, I discussed some of the contributions that the visual arts-based methods used in the TRRG could make to the practice of popular education in trauma psychoeducation, illustrating their power in contributing to collective recovery and reconstruction. Rendering distress visually facilitates a process of detachment and disembodying from these emotions, allowing for increased ease with analysis. As a collective undertaking, participants experience a distancing from distress which paves the way for dialogue. The provision of input on the diagnostic criteria for PTSD, depression, and substance use, contributed to efforts at creating some sense of order in the participants' lived chaos. The process of visual expression in a group setting, dialogue, collective analysis, and presentation of information in a comprehensive way was regarded as an important aspect of participatory and liberative learning.

Other aspects of the participants' experiences were uncovered in the course of using visual arts-based methods. These included spiritual dimensions of the experience of trauma, ways of meaning-making, and the creation of community. That trauma
adversely affects humans at a spiritual level is well-known. That this was rendered visually and collectively discussed in the TRRG appeared to be in itself a spiritual experience for some participants; the recognition and validation of these contributed to efforts at healing. Meaning-making was collectively undertaken also using a visual arts-based method which facilitated systemic and structural discussion of meaning for the group. In the course of these discussions, a community of learning and support was created which involved unanticipated individual connections which contributed to addressing the common sense of isolation.

I believe that the activities undertaken in the TRRG have entrenched in the participants the desire and competencies necessary to ensure dialogic, participatory and liberative processes in the recovery and reconstruction efforts they participate in.
CHAPTER SEVEN

TAKING POPULAR EDUCATION INTO CLINICAL SETTINGS
FOR COLLECTIVE TRAUMA RECOVERY AND RECONSTRUCTION

Although there are some aspects of Freire’s popular education framework that are universal, some need to be extended in consideration of the realities of this study. What follows is a discussion of the application of popular education practices to clinical settings. Here I outline some key considerations that should underlie a framework appropriate to psychoeducation initiatives for collective trauma recovery and reconstruction.

I have argued that trauma needs to be understood as collective, complex, and continuing. In what follows, I outline some key considerations that have arisen from this study. These should be taken into account when using popular education in reconstruction and recovery from trauma in clinical settings. Central to these considerations is the importance of contextualizing popular education initiatives within continuously changing realities and the importance of conducting recurring needs assessments. They also require the development of meaningful partnership between the participants and facilitator in contexts of trauma.

Contextualizing in Trauma Recovery and Reconstruction

Clinical Considerations Need to be Taken Into Account

It is important to take clinical considerations into account in psychoeducation initiatives like this while not compromising participatory, dialogic, and transformative processes. These include the following points:

a. Participation needs to be clinically-indicated – it is essential that participation
is limited only to individuals for whom initiatives like this are appropriate. Just because a person is suffering from trauma-related distress and is interested in being part of activities like these does not make it sensible for them to do so. The most important consideration is always safety. Najavits (2000, p. 5) states that “the most urgent clinical need” of individuals suffering from trauma-related distress “is to establish safety.” There needs to be a careful evaluation of whether these individuals are equipped with the necessary competencies to manage the effects of the project’s discussions and processes and remain safe. These competencies include: the ability to use effective coping strategies; the capability for self-activation in accessing resources, particularly for emergent mental health concerns; the capacity to set boundaries to ensure safety; the ability to do cognitive work (e.g., participate in dialogue and analysis); the capability to engage in group processes, particularly united action; among others.

b. Be prepared for, be able to determine the possibility of, and know when retriggering is happening. In addition to this, it is also important not just for the facilitator but also for participants, to be able to understand, validate, support, and help manage trauma-related symptoms, when they emerge. It is important to possess competency in handling crisis and urgent concerns, deescalating, setting boundaries, and referral to resources.

c. Control is essential in dealing with trauma, particularly in managing long-term effects (Shaley, 1999). Distressing events are typically characterized by the lack of control not just over the occurrence of harmful events but also over the effects (e.g., persistent intrusive memories, avoidance, hyperarousal, depression, substance abuse) of these incidents (APA, 2000).
It is important to consider that undertaking participatory processes in the context of popular education is not simply as a process by which participants enhance their capability to decide over the various aspects of the project but that doing so increases a sense of control over their lives which is essential in recovery and reconstruction. This added clinical dimension makes it even more important that participatory processes are actualized in meaningful ways.

d. The development of critical consciousness in contexts of trauma takes into account not just the systemic and structural roots of (re)traumatization, but also the roots of individual distress as they relate to these systems and structures. This is achieved by exploring the sources of a person’s anguish including but not limited to cognitive distortions (e.g., deeply-held belief that one is worthless, inadequate, or worthless) due to violence from family, school, community, media, and other systems and structures. To miss this component of trauma-related distress and focus on only on surface-level manifestations (i.e., symptoms) or only on systems and structures (i.e., ‘blame your family,’ or ‘blame the government’) misses an essential piece of recovery and reconstruction. Aronowitz (1997) describes oppression as not just involving systems and structures but also the psychological being of oppressed peoples with respect to their consciousness. In is in a context such as this that having a clinical background not just in individual trauma psychotherapy but also in facilitating trauma groups combined with significant experience in popular education proves beneficial. It is useful to have competencies in trauma and popular education work in terms of, but not limited to, the following:
1. contributing to the creation of a safe space for dialogue about current situations, symptomatology, alternatives; engaging processes aimed at building trust in groups, helping in establishing and protecting boundaries, discussing distressing experiences in non-distressing ways, identifying and managing emerging distress (particularly that which may result in self-harm, including suicide), and others;

2. identifying and working in partnership on possible trauma-related individual- and group-held belief systems that obstruct self-empowering processes (.e.g., victim-identity, a sense of worthlessness, a sense of inadequacy and lack of agency, internalized ‘mental patient role’, among others);

3. identifying possible clinical and other courses of action to take as needs and issues emerge (e.g., suicidal or homicidal ideation, cases of child/dependent adult/elder adult abuse, need for community resources);

4. engaging dialogic and analytical processes about individual trauma-related distress in the context of systems and structures that facilitate (re)traumatization with the awareness of and competency in dealing with possible retriggering; and,

5. taking these clinical considerations into account in engaging group processes towards collective action.

Not ‘Banking’ but ‘Problem-Posing;' Not ‘Regulative’ but ‘Discursive:' Vital to Recovery and Reconstruction

As described earlier in this dissertation, the ‘banking method’ of education regards participants as empty repositories for knowledge, domesticates them into
inaction, and incapacitates them from transforming their contexts. In addition, it
sabotages critical thought and fosters authority-dependence on teachers. Problem-
posing education, on the other hand, considers people’s contexts and advances
dialogue in terms of co-intentionality: teacher is student and student is teacher with both
recognizing the need to engage in social change work for their mutual liberation (Freire,
1998).

The ‘banking’ method corresponds to ‘regulative’ approaches in psychotherapy
(and psychoeducation) which have the following assumptions:

1. An underlying cause or basis of pathology;
2. The location of this cause within the individuals and their relationships;
3. The diagnosability of the problem; and,
4. Treatability via a specifically designed set of techniques (Kaye, 1999, p, 21).

There is an assumption of how an individual ‘should’ or ‘shouldn’t’ be or behave based
on suppositions of ‘normal’ and ‘abnormal.’ Cognitions and behaviors are thus
‘regulated’ so a person thinks and behaves ‘normally’ and only this is what is
acceptable. This paradigm has been criticized in that notions of what is ‘normal’ and
‘abnormal’ are potentially pathologizing and that this socially regulative approach
maintains the unjust social order (Kaye, 1999). The ‘discursive’ approach, on the other
hand, does not attribute knowledge to only one source (therapist/educator) who is
tasked with acting on another (client/participant) to change her/him (Kaye, 1999). Like
problem-posing education, the discursive approach not only critically analyses but also
challenges systems and structures. Parker (1999) describes how the purpose of this
approach is to contextualize people’s problems within their systems and structures and
understand the role that patterns of power have in reinforcing people’s belief that they
can not do anything about their situation. This discussion by the participants speaks to these points:

J: Personally, I would almost like to redo the whole course (laughs) with a bit more focus, or an extension group so there is more people who are in it. This is one of the things that I feel would help me in healing.

I: I want us to talk more about family. How you deal with them, them with you. It’s part of the current problems I have, part of the solution. You’ll never get better without the support of family and friends, of a community you have.

A: We need that supportive community. Majority of us don’t have that and a lot of people don’t know about places like this, about our group. I tried to get a buddy of mine to come and he was able to get support after a while. Not everybody has that and people have never heard of this place. This place has been great.

L: For me this place has been a lifesaver. My PTSD stuff is directly related to a medical misadventure in Toronto where a psychiatrist threatened that if I left his care he’ll make damn sure that nobody touched my case which is exactly what he did. And I could not access services for twenty years. And everywhere I went, I was blacklisted. And within a year and a half of coming here to Vancouver, I got services. So there is this institutional thing, too.

K: Oh, when I went to VGH it was like there was this doctor who saw me and I was explaining what was going on and I obviously had threatened him. Just because I am knowledgeable about mental illness, mostly just because I have general knowledge like most people in this society or just being really smart. He made it so that I was trying to be sicker than I was and I just wanted something, maybe medications? So what do you do? What can you do? We need to do something about things like this.

L: Did you go back? Did you see someone else?

K: No, I went to another psychiatrist. They didn’t even know why I was diagnosed with Borderline when he knew I was suffering from complex PTSD. Had I held on to that other doctor I would have been really in a bad situation. Is there a system where you can tell people about things like this? Rate a doctor?

L: Online there is rateadoctor.com.

K: Some people may just get mad. All this crap they experience. Isn't there an organization that polices where you can report doctors to

R: Yes, there’s this list where you can put in a psychiatrist’s name and you look that up. I think it’s the BC College of Physicians and Surgeons and if there is any complaint against a doctor that’s where you can do it.
A: It's also frustrating this whole thing about PTSD when people don't really understand you and that's where they put you but they don’t really know what all that means. There was this one time that I was denied services because, although I was sick, I was not psychotic, so I was not sick enough. Many people have problems but when they are not in the extreme, they don’t get services.

K: Yeah. I have a friend who is really bad and goes through episodes for several months and he’s had the experience of being brought to this place where they just leave you there and not give you anything. So you either get in this horrible situation or told that you’re not sick enough.

J: They think that you’re not participating in your recovery or you can't 'cause you’re crazy.

I: I found that when I was ‘middle class,’ I got good treatment in a middle class hospital but when it was perceived that I was not and that I was undereducated, I was treated differently. My situation had not changed, just my socio-economic status but I was treated differently. If you are a doctor, student, or whatever, you get treated well. And I have a Master’s degree!

K: We need to do something about these issues. We can’t just let them continue. And I think we should also work on anticipatory trauma prevention. Like when I might be in a situation when I might be traumatized in some way, how to handle it, instead of totally not doing it or ignoring the situation and making things worse. So how do you prevent yourself from getting into more trauma. We need systems for these things.

J: Yeah. You may have the tools to get out of some of these difficult times. I get through somehow. I get back on my feet. But then you're retraumatized, you don’t remember those tools. We need some kind of on-going group, as well.

P: That’s how it was for me. I did not know I was depressed until I blew up. I can’t tell the signs and I had no support. I just blew up.

A: Have a place to go to where people have an understanding of what you’re going through and help in responding in an appropriate way.

K: Yeah.

S. So knowing all of these things, what activities can we possibly do? We can brainstorm but don’t think that your suggestion is something that we need to do. We just want ideas for now.

L: We can put on a skit?

R: Yes, sure. That’s a great idea. One of the things we talked about was doing a panel presentation where each of us can talk about an aspect of all our
experiences. So somebody can talk about different experiences. There are groups who have talked to people who made laws or policies. I don’t know if there is something going on. There maybe something going on.

L: We could contact provincial and federal agencies and municipal. We talked about the Mayor at some point there.

S: So we’ll bombard him with emails? It may be good to do something to convince the people who have the key to the money bags.

A: So, talk to or present to provincial, federal agencies, guest on CBC show, Mayor Robertson. Another approach is that since we’ve been doing a lot visual and a lot of the visual we used were really, really helpful in discussing these things. So we can do a panel presentation and each one of us, or we can pair up, and do a sort of a visual art work and make our discussion spin-off from that.

L: I nominate K! I see her drawings and it looks like a picture book.

J: I’m pushing also for an indefinite group and expanding the members. We have to have this service.

This and other discussions using problem-posing and discursive approaches between the TRRG participants facilitated recovery and reconstructive processes.

There was not one source of knowledge about trauma and recovery as all the participants felt and showed that their experiences and ideas were equally valid as everyone else’s; everyone participated as ‘teacher and student’ and ‘student and teacher.’ There was not a sense of set ways that ‘change’ needed to happen in terms of an idea of what is ‘normal’ as defined by an ‘expert’; the participants spoke from a position of confidence and self-assurance about their notions of what needs to happen, what recovery and reconstruction are. There was not a sense that they accepted inaction and that their situation was unchangeable; it was imperative that their context be analyzed and collective action be undertaken to bring about more systems- and structures-based change.
It is crucial therefore to use dialogue to help ensure that knowledge is not treated as an object to be learned and simply restated. The focus needs to be on how this knowledge is relevant and applicable to participants’ contexts (Freire, 1970).

Trauma Psychoeducation to United Action

The TRRG Psychoeducation Approach as the Continuing Practice of Freedom

Goulet (1973, p. viii) explains how Freire’s notion of education as the practice of freedom initially involved the “historical process by which the oppressed struggle unremittingly to ‘extroject’ the slave consciousness which oppressors have ‘introjected’ into the deepest recesses of their being.” This process consequently included the “special oppression masked by democratic ‘freedom’ or ‘civil liberty,’” and emphasizes “liberation as being both a dynamic activity and partial conquest of those engaged in dialogical education.”

This ‘slave’ consciousness ‘introjected’ by oppressors upon the oppressed is parallel to the ‘mental patient’ role that various social systems and structures have imposed upon consumers of mental health services which many experience as internalized stigmatization. The “special oppression masked by democratic freedom” is parallel to the “stigmatization of the mentally-ill in the context of supposed commitment to social justice” by the community of mental health and other social service providers. Wahl (1999, p. 12-13) describes this tragedy

. . . whereby stigmatized individuals may come to share the same beliefs as the larger population and to view themselves in similarly disparaging ways . . . Because they believe that they are flawed, unworthy, and incompetent, stigmatized individuals may act in ineffective, unmotivated, or even pathological ways that confirm the expectations that society holds for them. Those professionally diagnosed with a mental illness are seen as less capable and less competent, with undesirable characteristics, such as dangerousness and poor grooming. Their opinions and feelings, presumed clouded by mental confusion, are not respected . . . They accept the social
definitions of inferiority, feel ashamed and discouraged, and fulfill society’s expectations by adopting the specified ‘mental patient’ role.

The attitudes of the general public, mental health and other social service providers, and the media, towards mental health service consumers include such descriptions as: ‘dangerous,’ ‘dirty,’ ‘unpredictable,’ ‘worthless,’ ‘aggressive,’ ‘violent,’ ‘morally-flawed,’ ‘sinful,’ ‘apathetic,’ ‘hostile,’ ‘irritable,’ and ‘moody.’ In addition to these, other descriptions used are: ‘argumentative,’ ‘disorderly,’ ‘immature,’ ‘impatient,’ ‘irresponsible,’ ‘selfish,’ and ‘bad.’ In their various realms of social interactions, they are generally treated with rejection, as if they were invisible, of no account, or labeled as ‘mentally-ill.’ There is empirical basis for this from numerous studies (Wahl, 1999, pp. 12-23). The participants:

A: I remember getting frostbite on my hands after New Year’s. I was on the streets from a shelter. They kicked me out on the streets. You can’t stop when it’s that cold and I was just so tired and I sat down and rested and fell asleep and someone woke me and I got frostbite on my hands. So I went to St. Paul’s Hospital and the way I was treated in that place! Some of those people with that ‘holier than thou’ attitude.

L: Exactly. People who can’t communicate because of mental health issues are turned away.

K: Even the terms the mental health community uses to describe us: ‘compliant,’ that casts people in a bad light if you’re not and who does it really help if you are. When you just ‘comply?’

S: Oh yeah! And if you’re not then you’re put on a list and they don’t let you stay. If you try to get in another one, they call the other shelters who says that you were problematic and so they don’t let you stay there either!

R: Yeah. Or they just say you’re a ‘difficult’ client.

S: Yup and you’re fucked and you’re out in the cold. I have all my belongings

J: Actually I’ve been to the hospital many times when I have had crisis. I don’t have a doctor there but the way I’ve been treated has just been bizarre. I have angina and panic attacks and I also experience high anxiety which exhibit all the same symptoms. Coming to the hospital in crisis, they say I need ID. This took me over a year to get. I couldn’t get a BCID until I have my birth certificate and it all took me a year. Which is another issue. Some providers treat this needing an ID thing as an opportunity to teach me to take
responsibility for myself. But I ended up running around in circles until I got to see a pro bono lawyer. So, I’ve gone in there and it’s been bizarre. I go in there and they seem to think I’m going in there to get drugs or I’m seeking attention. And you get these patronizing attitudes. Part of my PTSD is sexual abuse by a physician, that’s part of it, and they use that to jinx me out of things. They see that in my records and no one believes me and they treat me like I’m crazy. They just push you out the door and that’s it.

This exchange, similar to some others during the TRRG, provided the participants with an opportunity to critically analyze these experiences and create new meanings. These discussions also helped redefine how these experiences were unjust where before many felt like they deserved to be treated this way. As Carlsen (1988) defines it, meaning-making involves critical examination of systems and patterns of thinking that are based on internalized oppression (i.e., the mental patient role) which reinforces and sustains systems of distress. In popular education, this is extended to include the examination of systems and structures of oppression (and traumatization) and how these can be transformed through united action. Continuing the participants’ exchange:

S: At St. Paul’s, depending on the time of day or night, they basically give you a bus ticket and tell you to hit the road. Social workers tell you there’s no beds here or there and they just give you a bus ticket.

L: Well, we have a new mayor

S: Yeah, he’s supposed to address. I voted for him and the number one issue on his website is homelessness.

R: I was an adviser on disability issues in Ontario many years ago and one of the things we can do is to put political pressure. Although you get all these grandiose heads of departments. As soon as you get a politician, they present this wonderful sort of thing, that everything is fine.

A: Well, if we have enough voices saying to the person saying ‘it’s all fine’ then maybe they’ll hear it this is the reality that needs to be addressed cause I’m hopeful that we can do something to make change together.

J: I would hope you’re right. It would be good to have a hearing with a lot of people who’ve had these experiences come and speak about what impact these had on their lives

J: There’s a good show on CBC called ‘White Coats, Black Arts’ and it’s about relationships with doctors and it may be good to go on this show to
talk about what we talk about.

I: You know what really peaked my thing? I have been ripped apart by the security guards at St. Paul’s. I have been hogtied, told to leave the property by their security. One time I had an abscess on my arm and they ripped the bandage right off and they made me leave the property. I’m not shitting you, I’m not lying to you.

S: I’m talking about physical and emotional abuse. Saying things that they have no right to say. If you look like a so-called ‘drug addict,’ which I probably was at the time coming off the dope, which is why I wanted some help. Oh my God! The things they said to me. They called me names and chased me away. And they would come at you until you crossed the street. You need to cross the street. You know what they call it now? Protection services. Basically they’re protecting staff and themselves. They’re not there to protect patients. And it’s very intimidating when you first walk into it. And you get all these hoity-toity people coming in from the West End, and then there’s you, right?

M: Did you get to talk to someone about that?

S: Who do you talk to? If you’re homeless, you’re a non-person.

J: What does it take for people to treat us with dignity?

R: It sounds like a lot of these people are burned out.

L: Well, they should not be doing this work

K: Or should get help for it.

It is in the sense that the TRRG facilitates the ‘extrojection’ of the ‘mental patient role’ through collective critical analysis of individual problems in relation to systems and structures of (re)traumatization towards united action that this conversation above is an example of education as a practice of freedom. The process of critical analysis of one’s context in order to identify systemic and structural roots of problems to the extent that there is a forward movement towards realizing the need to undertake action for meaningful change is what Freire (1998) called ‘conscientization’ or ‘formation.’

The way that the conscientization/formation process is experienced depends on numerous factors, first and foremost of which is the composition of the group; there is not one way of undertaking this. A lot depends on the individuals who make up the
group and what they bring to the table. In the TRRG, this process came about through
dialogue which naturally included discussions about and analysis of systems and
structures that have and continue to facilitate trauma. As facilitator, I did my part to
contribute to the participants’ efforts to frame the discussions to not simply be about
individual but also systemic and structural problems. This collaboration in undertaking
critical analysis of social contexts resulted in discussions in the group regarding
traumatization from systems and structures that were concretely causing them anguish:
mental health and other social service providers; family systems; school and community
systems and structures; and various individuals and groups who discriminated against
them based on gender, faith, mental health status, class, and age. This new awareness
facilitated a discussion on concrete next steps in united action for meaningful change,
the continuing practice of freedom.

**Collective Action**

The contextualization of individual and collective trauma-related distress in
systems and structures facilitated the identification of group-level needs necessary for
forging unity for collective action (Freire, 1995). The participants’ shared anguish can
not be detached from these structures; it is a disservice to merely address the
manifestations of devastating social ills without undertaking efforts to deal with their
sources. Again, disregarding contexts of social inequities that have played a part in
reproducing these may result in us assisting individuals to “adjust to the unjust” (Cross,

The participants talked about action steps they could undertake as a group
which included engaging in dialogue with mental health and other social service
providers, hospital security staff, and law and policy-makers, to increase awareness
about trauma-related distress and ways of working together to meet common goals.
There was a consciousness about needing and wanting to work in partnership with these systems and structures in response to needs for information and education, awareness-building, addressing compassion fatigue or secondary/vicarious traumatization of providers, and advocating for their rights as consumers of mental health services. They identified the end goals to include building community and systems of support and mutual caring and well-being.

The process of discussing the problems, gaps, and suggested action steps, represented enhanced control not just over their overall situation or over what was simply accepted in the past (e.g., systems and structures can not be changed), but a realization that collectively, some aspects of their reality can be changed. Part of the discussion was as follows:

L: So, can we actually do a presentation to some people and are we actually going to do it?

R: Yeah, yeah, that’s an idea. It’s a possible strategy for creating some change because it’s different if you’re talking to your therapist about how a certain person treated you. The response usually is how can you deal with those effects and how you can feel better. It’s not, ‘somebody needs to talk to this person or this institution because this person is traumatizing clients every single day and they’re talking to them in those ways.’ That is quite disempowering. That’s not what social services is about. So that’s the relationship of this to what we’ve been talking about. But it is also important to recognize what’s been going on with us as individuals so there’s that meeting together of both.

J: Well I can give you a specific example right now, one of the things is disempowerment as a from of abuse and if you go to a service and somebody is acting inappropriately and you go to another service provider and you say this what’s happening and they throw back to you and say ‘feel your feelings’ rather than making the provider accountable, It puts them in a dangerous position, too, because there is so much invested in those groups in terms of maintaining themselves, protecting their jobs. There is so much abuse than happens in social services that never get addressed.

A: Yeah, I totally hear what you’re saying. There are some people who would not want to do anything about it. This is someone’s medical career, it’s somebody who is ‘mentally ill’ making these charges.

I: Well, it’s someone’s career versus someone’s life
L: Yeah, but that’s not how people see it. So that’s the question, if we do decide to undertake a strategy we want that strategy to be constructive. But not just constructive but one that stands a chance. Especially since it’s the first time we’re going to be doing something. We may start with the staff of CCD or we may invite people who might benefit from hearing a group.

M: We discussed issues around home, social services, mental health services, home and family, darkness and public spaces, hospital and psych ward, providers. Last group, some suggestions we came up to respond to these distresses including: client services training, education for people in the frontline of services, people who deal with consumers, answers calls,

S: But can you really? How do you build compassion in others?

R: Even our Prime Minister because of economic woes, finally has opened up to it but someone asked how about benefits and his response was that, ‘well, we don’t want to make it too easy for people to receive these services.’ And I see stimulus packages but he’s got zero compassion or understanding. Who would want to continue, I know that there are people who do but having worked there but they need to develop compassion.

I: Oh yeah. Well my son had a social worker and she took everything personally. To her everything was a battle, like it was an attack on her. And I try to explain to her that my son is not getting this, this and this and he’s not getting it and things should be fair and he’s not getting it. Yeah, and she started yelling at us and it ended up just being this stupid yelling match. It was just nuts! She just took everything so personally. And some people are just like that.

J: Could be that she’s so overwhelmed with her job that she does not have time or energy to do what she need so she feels she is inadequate. Or the agency is inadequate.

K: But no one is really working on creating changes in these agencies. We just accept things the way they are.

L: And that’s what I have encountered going to the clinics around here. You know you correct them for example when they have a plan and they try to impose it on you and you say, ‘no, that’s not gonna work; then bam!

P: So what you’re saying is that people also need to understand ‘how’ to work with consumers. And that’s another skill. You may understand the problem but you may not know how to deal with people. That’s not really being done well by institutions.

J: In many clinics around here there is an attitude that because you’re an addict, because you’ve had a mental health issue, because you’re homeless, then you’re ignorant and you don’t have anything to contribute. They tell you what to do and you don’t do it, you’re blamed. That’s how it
works. When we’re dealing with persons going through issues, they need your help but they’re also intelligent enough to contribute to their recovery.

The following forms of systemic and structural traumatic distress were identified during the TRRG:

**Family and Home Life**
- use of violence, various forms of abuse, and neglect towards family members;
- existence of continuing abuse in the form of blaming, shaming, trivializing, threat, denial, and brushing off;
- lack of understanding among family members of trauma and related depression and substance abuse, their symptoms, and how they affect a person’s life; and,
- lack of efforts and services to address family issues particularly with individuals who have themselves been traumatized and manifest these through abusive behaviors.

**Mental Health Services**
- lack of understanding, denial, or trivializing among mental health providers (psychiatrists, psychotherapists, clinical social workers) of trauma and related depression and substance abuse, their symptoms, and how they affect a person’s life;
- inadequacy of mental health services that and competencies among mental health providers to consider and effectively help clients work on the effects of these mental health challenges; and,
- existence of disempowering or abusive relationships and service delivery that exacerbate trauma-related distress.

**Social Services**
- lack of understanding among social service providers of trauma and related depression and substance abuse, their symptoms, and how they affect a person’s life; and,
- inadequacy/insensitivity of services and service delivery that consider the effects of these mental health challenges and to provide effective interventions and services;

**In General Terms with Respect to Service Providers**
- lack of compassion on the part of service providers for people suffering from trauma and related depression and substance use (question asked as to how compassion can be developed in others); and,
- ill-treatment experienced from service providers who are suffering from compassion fatigue or vicarious/secondary traumatization.

**General Public**
Stigmatization and discrimination against consumers of mental health services in the forms of labeling, maltreatment, and being considered incapable, dangerous, and damaged.

The following possible action steps were identified in response to these gaps:
a. Panel presentation with service providers (CCD, VCH, Fraser Health, Raincity Housing, peer support workers), media, federal and provincial officials, and others.

b. Production and use of visual materials (posters, artworks) for discussions or panel presentations.

c. Production of a skit or role-play presentations.

d. Talk to federal or provincial officials: Mayor Robertson, Senator Michael Kirby, or the Canadian Commission on Mental Health, others.

e. Present at or participate in discussions on CBC radio (e.g., 'White Coats, Black Arts."

f. Write a letter to federal or provincial officials, or organizations such as VCH.

g. Advocate for continuing the TRRG to address continuing needs for psycho-education and support with CCD.

These possible action steps, as identified by the TRRG participants, are all in the context of humanization, as they were expressed with a collective desire for the `liberation` of both the oppressed (traumatized), who is dehumanized by injustice (traumatization), and the oppressors (staff working in systems and structures), who are dehumanized by committing injustice ((re)traumatization) (Freire, 1998).

The participants agreed to undertake action step `h` above, and advocate for the continuation of the TRRG. The participants met with CCD staff and presented this idea and discussed its aspects including rationale, objectives, desired content, methodology, and plans for recruiting new members. CCD staff members were very receptive to the idea and agreed to explore the possibility of continuing the TRRG. I shall discuss this meeting later in this paper.

Actually meeting with CCD staff to advocate for systemic and structural changes in service delivery to meet their collective needs further entrenched this sense of enhanced control in the context of self-agency as a group. They recognized how
actualizing efforts to address these problems may also help in eventually decreasing their individual distress and in preventing further (re)traumatization.

Summary

In this chapter, I discussed a framework for popular education in psychoeducation initiatives towards collective trauma recovery and reconstruction. This framework extends popular education theories to include aspects and components necessary for undertaking psychoeducation work in situations of chronic, acute, and continuing trauma. This was achieved by contextualizing these initiatives in the realities of each participant and their individual and collective needs for recovery and reconstruction from trauma.

It was important to conduct these initiatives with clinical considerations in mind; collective initiatives must be appropriate to needs not just in terms of psychoeducation but consistent with the participants’ clinical goals for recovery. It is vital to ensure that any and all participants are appropriate for a group in terms of their ability to tolerate and benefit from the processes involved in trauma-focused dialogue, collective analysis. Also, undertaking action needs to be based on sound clinical judgment. Otherwise, the risk for harm is increased and these initiatives may result in injury rather than benefit.

The translation of this pedagogy into united action was the continuing practice of freedom. This was actualized by the participants’ efforts at developing their individual and collective consciousness towards being more critical of systems and structures of (re)traumatization to advance their humanization. In the end, the participants were able to undertake collective action based on a careful assessment not just of their needs but also of their current capabilities. This respect for their processes, realities, and possibilities for concrete achievement, as well as the realization of the capacity for
actually undertaking this, indicates the accomplishment of various objectives towards recovery and reconstruction.
CHAPTER EIGHT
PROJECT SUMMARY AND IMPLICATIONS

Project Summary

The centrepiece of this participatory action-research project was the Trauma Recovery and Reconstruction Group (TRRG), a twelve-week psychoeducation initiative designed by me and implemented with consumers of mental health services at the Centre for Concurrent Disorders (CCD). This project illustrated the contributions that the use of popular education (using visual-arts based methods) can make to psychoeducation for recovery and reconstruction efforts undertaken by a small group of participants who were living in contexts of chronic, acute, and continuing trauma (and depression and substance abuse). The use of this framework involved dialogic, participatory, and transformative processes in collective context analysis, needs assessment, design, implementation, and evaluation, moving towards undertaking action, not just to address individual symptoms (recovery), but also to actualize more systems- and structures-based change (reconstruction). One essential feature of this initiative is its contextualization in clinical considerations related to individual and collective complex trauma symptomatology. This project merged clinical considerations for continuing complex trauma psychoeducation work with popular education in the context of social action.

It is important to restate at this point that the approach used in this particular project is appropriate to a specific population. Undertaken in a clinical setting (in this case, CCD) this particular approach applies to individual consumers of mental health services who endorse past, recent, and continuing trauma-related distress and related mental health concerns (depression and substance use). In addition, these participants...
were interested in being part of the activities involved in this research project, particularly the TRRG. Their participation was clinically-indicated which not only meant that being a member was beneficial to them but that they were also equipped with the necessary competencies to manage the effects of the project’s discussions and processes. As stated in chapter 5, these competencies include: the ability to use effective coping strategies; the capability for self-activation in accessing resources, particularly for emergent mental health concerns; the capacity to set boundaries to ensure safety; the ability to do cognitive work (e.g., participate in dialogue and analysis); and the capability to engage in group processes, particularly united action.

This approach may not be well-suited for individuals who have not experienced (re)traumatization from specifically systems- and structures-based sources of distress. This experience implies a significant lack of or access to resources whether material or otherwise, which is typical of life circumstances of the poor, oppressed, and disenfranchised.

The nature of traumatic experiences that were shared by the members of the TRRG was long-term inter-personal or systemic violence: childhood physical, sexual, emotional, and psychological abuse or neglect; stigmatization and discrimination; poverty; disempowerment; community violence; retraumatization by mental health and other service providers; among others.

The scope of this project is limited to these realities. Individuals and groups suffering from trauma from natural disasters are not within the reach of the discussions of this project. I do, however, hope that future efforts will include other similarly distressing human experiences particularly with those who suffer from long-term and continuing traumatic distress whose lives have also been devastated by natural disasters.
Serving as backdrop to the TRRG were explorations on the various aspects of popular education theories that were relevant to this research study. These were later connected to theoretical foundations for trauma psychoeducation towards collective recovery and reconstruction. Some of these included aspects of Freire’s pedagogy involving contextualization, critical analysis of systems and structures, humanization, problem-posing education, dialogue, conscientization, education as the practice of freedom, collective action, and praxis (action-reflection). These theoretical foundations served as the basis for designing the TRRG, a twelve-week group psychoeducation approach.

Trauma was likewise explored emphasizing the collective, complex, and continuing nature of trauma as evidenced by the ongoing social suffering shared by individuals, groups, and communities. The dominant individualized orientation to trauma and recovery was noted as were other worldviews to underscore the reality that there is not one definition of trauma and, for that matter, recovery and reconstruction. It is vital to contextualize these initiatives in the participants’ universe (Freire, 1998) and to not simply be based on the ideas of one ‘expert’ (e.g., mental health worker, researcher).

Defining collective approaches to addressing collective needs is crucial, particularly as the majority of current responses to trauma are individual or individual-focused, even when undertaken in group settings. Those who are most affected by trauma can be greatly assisted through their meaningful participation in efforts to address distress that employ dialogic, participatory, and transformative processes to facilitate united action. It is essential to shift the paradigm of working with survivors of trauma from one that is mental health service provider-centered (i.e., psychotherapists
and psychoeducators define the content and methods used) to one that is participatory (i.e., undertaken in meaningful partnership; participation, not just consultation).

Analyzing the systemic and structural contexts of these distressing human experiences using popular education as framework alters the common perception that recovery from trauma rests solely on the individual survivor. Although there are benefits to assisting individuals in acquiring or enhancing more adaptive coping strategies, there needs to be parallel efforts at addressing contextual sources of (re)traumatization, particularly in situations where people are disadvantaged, oppressed, or are otherwise treated unjustly. The reality is that, in innumerable instances, social systems and structures are complicit in (re)traumatizing individuals. Family, school, community, mental health and other social services, economic, political, cultural, and spiritual systems and structures can entrench violent, discriminatory, and oppressive beliefs, behaviors, policies, and practices. This is most relentless with disadvantaged individuals, groups, and communities who are in life circumstances characterized by poverty, ill-health, miseducation, stigma and discrimination, lack of opportunities and resources, lack of power over decisions, organized terror, or war.

Political and professional processes powerfully shape the responses to types of social suffering. These processes involve both authorized and contested appropriations of collective suffering . . . The state, its institutions, and groups that contest state control press medicalization for its advantages in regulating persons, their bodies, and networks. But this is not only the form that political and professional processes of constructing and contesting social order take place. Public policies and programs have created some of the worst instances of social sufferings; even in seeking to manage social suffering, they have, through intended and unintended effects, intensified human misery (Kleinman, Das, & Lock, 1997, p xii).

United action stands as a viable option in addressing more systems- and structures-based sources of trauma to actualize more meaningful change.
Another unique aspect of this project was the use of visual arts-based methods. These methods significantly enhanced the participants’ ability for collective expression and critical analysis. The visual arts-based methods included: visual dialogue, individual illustrations, participatory visual appraisal, and context mapping of distress and recovery. These facilitated the representation of embodied thoughts and feelings, helped with transcending the power of distressing experiences, and allowed for collective reflection and analysis to reveal group themes and issues which all served as basis for collective action.

An aspect of recovery and reconstruction that was emphasized in this study is meaning-making. This, for the purposes of this project, involved the critical reexamination of systems and patterns of thinking that are based on internalized oppression which reinforces negative thoughts and feelings which, in turn, can sustain systems of distress. As stated earlier, these initiatives departed from an ‘individualizing focus’ that can result in those involved being “oblivious to the socio-cultural constitution of the difficulty or its location in adverse social conditions” (Kaye, 1999, p. 24).

As stated earlier, this participatory action-research project makes theoretical, methodological, as well as practical contributions to the practice of popular education (particularly using visual arts-based methods) in collective trauma recovery and reconstruction. Undertaken in three stages, this project contributed to the participants’ efforts at addressing not just individual symptoms, but also systems and structures that enable/reproduce (re)traumatization. The work of this project significantly expands and deepens theoretical and practical knowledge about the use of popular education in trauma psychoeducation in contexts of chronic, acute, and continuing trauma and how these significantly enhance collective recovery and reconstruction. Methodologically, it provides a model for employing participatory, arts-based, and capacity-building approaches in the context of trauma and related mental
health issues towards collective recovery and reconstruction. This model includes identifying particular visual arts-based methods which enhance initiatives in the expression of trauma-related distress and recovery, the critical analysis of systemic and structural roots of collective trauma and retraumatization, and the identification and actualization of approaches to collective recovery and reconstruction through united action. Practically, it contributes to recovery and reconstruction efforts of groups in contexts of chronic, acute and continuing trauma through the actual conduct of the TRRG creating a community of collective learning and mutual support.

One of the themes that emerged from this project included the collective, complex, and continuing nature of trauma and the reality of shifting contexts requiring continuing needs assessments. I emphasized the importance of clinical considerations that need to be taken into account when using dialogic, participatory, and transformative processes. In addition, other findings included the need for safe spaces to achieve the goal of recovery and reconstruction. The group illustrated the power of mutual learning, using problem-posing education, conceptualized in this psychoeducation project as the practice of freedom. It led to conscientization, humanization, and praxis. The project also pointed to other matters that need to be considered when using collective popular education processes with traumatized groups including difficulties with memory and cognitive distortions and silencing and the shattering of the self. That being said, this project was based not just on participants’ deficits or trauma-related vulnerabilities, but also on their trauma-related strengths and capacities. In terms of methodology, the power of visual arts-based methods in collective expression and critical analysis was also explored through the use of visual dialogue, individual illustrations, participatory visual appraisal, and context mapping of distress and recovery. Making sense of trauma-related chaos; exploring trauma and recovery based on different worldviews; and meaning-making, in general, were
investigated. The practical contributions of the TRRG included the building of a community of psychoeducation and support. In the end, this project contributed to the participants’ efforts at recovery and reconstruction by facilitating collective action in advocating for the continuation of the TRRG at the CCD to sustain the group’s efforts at ensuring a community of continuing psychoeducation and support.

Based on the participants’ objectives, the TRRG contributed to their ability to:

1. enumerate and explain strategies in ensuring safety and stabilization after conducting an inventory and assessment of those used, ones that they would like to use more often, and ones they would like to acquire; project activities also facilitated experiential learning and provided additional competencies in the use of more adaptive strategies to deal with symptoms and systems as evidenced by content of discussions and visual materials produced;

2. explain trauma (particularly PTSD), depression, and substance abuse and the links between these, in several ways (and based on different worldviews) that are relevant to recovery and reconstruction efforts through dialogue using visual arts-based methods, input, and critical analysis of various aspects of chronic, acute, and continuing trauma-related distress as evidenced by statements and explanations made during the TRRG group sessions, the Second Group Discussion and the Second Individual Interviews;

3. discuss negative patterns of thinking and how these inform and affect trauma-related distress and recovery and reconstruction efforts based on information shared and collectively discussed during the TRRG;

4. enumerate and critically discuss some systemic and structural sources of (re)traumatization based on their actual experiences and how these affect individual
and collective distress as discussed and outlined in the TRRG Discussion of Action Steps document;

5. enumerate agreed-upon action steps in response to systemic and structural (re)traumatization and describe concrete steps undertaken to actualize changes in the system and structure of delivery of services to individuals experiencing trauma-related distress also as outlined in the TRRG Discussion of Action Steps document and demonstrated in the meeting with CCD staff for the continuation of the TRRG; and,

6. describe more manageable levels of trauma-related distress in the context of the community of collective learning and support that was built through the TRRG as evidenced by affect displayed, statements made, interactions conducted, and new relationships forged during project activities.

TRFPR – A New CBPR-Oriented Approach Towards Recovery and Reconstruction

Trauma Recovery-Focused Participatory Research (TRFPR) is a research method oriented in Community-Based Participatory Research (CBPR) which brings together two important undertakings: participatory action-research and trauma recovery and reconstruction in the context of dialogic, participatory, and transformative processes. At the same time that participants are engaged in a partnership through the different phases of research to contribute to the body of knowledge on trauma recovery and reconstruction, the processes simultaneously contribute to their efforts at recovery and reconstruction from chronic, acute, and continuing trauma.

These processes began with establishing the meaningful participation of each participant in individual and collective context analysis and the designing of the TRRG. The process by which participants themselves analyzed their context and identify individual and collective needs is not simply an exercise in data gathering but is likewise
crucial to recovery and reconstruction efforts. As explained earlier in this dissertation, one of the themes of trauma is lack of control (Herman, 1997). Having power over the matters that affect an individual or group that has experienced lack of control due to trauma contributes significantly to well-being. This is true for the sense of silencing, as well, where many feel retraumatized when they are or feel they are not allowed to express themselves. In addition, the TRRG also facilitated the development or enhancement of the participants’ skills in critical thought and analysis, meaning-making, contextualizing symptoms in systems and structures, and forging unity/building community for collective action, among others.

Meaning-making is a particularly important aspect of recovery and reconstruction and the use of visual arts-based methods in the context of TRFPR is specifically significant. Carlsen (1998) states how the process of gathering data facilitates a ‘joining’ of meaning which may involve exploring new ways of looking at this data. Patterns and processes are identified and, in collective contexts, allow for the “identification of themes towards creating new meanings related to personal histories and philosophies, cognitive structurings, emotion, image and ideal, and behavior” (p. 92).

TRFPR contributes to addressing the participants’ mutual goals through the conduct of activities that support clinical considerations related to ensuring safety, creation of safe spaces for learning and symptom management and prevention of retriggering. In addition to these, it also contributes to the establishment of links between individual symptomatology and systemic and structural origins of trauma, while respecting, building on, and utilizing participants’ strengths and capacities. In the case of the TRRG, this method also facilitated the exploration of theories related to the various aspects of the study; in this case, popular education, trauma psychoeducation,
the use of visual arts-based methods, meaning-making, and recovery and reconstruction. Efforts were directed toward united action, to address more issues and needs.

The TRRG created a balance between research and action involving a contribution to efforts at addressing participants’ individual and collective needs; building of community of mutual learning, support, and rights advocacy; and undertaking of collective action to address more systems- and structures-based issues and needs.

TRFPR is a new approach to research that contributes to recovery and reconstruction processes through its various activities and which is consistent with popular education in terms of employing dialogic, participatory, and transformative processes in efforts towards meaningful social change.

Project Implications

It is important to remind the reader that this project essentially involved only six participants and, as such, is limited in its scope. The findings of this research are based on the experience of this small sample. It is hoped, in fact essential, that future iterations of this project be undertaken to provide additional basis for advancing the following project implications and for confirming my assertions of the value of this approaches.

Practice and policy implications of this project are in terms of individual treatment plans to routinely include client participation in a psychoeducational group, programs of mental health agencies to ensure delivery of trauma-related services, the conduct of psychoeducation initiatives in contexts other than mental health agencies (e.g., community-based organizations and other formations), the establishment of a
network of groups for trauma psychoeducation and support, and changes in policies involving mental health, in the context of trauma.

**Changes in Individual Treatment Plans**

From the research data and the successful meeting of the objectives, this project points to need for significant modifications in services provided to individual mental health consumers such that they include participation in group psychoeducational process for trauma recovery and reconstruction. It is common practice for individual consumers to receive one-on-one therapy and to be later encouraged to participate in other program activities such as group psychoeducation. Treatment plans could routinely include the participation of individual clients in collective initiatives such as the TRRG for more comprehensive and responsive approaches to addressing mental health needs. Treatment plans outline the goals, objectives, activities, timeframe, and resources needed to address mental health concerns identified in partnership between the therapist and consumer. This plan should be agreed upon by both therapist and client and also evaluated together at the appropriate time. These plans are designed to guide treatment through a course of action that is clear and agreeable to both the therapist and the consumer.

To routinely include group psychoeducation in treatment plans requires that providers recognize not just the collective nature of trauma and the necessity of collective learning and support in recovery and reconstruction but also that this collective approach be established right from the very beginning. The individual mental health consumer still has the right to refuse, of course, but framing services this way facilitates the appreciation of and more likely participation in these collective efforts. Okin and Bocellari (2007) advance the need for comprehensive approaches to trauma recovery and reconstruction to include various treatment modalities including
psychoeducation not merely as a possible later option but as a necessary component of treatment. By extension, the above-mentioned psychoeducational processes could be used for initiatives involving not just trauma-related distress, but also other mental health challenges.

**New Trauma-Related Services**

For mental health service agencies, policy changes could be effected involving the establishment of new services towards trauma recovery and reconstruction. Data from this research provides basis for the TRRG as an essential component of individual and collective healing described by its participants as foundational in dealing with other mental health concerns and systemic and structural issues. Numerous mental health challenges involve trauma-related distress that remains untreated due to lack of awareness of and competencies to deal with these, even in terms of psychoeducation. It is thus necessary to assist staff not just with respect to learning about trauma (and trauma-related mental health issues) but also in the use of popular education. In addition, resources need to be allocated to ensure service delivery including funds for materials, activities, and possible speakers.

**Applications in Other Contexts**

Many organizations individuals and groups/communities in contexts of chronic, acute, and continuing trauma, do not yet have programs to address this mental health concern. Horsman (2000) argues for incorporating considerations related to trauma in learning contexts as these affect people’s efforts at self-development and well-being. The collective nature of trauma, as well as trauma itself, experienced by groups/communities in contexts of community violence, state-sponsored terror, and war, necessitates collective responses. In such situations, initiatives that encourage large numbers of people to work together on mental health issues that affect them
simultaneously are imperative. Community-based/people’s organizations or other not-for-profit groups working for systemic and structural social change could add a program to address mental health concerns to their agenda. Organizations that value dialogic, participatory, and transformative processes could use the TRRG as an approach to group psychoeducation to enhance organizing efforts and social change work. The TRRG uses popular education as framework and is consistent with the principles of context-based, people-centered, and systems- and structures-based change. This model could also be used for education of mental health professionals, particularly those exposed to distressing situations and traumatized populations and may be suffering from vicarious traumatization.

**Establishing a Network of TRRGs**

A network of TRRGs could be established to further enhance opportunities for collective learning and support between groups in different life situations. This would provide additional venues for co-learning and support. In addition to this, the prospects for more effectual consumers’ rights advocacy would be increased with greater numbers of people working on realizing systems- and structures-based change based on their needs. Specific groupings with this network could work together to identify particular needs for learning, support, and advocacy. Examples of these may include: better housing, additional financial resources, better attention to physical care needs (e.g., chronic pain), and issues affecting youth, women, battered spouses, families, etc.

**Policy Changes**

Changes in mental health policy at the levels of Vancouver Coastal Health and the Province of British Columbia could state the need to provide trauma-focused services for individuals and groups. This could include psychoeducation initiatives designed to comprehensively address trauma-related distress. At the present time,
there do not appear to be policy considerations for trauma-focused services and how these need to be delivered. Although Vancouver Coastal Health is currently working on a paradigm shift towards more programs and services being trauma-focused, mental health policies remain silent, vague, or stated in overly general terms in relation to ensuring the delivery of trauma services, particularly psychoeducation as a necessary component of treatment (please see Appendix S).

It is necessary to outline policies that establish the need not just for trauma-focused services but for comprehensive approaches to treatment which include psychoeducation in collective contexts.

Towards a New Diagnosis: ‘Continuing Complex Traumatic Stress Disorder’ (CCTSD)

In a discussion about experiencing traumatic stress, depression, and substance abuse across the lifespan, one participant stated:

R: They’re all connected; trauma led to depression which led to substance use which led to trauma. Not one can exist on its own. You compound the problem by looking for ways to deal with those and you use substances and it compounds the problem. One is not primary over another. They are all connected. It is one experience.

These statements describe a reality that all of the participants (and many others) continue to experience. Traumatic stress can maintain its presence in people’s lives for extended periods of time. This section of this paper advances a new diagnosis to capture the reality that many individuals face, which I call ‘Continuing Complex Traumatic Stress Disorder (CCTSD).’

Although I have misgivings about using the word ‘disorder,’ I am using it in relation to PTSD as defined in the diagnostic canon and to provide a contradistinction to a human condition taken in its broader context. Before I discuss CCTSD, it is helpful to again look at what Herman (1997) has already written about complex PTSD. The
cumulative effects of trauma across the lifespan characterizes complex traumatic
distress which Herman (1997, p. 120) refers to as complex PTSD:

In survivors of prolonged, repeated trauma, the symptom picture is often far
more complex. Survivors of prolonged abuse develop characteristic personality
changes, including deformations of relatedness and identity. Survivors of abuse
in childhood develop similar problems with relationships and identity; in addition,
they are particularly vulnerable to repeated harm, both self-inflicted and at the
hands of others. Complex PTSD includes alterations in affect regulation,
consciousness, self-perception, perception of perpetrator, relations with others,
and systems of meaning.

I agree with Herman on most of these points but would like to add how data
from this project advances that it is fairly common that people experience complex
traumatic stress not as ‘post’ but, in fact, as a continuing reality. Hence, I argue for
Continuing Complex ‘Traumatic’ Stress as a replacement for diagnostic language that
includes the notion of ‘Post-Traumatic.’ The participants in the TRRG described layers
of trauma-related distress consisting of past remote, recent, and current or emergent
trauma. Herman’s (1997, p. 121) definition of complex PTSD includes the development
of “characteristic personality changes,” “deformations in relatedness and identity,”
“alterations in affect regulation, consciousness, self-perception of perpetrator, relations
with others, and systems of meaning,” which all point to a state of elevated risk for
(re)traumatization. For many who are experiencing this, even mild triggers can be
devastating.

It is critical that the symptom picture of individuals experiencing ‘post-’ traumatic
distress is recognized as notably different from that of those one who are experiencing
this in a continuing way. As a reminder, the diagnostic criteria for PTSD states that “a
person has been exposed to a traumatic event,” either by direct experience or
witnessing, and the person’s response was “significant fear, helplessness, or horror”
(APA, 2000, p. 467). To be diagnosed with PTSD, the individual must meet the requisite
number of entries under the three main cluster symptoms of re-experiencing, avoidance, and hypervigilance.

What if the person, however, has been exposed and continues to be exposed to traumatizing events? People in contexts of domestic violence, community hostility, organized or state-sponsored terror, or war, for example? For many individuals, certainly for most of the participants of the TRRG, trauma is continuing. It is thus important to define the experience of individuals experiencing distress from chronic, acute, and continuing trauma in order that these concrete experiences can be understood and responses to these realities are appropriate and relevant.

In addition, as has been advanced in the paper several times, it is important to expand the definition of complex trauma to include not just its symptomatology but also its context, including the systems and structures that are implicated in facilitating (re)traumatization.

I advance the following criteria for Continuing Complex Traumatic Stress Disorder (CCTSD) based on data from this study (adapted from the APA’s (2000. pp. 467-68) and Herman’s (1997, p. 21) diagnostic criteria for PTSD) as a contribution to the current discussion on revising PTSD:

A. A person, group, or community has been, is, and continues to be exposed or subjected to traumatic experiences including those facilitated by other individuals or groups or unjust and oppressive systems and structures in which all of the following are present:

1) the person, group, or community, experienced, witnessed, or was subjected to experiences that involved actual or threatened death or serious injury or threat to the physical integrity of others including various forms of repeated abuse and neglect in childhood, significantly distressing experiences in adulthood, and continuing existence in a context of systems-and structures-based (re)traumatization;

2) the person’s, group’s, or community’s response involved intense fear, helplessness, or horror, which resulted in lifelong distress characterized by clinically-significant trauma-related distress in the form of anxiety,
depression, and substance abuse/dependence across the lifespan.

B. Trauma-related distress is persistently experienced in one of more of the following ways as a result of sustained re-experiencing, avoidance, and hypervigilance:

1) an enduring sense of a shattered self due to a persistent lack of control over the different aspects of one’s person and one’s life (i.e., physical body, thoughts, emotions, behaviors, events, relationships, and the systems and structures that impacts one’s well-being) and the sense of chaos that comes from dysregulation of affect and disorganization in one’s existence;

2) a chronic sense of being trapped, feeling hopeless, and consistent failure of efforts at healing with many finding themselves caught in a downward spiral without any indication of or experiencing consistently transitory relief;

3) an unrelenting sense of falsehood, dissociation, and disconnectedness of self and with reality including artificial experiences with happiness, intimacy, wholeness, and other positive and affirming emotions; alterations in self-perception involving a sense of defectiveness, defilement, shame, guilt, and self-blame;

4) a persistent sense of being stigmatized, branded, or marked for life in most if not all aspects of life, relationships, and various social roles, simultaneous with a sense of inescapable distress that comes from being so despite countless attempts to lead a life worth living;

5) a sense of relentless and recurring torment also due to encounters with systems and structures that have entrenched (re)traumatization whether intended or otherwise;

6) a sustained sense of the inevitability of plunging into a bottomless, dark, inescapable void which represents enduring and immobilizing despair with no way out;

7) a persistent sense of affinity to or fleeting ideas of an ultimate ending of life linked to an existence with the only the prospect of endless despair;

8) an unrelenting sense of being subjected to ceaseless and overwhelming physical pain and the anguish that comes from persistently feeling depleted which may manifest in self-injurious cognitions and behaviors, dysphoria, and interminable resignation;

9) chronic difficulty with unexpressed or explosive anger due to countless losses and difficulties with tolerating distress not just from internal cues but from unrelenting struggles with social systems and structures; and,
10) a sense of incessant alterations in systems of meaning of one’s life, relationships, and future.

C. System- and structure based sources of (re)traumatization persistently prevail upon the person’s, group’s, or community’s existence and well-being requiring engagement in dialogic, participatory, and transformative processes towards meaningful change.

D. Duration of the distress is across the lifespan in varying degrees of severity, oftentimes experienced in frequently shifting levels of distress and well-being.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

CCTSD appears to be fairly common among individuals who have experienced various forms of abuse and neglect beginning early in life and continuing throughout adulthood involving interpersonal and systemic/structural violence. These experiences typically entrench negative and disparaging self-regard in the individual in the form of self-blame, shame, guilt, and at times prohibitive or self-destructive feelings of inadequacy and being a failure. These also pave the way for lifelong self-perceptions of worthlessness, hopelessness, and helplessness often accompanied by depression and substance abuse/dependence adversely affecting the physical, psychological, emotional, academic, social, relational, occupational, and spiritual lives. Social systems and structures are complicit in these experiences, with issues needing to be addressed through collective action.

It is vital that CCTSD, as advanced by this dissertation, contributes to the current discourses on redefining PTSD for DSM-V.

**Undertaking this Project: My Experience**

To discuss some of the more significant aspects of my experience in undertaking this project, I shall use the popular education framework components of context, content, and methodology.
The first part of this discussion is in consideration of the importance popular education places on contextual analysis in order to provide a foundation for deeper understanding of human experiences.

**Context**

I decided to apply for a PhD program in 2005 to conduct this participatory action-research project based reflections of my life at that point in time. These reflections included: feeling that it was time to convene my passions in popular education, trauma psychoeducation, visual arts and visual arts-based methods, conducting research and writing, undertaking analysis and reflection, in the context of my lifelong commitment to and involvement in social change work for nearly twenty years. In addition to this, I felt that it would be helpful to synthesize what I consider to be enormously valuable lessons I have been fortunate enough to learn in actualizing contributions to collective trauma recovery and reconstruction. I was and continue to be animated about helping identify and articulate collective approaches to recovery and reconstruction to contribute to efforts of groups or communities living in contexts of chronic, acute, and continuing trauma-related distress. I worked with numerous individuals and groups who were diagnosed with PTSD, particularly in San Francisco, when the reality was there was nothing ‘post’ about their traumatic stress: the only certainty was the promise of continuing (re)traumatization. I worked with even more individuals and groups, particularly in the Philippines, who were not even fortunate enough to be diagnosed with PTSD. Neither were there any mental health professionals nor an awareness of the need to address such individuals in severely disadvantaged and oppressed, certainly traumatized, circumstances. Furthermore, I felt that I could, with a doctorate degree, be able to contribute in more significant ways, position myself
strategically in sustaining these contributions, and be better able to contribute to people’s efforts at helping themselves bring about meaningful social change.

Bringing various aspects of my passions and my life’s work together in this project felt like a natural, logical next step to what was going on in my life in 2005. At that point, in addition to having been involved in popular education and social change work for over ten years, I had worked as a trauma psychotherapist for nearly five years, including facilitating trauma groups for over two years using some aspects of popular education as framework. The content of these groups, however, was based on a treatment manual which was individual-focused and not participatory, dialogic, or transformative in nature. I felt strongly that it was necessary to design an approach to trauma psychoeducation using popular education as framework with the content and methodology based on participants’ contexts and largely determined in meaningful partnership with them. I nurtured this idea and decided that it would be beneficial to conduct research in this area and actualize a way for this approach to be used. On a more practical level, I wanted to continue to live outside the Philippines in consideration of the lack of educational and employment opportunities and other resources there at the present time, particularly with respect to trauma work.

This project was conducted in partnership with consumers of mental health services and the staff at CCD with whom I was fortunate to have worked. The CCD Coordinator and staff were very supportive of this project and treated me with warmth and respect. The participants were very open and hardworking and made this project the success that it was. These factors played a significant role in my sustained motivation with this project, particularly in preparing for and facilitating the twelve-week group.
Content

I took great pleasure in and valued the processes involved in undertaking this project. This is in reference not just to conducting the TRRG but more to my own processes as researcher and facilitator. These processes included: the nurturing of my passions integrated in this one location and juncture in my life; the conceptualization and implementation of this project in relation to what had transpired thus far in my life; sustaining energy for the project’s many activities even when things seemed to be very encumbered; maintaining diligence, focus when many other things were diverting, remaining open and at the same time critical (including of my own work), and, insisting on doing my best even when I was at my worst.

It would not be possible for me to describe all that I went through during this project but some feelings rise to the surface when I think about these challenges.

I am thrilled with the outcome of this project. The fact that our objectives were, for the most part, realized, particularly in translating pedagogy into action, is very important and precious to me. The group’s decision to advocate for the continuation of the TRRG, actually meeting with CCD staff for this purpose, expressing what they did, and for the CCD staff to be very supportive, was quite enthralling. I was ecstatic with how this project made concrete and positive contributions to the recovery and reconstruction efforts that the participants were undertaking for themselves through the project’s dialogic, participatory, and transformative processes. As stated earlier, this resulted in the participants’ advocating for systemic and structural changes at CCD resulting in the provision of new services, reallocation of funds, reassignment of staff, training of staff to conduct the TRRG, and provision of other resources, for the continuation of the TRRG.
I am very pleased that the participants created a community of mutual learning and support and developed critical consciousness and unity to desire and take concrete steps to sustain this. At certain points during the conduct of this project, I wondered if things would work out, particularly if we would be able to work together to contribute to recovery and reconstruction efforts and actualize collective action. There were days when I felt that things may not translate. I soon realized that these were moments when I would forget: to trust people, trust process, and to be humble enough to allow for things to unfold the way that they need to. I (re)learned many lessons from this and other processes.

I truly value what I have learned about popular education theory, trauma psychoeducation and ensuring more discursive rather than regulative processes, the use of visual arts-based methods and the power behind collective expression and critical analysis, recovery and reconstruction discourses and the various ways that people in deeply distressing contexts are at the same time in positions of strength, and actualizing creative approaches to contributing to advancing meaningful social change.

I do not want to repeat here all that I have learned from this project as I have discussed many of these in this dissertation. Reflecting on these, though, I am left with the feeling of being full. I have learned so much and know that I yearn to continue to learn.

**Methodology**

From the very beginning, from when I first became a popular educator, I tried to make certain that participatory, dialogic, and transformative process were ensured in learning initiatives. I knew that not only is contextualizing key, but that it is imperative that this be done with the meaningful participation of as many participants as possible. I conducted individual needs assessments with most, if not all, potential participants of
initiatives I was involved in and I made certain that participants participated in creating and finalizing the design of these undertakings. Learning was facilitated through dialogue and participatory processes, using as many visual arts-based methods as possible, towards developing critical consciousness to contribute to unifying for collective action. Such was the case with this group.

It was valuable in the beginning to witness how the potential participants of the TRRG were unfamiliar with but certainly welcomed their meaningful participation in the various phases of the group, rather than merely being consulted about them. As a clinician, it was important for me to contribute to this self-empowering process and help enhance opportunities for healing. As a popular educator, I value such opportunities for co-intentional education. Certainly, such participatory processes ensure the relevance of these initiatives in people’s lives and their desire for appropriate transformations in their situations.

Undertaking this project as researcher, facilitator/educator, and clinician was not without its challenges. In the context of participatory approaches, as was used in this project, these co- incidental roles needed to be managed so I was able to simultaneously facilitate the realization not just of the research objectives, but also the educational and clinical ones. It was necessary to be clear about these parallel processes and how to facilitate their translation into psychoeducation initiatives that meaningfully contributed to the participants’ efforts at collective recovery and reconstruction. Schein (2001, p. 228) describes the role of the researcher in clinical settings as involving:

. . . the gathering of data that are created by people seeking help. The researcher in these settings is called in because of his or her helping skills and the subject matter is defined by the client. It is my argument that if the helper takes an attitude of inquiry, this enhances not only the helping process but creates the opportunity for
using the data that are produced to build concepts and theory that will be of use to others.

I found that it was vital to take “an attitude of inquiry” to ensure that I was able to help enhance the concurrent processes of research, psychoeducation, and recovery and reconstruction. Although the research, educational, and clinical needs were equally valuable, however, it was crucial that clinical needs of the participants were, at relevant moments, in the foreground.

In addition, it was essential to identify the appropriate level of involvement with the participants in the context of the nature of these co-incidental roles. Adler and Adler (1987, p. 8) advance the notion of a “continuum of roles researchers can choose to take (e.g., empathic but less involved, fully committed convert) . . . to ensure a fit in the worlds they are studying.” It was vital that I continuously assessed the appropriate level of my involvement with the participants in order to ensure that none of my roles were compromised.

Schein, (2003) describes a category of research where there is “high researcher and high subject involvement” where the researcher’s orientation is to uphold research standards and only secondarily focus on the needs of the participants when the latter’s role is mainly to validate data. Although I diverge from Schein’s notion that participants’ needs are only secondary to research standards, my role involved creating conditions for “high subject involvement” that led not only to generate crucial data using popular education processes but also to ensure that participants’ clinical needs were attended to.

It was valuable to constantly remind myself, while I was undertaking this research study, how it was essential that the research component did not compromise the TRRG, particularly the recovery and reconstruction processes that the participants were actualizing. There were points when I thought that directing conversations towards
illuminating theoretical approaches would be very helpful for my research, but this would not have been sound clinical practice. There were some points in some sessions when I felt compelled to undertake deeper explorations into internal processes of critical consciousness-building, or the use of participatory and dialogic methods, and other similarly interesting discussion points. These would have served my objectives but derailed the more important processes of the group. In these situations, I always opted for what I felt was most beneficial to the participants in terms of their efforts at well-being. It was thus necessary to constantly be aware of how each participant was doing in each session and how the session’s activities were contributing to their efforts at recovery and reconstruction. It was vital not just to ensure that the conversations and activities were doing no harm to the participants, but that the participants were actually benefiting from the group. Working under this principle also made it essential to continuously assess and contextualize these initiatives in the participants’ efforts at individual and collective recovery and reconstruction. It was thus vital to be aware not just of what was happening in the sessions but also what each participant was going through in relation to what was being undertaken in the TRRG. As an essential component of TRFPR, this assessment and contextualization was, in itself, honing the research modality.

Though the conduct of the group was constantly revealing in terms of the research model, it was also crucial to ensure that the methods used in the discussions did not merely serve the purposes of the research component of this study. I was interested in exploring the contributions that visual arts-based methods in the context of popular education makes to collective recovery and reconstruction, but the appropriateness of these methods needed to be carefully and comprehensively analyzed for each activity. There were occasions when I had initially planned to use
visual arts-based methods (eg., in the discussion on healthy and unhealthy relationships) but this did not seem appropriate at the time. It was at these points that I needed to place more importance on the participants’ needs and be comfortable with those decisions.

Another challenge was how to remain neutral and objective, particularly in the conversations about how mental health providers can (re)traumatize mental health consumers in service delivery. It was crucial to be open, not be defensive, and continue to help create a safe and trustful environment, while remaining cognizant of the twin processes of conducting the research and facilitating the TRRG. In the end, the participants appreciated how I was able to handle this rather complex role stating how they “never felt like they couldn’t express themselves” and that I as facilitator was “objective and able to keep things flowing how they should.”

In practical terms, it was challenging to be constantly aware of my dual role as facilitator and researcher. There was a significant amount of information that needed to be simultaneously processed. This included research and clinical material, and how to converge these in a seamless initiative for the purposes of contributing to the participants’ efforts at recovery and reconstruction. All this needed to be undertaken while remaining focused and present, with the appropriate attitude of non-arrogance and openness.

**Suggestions for Future Research**

Areas for future research include exploring the implementation and outcomes of using the TRRG approach in other contexts, particularly where there is extreme poverty, powerlessness, oppression, violence, war, and other forms of continuing trauma. It is common that there are severely limited resources for mental health
services in such contexts, making efforts that respond to the needs of larger numbers of people even more relevant. Examples of this may include research using the TRRG approach with community-based people’s organizations in Third World and inner-city contexts. In addition, future research may also be conducted with specific populations like soldiers, veterans, and their families, indigenous peoples, women’s groups, and youth organizations.

I believe that it is crucial for initiatives like this to be undertaken in resource-constrained contexts as these efforts critically analyze not just individual symptomatologies but systems and structures that entrench (re)traumatization. It is highly likely that people in these situations have and continue to experience repeated distress and may benefit greatly from collective approaches that seek to also address systemic and structural origins of (re)traumatization.

One other area for future research is on expanding the theoretical foundations for the use of popular education as framework in collective trauma psychoeducation with groups or communities, particularly those in contexts of continuing trauma due to community violence or state-sponsored terror or war. In these circumstances of shared trauma, collective approaches such as the TRRG could greatly contribute to addressing individual and group needs for recovery and reconstruction. Organizations working for social change may benefit from acknowledging and addressing the mental health needs of its members in a way that is consistent with participatory, dialogic, and transformative processes. Many organizations, such as the majority of those I worked with in the Philippines, have yet to appreciate and incorporate programs to also address mental health concerns in the context of social change work.

It may also be useful to continue the exploration into other aspects of popular education theory, particularly those of other theorists, in relation to collective trauma
recovery and reconstruction work. This project was not, by any means, able to comprehensively incorporate a consideration of all of Freire’s ideas and it may be advantageous to conduct further study on these, as well as theoretical foundations of approaches of other popular educators.

Further exploration of other visual arts-based methods would be advantageous, particularly with communities that have divergent worldviews, or where there are indigenous forms of visual expression and collective learning. I believe that the identification and use of such methods can provide similar opportunities for collective expression and critical analysis of systems and structures in ways that are culturally sensitive and appropriate.

Another area for future research would be collective meaning-making in the context of trauma recovery and reconstruction with other groups. The use of action-oriented approaches in other settings can be useful in identifying particular adaptations of popular education as frameworks for psychoeducation. Although process-based interventions are more time-consuming, thus difficult to actualize in resource-constrained contexts, the gains in terms of more meaningful recovery and reconstruction make these undertakings cost-effective and worthwhile.

Limitations of the Study

Although fifteen participants were initially recruited to this project, there was attrition and only six remained. Given the intensive nature of the TRRG and the importance of monitoring and constantly assessing the participants’ needs and trauma-related distress, it was beneficial, indeed essential, to have a small group. While the number of participants in this study is limited to six, the smaller number allowed for a deeper engagement with their experiences which contributed to what might be called a
‘thick description’ and rich and nuanced investigation of the meaning of trauma in the lives of these participants. While I would not recommend that other TRRG projects work with large groups, more research is needed to expand the numbers of participants and further develop the ideas outlined here about the application of the TRRG and TRFPR.

Another limitation to be considered is the clinical setting. As with any popular education project, context matters, and so the location of this project has significantly shaped the kinds of data collected and issues that emerged. My background, social location and theoretical stance also shaped the research, the facilitation of the TRRG, the analysis, and the identification of themes. Other research, led by different researchers, who may incorporate other frameworks and worldviews, will likely result in different findings and arguments.

“ASAP”

The participants of the TRRG described living what can be considered a distressing existence among the ruins of their traumatized lives. Through years, even decades, each of them has struggled to recover and reconstruct, oftentimes to experience only the promise of continuing devastation. Their vigorous efforts in the TRRG revealed their individual and collective strength in intensifying their efforts at rebuilding a community of learning and support that actually works for them. They forged their unity to continue working not just to patch up holes or fill in gaps but to reconstruct the very foundations of what they define as lives worth living, asserting in no uncertain terms that systemic and structural origins of (re)traumatization be addressed in ways that contribute to humanization of everyone affected. There is no longer a silence. As Morris (1997, p. 30) states how we
... may confront halting and troubled voices, voices that are angry and confused, hurt, exhausted, foolish, blasphemous. The content of the utterance, while crucial to its writer or speaker, matters less in suggesting (what can be told us) about suffering than the sheer act of speech itself: affliction has at last broken through onto language. We are finally in the presence of words that cross over from the other side of torment.

In response to the question to the participants as to when they would like the TRRG to begin again, they simply replied, “ASAP.” “Yes,” reiterated another, with decided strength of purpose like she never seemed to have ever had before, “ASAP.”
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APPENDICES


A. The person has been exposed to a traumatic event in which both of the following have been present:
(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following
(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
**CERTIFICATE OF APPROVAL - FULL BOARD**

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<td>UBC/Education/Educational Studies</td>
<td>H08-01398</td>
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**INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:**

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**OTHER LOCATIONS WHERE THE RESEARCH WILL BE CONDUCTED:**

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**CO-INVESTIGATOR(S):**

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<th>Name</th>
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<td>Moises Umali Escueta</td>
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**SPONSORING AGENCIES:**

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**PROJECT TITLE:**

Popular Education in Collective Trauma Recovery: Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

**REB MEETING DATE:**

July 10, 2008

**CERTIFICATE EXPIRY DATE:**

July 10, 2009

**DOCUMENTS INCLUDED IN THIS APPROVAL:**

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<th>Date</th>
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<td>June 20, 2008</td>
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<td>July 24, 2008</td>
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The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

**Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:**

Dr. M. Judith Lynam, Chair
Dr. Ken Craig, Chair
Dr. Jim Rupert, Associate Chair
Dr. Laurie Ford, Associate Chair
Dr. Daniel Salhani, Associate Chair
Dr. Anita Ho, Associate Chair
# CERTIFICATE OF APPROVAL – FULL BOARD AMENDMENT

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<tr>
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<td>Vancouver Community</td>
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</table>

Other locations where the research will be conducted:

- N/A

## CO-INVESTIGATOR(S):

- Moises Umali Escueta

## SPONSORING AGENCIES:

- N/A

## PROJECT TITLE:

- Popular Education in Collective Trauma Recovery:
- Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

**Expiry Date** - Approval of an amendment does not change the expiry date on the current UBC BREB approval of this study. An application for renewal is required on or before: **July 10, 2009**

## REB MEETING DATE:

- October 23, 2008

## AMENDMENT(S):

### AMENDMENT APPROVAL DATE:

- October 31, 2008

### Document Name | Version | Date
|-----------------|---------|------|

The amendment(s) and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

### Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

- Dr. M. Judith Lynam, Chair
- Dr. Ken Craig, Chair
- Dr. Jim Rupert, Associate Chair
- Dr. Laurie Ford, Associate Chair
- Dr. Daniel Salhani, Associate Chair
- Dr. Anita Ho, Associate Chair
Vancouver Coastal Health Research Institute (Vancouver Community)  
Research Study  
CERTIFICATE OF APPROVAL

INVESTIGATOR(S):  
BUITENW/CK, Shana - PI  
Ecclesta, Moses Unnal - Co-investigator  
UBC, Department of Educational Studies

TITLE of PROJECT:  
Popular Education in Collective Trauma Recovery: Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

TERM:  
Approval has been granted until July 25, 2008

APPROVAL TO CONDUCT RESEARCH AT VANCOUVER COMMUNITY SITES OF VANCOUVER COASTAL HEALTH RESEARCH INSTITUTE IS BASED ON:

☐ Research Ethics Review and Approval by (name of REB): UBC BREB  
Application No: H08-01398 Approval Date (y/m/d): 2008-07-25
☐ VCH Confidentiality Acknowledgement for Access to Personal Information
☐ Funding Source: N/A
☐ Approval to Conduct Research at VCHRI: Approval No: VC8-033

Approved Sites (list):
☐ Centre for Concurrent Disorders
☐ 
☐ 
☐ 
☐ 

Val Vanessa, RN, MS  
Director, Vancouver Community  
Assistant Director, VCHRI – VC  
Date: 2008-08-27  
Copy: Principal Investigator  
Vancouver Community
Appendix E - Therapists’ Orientation Protocol

THE UNIVERSITY OF BRITISH COLUMBIA

Stage One: Therapists’ Orientation Protocol

Project Title

Popular Education in Collective Trauma Recovery:
Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

Introduction

My name is Mok Escueta, a second-year PhD student at UBC. I am conducting an action-research project that seeks to explore the contributions that popular education, particularly using visual-arts based methods, can make to recovery/reconstruction efforts of communities in contexts of chronic, acute, and continuing trauma. Trauma (whether physical/sexual assault, or organized violence/terror, war) is not simply an event that affects the individual manifested through symptoms. They are incidents that affect us collectively and have root causes in our social systems and structures as evidenced by our shared suffering. The title of this project is ‘Popular Education in Collective Trauma Recovery: Meaning-making in Contexts of Seemingly Inexhaustible Distress.’

This study is designed to contribute to your clients’ efforts at recovery from trauma in the context of collective efforts and is considered as part of your over-all treatment plan here at CCD. This is not a therapy group. It is a psychoeducation group designed to provide information and venues for discussion of various aspects of collective recovery from trauma using popular education, particularly visual arts-based methodologies, as framework. Education, particularly popular education using visual arts methodologies, plays a key role in the process of analyzing the root causes of trauma in order that
these may be addressed through united action. Visual arts-based methodologies can help facilitate the expression of individual and collective distress towards collective meaning-making.

I am currently in the process of recruiting participants to this study and would like to request referrals from you. I am hoping that you will refer clients you work with who meet the criteria for participation in this study.

Inclusion Criteria

The participants who will be selected for this research will be English-speaking adult clients of the Centre for Concurrent Disorders (CCD). They will be individuals who are receiving psychotherapy services for mental health issues, particularly anxiety due to a trauma-related diagnosis. These individuals will be referred by their therapists and to whom participation in the activities (group sessions on trauma and recovery) of this study is clinically-indicated. This is to say that these individuals may benefit from these collective initiatives in the context of other efforts towards recovery. This determination will be based on the therapist's clinical judgment as to whether the individual can benefit from psychoeducation initiatives in a group context based on, but not limited to, the following considerations:
1. whether the individual's efforts at recovery/reconstruction can be significantly enhanced by receiving more information and education about trauma and trauma recovery/reconstruction through discussions with other individuals who have similar experiences;
2. whether the individual can benefit from collective discussions about trauma and trauma recovery/reconstruction and in the process, provide and receive support and learning from other individuals in similar situations that is not possible in individual sessions; and,
3. whether the individual also has needs for recovery/reconstruction that are beyond the individual level including considerations such as rebuilding collective systems and networks of support, reconstructing collective identity, addressing difficulties with creative expression that can be facilitated by group initiatives with other individuals in similar contexts, and responding to systemic barriers to well-being (lack of access to vital supports, services and opportunities). In addition to these, participants need to have adequate skills in self-stabilization or are able to access needed support when the need arises and are able to meet the requirements of group work. They also need to be able to give informed consent to this project and is interested in participating in this action-research.

Criteria:

a. Adult (19 years old and above) English-speaking clients of CCD.
b. Is referred by their individual therapist at CCD.
c. Has trauma-related anxiety possibly with other Axis I issues (substance abuse/dependence, depression).
d. Is able to give informed consent to this study.
e. Is able to agree and adhere to being clean and sober during all group activities.
f. Is able to agree and adhere to not engaging in assaultive or otherwise disruptive or harmful behaviour.
g. Is not actively suicidal.
h. Is not cognitively impaired.
i. Has skills in stabilization and/or is able to take necessary steps to access services/resources when the need arises.

j. May benefit from and is interested in participating in this study.

Exclusion Criteria

Excluded from this study are CCD clients who do not meet the above inclusion criteria. Along with these, clients who are symptomatic and to whom participating in group sessions may result in enhanced risk for harm are excluded from this study. Individuals whose ability to provide informed consent is compromised and are not able to participate in the activities of this research for the length of time it is designed to run are also excluded. Lastly, individuals who, though referred, are not interested in participating in this project.

Recruitment Process

Up to 20 adults who meet the inclusion criteria will be invited to participate in this study; participation will be entirely voluntary.

A project orientation session (please see attached therapists' orientation protocol) will be conducted with the CCD therapists at a staff meeting to begin the process of referring clients. Hard copies of the project's protocol mentioned above will also be provided to therapists prior to this meeting. Therapists will then extend invitations to participate in this study to prospective participants during their individual sessions with their therapists. Therapists will give potential participants copies of the consent form which outlines the purpose, procedures and contact information and will be told that they will have two to three weeks to decide to participate. They will also be asked to inform their therapist about their decision and if they are comfortable with their therapist giving their contact information to the researcher, they will do so to arrange a follow-up meeting. If the potential participant is not comfortable with their contact information being shared, s/he will be instructed to contact the researcher her/himself (the researcher's contact information is on the consent form). This recruitment period will last up to a month to provide CCD therapists adequate time to make a determination as to who may be appropriate to invite to participate in this study. This will likewise provide time for discussions about participating in this study to occur. Discussions about the possibility of coercion in the recruitment of participants will also be undertaken to ensure awareness and prevention of this. The decision to not participate will not have any impact or repercussion on the participant's access to services. The final list of participants will be finalized after discussing these with the researchers.

Once the participants have decided to participate and the researcher has made contact with them, (2 to 3 weeks after referral by their therapist) the researcher will meet with each potential participant to go over the project and answer any questions about the study (please see attached participants' orientation protocol) and to cover important aspects of participation including consent, confidentiality, risks, and benefits. The researcher will show the suggested outline of session topics (see above) to each potential participant to give them an idea of what these sessions might look like. This outline, however, will be finalized after discussions with them. The potential participants will also be asked if there was a sense of coercion to participate in this study and, if so,
this will be addressed. The researcher will ensure the potential participants that they
should not feel any pressure to participate in this study and that if they do, then they
should not participate. The potential participant may choose not to participate in this
study despite being referred. They will also be informed that their decision to participate
or not participate will not have any impact or repercussion on their access to CCD
services.

Following this meeting, the participants will have one month to think about being part of
stage two of this study. This will hopefully provide them with enough time to reflect on
the various aspects of taking part in this study and make an informed decision about
participation. Although prospective participants will be encouraged to participate in this
study to its conclusion, they will have the right to leave the group when they feel that
there is a need to, with no questions asked.

Project Objectives

General Objective
The general objective of this action-research project is to explore the contributions that
popular education (particularly using visual arts-based methodologies) can make to
efforts being undertaken by a group or community collectively experiencing the effects
of chronic, acute, and continuing trauma including the oppressive forces of poverty,
v Violence, and mental health challenges, towards collective recovery/reconstruction.

Specific Objectives
For the Participants:
This study seeks to contribute to the efforts of its partner group or community towards
collective recovery/reconstruction (specifically in terms of collective meaning-making)
from trauma-related distress in the context of psychoeducation using popular education
as framework.
In particular, it is hoped that by the end of this study, the participants will be able to:
1. critically explain the collective effects and systemic/structural roots of trauma and
related (mental health) issues based on their worldviews using visual arts-based
methodologies;
2. enumerate and explain ways to actualize collective recovery/reconstruction from
trauma also using visual-arts based methodologies; and,
3. display more manageable levels of trauma-related distress in the context of
collective meaning-making based on indicators formulated by the participants.

For the Researcher:
This study seeks to identify popular education approaches using visual arts-based
methodologies that can contribute to efforts of groups/communities at
recovery/reconstruction in the context of collective distress due to chronic, acute, and
continuing exposure to trauma.
In particular, it is hoped that by the end of this study, the researcher will be able to:
1. articulate theoretical foundations of initiatives that contribute to efforts of groups at
collective recovery/reconstruction in the context of popular education;
2. identify methodologies, particularly in the context of visual research, that are
relevant to group/community needs for meaning-making in relation to the objectives of
this study; theorize about collective semiotics and collective content analysis; and,
3. Identify approaches and methodologies in the context of this research that may be replicated by other groups/communities experiencing collective trauma-related distress.

Suggested Design

The final design of this research will be undertaken in consultation with the participants. Given this participatory approach, the study involves three stages as follows:

Stage One: Will include a project orientation session with CCD therapists (please see attached therapists' orientation protocol) to facilitate the process of referring clients to participate. Therapists will then extend invitations to participate in this study to some of their clients during their individual sessions with them. The researcher will then meet with each client to answer questions and address concerns they may have regarding participating in this study.

Stage Two: Will include individual interviews (please see attached individual interview protocol) with those who have agreed to participate to inquire about what needs and expectations the participants may have in relation to the nature and content of this project; interviews will last from 1 to 2 hours. A group project orientation (please see attached participants' project orientation protocol) lasting 2 hours will likewise be conducted with all the participants to discuss the details of this study including the data collection procedures. Both of these will be audio recorded with consent of the participants. Once this stage is complete, an addendum to the ethical review will be submitted which describes these specific methods (observation and interview protocols will be also submitted).

The data collection methods discussed will be used in 16 group sessions on trauma and collective recovery will also be conducted at this stage. It is anticipated that the following methods of inquiry will be used for stage two of this research: 1) focus groups, 2) observation data in the form of field notes and video (to include only participants who give consent to being videographed) that will record activities, interactions between participants, and interactions between participants and researcher/facilitator, 3) researcher/facilitator field notes written at the end of each session, 4) gathering of materials generated in stage two including visual artifacts and other text materials (for content analysis, etc.). These group sessions will be audiotaped.

These group sessions will also be documented through photographs and video which will used only for the purposes of this study: analysis of various activities, collective methods used, interactions between participants and between participants and researcher, group dynamics, and other group processes. Only participants who consent to being photo/videographed will be included in photos/videos. Seating, blocking, camera angles, and other special arrangements, including ones that participants may identify, will be made (in a way that these participants are comfortable with) so that those who do not consent to being photo/videographed will not be visible in these. Photographic images identifying any of the participants will not be used in any future publications or reproductions; no video recorded data or excerpts of these identifying any of the participants will become public.
As mentioned earlier, since this study will be conducted using participatory methods, the participants may decide to produce visual images (drawings, illustrations, paintings, photographs, video, etc.) that may also be relevant for analysis. Given that the researcher is also the group facilitator, an observer will be present to help to generate observation data during the group sessions. This observer will be a staff member of CCD who has a background in popular education. The participation of this observer is crucial in several respects: in generating observation data, in identifying contributions that this study may have to CCD group initiatives in terms of methods and approaches, in identifying contributions to other programmatic aspects of service delivery.

Stage Three:
Individual interviews will again take place lasting 1-2 hours and a focus group lasting 2 hours will also be conducted to generate relevant data with respect to the content and methodologies used in this study. Visual images produced in Stage two and at this stage (drawings, illustrations, etc.) may also be analyzed. Aside from serving as sources of data, these individual interviews and focus groups will provide venues for reflection and analysis on the content and process of this study which can also contribute to the participants' recovery/reconstruction efforts.

Possible topics to be covered during the second stage of 16 weekly meetings/workshops include:

I. Project Orientation: Designing this Study
II. Safety and Stabilization
III. The Nature and Impact of Trauma
   A. Different Ways of Defining Trauma Based on Diverse Worldviews
   B. Trauma-related Distress
   C. Individual Trauma
   D. Collective Trauma
IV. Embodied Pain
   A. Physical
   B. Cognitive
   C. Emotional
   D. Spiritual
V. Social Suffering: From Symptoms to Systems
VI. The Nature of and Actualizing Recovery/Reconstruction
   A. Individual
      1. Self-Care and Nurturing
      2. Compassion
      3. Setting Boundaries and Establishing Healthy Relationships
      4. The Split Self and Integration
      5. Individual Meaning Making
   B. Collective
      1. Redefining Collective Identities and Social Roles
      2. Re-establishing Networks of Support
      3. Using Community and Other Resources
      4. Collective Meaning Making
      5. Addressing Collective Issues through Collective Action
VII. Synthesis and Reflection
   A. Lessons and Insights
   B. Next Steps

There will be one staff member of CCD who will be present in these group sessions as an observer.

Stage Three: will involve final individual interviews and a focus group to gather data on the activities and processes undertaken in this project.

Time Needed

Each participant will dedicate a total of 32 hours over a 20-week period to this study. This is made up of the following:
1 to 2 hours for an individual interview and 2 hours for a project orientation which will be conducted at Stage Two.
24 hours for 16 group sessions of 1 hour and 30 minutes each which will also be conducted at Stage Two.
1-2 hours for an individual interview and 2 hours for a focus groups at Stage Three from which additional data for this research will be collected.

Confidentiality

We will respect the right of each participant to confidentiality. This means that their identity will be kept strictly confidential and no one will be identified by name in any reports of the completed study. All documents will be identified only by code number and kept in a locked filing cabinet. This includes all notes, records, photographs, videos, and visual materials produced in the course of this study. All computer files will be password protected. No confidential information will be collected or exchanged by email.

Only limited confidentiality, however, can be offered in focus groups as the researcher cannot control what participants do with information discussed. There is a possibility that identifiable information from these groups may be released by other participants. We will encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed. In addition to this, all allegations that a child may be abused, neglected, or otherwise in need of protection will be reported to the proper authorities as required by the Child, Family and Community Service Act of B.C.

Potential Risks

Potential risks to participating in this research include possible retriggering in the course of exploring trauma-related distress. This means that the participant may experience some distress from being reminded of certain aspects of their past experiences in the course of group sessions. It is important to state, however, that the emphasis of these
discussions will be on dealing with trauma-related distress and not on the traumatic experiences themselves. This will help minimize the possibility of retriggering.

In response to this, however, as stated earlier, it is required that the participant has an individual therapist who they will continue to see and agree to receive services from when additional needs arise. It is their individual therapist who has made the referral for them to be part of this study and the therapist is in the best position to help respond to these needs. Best efforts will be undertaken so that the participant will have the option to meet with their therapist after group sessions. If this is not possible, arrangements will be made so that an on-call therapist is available after each group session, as is possible.

In addition to these steps, the initial stages of this study include discussions on safety and stabilization and a review of effective strategies to deal with trauma-related distress. In order to further enhance the participant's ability to deal with possible retriggering, we will also have discussions on additional strategies to deal with these situations. Each participant will also be provided with a list of resources/services to contact when the need arises. These will be reviewed periodically in the course of this study.

Potential Benefits

Potential benefits to the participant to this study include:
1. significantly enhanced process of recovery/reconstruction from traumatic distress;
2. knowledge about trauma and other mental health issues including information on their nature, symptoms, course, and ways to address these in the context of collective initiatives;
3. enhanced support from fellow participants who most likely share similar experiences and needs;
4. decrease in the sense of isolation commonly associated with trauma;
5. increase in knowledge and skills on coping and responding to systemic and structural roots of traumatic distress in the context of collective efforts;
6. the development of a sense of community which will play a significant role in recovery/reconstruction efforts;
7. increase in a sense of belonging which is an important aspect of trauma recovery;
8. development/enhancement of skills in creative expression of trauma-related distress in the context of meaning-making;
9. decrease in likelihood of experiencing distress when retriggered; and,
10. over-all decrease in trauma-related distress.

The Researcher

I am currently a second-year student in the PhD in Educational Studies program at UBC. I am a Registered Social Worker (RSW) in British Columbia, and a Licensed Clinical Social Worker (LCSW) in California. I hold a Bachelor of Science in Social Work (BSSW) degree from the University of the Philippines (UP), and a Master of Social Work (MSW) degree from San Francisco State University (SFSU).
I have a combined total of over fifteen (15) years of experience as a professional social worker in the fields of mental health (particularly trauma psychotherapy), education work, and community development work. Most of my life and early work experience was amidst great turmoil under the fascist Marcos dictatorship and later under similarly repressive regimes in the Philippines. For most of those fifteen (15) years, I was involved in the conduct of needs assessment, design, facilitation, and evaluation of education initiatives based on Paulo Freire’s popular education framework. I worked with numerous groups and communities in the Philippines including landless peasants, indigenous peoples, urban poor, peasant youth, university students, visual artists, upland farmworkers, lawyers/para-legals, other development workers, people living with HIV/AIDS, volunteer caregivers, and others. I was in leadership and membership positions of several student, advocacy, and professional organizations. I am also a visual artist and have a background in graphics works, 3D, and in conceptualization and production of visual arts-based materials/methodologies in popular education initiatives.

My most recent employment was more than five (5) years as a Clinical Social Worker II with the Trauma Recovery Center (TRC) of the University of California San Francisco (UCSF) School of Medicine where I worked as a trauma psychotherapist in the public sector. As a trauma psychotherapist with the TRC, I provided individual psychotherapy services to adult patients who recently experienced severe trauma and often had histories of poverty, injustice, homelessness, substance abuse and/or chronic mental health issues. In addition to this, I also conducted needs assessment for, designed, facilitated, and evaluated, trauma recovery groups of individuals experiencing distress from trauma and co-existent mental health challenges. Significant aspects of this experience with these and other groups I worked with in the past inform my doctoral research.

My research background includes conducting a study in my Master’s program using methods similar to the ones that will be used in this study (action-research, interviews, focus groups, and analysis of visual images). I also worked as a research assistant at UBC on a project that analyzed visual images. Aside from taking classes in research methods in my Master’s program, I also took a class in Visual Research Methods in my first year in the PhD program at UBC.

My supervisor is Shauna Butterwick, PhD, of the Department of Educational Studies at UBC. She may be contacted at (604) 822.3897 or by email at shauna.butterwick@ubc.ca I can be contacted at (604)671.7276 or by email at mokubc@interchange.ubc.ca

Please feel free to ask questions at this point.

Thank you very much!
Appendix F – TRRG Inclusion and Exclusion Criteria

The Trauma Recovery and Reconstruction Group
The Centre for Concurrent Disorders

Inclusion and Exclusion Criteria

Inclusion Criteria

The participants who were selected for this research were English-speaking adult clients of CCD. They were individuals who were receiving psychotherapy services for mental health issues, particularly anxiety due to a trauma-related diagnosis. These individuals were referred by their therapists and to whom participation in the activities of this study was clinically-indicated. This means that their therapists determined that these individuals would likely benefit from these collective initiatives in the context of other efforts towards recovery and reconstruction that they were undertaking for themselves. In addition to these, participants needed to have adequate skills in self-stabilization, were able to access needed support when the need arose, and were able to meet the requirements of group work. It was also necessary that they were able to give informed consent to this project and were interested in participating in this action-research.

The following criteria were used:

a. Adult (18 years old and above) clients of CCD.
b. Referred by their individual therapist.
c. Has trauma-related anxiety possibly with other Axis I issues (substance abuse/dependence, depression).
d. Is able to give informed consent to this study.
e. Is able to agree and adhere to being clean and sober during all group activities.
f. Is able to agree and adhere to not engaging in assaultive or otherwise disruptive or harmful behaviour.
g. Is not actively suicidal.
h. Is not cognitively impaired.
i. Has skills in stabilization and/or is able to take necessary steps to access services/resources when the need arises.
j. May benefit from and is interested in participating in this study.
Exclusion Criteria

Excluded from this study are CCD clients who did not meet the above inclusion criteria. Along with these, clients who were symptomatic and to whom participating in group sessions may have resulted in enhanced risk for harm were excluded from this study. Individuals whose ability to provide informed consent and participate in the activities of this research for the length of time it was designed to run were compromised were also excluded. Lastly, individuals who, though referred, were not interested in participating in this project.
Stage Two: Participants' Project Orientation Protocol

Project Title

Popular Education in Collective Trauma Recovery:
Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

Introduction

Thank you for agreeing to participate in this study. As we had talked about, I am conducting this action-research project on how education can help in collective trauma recovery. I have spoken with each of you individually and talked about having this group meeting to discuss various aspects of the study. We are now meeting as a group to discuss various aspects of the study. Let us begin with a discussion about this study.

This study is designed to contribute to your efforts at recovery from trauma in the context of collective efforts and is considered as part of your over-all treatment plan here at CCD. This is not a therapy group. It is a psychoeducation group designed to provide information and venues for discussion of various aspects of collective recovery from trauma using popular education, particularly visual arts-based methodologies, as framework. Education, particularly popular education using visual arts methodologies, plays a key role in the process of analyzing the root causes of trauma in order that these may be addressed through united action. Visual arts-based methodologies can help facilitate the expression of individual and collective distress towards collective meaning-making.

Objectives

The objectives of this study are:

General Objective

The general objective of this action-research project is to explore the contributions that popular education (particularly using visual arts-based methodologies) can make to
efforts being undertaken by a group or community collectively experiencing the effects of chronic, acute, and continuing trauma including the oppressive forces of poverty, violence, and mental health challenges, towards collective recovery/reconstruction.

Specific Objectives
For the Participants:
This study seeks to contribute to the efforts of its partner group or community towards collective recovery/reconstruction (specifically in terms of collective meaning-making) from trauma-related distress in the context of psychoeducation using popular education as framework.
In particular, it is hoped that by the end of this study, the participants will be able to:
1. critically explain the collective effects and systemic/structural roots of trauma and related (mental health) issues based on their worldviews using visual arts-based methodologies;
2. enumerate and explain ways to actualize collective recovery/reconstruction from trauma also using visual-arts based methodologies; and,
3. display more manageable levels of trauma-related distress in the context of collective meaning-making based on indicators formulated by the participants.

For the Researcher:
This study seeks to identify popular education approaches using visual arts-based methodologies that can contribute to efforts of groups/communities at recovery/reconstruction in the context of collective distress due to chronic, acute, and continuing exposure to trauma.
In particular, it is hoped that by the end of this study, the researcher will be able to:
1. identify ways to contribute to efforts of groups at collective recovery/reconstruction in the context of popular education;
2. identify methodologies that are relevant to group/community needs for meaning-making in relation to the objectives of this study; and,
3. identify approaches and methodologies in the context of this research that may be replicated by other groups/communities experiencing collective trauma-related distress.

The final design of this research will be undertaken in consultation with the participants. Given this participatory approach, the study involves three stages as follows:

Stage one involved the recruitment of participants. You have gone through this process of being referred by your therapist and you deciding to participate. This also includes the individual interviews conducted with each one of you. We talked about what needs and expectations they may have in relation to the nature and content of this group.

Stage Two: This stage includes this project orientation which is being conducted for us to discuss the details of this study including topics and data collection methods which we will be talking about later.

The data collection methods we will be talking about will be used in the 12 group sessions on trauma and collective recovery that will be also be undertaken in this stage. These group sessions will be audiotaped.

Possible topics for these 16 group sessions include:
I. Project Orientation: Designing this Study
II. Safety and Stabilization

III. The Nature and Impact of Trauma
   A. Different Ways of Defining Trauma Based on Diverse Worldviews
   B. Trauma-related Distress
   C. Individual Trauma
   D. Collective Trauma

IV. Embodied Pain
   A. Physical
   B. Cognitive
   C. Emotional
   D. Spiritual

V. Social Suffering: From Symptoms to Systems

VI. The Nature of and Actualizing Recovery/Reconstruction
   A. Individual
      1. Self-Care and Nurturing
      2. Compassion
      3. Setting Boundaries and Establishing Healthy Relationships
      4. The Split Self and Integration
      5. Individual Meaning Making
   B. Collective
      1. Redefining Collective Identities and Social Roles
      2. Re-establishing Networks of Support
      3. Using Community and Other Resources
      4. Collective Meaning Making
      5. Addressing Collective Issues through Collective Action

VII. Synthesis and Reflection
   A. Lessons and Insights
   B. Next Steps

These group sessions will also be documented through photography and/or videotaping if you have given consent. These photographs and video will be used only for the purposes of this study: analysis of various activities, collective methods used, interactions between participants and between participants and researcher, group dynamics, and other group processes. Only if you consent to being photographed and/or videotaped will you be included in photos and/or videos. If you do not wish to be photographed or videotaped, seating, blocking, camera angles, and other special arrangements, including ones that you may identify, will be made (in a way that participants are comfortable with) so that you will not be visible in these. Photographs identifying any of the participants will not be used in any future publications or reproductions; no video or excerpts of these identifying any of the participants will become public.

Stage three will involve final individual interview and a focus group interview to reflect on the process.

Time Needed

Each participant will dedicate a total of 26 hours over an 18-week period to this study. This is made up of the following:
1 to 2 hours for an individual interview in Stage One and 2 hours for a project orientation which will be conducted at Stage Two.
24 hours for 16 group sessions of 1 hour and 30 minutes each which will also be conducted at Stage Two.
1-2 hours for an individual interview and 2 hours for a focus groups at Stage Three from which additional data for this research will be collected.

Confidentiality

We will respect the right of each participant to confidentiality. This means that your identity will be kept strictly confidential; you will not be identified by name in any reports of the completed study. All documents will be identified only by code number and kept in a locked filing cabinet. This includes all notes, records, photographs, videos, and visual materials produced in the course of this study. All computer files will be password protected. No confidential information will be collected or exchanged by email. Only limited confidentiality, however, can be offered in focus groups as the researchers cannot control what participants do with information discussed. There is a possibility that identifiable information from these groups may be released by other participants. We will encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed. In addition to this, all allegations that a child may be abused, neglected, or otherwise in need of protection will be reported to the proper authorities as required by the Child, Family and Community Service Act of B.C.

Potential Risks

Potential risks to participating in this research include possible retriggering in the course of exploring trauma-related distress. This means that the participant may experience some distress from being reminded of certain aspects of their past experiences in the course of group sessions. It is important to state, however, that the emphasis of these discussions will be on dealing with trauma-related distress and not on the traumatic experiences themselves. This will help minimize the possibility of retriggering.

In response to this, however, as stated earlier, it is required that the participant has an individual therapist who they will continue to see and agree to receive services from when additional needs arise. It is their individual therapist who has made the referral for them to be part of this study and the therapist is in the best position to help respond to these needs. Best efforts will be undertaken so that the participant will have the option to meet with their therapist after group sessions. If this is not possible, arrangements will be made so that an on-call therapist is available after each group session, as is possible.

In addition to these steps, the initial stages of this study include discussions on safety and stabilization and a review of effective strategies to deal with trauma-related distress. In order to further enhance the participant's ability to deal with possible retriggering, we will also have discussions on additional strategies to deal with these situations. Each participant will also be provided with a list of resources/services to contact when the need arises. These will be reviewed periodically in the course of this study.
Potential Benefits

Potential benefits to the participant to this study include:
1. significantly enhanced process of recovery/reconstruction from traumatic distress;
2. knowledge about trauma and other mental health issues including information on their nature, symptoms, course, and ways to address these in the context of collective initiatives;
3. enhanced support from fellow participants who most likely share similar experiences and needs;
4. decrease in the sense of isolation commonly associated with trauma;
5. increase in knowledge and skills on coping and responding to systemic and structural roots of traumatic distress in the context of collective efforts;
6. the development of a sense of community which will play a significant role in recovery/reconstruction efforts;
7. increase in a sense of belonging which is an important aspect of trauma recovery;
8. development/enhancement of skills in creative expression of trauma-related distress in the context of meaning-making;
9. decrease in likelihood of experiencing distress when retriggered; and,
10. over-all decrease in trauma-related distress.

As I mentioned in our individual interview, this study is participatory in nature. What has been prepared and just presented to you is only a suggested design. This means that we will decide the various aspects of this study, including what we want to talk about, how we want to talk about these, and how we will gather information about what we do together.

The following questions are designed to begin this conversation. Please answer the following as best you can.

1. What collective needs for trauma recovery do you hope will be addressed by our group sessions?
2. What topics on trauma and recovery would you like to discuss in our group sessions?
3. What methods would you like to use in discussing these topics?
4. What methods for gathering data would you like to use to gather information about these group sessions?
5. What works best for you in terms of schedules for our group sessions?

Thank you very much!
CONSENT FORM

(This consent is for a research that is part of a thesis for a doctoral degree.)

Title of Study

Popular Education in Collective Trauma Recovery:
Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

Principal Investigator: Shauna Butterwick, PhD
Faculty, Department of Educational Studies
(604) 822.3897

Co-Investigator(s): Mok Escueta, MSW, RSW
PhD Candidate, Department of Educational Studies
(604) 671.7276

Purpose:
You are being invited to take part in this participatory action-research because you are a client of the Centre of Concurrent Disorders (CCD) and have experienced trauma-related distress and, possibly, other mental health concerns. Your individual therapist has made this referral based on the belief that it is appropriate for you to participate in this study and that doing so would be beneficial to you. This is not a therapy group, it is an educational one.

This study seeks to contribute to your efforts at recovery from trauma and other mental health issues along with other individuals in similar situations through education and skills building courses. A special emphasis of this group is collective approaches to recovery using visual arts-based methodologies to address collective needs.

Study Procedures:
You will be asked to dedicate a total of 26 hours over an 18-week period to this study. This is made up of the following:
There will be an individual interview lasting 1-2 hours and a 2-hour project orientation which will be conducted at the beginning of this study to discuss details of this study.
For this individual interview, you will be asked about your individual needs and expectations regarding the content, methodology, and other aspects of participating in this study. For the project orientation, we will be discussing details of this study in terms of participants’ collective needs, topics, methods, ways to gather data, and scheduling.

There will be 12 weekly group sessions lasting 1 hour and 30 minutes each for a total of 18 hours. Each group session will cover a different topic dealing with various aspects of trauma recovery ranging from safety and stabilization skills to approaches to collective responses to trauma. Discussions during these weekly meetings will involve using arts-based methods such as taking photographs, creating drawings, making collages, etc. These art forms will be used because they are powerful ways to express the meaning of certain experiences that you have. There will be one staff member of CCD who will be present in these group sessions as an observer. These group sessions will be documented through digital audio recording.

These group sessions will also be documented through photographs and video recording if you give consent to being photographed and/or videotaped. If you do not want to be photographed and/or videotaped, special arrangements will be made with seating, blocking, camera angles, and other ways, so that you will not be visible in these. Photographs identifying any of the participants will not be used in any future publications or reproductions; no video taken or excerpts of these identifying any of the participants will become public.

There will also be an individual interview lasting 1½ hours and 2-hour focus group towards the end of this study from which additional data will be collected including your ideas and reflections about the activities of this study. For this individual interview, you will be asked about what you learned, what approaches worked for you, and recommendations you may have regarding the group sessions. For the focus group, we will discuss lessons learned as a group, what approaches worked for participants, and recommendations the group may have for the group sessions.

Potential Risks:
Potential risks to participating in this research include possible retriggering in the course of exploring trauma-related distress. This means that you may experience some distress from being reminded of certain aspects of your past experiences in the course of our group sessions. It is important to state, however, that the emphasis of our discussions will be on dealing with trauma-related distress and not on the traumatic experiences themselves. This will help minimize the possibility of retriggering.

It is therefore required that you have an individual therapist who you will continue to see and agree to receive services from when additional needs arise. It is your individual therapist who has made the referral for you to be part of this study and s/he is in the best position to help you respond to these needs. Best efforts will be undertaken so that you will have the option to meet with your individual therapist after group sessions. If this is not possible, arrangements will be made so that an on-call therapist is available after each group session.

The initial stages of this study include discussions on safety and stabilization and a review of effective strategies to deal with trauma-related distress. In order to further enhance your ability to deal with possible retriggering, we will also have discussions on
additional strategies to deal with these situations. You will also be provided with a list of resources/services to contact when the need arises. These will be reviewed periodically in the course of this study.

There are also risks to confidentiality from the nature of group activities. Please refer to the Confidentiality section of this Consent for more information on this.

Potential Benefits:
Potential benefits to you as a participant to this study include:
1. significantly enhanced process of recovery/reconstruction from traumatic distress;
2. knowledge about trauma and other mental health issues including information on their nature, symptoms, course, and ways to address these in the context of collective initiatives;
3. enhanced support from fellow participants who most likely share similar experiences and needs;
4. decrease in the sense of isolation commonly associated with trauma;
5. increase in knowledge and skills on coping and responding to systemic and structural roots of traumatic distress in the context of collective efforts;
6. the development of a sense of community which will play a significant role in recovery/reconstruction efforts;
7. increase in a sense of belonging which is an important aspect of trauma recovery;
8. development/enhancement of skills in creative expression of trauma-related distress in the context of meaning-making;
9. decrease in likelihood of experiencing distress when retriggered; and,
10. over-all decrease in trauma-related distress.

Potential benefits to other members of society, particularly groups/communities that have experienced trauma-related distress include:
1. identification of education approaches that will contribute to efforts of groups at collective recovery/reconstruction;
2. identify methodologies that are relevant to responding to group/community needs for meaning-making towards collective recovery/reconstruction;
3. identify approaches and methodologies that may be replicated by other groups/communities experiencing collective trauma-related distress.

The findings of this study will also be shared with you. This will be undertaken by conducting a group session to discuss the findings of this study. It is hoped that this information may also benefit you or contribute to your efforts at recovery/reconstruction. You will be notified at the appropriate time when and where this will be conducted.

Confidentiality:
1. Your identity will be kept strictly confidential; you will not be identified by name in any reports of the completed study. All documents will be identified only by code number and kept in a locked filing cabinet. This includes all notes, records, photographs, videos, and visual materials produced in the course of this study. All computer files will be password protected. No confidential information will be collected or exchanged by email.
2. Only limited confidentiality can be offered in focus groups as the researchers cannot control what participants do with information discussed. There is a possibility that identifiable information from these groups may be released by other participants. We will encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group; however, we cannot control what other participants do with the information discussed.

3. All allegations that a child may be abused, neglected, or otherwise in need of protection will be reported to the proper authorities as required by the Child, Family and Community Service Act of B.C.

Remuneration/Compensation:
In order to defray the cost of transportation each participant will be provided with a bus ticket for each session attended. These will be given at the end of each session.

Contact for information about the study:
If you have any questions or desire further information with respect to this study, you may contact Shauna Butterwick, PhD or one of her associates at (604) 822.3897.

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your access to further services from this Centre.

Your signature below indicates that you have received a copy of this consent form for your own records. Your signature also indicates that you consent to participate in this study.

<table>
<thead>
<tr>
<th>Participant’s Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td>Printed Name of Participant</td>
<td></td>
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</tbody>
</table>

Consent to Photography, and/or Videotaping
Your signatures below indicate your consent to or consent to special arrangements with respect to being photographed and/or videotaped. Please check the appropriate box.

Photography □ Yes □ No, but give consent to special arrangements as outlined in the Study Procedures.

<table>
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<tr>
<th>Participant’s Signature</th>
<th>Date</th>
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Videotaping □ Yes □ No, but give consent to special arrangements as outlined in the Study Procedures.

| Participant’s Signature | Date |
Appendix I – First Individual Interview Protocol

THE UNIVERSITY OF BRITISH COLUMBIA

Stage Two: Individual Interview Protocol

Popular Education in Collective Trauma Recovery: Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

Thank you for agreeing to participate in this study. As we had talked about, I am conducting this action-research project on how education can help in collective trauma recovery. This study is designed to contribute to your efforts at recovery from trauma in the context of collective efforts and is considered as part of your over-all treatment plan here at CCD. This is not a therapy group. It is a psychoeducation group designed to provide information and venues for discussion of various aspects of collective recovery from trauma.

I am conducting this initial interview to get some information about your current situation and some ideas about your needs and expectations about participating (we will talk about these again at the beginning of our group sessions). This information will be used in the process of designing the activities of this study.

1. What about your current situation made you interested in participating in this study?
2. What are your individual and collective needs for recovery do you have do you feel might be responded to by this group?
3. What are your expectations about this group in terms of the following:
   a. content (what we’ll talk about)
   b. methodology (how we’ll talk about these matters)
   c. other participants (who and how they will be)
   d. facilitator (how this will be facilitated)
   e. logistics (time, place, other arrangements)
4. What strategies have you found useful in responding to your needs for recovery?
5. Do you have concerns about participating in this group? Please explain.
Stage Two: First Group Discussion Protocol

Popular Education in Collective Trauma Recovery: 
Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

Thank you for agreeing to participate in this study. As we had talked about, I am conducting this action-research project on how education can help in collective trauma recovery. This study is designed to contribute to your efforts at recovery from trauma in the context of collective efforts and is considered as part of your over-all treatment plan here at CCD. This is not a therapy group. It is a psychoeducation group designed to provide information and venues for discussion of various aspects of collective recovery from trauma.

I am conducting this focus group to discuss the ideas that we talked about in the individual interviews about the design of the 12 sessions. We will be talking about what topics will be good to talk about in our weekly sessions and how we will be talking about them. We will also be talking about other aspects of the group. Lastly, we shall be discussing the research component of this project.

Welcome and Introductions
Let us introduce each other by mentioning our names and saying something about ourselves. Please keep in mind what we talked about regarding not mentioning details of our traumatic experiences or other information that may potentially be retriggering to others.

Expectations Check
Group Guidelines
I. Introductions
II. Expectations Check
III. Group Guidelines
6. What about your current situation made you interested in participating in this study?
7. What are your individual and collective needs for recovery do you have do you feel might be responded to by this group?
8. What are your expectations about this group in terms of the following:
   a. content (what we'll talk about)
   b. methodology (how we'll talk about these matters)
   c. other participants (who and how they will be)
   d. facilitator (how this will be facilitated)
   e. logistics (time, place, other arrangements)
9. What strategies have you found useful in responding to your needs for recovery?
10. Do you have concerns about participating in this group? Please explain.
Appendix K - Second Group Discussion Protocol

THE UNIVERSITY OF BRITISH COLUMBIA

Stage Three: Second Group Discussion Protocol

Popular Education in Collective Trauma Recovery: Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

Thank you very much again for your participation in this study. At this point, I would like to ask a few questions regarding your experience as a group, particularly what you have learned and what you feel may be helpful in conducting this group again in the future.

Please answer the following questions as best you can:

1) What is your general reaction to the activities of this project?

2) What lessons did you learn from it? In what ways do you feel that these lessons might relevant to you?

3) What collective needs for trauma recovery were addressed by our group sessions?

4) Which topics do you feel were useful? To others who might be interested in participating in a group like this in the future?

5) What methods or approaches do you feel were helpful to you? To others who might be interested in participating in a group like this in the future?

6) Any final comments or suggestions?
Stage Three: Second Individual Interview Protocol

Popular Education in Collective Trauma Recovery: Visualizing Meaning in Contexts of Seemingly Inexhaustible Distress

Thank you very much again for your participation in this study. I would like to remind you that you are not required to answer these questions; you can decline to answer any without repercussions. I also would like to remind you that if you have any concerns about your treatment as a subject of this research you may contact the Research Subject Information Line in the UBC Office of Research Services at (604)822-8598 or if long distance email to RSIL@ors.ubc.ca. At this point, I would like to ask a few questions regarding your experience as an individual, particularly what you have learned and what you feel may be helpful in conducting this group again in the future.

Please answer the following questions as best you can:

1. Do you have anything to add in terms of your general reaction to this project?

2. Do you have anything to add in terms of the following:
   - topics -
   - methods –
   - facilitation –
   - other participants –
   - venue –
   - schedule/time –
   - food –
   - materials used –
   - other aspects of the group -
3. What are your thoughts and feelings about the participatory and participant-centered process we underwent in this group?

4. How did you feel about coming to group weekly?

5. What was it like being in this particular group? About participating in the activities and discussions?

6. How did you feel about interacting with the other group members from the beginning and throughout the 12 weeks?

7. How do you feel about the quality of interactions between you and the other participants? The facilitator?

8. How was your comfort level with the group from the beginning and throughout the 12 weeks, with expressing yourself, exchanging ideas, discussing differing ideas, and coming together on common ideas towards action?

9. What lessons did you learn from it? In what ways do you feel that these lessons might relevant to you?

10. What of your needs for trauma recovery and reconstruction were addressed by our group sessions?

11. What did you not like about this group? What would you change about this group?

12. Which topics do you feel were useful to you? To others who might be interested in participating in a group like this in the future?

13. What methods or approaches do you feel were helpful to you? To others who might be interested in participating in a group like this in the future?

14. How do you feel about the community of support and collective identity that were created?

15. Any final comments or suggestions?
Appendix M - TRRG Group Guidelines

Trauma Recovery and Reconstruction Group
The Centre for Concurrent Disorders

Suggested Group Guidelines/Group Rules

- Please come on time. The group starts at 3:00 and will end at 4:30.
- Please silence all cell phones. Please refrain from making or taking calls unless it is an emergency.
- Please respect whoever is speaking. Let us have only one speaker at a time. Please be conscious of how much time we take in speaking as we want to make sure that everyone has the opportunity to express themselves.
- Respect other people’s views and opinions. We are different, have different experiences and this is fine.
- Please be clean and sober for group. We will ask you to leave if you are intoxicated or are otherwise under the influence of substances.
- Please respect each other. No name calling, swear words, or insults.
- Assaultive or disruptive behaviour is not acceptable in group and anyone who engages in these will be asked to leave.
- Everything we are going to be talking about in group is confidential. Please refrain from disclosing any names, information, or content, particularly any that in any way could identify or refer to a fellow participant. This is an important point as we are building safety and trust in our group.
- Please feel free to let the group know if you need to step out during group for whatever reason and not just get up and leave.
- Please inform Mok (604.671.7276) or CCD (604.255.9843) if you are unable to make it to a session. 3 unexcused absences will mean that you are out of the group.
Appendix N - Coping Skills Self-Inventory

Trauma Recovery and Reconstruction Group
The Centre for Concurrent Disorders

A Self-Inventory of Some Examples of Safe Coping Skills
(Please check the appropriate column on the right.)

<table>
<thead>
<tr>
<th>Coping Skill</th>
<th>Able to Use Often</th>
<th>Able to Use Sometimes</th>
<th>Have Not Used But Would Like to Try To</th>
<th>Unable to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask for help. Reach out.</td>
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<td></td>
<td></td>
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<tr>
<td>Inspire yourself.</td>
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<td>Set a healthy boundary. Say ‘no’ to protect yourself.</td>
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<td>Leave a bad situation.</td>
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<td>Persist. Never give up.</td>
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<td>Honestly express your thoughts and feelings.</td>
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<td>Seek understanding first, not blame. Learn to analyze your behaviour and grow from what you learn.</td>
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<td>Pace yourself. If things feel overwhelming, take it slow, if things seem to be stagnant, make things go faster.</td>
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<td>Notice exactly when you make a bad decision. Think about this moment, what goes on, and ways to make healthier choices.</td>
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<td>When in doubt, choose the healthier option though it is usually the most difficult.</td>
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<td>Coping Skill</td>
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<td>Ask others if what you believe is accurate, what you do is healthy.</td>
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<td>Above all, do what heals. Focus your energies on what matters.</td>
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<td>Trust the process, keep moving forward as the only way out is through.</td>
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<td>Engage in healthy activities.</td>
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<td>Expect growth to feel uncomfortable.</td>
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<td>Let go of destructive relationships. If it can’t be fixed, detach.</td>
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<td>Detach from emotional pain. Practice grounding.</td>
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<td>Keep working on the material. Practice and participation help.</td>
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<td>Focus on now and how to make today better, not how bad the past was or the future might be.</td>
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<td>Replace destructive activities.</td>
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<td>Pretend you like yourself and see how differently the day goes.</td>
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<td>There are usually different sides of you that see and feel differently about things (substance use, relationships, old behaviours, etc.). Accept that they are there for a reason and try to integrate the split self.</td>
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<td>Praise yourself.</td>
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<td>Nurture yourself, do something you enjoy.</td>
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<td>Practice delaying a self-destructive act as long as possible, if you can’t avoid doing it.</td>
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<td>When in doubt, don’t. If you suspect danger, stay away.</td>
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<td>Fight the trigger.</td>
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<td>Notice the source of criticism or advice before accepting it.</td>
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<td>Do what you know helps even if you don’t feel like it.</td>
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<td>Choose the best solution you can right now. Don’t wait.</td>
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<td>Attend a meeting.</td>
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<td>Get others to support your recovery</td>
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<td>Protect yourself from illness. Engage in safe activities.</td>
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<td>Reach for and use community resources.</td>
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<td>Notice what you can control.</td>
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<td>Learn from experience.</td>
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<td>Solve the problem. Don’t always take things personally.</td>
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<td>Watch for danger signs. Don’t ignore red flags.</td>
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<td>Talk yourself through difficult times. Do positive self-talk to validate how hard things can get for you sometimes and that you will get through this, too.</td>
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<td>Have a good cry.</td>
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<td>Be compassionate to yourself. Care for and respect yourself.</td>
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<td>Do the best you can with what you have. Make the most of what you have.</td>
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<td>Create meaning. Recreate meaning.</td>
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<td>Choose self-respect.</td>
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<td>Discover! Find out if what you believe in your head to be true is true.</td>
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<td>Take good care of your body. Do what is healthy.</td>
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<td>List your options. Don’t accept that you always have one choice only.</td>
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<td>Try something new; sometimes anything is better that old ways.</td>
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<td>Structure your day to do healthier things.</td>
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<td>Set an action plan ahead of time; do what is healthier.</td>
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<td>Create new ‘tapes.’</td>
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<td>Protect yourself from destructive people, bad situations, and substances.</td>
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<td>Talk to yourself gently and stop being hard on or punishing yourself.</td>
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<td>Plan things out. Don’t act on impulse.</td>
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<td>Setbacks are not failures.</td>
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<td>Find new rules to live by.</td>
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<td>Identify negative beliefs and work on them.</td>
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<td>Tolerate the feeling. No feeling is final; help yourself get through it safely.</td>
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<td>Think of the consequences of what you do tomorrow, next week, next year.</td>
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<td>Find a healthy way to reward yourself.</td>
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<td>Set a deadline. Make healthy things happen at a specific date.</td>
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<td>Make a commitment and praise yourself when you do what's right in recovery.</td>
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<td>Listen to your needs.</td>
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<td>Rethink things. Think in a way that helps you feel better.</td>
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<td>Attend sessions.</td>
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<td>Create a buffer. Put something between you and danger (time, distance, inaccessibility.)</td>
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<td>Say what you really think when it is appropriate.</td>
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<td>Get organized.</td>
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<td>Choose safety. Stay safe.</td>
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<td>Notice the cost of negative behaviours.</td>
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<td>Move toward the opposite of what is harmful.</td>
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<td>Replay a negative scene in your mind to review it and what you can do better next time.</td>
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<td>Use kinder language when you talk to yourself and others.</td>
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<td>Create mental pictures of healthier situations (going to your ‘safe place.’)</td>
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<td>If one way does not work, try another.</td>
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<td>Link PTSD, depression, and substance use.</td>
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<td>Alone is better that being in a bad relationship.</td>
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<td>Act. Don’t wait around until you feel motivated. Start now.</td>
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<td>Create a new story of your life. Rewrite being a ‘victim’ to being a ‘hero.’</td>
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<td>Avoid avoidable suffering. Prevent bad situations, events, and relationships in advance.</td>
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<td>Prioritize healing above all.</td>
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Appendix O – Examples of Cognitive Distortions

Trauma Recovery and Reconstruction Group
The Centre for Concurrent Disorders

Some Examples of Automatic Negative Patterns of Thinking

1. **Mind Reading**: You assume that you know what people think without having sufficient evidence of their thoughts: ‘That person thinks I’m a loser.’ ‘She does not like me.’ ‘He will never want to be with me.’

2. **Fortunetelling**: You predict the future negatively. Things will get worse, or there is a danger ahead. ‘I’ll just relapse again, anyway.’ ‘Things will just be as bad as before, nothing will change.’ ‘I’m gonna fail like I always do.’

3. **Catastrophizing**: You believe that what has happened or will happen will be so awful and unbearable that you won’t be able to stand it. ‘I’ll lose everything.’ ‘It’s hopeless, I should just stop trying. It will just be a disaster like it always is.’

4. **Labelling**: You assign global negative to traits about yourself or others. ‘I’m undesirable.’ ‘Once an addict, always an addict.’ ‘He’s a bad person.’ ‘He’s a basket case.’

5. **Discounting Positives**: You claim that the positive things you or others do are trivial. ‘Yeah, well, I did so many things wrong in the past, it doesn’t matter that I did well today.’ ‘So what if I did well, I’m still a bad person.’ ‘Yeah, I was only clean and sober for a month. I’ve relapsed and am using again. I’m hopeless.’

6. **Negative Filtering**: You focus almost exclusively on the negatives and seldom notice the positives. ‘Look at all the people who don’t like me.’

7. **Overgeneralizing**: You perceive a global pattern of negatives on the basis of a single incident. ‘This always happens to me. I always fail. I’m just hopeless.’

8. **Black or White Thinking**: You view events or people in all-or-nothing terms. ‘I got rejected before, I’ll always get rejected.’ ‘That didn’t work so nothing will.’

9. **Shoulds**: You interpret events in terms of how things should be, rather than simply focusing on what is. ‘I should not be in this situation at this point in my life by now.’ ‘I should do well and if I don’t that just means I’m a failure, as always.’

10. **Personalizing**: You attribute a disproportionate amount of the blame to yourself for negative events, and fail to see that certain events do not have anything to do with you. ‘He looked at me strangely; I must have done something wrong.’ ‘She did not smile at me, she must not like me. Why do people not like me?’
11. **Blaming:** You focus on the other person as the source of your negative feelings, and you refuse to take responsibility for changing yourself or not making your well-being dependent on others. ‘If you treated me better then I wouldn’t have used.’ ‘If you would just stop making me feel bad, then things would be great. You always make me feel bad.’

12. **Unfair Comparisons:** You interpret events in terms of standards that are unrealistic – for example, you focus primarily on others who do better than you and find yourself in the comparison. ‘She’s more successful than I am.’ ‘They are all doing better than I am.’

13. **Regret Orientation:** You focus on the idea that you could have done better in the past, rather than on what you can do better now. ‘If only I worked on myself when I was young.’ ‘If only I did not start using.’

14. **What If?** You keep asking a series of questions about ‘what if’ something happens, and you fail to be satisfied with any of the answers. ‘Yeah, but what if I fail?’ ‘What if people in the group don't like me?’ ‘What if things don't go well?’

15. **Emotional Reasoning:** You let your feelings guide your interpretation of reality. ‘I still always feel depressed so nothing I'm trying is working.’

16. **Inability to Disconfirm:** You reject any evidence or arguments that might contradict your negative thoughts. For example, when you have the thought, ‘I'm unlovable,’ or ‘Nobody likes me,’ or ‘I'm hopeless,’ you reject any evidence that this is not true.

17. **Judgement Focus:** You view yourself, others, and events in terms of evaluations as good-bad or superior-inferior, rather than simply describing, accepting, or understanding. You are continually measuring yourself and others according to arbitrary standards, and finding that you and others fall short. You are focused on the judgements of others as well as your own judgements of yourself. ‘I'm not attractive enough or good enough for others to like me.’ ‘I'm just a failure. I'm hopeless as I have always been.’ ‘Look how they like her. Nobody likes me.’

18. **Sympathism.** You constantly strive to gain the sympathy of other by regarding yourself or your situation to always be in a bad state or that you are a victim. You regard this as your identity and refuse to consider that you have and that you can use your power to being about change. You also use this to make others like you or care for you. ‘Yeah, I had a bad life. Poor me.’

Appendix P – Action Discussion Document

The Trauma Recovery and Reconstruction Group
The Centre for Concurrent Disorders

Action Discussion Document

We identified how systems and structures facilitate retraumatization based on a discussion of systemic and structural sources of distress. These include:

**Home/Family**
- use of violence, abuse, neglect towards family members
- existence of continuing abuse in the form of blaming, shaming, trivializing, threat, denial, and brushing off
- lack of understanding among family members of trauma and related depression and substance abuse, their symptoms, and how they affect a person’s life; and,
- lack of efforts and services to address family issues particularly with individuals who have themselves been traumatized and manifest these through abusive behaviours.

**Social Services**
- lack of understanding among social service providers of trauma and related depression and substance abuse, their symptoms, and how they affect a person’s life; and,
- inadequacy/insensitivity of services and service delivery that consider the effects of these mental health challenges and to provide effective interventions and services;

**Mental Health Services**
- lack of understanding, denial, or trivializing among mental health providers (psychiatrists, psychotherapists, clinical social workers) of trauma and related depression and substance abuse, their symptoms, and how they affect a person’s life;
- inadequacy of mental health services that and competencies among mental health providers to consider and effectively help clients work on the effects of these mental health challenges; and,
- existence of disempowering or abusive relationships and service delivery that exacerbate trauma-related distress.

**In General Terms with Respect to Service Providers**
- lack of compassion on the part of service providers for people suffering from trauma and related depression and substance use (question asked as to how compassion can be developed in others?); and,
- ill-treatment experienced from service providers who are suffering from compassion fatigue or vicarious/secondary traumatization.
Gaps and Strategies

We identified gaps that need to be addressed after analyzing the above. These include needs for strategies involving:

1. Helping service providers and other individuals and groups involved in our care to understand what trauma and related depression and substance abuse/dependence really are and how these affect consumers.

2. Explore ways to assist in identifying and managing compassion fatigue or vicarious/secondary traumatization.

3. Helping service providers and other individuals and groups involved in our care to acquire competencies in working with consumers experiencing distress from trauma and related depression and substance abuse/dependence.

4. Advocacy for an end to discrimination against consumers of mental health services in the forms of labeling, regarding them ignorant or as individuals who are simply wanting to scam the system.

5. Advocacy for an end to victim blaming or victimizing of consumers of mental health services.

6. Helping service providers and other individuals and groups involved in our care to understand the course of trauma-related distress and related depression and substance use throughout lifetimes (many individuals suffer from chronic distress through years, even several decades).

7. Address continuing needs of our group in terms of continuing a group for maintenance. Continuing needs identified in terms of psycho-education and support. Particular emphasis on family interventions, developing family as well as community support, and prevention of anticipated (re)traumatization (anniversaries, upcoming events or finding oneself in distressing contexts). Desire to recruit new members and expand the group.

Possible Action Steps

The following possible action steps were identified:

1. Panel presentation with service providers (CCD, VCH, Fraser Health, Raincity Housing, peer support workers), media, federal and provincial officials, others.

2. Production and use of visual materials (posters, artworks) for discussions.

3. Production of a skit or role-play presentations.
4. Talk to federal or provincial officials, Mayor Robertson, Senator Michael Kirby, or the Canadian Commission on Mental Health.

5. Present at or participate in discussions on CBC radio.

6. Write a letter.

7. Advocate for continuing a group to address continuing needs for psycho-education and support.

**Action Step Agreed Upon**

We agreed on the following action step after discussing considerations like individual and group readiness for particular actions, where we are in our recovery as individuals and as a group, priority needs, relevance, continuing needs, and what we feel we would like to do at this point.

Action Step:
Advocate for a continuing group and talk to CCD about this possibility. Discussion points raised with respect to this included need for a continuing psycho-education/support group with more emphasis on psycho-education but not disregarding the supportive component. Other suggestions included identifying a particular skill for dealing with continuing distress in each session, use of worksheets/a workbook, invitation of speakers for particular topics, conduct of group for one hour instead of one-and-a-half hours, recruitment and expansion of group but keeping it closed and by invitation, and continuing ensuring safety in our group. We also agreed

We scheduled a **discussion on Monday, February 23**\(^{rd}\), **at 3pm, at CCD**, to talk about further details of the group.

**A meeting with CCD has been scheduled on Monday, March 2**\(^{nd}\) **at 3pm, also at CCD.**

Mok will do reminder calls to everyone on the morning of Monday, February 23\(^{rd}\).

Thank you very much and see you then!
Appendix Q – Participatory Visual Appraisal: Processing

1. Each participant was given one minute to create a visual image in response to what was written on each piece of flip chart paper. In this exercise, these were: ‘Trauma,’ ‘The Effects of Trauma,’ ‘Depression,’ ‘The Effects of Depression,’ ‘Substance Use,’ and ‘The Links Between Trauma, Depression and Substance Use.’

2. After each participant had the chance to create their visual image, each of them was asked to briefly describe what they drew. This was done by discussing one piece of paper at a time. I wrote these brief descriptions in red ink beside their image to facilitate naming and a collective understanding of these.

3. Each participant was then asked to say something about their drawing. This was undertaken until all of the participants had the chance to speak.

3. In the course of this exercise, participants were encouraged to say something about what others said and to engage in dialogue, particularly in terms of how they relate to other participants’ ideas and experiences.

4. Participants were also encouraged to include associations of these discussion points to other lived experiences, to provide material from their ‘visual world:’ their environment, spaces, structures they found themselves in, among others.

5. Along the way, either myself, the facilitator, or the participants were engaged in identifying and describing common themes in these ideas and experiences.

6. In addition to this, these conversations also facilitated the expression of validation and support for the other participants.

7. The exercise ended when the group felt like they had expressed what they needed and wanted to cover. Synthesis points from all discussions of all the pieces of paper were outlined to close this session.
Appendix R – Context Mapping of Distress: Processing

1. Each participant was asked to illustrate every single location or context they found themselves in presently. For some, this included their home, neighborhoods, mental health and social service agencies, streets, institutions, parks and other public spaces, etc.

2. Beside each location of context, participants were asked to rate on a scale of 1-10 (10 being the highest) the level of trauma-related distress (including that which involves depression and substance abuse) and recovery they experienced.

3. Each participant then engaged in critical analysis of these locations and contexts in terms of distress and recovery and the factors that inform these.

4. After each participant had drawn their map, they were asked to briefly talk about these. It was agreed that each person would make a determination of how much they felt safe and comfortable with describing. At times, I redirected participants when the potential for retriggering others with distressing descriptions seemed to be occurring.

5. After each participant drew their map and talked about the map, dialogue ensued in terms of how each participant related to what the others had said. Common themes were identified with respect to not just individual difficulties but systemic and structural sources of traumatic distress and recovery, as well.

6. The session ended with a review of the points raised by the participants, particularly in terms of systems- and structures-based concerns. This information was used as basis for later discussions on how to address systems- and structures-based problems and how to use systems- and structures-based sources of recovery for promoting collective well-being.
Appendix S - Vancouver Coastal Health Adult Team Mandate

Relevant portions state:

The Vancouver Community Mental Health Service (VCMHS) provides service to individuals who suffer from a serious and persistent mental illness and whose functional impairment requires a broad range of coordinated services provided by an interdisciplinary team.

Diagnostically, clients primarily fall into one of two categories:
1) Schizophrenia and other psychotic disorders, and
2) Mood disorders, i.e. bipolar and major depressive disorders.
Services are also provided to individuals who have co-occurring disorders such as personality disorders, substance abuse/misuse, mental challenges, etc.

Characteristics that generally describe the above population include:
1) History of multiple psychiatric hospitalizations
2) Unstable housing and/or relationships
3) Difficulties with activities of daily living
4) High risk for co-occurring medical conditions
5) Refractory treatment history
6) High risk of causing harm to self or others

The Goals and Primary Therapists’ Role policies, for their part, state:

Goals:
1) To promote the emotional well-being and effective interpersonal functioning, productivity, and community adjustment of each individual;
2) To ensure that comprehensive treatment goals are set and that treatment activities, based upon these goals, are organized and implemented;
3) To ensure full utilization of individual and community support systems, as well as appropriate community services in the attainment of treatment objectives;
4) To ensure that documentation is clinically useful, meets legal requirements and adheres to ethical standards.

Primary Therapists’ Role:
1) Clinical Responsibility
   Individual case management is the responsibility of the primary therapist and requires an understanding of the resources within the team, the Service and the wider community.
   Once the case has been assigned, the therapists’ goals are to assess the patient and initiate a therapeutic treatment program that includes:
   a) arranging a comprehensive assessment to determine the nature of the problem and the appropriateness of service;
   b) defining therapeutic objectives suitable to the patient’s level of functioning; whenever possible, mutual should be reached with the patient;
c) developing a program to implement these objectives, taking into consideration the following factors:
   - the frequency of meetings of the patient and the therapist;
   - the use of the team and Service personnel;
   - the use of ancillary community resources;
   - the possible use of medication;
   - the involvement of other significant individuals;
   - the patient’s social network;
   - the recognition that the objectives and program may change periodically and require review by the therapist and patient.

2) Consultation Responsibility

   The therapist arranges for the ongoing consultation with the Unit Manager and the members of the treatment team, including:
   a) consultation with the physician and, in non-routine situations, the Unit Manager prior to hospitalization.
   b) periodic psychiatric reassessment requires and a review of medication is consultation with the physician, at a minimum of four times a year;
   c) formal, annual case review with the Unit Manager, physical and other members of the team as set out in the ‘Case Review’ policy section of this manual;
   d) consultation, as required: within the team (e.g., occupational therapist); within the Service (e.g. psychological testing, Venture, Mental Health Liaison Program); and within the community (e.g., general practitioners, sheltered workshops) (Vancouver Coastal Health, 2009).