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There is an extremely high percentage of American women who have experienced
abuse as children. The consequences of these experiences are pervasive and severe
including lifelong patterns of wounding. Research on the health of these women suggests
that they are socially isolated, have significant health problems, are socially and
economically at-risk, and are particularly vulnerable to further abuse in intimate
relationships and with healthcare providers. There is a dearth of literature which
addresses healing and the potential for healing as a global construct in the life patterns of
these women. This was a descriptive, exploratory study to examine the potential of
participatory dreaming (a group facilitated waking dream process using imagery and art)
on unitary healing in women abused as children. A qualitative unitary appreciative
inquiry was done with a purposive sample of 12 women recruited from two metropolitan
areas of North Carolina. The findings suggested that participatory dreaming was an
effective and powerful method of illuminating healing as a process and offering the
possibilities for change and transformation in the lives of these women who experienced
abuse as children. The patterning focus of this study demonstrated that healing from
childhood abuse is a unitary phenomenon which may be appreciated in the context of the
wholeness inherent in the lives of these women.

WOMEN ABUSED AS CHILDREN AND PARTICIPATORY DREAMING:

A STUDY OF UNITARY HEALING

by

Elizabeth J. Repede

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Approved by

_____
Committee Chair

This study is dedicated to the participants who have shared a part of their healing journey with me and to all women and men who are healing from childhood abuse.

This dissertation has been approved by the following committee of the Faculty of

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CHAPTER I

STUDY PATTERNING FOCUS

Women Abused as Children

The lives of women who experienced abuse as children are characterized by

unique and pervasive life patterns of wounding. Research on the health of these women

suggests that these women are often socially isolated, have significant health problems,

are socially and economically at-risk, and are particularly vulnerable to further abuse in

intimate relationships and with healthcare providers (Bonomi, et al., 2008; Felliti, et al.,

1998; Glaister & Abel, 2001; Tudiver, et al., 2000). In particular, the imbalance in power

in relationships in the healthcare system creates potential for further vulnerability. Most

of the research done to date in women abused as children has focused on identifying

health problems, treating isolated symptoms or symptom clusters, or addressed the

biopsychosocial impact of the abuse on adult women (Bonomi, Cannon, Anderson,

Rivera, & Thompson, 2007; Bonomi, et al., 2008; Edwards, Holden, Felitti, & Anda,

2003; Hulme, 2000; Nicoliadias, Curry, McFarland, & Gerrity, 2004). However,

symptoms are often isolated and treated without consideration for broader and contextual

associations with ecological and unitary perspectives.

While a majority of the literature on women who experienced abuse in childhood

is symptom based, there is a dearth of literature which addresses healing and the potential

for healing as a global construct in the life patterns of these women (Godbey &
Hutchinson, 1996; Martsolf & Draucker, 2005). The literature which exists on healing is
also limited to narrowly defined constructs such as post traumatic stress symptoms
(Kaminer, 2006), dissociation (Hall, 2003), coping (Brand & Alexander, 2003), or self-
esteem (Kriedler, 2005). Additionally, healing has been defined as an individual process
in most other research despite the fact that childhood abuse and its aftermath is a socially
constructed illness (Erickson, 1995). Childhood abuse is by nature a participatory event,
occurring within a personally, familial, culturally, and socially mediated perceptual field.
The focus on individual healing may foster a sense of isolation and separateness,
reinforcing the myth that they must bear the burden of a society which condones violence
against women and children as a matter of course.

While core constructs in identity development and spiritual disharmony are
emerging and gaining attention in the healing literature with these women, there are no
studies in the literature on healing from a unitary-transformative paradigm in women
abused as children. Narrative (Hall, 2000), grounded theory (Godbey & Hutchinson,
1996), and Denzin's qualitative method of interpretive interactionism (Glaister and Abel,
2001) have been used as methodologies grounded in qualitative perspectives to explore
healing in women abused as children in the nursing literature, but these still arise from a
traditional perspective of healing as an outcome rather than a process. The qualitative
reports of healing by the women themselves suggest that healing is neither linear nor
acontextual. Research methodologies are needed which can accommodate the fluid,

contextual, complex, uncomfortable, and often reiterative process of healing which is simultaneously synchronistic and sequential in women abused as children.

Unitary Healing

Visionary methods of research which support the epistemic and ontological constructs of nursing as a unitary- transformative discipline are needed (Malinski, 2005). Unitary healing is a new conceptualization of healing in which healing is viewed as an appreciation of wholeness through knowing participation in change that is both transformative and emancipatory (Cowling & Repede, 2009). A unitary conceptualization of healing is distinct from the synthesized view which combines complementary theories under the overarching theme of striving toward an ideal of wholeness (Cowling, 2000). In a unitary perspective, humans are irreducible wholes within an ecological matrix which is an irreducible whole, i.e. human field patterns contiguous with environmental field patterns in an already complete state of wholeness (Cowling, 2000). The ontological crux of distinction of unitary theory is that wholeness is not an ideal or a goal. Wholeness and healing are inherent in every moment and can be appreciated in the context of the life patterning of the unitary human (Cowling, 2000).

Unitary appreciative inquiry (UAI) is a participatory methodology grounded in Roger's science of unitary human beings (SUHB) (Rogers, 1992). The tenets of the SUHB which form the basis for a theory of unitary healing are fourfold (Cowling & Repede, 2009). Initially, humans are essentially and inherently whole, unified beings or fields of energy. Secondly, human life coexists and emerges through its relationship and

participation with the environment in a mutual process which is continually unfolding. Thirdly, human life expresses itself in patterning that can be known through its manifestations, both direct and indirect. And finally, human life carries an infinite potential for health and well-being which is pandimensional and unpredictable.

In Cowling's (2008) unpublished UAI research with women abused as children, appreciating wholeness has been shown to support transformation through participation in the lives of these women. Using a synoptic approach, that which ". . . appears, separate, fragmented, or disparate is brought together to see a patterning within wholeness" (Cowling & Repede, 2009, p. 2). Change and transformation are shaped by individuals and collectives through an appreciative stance toward life's wholeness, through knowing participation in the process of change, and through emancipatory awareness and action (Cowling & Repede, 2009).

Participatory Dreaming

Dreaming is a universal phenomenon across cultures. The metaphor of the dream extends into every domain of human inquiry such as art and literature, science, myth, and spirituality (Littlewood, 2004). Trance, meditation, guided imagery, paranormal, and other states of 'beyond waking' consciousness identified by Rogers (Watson, 1999) are the basic transpersonal and intra-psychic elements of dreaming. Dreaming contains a template for universal, collective, and individual healing within the universal, kairotic, and pan-dimensional qualities of dreams and dream-like states (Tedlock, 2004).

Dreaming is conceived of as a participatory dance between the dreamer and the dream moving in images, sensations, and sounds. A participatory relationship exists between the dreamer and his/her dreams based upon both unique and universal intrapsychic elements of consciousness (Jung, 1964). Dreams are both personally informative and socially constructed, providing a vision for personal and social transformation (Dombeck, 1995; Lawrence, 2003). Participatory dreaming is a conceptual model of dreaming which was developed to conceptualize the participatory and collective nature of dreaming as a unitary field of consciousness (Repede, in press). Using participatory dreaming to appreciate the template of wholeness that originates in mythical, archetypical and paratelic modes of cognition may illuminate patterns and infinite possibilities for healing and appreciating wholeness in women abused as children. The patterning focus of this study is to explore the potential of unitary healing through participatory dreaming in women who experienced abuse as children.

Population of Study

Women abused as children have often been an invisible group. Because the violence is not occurring in the present time, the ramifications for the health and well-being of these women due to past trauma is often overlooked by the health care community (Felliti, et al., 1998). The life patterns of women abused as children often include post traumatic stress symptoms, increased physical health problems, increased depression and anxiety, difficulty with relationships, and higher rates of substance abuse, obesity, nicotine addictions, and incarceration than women who were not abused

(Bonomi, et. al., 2008; Department of Justice [DOJ]a, 2004; Felliti, et al., 1998; Hall, 2003; National Criminal Justice Reference Service [NCJRS], 2008; Stovall-McClough & Cloitre, 2006). Patterns of repeated abuse as adults are common in women who were abused as children (DOJa, 2004). The women themselves often do not realize the connection between health problems, chronic pelvic pain, migraine headaches, irritable bowel syndrome, depression, substance abuse, mental disorders, and dysfunction in life patterns (Godbey & Hutchinson, 1996; Hall, 2003; Springer, Sheridan, Kuo, & Carnes, 2007). Women report feeling stigmatized, invisible, broken, shattered, dysfunctional, and afraid of passing the traumatic effects onto loved ones (Cowling, 2008).

Women abused as children are diverse cross-culturally, socio-economically, and ethnically (DOJa). Patterns of childhood abuse vary from abandonment, neglect, emotional, physical, and/ or sexual abuse, to living with impaired or incarcerated parents or householders (Felliti, et al., 1998). Some similarities of effects of abuse were found across all age groups of adult women (Center for Disease Control, [CDC], 2008).

Study Sample

The study sample was 12 adult women (over 18 years of age) who self-described an experience of childhood abuse. No attempt was made to qualify or quantify the abuse other than participant report that childhood abuse occurred. Because of the diversity of the study population, efforts were made to select multicultural participants through a convenience sample recruited from the communities of the greater Greensboro and Charlotte metro areas of North Carolina. Participants were screened for ability to function safely in a group setting.

Purpose of Study

This was a descriptive, exploratory study to examine the potential of participatory dreaming on unitary healing in women abused as children. The conceptual framework for the study was unitary healing. Specifically, UAI, a participatory, qualitative methodology based within a unitary healing conceptual model, was used for this study. Unitary healing was conceptualized as an appreciation of the inherent wholeness reflected in the life patterns of women abused as children and the illumination of possibilities for transformation and emancipation through knowing participation and change. Unitary healing was defined as the appreciative reflections of both participants and researcher portrayed through a group aesthetic creation and synopsis of individual participants' journals through a facilitated participatory dreaming research group of women abused as children. Participatory dreaming was conceptualized as a beyond waking process invoking the collective imagination and creative action of women abused as children to illuminate the possibilities for healing, transformation, and emancipation in their lives and in society. Participatory dreaming was operationalized as a researcher facilitated group process using communal dialogue, imagery, and incubated daydreams to envision healing in women abused as children in a participatory action research study.

Research Questions

The research questions were:

(1) What changes/ transformations occured, if any, with participatory dreaming as a unitary healing approach in women who have experienced childhood abuse?

(2) What is the nature of unitary healing examined through participatory dreaming from the perspective of women abused as children?

Theoretical Orientation

The theoretical orientation for this study was unitary healing, a new conceptualization of healing arising from a perspective of the inherent wholeness and uniqueness which is present in all beings (Cowling & Repede, 2009). Unitary healing is grounded in Rogerian science (Rogers, 1992), and informed by Barrett's theory of power as knowing participation in change and a participatory worldview (Barrett, 1990). The six focal and process aspects which are the foundation for a science and practice of wholeness are (1) wholeness, (2) appreciation, (3) participation, (4) knowledge, (5) emancipation, (6) change/ transformation (Cowling & Repede, 2009).

A major tenet of unitary healing and UAI is a participatory evolutionary reality which arises from a cosmos whose form is relational and ecological (Reason & Bradbury, 2001). Participation is seen as a political statement of democratic ideals, a process of consciousness raising, and an educational and ecological perspective from which power, human nature, and the ecosystem are inherently interrelated (Reason & Bradbury, 2001).

The overall purpose of participatory research is to liberate consciousness on individual and collective or community levels in order for life to flourish, less as a search for truth, but more as a means to heal the alienation of the human experience in the modern world (Reason & Bradbury, 2001). An intentional interplay occurs between both sense-making and reflection and experience and action (Heron & Reason, 2001). Beauty and spirit are envisioned as necessary components of a resacralized and reenchanted world in which spirituality is not seen as an end state, but as

> . . . simple openness to everyday participative experience, feeling that subject and object are in an inseparable, seamless field of imaging and resonance- a field with infinite horizons, is itself a spiritual experience (Heron, 2001, p. 11).

In this study, spirituality was conceptualized as a unitary, pandimensional experience.

The ontology of a participative world view requires an extended epistemology arising from the necessary practicality of being and acting in the world, and with a clear understanding of the relationship between knowledge and power (Reason & Bradbury; Reason, 2005). This produces a double objective for participatory research in general: (1) to produce knowledge and action which is directly useful via research, education, and political and social change; and (2) to raise consciousness by creating a space in which people are self empowered through a process of constructing and using their own knowledge (Heron, 2001; Reason, 2005). With inherently feminist and emancipatory overtones, the participant moves away from a paternalistic stance of other-validation and into self-validation and self-discovery (DiCowden, 2003; Heron, 2001; Reason & Bradbury, 2001).

Reason and Bradbury (2001) advocate for an epistemological shift in research toward embodied ways of knowing that are relational, representational, and reflective. Relational knowing arises in the process of living in context within community. Representational knowing provides explanation through understanding meaning. Reflective knowing raises consciousness through the perceptual awareness of social, cultural, and political norms, and by envisioning what ought to be.

The extended epistemology of participatory inquiry is based upon four interdependent ways of knowing which emphasize a moment-to-moment quality of attention which is intentional and reflexic (Heron & Reason, 2001; Reason, 2005). They extend

> beyond orthodox empirical and rational Western views of knowing, and embrace a multiplicity of ways of knowing that start from a relationship between self and other, through participation, and intuition. They assert the importance of sensitivity and attunement in the moment of relationship, and of knowing not just as an academic pursuit but as the everyday practices of acting in relationship and creating meaning in our lives. (Reason, p. 207)

Experiential knowing is an in-depth knowing encountered in the direct experience of other, whether person, place, or thing (Reason, 2005). It is acquired through empathy and resonance (Reason & Bradbury, 2001). Presentational knowing is expressive, arises from experiential knowing, and uses aesthetics to communicate through story, art, music, and dance (Heron, 1996; Reason, 2005). Propositional knowing occurs through words, ideas, and concepts (Heron & Reason, 2001). Practical knowing in the form of interpersonal, intrapsychic, political, and transpersonal skills consummates or brings life to the other ways of knowing (Heron & Reason, 2001) While all four ways of knowing

are interactive, practical knowing is viewed as primal in a participatory world-view, as it is the basis of both action and reflection (Reason, 2005).

A unitary theory of healing requires unitary methods of inquiry which arise from the ideal of a participatory cosmos whose ontological foundation is inherent wholeness. One such method is UAI, developed as an ". . . orientation, process, and approach for illuminating the wholeness, uniqueness and essence that are the pattern of human life." (Cowling, 2001, p.32). UAI was developed as a response to the call for methodologies that integrate and advance both nursing science and theory (Cowling, 2001; Cowling, 2006). UAI is grounded in the Rogerian conceptual model of the SUHB (Cowling, 2004) and arises within a participatory worldview (Cowling, 2005). The five theoretical assumptions of UAI which make it ideally situated for a unitary-transformative inquiry into healing and participatory dreaming in the lives of women abused as children are: (1) the nature of the cosmos as participatory wholeness, (2) patterning as the focus of practical being and acting in the world, (3) unitary knowing as a function of extended epistemologies, (4) unity as a relational, ecological form of inclusiveness and transcendence, (5) purpose and meaning which are open to reconciliation without boundaries (Cowling, 2007, 2001).

Healing as emancipation allows for a freedom associated with ". . .appreciating wholeness through participating to create deeper, wider, more encompassing awareness . . . which illuminate greater possibilities for change and transformation" (Cowling & Repede, 2009, p. 3). One of the recurring life patterns described by women abused as children is the pervasive perception of being broken, fragmented, or distorted (Cowling,

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2008). Current methods of research and interventions often reflect this sense of brokenness by focusing on parts of the personality or life that are in need of repair or categorized as dysfunctional (Godbey & Hutchinson, 1996; Hall, 2003) rather than on contextual life patterns which may reflect a sense of meaning or purpose within symptoms or relationships. UAI as a method of unitary inquiry seeks to realign the fundamental perception of wholeness by seeking to uncover or illuminate the unique life patterns of women abused as children thereby creating a relational space within which healing may occur as appreciation and knowing participation with what is.

Significance for Nursing Science

This study may potentially impact nursing at several levels of significance. Women abused as children are estimated to represent over 27 percent of the adult female population of the USA and with higher rates internationally, creating a large group of women with health consequences (ChildHelp, 2008). The nature of the life patterning for this large population of women impacts individual, family, and social health patterns which are the basis of nursing practice. Most of the research on women abused as children is outside the domain of nursing and falls under the epistemological framework of disciplines such as medicine, psychology, and social work, leaving the nursing perspective conspicuously absent (CDC, 2008; Creedy, Nizette, & Henderson, 1998; Edwards, et al., 2005; Ferrara, 2002; Glaister & Abel, 2001). Research on healing as perceived by women abused as children is scarce and has large gaps across age, culture, and socioeconomic profiles (Hall, 2003). There is a dearth of qualitative research with

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women abused as children, leaving the voices of the women themselves yet unheard. Most of the quantitative and qualitative research on healing is limited to incest and sexual abuse survivors, versus women who have experienced physical, emotional, or mixed types of abuse (Martsolf & Draucker, 2005). How the life patterns of these women have been affected by childhood abuse is relatively unstudied, particularly from the perspectives of the women themselves (Glaister & Abel, 2003; Hall, 2003). This was the first study found in the literature which explored the impact and perception of healing as a participatory community of women and healing through dreaming from a unitary-transformative perspective in women abused as children. This study also has expanded the existing ontological and epistemological constructs of nursing itself through the exploration of a unitary inquiry based upon inherent wholeness and unitary healing.

Summary

The triumvirate of nursing paradigms defined by Newman, Sime, and Corcoran Perry (2002) as the particulate-deterministic, interactive-integrative, and the unitary-transformative could each provide distinct and overlapping frameworks from which to situate theories about healing in the lives of women abused as children. However, a unitary model that addresses the pervasive and complex effects of childhood abuse in adult women is needed to guide our understanding of childhood abuse as a life pattern. Unitary healing is a new theoretical model which seeks to uncover the inherent wholeness that exists in each woman's life in an ecological stance with herself and her world. UAI is a transpersonal inquiry model combining research and praxis which arises

out of appreciation and participatory knowing resulting in the possibilities for illumination, transformation, and change for women as individuals and as a community. Participatory dreaming is an extended epistemological method which offers access to the imaginal, the transpersonal, and the collective templates for healing which is part of a unitary worldview. The purpose of this study was to illuminate our understanding of healing in the life patterns of women abused as children and assess the potential of participatory dreaming for healing in the lives of these women.

CHAPTER II

REVIEW OF LITERATURE

The review of literature for this study addresses two themes. The primary theme is a review of the literature from the elements within the research questions- women who have experienced abuse as children, healing in women abused as children, and dreaming in healing with a focus on participatory dreaming. A secondary theme will be a sensitizing perspective which relates the theoretical orientation of unitary healing to the study purpose in relationship to what is currently known about women who have experienced abuse as children. This review is from the therapeutic domains of nursing, medical, and psychodynamic literature on women abused as children, healing, and dreaming and from the social, psychological, and cultural anthropology literature on dreaming as a participatory phenomena. The literature review for this paper was done between February 2, 2008 and September 6, 2008 using the search terms violence against women, adult survivors, women abused as children, childhood abuse, survivors of abuse, child abuse, interventions, healing, therapy, holistic, therapeutic interventions, trauma, treatment, nursing, dreaming, social dreaming, and unitary healing in different Boolean combinations on PubMed, EBSCO, CINAHL, PsycINFO, Abstracts in Anthropology, and various governmental websites. Additional literature was obtained through the reference lists of cited articles and dissertation abstracts.

Women Abused as Children

The review of the literature for women abused as children was categorized into three primary domains. The first domain described the effects of childhood abuse on adult women from the epidemiological, sociological, and bio-psychosocial literature. The second domain described the qualitative life patterns of women who have experienced childhood abuse abstracted by this reviewer from the research and the significance of these patterns on the healing relationship with the healthcare provider/ healthcare systems. This was primarily from the nursing literature on women abused as children. The third domain reviewed the methodological issues inherent in the current research with women abused as children, making a case for a unitary design for this study.

The State of the Science of the Effects of Childhood Abuse on Adult Women

The initial research in healthcare on women abused as children evolved from serendipitous findings from studies on other medical conditions such as trauma, chronic pain syndromes, fibromyalgia, chronic fatigue syndrome, mood disorders, addictions, and obesity (Felliti, 2004; Rubin, 2005). The commonality of childhood abuse was discovered in many of the above studies by accident when researchers noted large percentages of respondents stating that they had experienced childhood abuse, particularly sexual or physical abuse. This also occurred in research involving special populations such as particular ethnic groups, immigrant women, and incarcerated women (Felliti, et al, 2004).

Case rates for women abused as children are difficult to estimate. This is due in part to the reluctance of women to disclose a prior history of abuse, the gray areas in

defining abuse in a culture where corporal punishment is considered normal, and the

societal nature of the primacy of the family unit (DOJa, 2004). Abuse as children in adult

survivors includes the categories of emotional, physical, and sexual abuse, neglect, and

exposure to violence in the home or community (DOJa, 2004). Felliti et al., (1998)

include the categories of living with household members who were substance abusers,

mentally ill or suicidal, or ever imprisoned in their research on adults who survive

adverse childhood experiences. Disabled children, American Indian/ Alaskan Native,

Asian/ Pacific Islander, Hispanic, and females have higher odds of childhood abuse than

other groups in the U.S. (HHS, 2008). In a DOJb report (1999) on prior abuse in prison

inmates, over 33% of incarcerated women had been abused as children and 87 % of

female prisoners who had spent their childhood in foster care reported a history of

childhood abuse. Among women who had been abused, 45% were incarcerated for a

violent crime compared to 29% who had not been abused.

In a DOJ study conducted from November, 1995 to May, 1996, 52% of surveyed

women (n = 8,000) said they were physically assaulted in childhood by an adult (Tjaden

& Thoennes, 2000). In an ongoing retrospective and prospective study of 9,508 adults,

over 54.6 % of women (n = 4,197) reported at least one category of abuse as children and

women had over twice the risk of men of having at least 4 categories of abuse as children

(Felliti, et al., 1998). In a study funded by the Center for Disease Control (CDC) on adult

reports of childhood abuse and the relationship with health, significant findings continue

to emerge as the participants are followed longitudinally (CDC, 2008). The initial

population was selected between 1995 and 1997 and surveyed through an HMO cohort.

Adults over the age of 18 were surveyed about Adverse Childhood Experiences (ACE).

Physical abuse in childhood was the most common, with slightly higher rates for men,

while sexual abuse was less common, but almost 50% higher in women. For the women

in this study, 27 percent reported physical abuse, 25 percent reported sexual abuse, and

13 percent reported emotional abuse (CDC, 2008). These rates of abuse are generally

consistent with rates in other national studies (Tjaden & Thoennes, 2000). This

population was predominantly white (74.8%), over age 60 (46.4%), and college graduates

(39.3%). In this study, the risk of the following health problems is positively correlated

with increased ACE scores: alcoholism, COPD, depression, fetal death, health-related

quality of life, illicit drug use, liver disease, risk for intimate partner violence, multiple

sexual partners, sexually transmitted diseases, smoking, suicide attempts, and unintended

pregnancies. Like much of the research on the effects of childhood abuse in adults, this

study was stimulated by the serendipitous findings of a large number of adults who had

experienced ACE in a study at Kaiser-Permanente looking at the origins of addictions

(Felliti, 2004).

The long-term sequellae of abuse was noted up to 40 years after the events in a

population-based survey (N= 2,051) comparing adverse physical and mental health

outcomes in middle-aged men and women survivors of physical child abuse (Springer, et

al., 2007). Decades after childhood physical abuse, survivors of abuse had statistically

higher rates of depression, anger, anxiety, physical symptoms, and illnesses such as

hypertension, heart disease, asthma, and lung problems. Rates of ulcers were over one

and a half times greater and rates of liver problems were over two and a half times higher

in adult victims of child abuse than in non-abused adults. Controlling for family background, age, sex, and other childhood adversities such as death of a parent slightly attenuated results, but results were still significant in all areas.

Economic factors that are associated with child abuse include neighborhood residential characteristics such as income level, median housing/ property values, unemployment rate, poverty rate, and low economic status (Coulton, et al., 2007). Structural characteristics of neighborhoods that are economically based and associated with increased rates of childhood abuse include residential instability, increased child care burden, overcrowding, vacant housing, lower female participation in the job market, and density of alcohol stores within the area (Coulton, et al., 2007). Interaction effects between rates of community violence and the effect of community violence on parent-child interactions have also been documented in the literature as contributing factors to childhood victimization (Coulton, et al., 2007). Because women abused as children are often caught in repetitive cycles of abuse, poverty, and victimization, identifying communities at risk focuses on up-stream measures for prevention of child abuse as well as focused interventions for affected women (FVPF, 2008).

Economic effects of abuse affect the health of women abused as children on both individual and community levels. A study of 3,333 women was done with members of a group health plan in the Pacific Northwest who completed a telephone survey on their history of childhood abuse, their health status, and their health care utilization patterns (Bonomi, et al., 2008). The four categories of physical abuse, sexual abuse, both physical and sexual abuse and neither physical nor sexual abuse were used to group women.

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Almost 34% of the sample reported some type of childhood abuse with sexual abuse as the highest frequency (59% of abuse cases). Women with a history of abuse were statistically more likely to be non-white, smoke, report depressive and physical symptoms, and have a higher body mass index. Women who were sexually abused alone or in combination with other types of abuse had a higher incidence of recreational drug use. Even though there were no statistical differences between women abused and those not abused in this sample in relation to asthma, diabetes, heart disease, hypertension, or pulmonary disease, healthcare costs were higher in women abused as children. Mean annual costs in 2004 dollars were $790.00 higher per person for women who had experienced both physical and sexual abuse, $502.00 higher for women with physical abuse only, and $382.00 higher for women with sexual abuse only.

After controlling for women's age and education, mid-life women abused as children were found to have higher rates of direct health care costs than non-abused women (Bonomi, et al., 2008). Women who suffered both physical and sexual abuse as children had 36 % higher annual costs in healthcare, while physical abuse alone increased annual costs 22 % (Bonomi, et al., 2008). They also had higher utilization of services for mental health, hospital outpatient, emergency department visits, primary care, specialty care, and prescriptions than those not abused (Bonomi, et al., 2008). In a retrospective community health study on both men and women in Ontario (N = 9,953) Chartier, Walker, and Naimark (2007) found similar utilization rates by type of abuse. They also found statistically higher odds between a history of childhood abuse and multiple health problems, poor or fair-rated health, pain that interferes with activities, disability due to

physical health, and frequent emergency room and specialist health visits (OR 1.3-2.2).

The odds of having health problems were statistically increased in females and younger

respondents.

Indirect expenses in the health of these women may be found in higher rates of

addictions, prostitution, incarceration, and lost productivity due to disease burden, life

style factors, and disruption in educational or socio-economic advancement (Felliti,

2004; DOJa, 2004). Adult earnings for sexual abuse victims were reported as 20% lower

than non-victims even in the presence of more education (Robst & Smith, 2008). Because

women abused as children may have a higher risk of impoverishment themselves, they

may be economically disadvantaged in seeking out or receiving treatment for sequellae of

childhood abuse (CDC, 2008).

Much of the recent medical literature on women abused as children has focused

on the symptoms and physiological effects of abuse or the psychiatric consequences of

abuse (CDC, 2008; Heim, Newport, Bonsall, Miller, & Nemeroff, 2001). Garno,

Goldberg, Ramirez, and Ritler (2005) found that half of patients (n=100) with bipolar

disease had a history of severe child abuse. Those with a history of severe emotional

abuse had a 3.29 higher risk (95% CI 1.4-7.77) of substance abuse comorbidity and 5.6

higher risk (95% CI 2.0-15.7) of past- year rapid cycling. The odds of having a lifetime

suicide attempt was 3.4 (95% CI 1.3-9.3) times higher in those who had experienced

childhood sexual abuse. Multiple forms of abuse were also significant for lifetime history

of suicide attempts (OR 1.466, 95% CI 1.095- 1.0964) and rapid cycling (OR= 1.48, 95%

CI 1.07-2.03). No gender differences were noted. Childhood sexual assault was

significantly associated with increases risk of depression (Hazard Ratio [HR] = 1.91, 95%

CI 1.59-2.32), suicide attempts (HR = 4.12, 95% CI 2.78-6.10), alcohol dependence (HR

= 2.98, 95% CI 2.31-3.83), rape after 18 years of age (HR = 3.58, 95% CI 2.31-5.54),

general conduct disorder (HR= 6.62, 95% CI, 3.55-12.33), and divorce (Odds ratio [OR]

= 2.53, 95 % CI 1.62- 3.94) for women in a study of 1,991 same sex adult twins (Nelson,

et al., 2002). Females were statistically more likely than males to develop comorbidities,

especially if CSA was associated with intercourse. In discordant twin pairs in which only

one twin experienced abuse, both twins had statistically higher rates of comorbidity than

in non-abused pairs of twins suggesting family dynamic effects. However, there were still

statistically higher rates of comorbidities across all categories for the discordant twin who

experienced abuse than for the non-abused sibling.

In fact, severe childhood maltreatment has been related to the development of

dissociative identity disorder (DID) as a method of coping with the trauma (Ellason,

Ross, & Fuchs, 1996; Ellason & Ross, 1997; Scott, 1999). Perry, Pollard, Blakeley,

Baker, & Vigilante (1995) have postulated that the development of dissociation arises

from the inability of the child to flee from the terror of the abuse. Overwhelming anxiety

causes the child to "freeze", as an adaptation which allows better localization of sound

and heightened visual capacity for scanning the environment for threats. However, with

continued and repeated abuse, the "freezing" escalates into complete dissociation from

conscious reality, which is an adaptive mechanism to protect the psyche from untenable

trauma. Future anxiety, even in small amounts can provoke an automatic dissociation into

multiple aspects of the core self, which have fractionated to protect the psyche from

different aspects of the trauma. Because DID is more common in women, sociologist Sara Scott (1999) theorizes a wider social construct of the disorder which focuses on the adoption of multiple identities as an alternative mechanism for achieving integrity and autonomy of the self in a culture (albeit a fractured self) which traditionally disempowers women, furthering the trauma of the original abuse.

Interventional research is often based primarily on symptom amelioration using medication (CDC, 2008). Anda, et al. (2007) found graded relationships between ACE scores and psychotropic prescription rates including antidepressants, anxiolytics, anti-psychotics, and mood stabilizing medications in 15,033 adults from an HMO. Persons with a score of five or more (indicating types of abuse) had a threefold increase in psychotropic prescription rates. Although the sample was 54% female, gender differences in medication use were not reported in the article.

Recent psychobiological studies using radiographic and immune assays suggest differences in the neurohormonal regulation of pain, mood, and immune function in women abused as children (Bremner, et al., 2005; Heim, et al., 2001). Post traumatic stress disorders (PTSD) are a common sequellae of childhood abuse (Stovall-McCough & Cloitre, 2006). Women with childhood sexual assault (CSA) were found to have significant reductions in hippocampal volume compared to non-traumatized women, a risk factor found in combat veterans with PTSD predisposing to them to affective and memory disorders (Stein, Koverola, Hanna, Torchia, & McClarty (1997). Severity of PTSD was a significant predictor of functional life impairment in 164 women with a history of physical and/ or sexual abuse (Cloitre, Koenen, Cohen, & Han, 2002).

Literature on the Life Patterns of Women Abused as Children

Coping

Studies on coping in women abused as children suggest beneficial effects of positive coping skills on life satisfaction, marital relationships, physical health, and social isolation as well as a relationship between severity and characteristics of abuse with type of coping (Brand & Alexander, 2003; Bryant-Davis, 2005; Wright, Crawford, & Sebastian, 2007). Findings were consistent across demographic variables for gender, education, and income. Abuse characteristics (type, coercion, perpetrator as father vs. other, and age of onset) accounted for as much variance in adult functioning as did recollections of coping mechanisms used as a child (Brand & Alexander, 2003).

In Bryant-Davis' (2005) study of African American men and women, 55% used spirituality and 52% used community support as a coping strategy, 29% used creativity and artistic expression, and 26% used activism as positive coping mechanisms. Perceived benefit following CSA and meaning-making was positively associated with less isolation and those who used avoidant coping had more depression in a study of 60 predominantly Caucasian women (Wright, Crawford, & Sebastian, 2007). Participants in this study identified six major benefits of the abuse experience: personal growth and development, spiritual/ religious growth, increased knowledge of sexual abuse, improved relationships with others, new coping skills, and improved parenting skills. Positive coping skills were characterized differently by participants than by researchers in all of the studies. Researchers using standardized instruments categorized coping in clinical terms such as avoidant, distancing, etc. Participants characterized coping as qualities of character,

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degree of relationality with self, other, and spirit, and through increased skills and knowledge.

Research suggests long-term differences in adult coping which may affect quality of life and impact life choices for women abused as children. In a study of 196 women comparing the coping strategies and current psychological adjustment of women without an abuse history (n=110) and women with a history of physical abuse (n= 38), sexual abuse (n= 26), or both (n= 22), women with any type of abuse history reported significantly poorer adjustment as adults than non-abused women (Futa, Nash, Hansen, & Garbin, 2003). College GPA was statistically higher in non-abused participants than in any abuse group.

Coping strategies also vary by cultural and ethnic orientation (Bryant-Davis, 2005). A qualitative study of 70 African American men and women abused as children suggested that racial/ reframing, humor, spirituality, community support, activism, creativity, desensitization, temporal framing, confrontation, and transcendence were important coping mechanisms in dealing with childhood trauma (Bryant-Davis, 2005). Differences in Hispanic- Anglo CSA experiences were found in a convenience sample of 151 adult women in an urban health clinic in Texas (Katerndahl, Burge, Kellog, & Parra, 2005). Hispanic women were more likely to report a family member as an abuser and to experience more self-blame than Anglo women. Increased acculturation was significantly associated with increased action in response to the abuse in Hispanic women. Sociodemographic and family variables were felt to be more associated with differences in groups than ethnicity alone in this sample. Other reports suggest major life choices

such as whether to bear children, marry, and even gender orientation are impacted by child abuse (Lovrod, 2005; Romito, Crisma, Saurel-Cubizolles, 2003).

There is discussion of practice considerations for women abused as children in the nursing literature (Cole, Scoville, & Flynn, 1996) but there is limited recent nursing research for this sub-group of women who have experienced violence (Hall, 2000). The effects of childhood abuse on particular life patterns associated with adulthood tasks were evaluated in a secondary analysis of data evaluated from a critical/feminist perspective (Hall, 2000). Interviews were done with 20 Midwestern, low income, urban women recovering from substance abuse who had experienced multiple forms of child abuse (Hall, 2000). Findings suggested that the women found school problematic, perceived themselves as having a lack of adult life skills, experienced problems with academic and health literacy, experienced challenges with both legitimate and illicit employment, and had areas in which they needed significant help in life. These areas included help with rage in themselves and on-going violence in their lives through partners, substance abuse, gender oppression, power inequalities in work and personal lives, impaired sexuality, and lack of a tangible future due to economic and educational disadvantage. Many of the women had run away from home at an early age to escape abuse.

Another study by Hall and Powell (2000) used a focused life story (narrative) design with 20 women who had experienced CSA to describe dissociative experiences (common in trauma survivors) and compare women's experiences of dissociation to prevailing healthcare provider views on dissociative experiences. Seven categories of dissociative experiences were identified by participants categorized by their relationship

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to healthcare providers' views and interpersonal issues: traditional descriptions, qualified descriptions, contrary descriptions, role of substances, social/contextual suppression, pain, and core issues. Many of the prevailing constructs of dissociation found in the medical literature contrasted with the women's perceptions of dissociation in their lives. For example, the medical belief that substance abuse was directly correlated to the desire to dissociate from memories of abuse was denied by many participants. Substance use often started between the ages of 9 to 14 due to easy access in the parental home. The main findings of the study suggest ". . . that survivors may or may not experience the phenomena medicalized as dissociation" (p. 200). The authors suggest that the circular effect in which the provider often engages the patient through a preconceived and distorted diagnostic lens strongly suggests the need for more qualitative research with women who have experienced childhood abuse.

Roman, Hall, and Bolton (2008) report study findings about the nature of interpersonal relationships in women who have thrived as adults despite childhood maltreatment. This was a narrative, analytical study with 44 women who self reported a sense of success in their adult lives despite childhood maltreatment. The sample was comprised of 33 White, nine African American, and two Hispanic women who ranged in age from 22 to 79 years, with 70% of the sample in their 40's. One to three interviews were conducted over six to nine months with 27 participants completing all three interviews and seven completing two interviews. The core finding from the study was described as a process termed 'becoming resolute', a process describing the strength of will for de-centering abuse in the life trajectory and struggling resolutely to avoid a return

to past suffering. This process enabled the women to struggle successfully through unique life patterns. Relationships that were transformative for these women were described as 'saw something in me' and 'no matter what relationships', indicating the illumination of never before seen possibilities and the power of a committed relationship for healing. A third less common type of relationship also found to be helpful in healing was a relationship with self which was transformed from either a 'I'll show them' or a 'who I m not' perception as a counterframe to negatively imposed ideals from others.

Godbey and Hutchinson (1996) conducted a grounded theory analysis of interviews from 10 women who had experienced incest to provide an explanatory schema to understand the healing process of adult female incest survivors. A theory of healing that called for the resurrection of buried parts of the integral self was formulated. The seven phases of healing will be discussed in the following section of the paper. Three studies reported by Glaister (1996, 1994) and Glaister and Abel (2001) on recovery in women sexual abuse survivors will be discussed in the section on healing.

In a nursing study of the relationship between lifetime patterns of physical and sexual abuse, depression, and suicide attempts among 30 pregnant Native American women, nearly half had experienced physical and/ or sexual abuse as children (Bohn, 2003). All of the 14 women who had experienced child abuse were revictimized as adults and experienced more lifetime abuse events than women not abused as children. Of the women who had attempted suicide, 56% had been abused as children and 100% of the women who had been both physically and sexually abused reported depression.

Women Abused as Children and the Healthcare Relationship

Stalker, Schacter, and Teram (1999) conducted a qualitative study with 27 women survivors of child sexual abuse in order to facilitate healing relationships with physical therapists and other practitioners such as nurses who touch clients during the encounter. The emergent themes included feeling safe (the overriding concern of all participants), stating a preference for a female or male provider, expecting information and explanations on the first visit, claiming the right to privacy, requesting ongoing information, explanation, and obtaining consent each time before the patient is touched, and validating the patients comfort level with each step. Being flexible and willing to modify any contact or exercises to the comfort of the client was deemed very important by participants.

Another area of research important to nursing practice is the evaluation of the effects of childhood victimization on the healthcare encounter (Tudiver, et al., 2000; Urbancic, 2004). In a national Canadian study on healthcare providers and women survivors of CSA (Tudiver, et al, 2000), primary care physicians were unaware of the prevalence of women who had experienced childhood abuse in their practice. Most reported little or no training during their medical education in dealing with women survivors of sexual abuse. Nurses were more aware than physicians of patient discomfort during exams and were sensitive to the possibility of abuse in women who were anxious or physically very uncomfortable with routine exams. However, both they and physicians verbalized needing more education in this arena. A few nurses had received advanced training through nurse practitioner or crisis intervention training, none had received any

training during their primary educational programs. Neither group routinely asked patients about an abuse history. Other barriers to good health care for survivors in primary care included lack of time, lack of flexibility due to high patient volumes and need for quick turn-around time in the clinic, focus on the physical complaints as the prime directive of the nurse, the physical environment with stark clinics and lack of space for privacy, and the traditionally uneven power dynamic between patient and provider in a client who fears loss of control.

In a survey of 395 U.S. nursing programs, 75% had not developed violence-focused student competencies and in 46% of programs who did, content on violence and women was introduced in one hour of didactic information or assigned readings only (Woodtli & Breslin, 2002). Warne and McAndrew (2005) found that mental health nurses seldom asked patients about CSA and when incidents were disclosed by patients, appropriate therapeutic interventions were rarely made. Nurses have been found to have much higher rates of CSA than mental health professionals or people outside the helping professions (Warne & McAndrew, 2005). An Institute of Medicine (IOM) report on the education and training of health professionals in family violence corroborates these findings (2002). Although a survey of 298 schools of nursing reported that their curriculum contained information on family violence including child abuse and neglect, only 53 percent of schools felt that it was adequately addressed. In a random sample of 1,571 clinicians in six disciplines including nursing, more than one-third reported receiving no training in family violence (IOM, 2002).

In conclusion, the research on the long lasting effects of childhood abuse suggests that women who have experienced childhood abuse are often socially isolated, have significant health problems, are socially and economically at-risk, and are particularly vulnerable to health care encounters which may require a degree of physical and emotional intimacy and vulnerability which feels unsafe to the adult survivor of abuse. Gaps in the literature abound, as research in this arena is relatively young within the last 12-15 years (Springer, et al., 2007). Much of the research on women abused as children is on CSA or combined adverse childhood experiences. There are few studies which compare the psychological effects of experiencing childhood abuse by gender for adults (Futa, et al, 2003; Springer, et al., 2007). Women of color, immigrants, elderly women, and disabled women have been particularly understudied (Bohn, 2003; Katerndahl, Burge, Kellog, Parra, 2005). Cross-cultural research on the family and social dynamics of abuse in women and children is limited (Edwards, et al., 2005). The reluctance of women to disclose a history of abuse or the lack of awareness of the possible consequences on health patterns and quality of life contribute to the invisibility of this group of women and contributes to the lack of research (Tjaden & Thoennes, 2000). Qualitative data are scarce and to a great degree, the actual voices of the women are still waiting to be heard (Hall, 2003). Nurses themselves may be more likely to be women abused as children suggesting further study is needed. The above literature review was primarily from social work, psychology, and medicine. There are few nursing studies in this arena. Lack of awareness, the scope of the problem, the invisibility of the women, and a lack of dedicated funding streams for research for women abused as children are contributory

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factors to the dearth of nursing research (Johnson, 2008). Three of the National Institute of Nursing Research (NINR) areas of emphasis are reducing health disparities, promoting health and preventing disease, and improving quality of life across the life span (NINR, 2008). It is clear from the above research that these women are a disparate population at risk for increased health problems and a reduced quality of life. Women who experienced childhood abuse are a vulnerable group with complex health issues. The health of women who experienced childhood abuse is a global and national healthcare issue with direct implications for nursing research.

Healing in Women Abused as Children

The state-of-science on healing in women abused as children is addressed in this section of the literature review. Other avenues of research beyond the scope of this paper would include healing and trauma, PTSD, comorbid health problems such as addictions, chronic pain, mood disorders, and complementary and alternative healing therapies which could be applied to women who experienced abuse as children, but have not. The current state-of-science in this arena is about 20 years old. Research has been largely focused on defining the problem and its scope, which was explored and evaluated in the previous section of the paper. Much of what does exist on healing in these women is in the arena of psychotherapy (including cognitive behavioral therapy [CBT], affect and interpersonal regulation, desensitization, and anger management) and pharmacotherapy (Cloitre, Cohen, Koenen, & Han, 2002; Kreidler, 2005; Paivio & Laurent, 2001). Although these modalities have been found to be helpful (Kriedler, 2005), some of the qualitative

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research with women abused as children suggests they are insufficient and maybe counterproductive if used inappropriately (Edmond & Rubin, 2004; Glaister & Abel, 2001; Godbey & Hutchinson, 1996).

There seem to be two divergent paradigms in this research which are the bio-psycho-social model, addressing symptom treatment or management, and the holistic model, which seeks to understand the effects of childhood abuse within the context of the women's lives. The former model appears (as noted by Dr. Hall, 2003) to have been developed on assumptions which may or may not be true but arose out of the current healthcare paradigms which often pathologize normative, adaptive functioning and tend to be outcome focused. The second model recognizes that healing is a process rather than an event and addresses the fact that ". . . childhood trauma is a result of a "*constellation of life experiences* as well as from a discrete happening, from a *persisting condition* as well as from an acute event" (Erickson, 1995, p.185).

Healing is defined differently within these two paradigms. Healing in the first model is conceptually defined as that which removes, ameliorates, or cures symptoms or disease processes and may be determined by the provider or the system (Dossey, Keegan, & Guzetta, 2005). The holistic model incorporates a mind- body- spirit approach, which suggests an integration of the whole, but may not represent a unitary- transformative perspective of inherent wholeness awaiting appreciation. The unitary- transformative healing model is defined as a process of uncovering meaning and appreciating one's inherent wholeness in relationship with self and other and is self determined (Cowling, 2000). While both holistic models have strengths and weaknesses, the diffuse

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constellation of life patterns which emerge in many women abused as children suggest

that the unitary- transformative model of healing may be a more appropriate approach;

however there is no published research available. For this study, only those studies which

extend current models of healing beyond traditional psychotherapy and medication such

as research on coping, group process, and non-pharmaceutical interventions will be

reviewed specifically.

Theories of Healing in Women Abused as Children from Psychology and Social Work

The largest body of theory on healing and abuse was found in the

psychotherapeutic domain. Feminist, relational, family, social constructivist,

psychodynamic, behavioral, and narrative theories are interwoven with trauma recovery

in the psychology and social work literature on healing in abuse survivors (Beveridge &

Cheng, 2004; Crossley, 2000; Naples, 2003; Oz, 2005). The three main stages to recovery

from trauma theory perspectives are the building blocks of these frameworks (Oz, 2005).

Stage 1 is stabilization which includes the decision to embark on therapy, establishment

of client therapist trust, educating the client about therapy, and providing tools for

managing emotional symptoms which emerge as therapy progresses. Stage 2 is trauma

resolution, approaching and dealing with the "wall of fear", the zone between the

traumatic event and the therapy process. Stage 3 is integration or moving beyond the wall

of fear, re-envisioning life through new perceptual filters, and terminating therapy. (It

should be noted that the psychological and social work literature on healing in these

women is applied primarily to childhood sexual abuse and incest, with few exceptions of

mixed abuse and gender-specificity for women).

Beveridge and Cheung (2004) have summarized existing theoretical models in

psychotherapy for incest treatment (Table 1).

Table 1.

Theoretical Modalities and Therapeutic Techniques in Healing Child Abuse
 (Adapted from Beveridge & Cheung, 2004, p. 109)

Theories	Therapeutic Goal	Literature
Behavioral	Developing new behavioral patterns	Wolfsdorf & Slotnick, 2001 Futa, et al, 2003
Cognitive Restructuring	Creating new belief systems and repatterni thought processes	Holman & Silver, 1996 Wolfsdorf & Slotnick, 2001
Crisis Therapy	Stabilizing emotional responses to focus on healthier life patterns	Dziegelewski & Resnick, 1995 Valentine, 2000
Developmental	Recreating a lost sense of self	Coyle & Enright, 1998 Ferrara, 2002 Freedman, 1999
Feminist	Focusing on personal empowerment	Laidlaw & Malmo, 1990 Naples, 2003 Oppenheimer, 1998
Gestalt (Body-mind connection	Reconnecting mind & body with focus on present	Armsworth, Stronk, & Carlson, 1999 Atlas & Goodwin, 1999
Grief and Forgiveness	Grieving lost childhood and forgiving self and others	Freedman, 1996
Group Approach	Use of group process for support and therapeutic reengagement of trauma	Morgan & Cummings, 1999 Palmer, et al., 2004 Tyson & Goodman, 1996 Wallis, 2002 Wolsdorf & Slotnick, 2001
Humanist	Reprocessing of traumatic memories with support of therapist	Meiselman, 1990 Price, 1993
Posttraumatic Stress & Self Constructivist	Using self reconstruction theories to support emergence of personal identity an process PTSD	Courtois, 2000 Miller, 2001 Pearlman, 2001
Psychoanalytic	Aesthetic and experiential exploration of childhood trauma	Ellis, 1990 Somer & Somer, 1997
Psychospiritual	Developing higher meaning from experiences of childhood abuse	Parker, Horton, & Watson, 1997
Solution-Focused	Using a Socratic method of questioning to arrive at personally derived solutions	Bishop & Fish, 1999
Integrative	Uses multiple modalities tailored to specific needs of client	Beveridge & Cheung, 2004; Briere, 2002

I have added an integrative model which Beveridge and Cheung (2004) describe in their article, as well as research which used one of these theories in the study of physical, emotional, or mixed types of childhood abuse. The goals of each theory are listed in the table. The integrative review of psychotherapy approaches by Martsolf and Draucker (2005) supports these theoretical categories.

An evaluation of these models through the literature shows the biopsychosocial model continues to dominate the research and therapeutic interventions with women abused as children. The behavioral, cognitive, and crisis theories appear to fall into a more positivist and post-positivist domain. Developmental and post traumatic stress theories have elements of structuralism and relativism. Feminist theory is feminist and critical theory based. The other theories appear to follow postmodern and postexperimental thought. All of them are intended to be emancipatory by nature, freeing the self from historical patterns of thought, feelings, and behaviors that no longer work for the individual. The theory that appears most tested in the literature is cognitive behavioral therapy, coming from both theoretical frameworks but with a predominance for a biopsychosocial approach (Beveridge & Cheung, 2004). While there are evidence-based outcome reports which suggest high efficacy for Abuse Related Cognitive Behavioral Therapy (AF- CBT) in children survivors of abuse, there were no similar recommendations found for adult survivors. The Center for Substance Abuse Treatment has released best practice guidelines for the treatment of comorbid substance abuse and childhood abuse (HHS, 2008). A combination of gender divided group therapy and a linear 12 step program following addiction recovery guidelines is recommended.

Medical Theories of Healing in Women Abused as Children

The prior review of the medical literature on healing in women abused as children supports bio-psycho-social and epidemiological theories more consistent with a modernist approach, although this is not explicitly stated in the literature. Only one report was found in the medical literature which actually contained a conceptual framework based upon the epidemiological findings from the ACE study which was not specific to women abused as children. This framework, called the ACE Pyramid, was created to guide the research process and assess gaps in the knowledge base of the population of adults who experienced negative childhood events (CDC, 2008). It arises from bio-psycho-social and epidemiological frameworks, but is intended to guide the scientific discovery process and is less about healing in adults abused as children. Further research from the ACE study was presented as a convergence of evidence from neurobiology and epidemiology (Anda, et al., 2006).

Childhood brain development and genomic expression have been explored as theoretical possibilities for the etiology of trauma based symptoms in adults. However, the medical literature in general does not seem to use theoretical models of explanation beyond the strictly empirical model. Psychiatry refers to psychodynamic theories and theories about memory, but they arise from the previously discussed theories which developed in psychology and social work (Gold, 2001).

Nursing Theories of Healing in Women Abused as Children

Creedy, Nizette, and Henderson (1998) developed a framework for practice with women survivors of CSA. The framework is developed from self-in-relation theory and

health promotion theory. It is specific to women's health, drawing on principles of object relations and self-psychology which validate women's ways of knowing as relational and contextual.

> Instead of using traditional strategies that confine our understandings to diagnosis and criteria, self-in-relation theory helps to account for the complex fabric of the lives of women, their intimate relationships, and relationships with others in the context of culture and oppression (Creedy, Nizette, & Henderson, 1998, p. 67).

Health promotion is said to complement self-in-relation strategies as it is a process which is both transformational and political. The model was developed to provide a framework for the delivery of holistic nursing care to include the "… dimensions of reciprocity, affirmation of self, community, and environment" (Creedy, Nizette, & Henderson, 1998, p. 67). Subsequent publications which discuss testing or refining of this model were not found.

No other specific theories were found relating to healing and childhood abuse in the nursing literature. Narrative (Hall, 2000), grounded theory (Godbey & Hutchinson, 1996), and Denzin's qualitative method of interpretive interactionism (Glaister and Abel, 2001) were used as methodologies grounded in qualitative perspectives to explore healing in women abused as children, but not as healing modalities (although it could be argued that healing may indeed occur as part of the process). Glaister (1996; 1994) used drawing for healing in women who experienced childhood maltreatment, but no conceptual model is provided. Kreidler (2007) used a group approach, described above in the psychological theories, for her work with CMI women who had been abused as children.

Nursing Research on Healing in Women Abused as Children

The nursing research, although scant, provides some of the best understanding of healing as determined by the women who have experienced abuse. Glaister and Abel's (2001) study with women who felt they had achieved a measure of healing from CSA used Denzin's interpretive interactionistic method to understand and describe the character of healing, healing facilitators, and impediments to healing from an insider's view. Healing was described as a complex and difficult process in which painful experiences were used to bring forth positive changes, increased well-being, and acceptance of themselves and of events in their lives. Persistence, despair, grief, change, hope, and reiterative cycles that moved between pain and a sense of well-being were characteristics of the process.

Healing was also characterized as acceptance of self and the development of a sense of well-being and joy (Glaister & Abel, 2001). The abuse was contextually framed within the personal environment of physical space, relationship with others, secrecy, and confusion. Healing was facilitated through information, relationships, experiential activities, inner strength, skill building, commitment to a long and arduous process, and by coming to terms with the abuse, the abuser, and the self. Healing relationships were with supportive and non-judgmental groups, therapists, family, clergy, friends, nature, and spiritual beings. Expression of feelings through art and writing were especially helpful. Time alone and journaling were helpful. Commitment to healing, self care, forgiveness, and expanded ways of thinking were crucial to the healing process. The primary factors that impeded healing were relationships with therapists and other

individuals who were not knowledgeable, who did not listen, who did not address contextual issues in treatment, or who advocated medication or treatments such as hospitalization, even with good intentions by the therapist. Interventions that supported inner strength, self-empowerment, and support were the most helpful. Participants saw the other major impediment as their own self-limiting beliefs, behaviors, and perceptions. Glaister anecdotally reports on the effective use of serial self- portraits in women victims of CSA to foster self awareness, insight, and provide motivation for the intense recovery process (1996) and expressive drawings to help survivors of abuse recognize healthy boundaries (1994).

Godbey and Hutchinson (1996) used a grounded theory approach to understanding healing in ten adult female incest survivors. Grounded theory was described as two facets of a basic social problem and a basic social process. The basic social problem is the burying of the integral self, in which the woman begins to acknowledge and recognize that she has buried parts of herself, both wanted and unwanted, in order to suppress the abuse. The basic social process is the work of healing to resurrect the soul, to uncover unprocessed feelings, memories, and to commit to a healing journey. The seven phases of resurrecting the buried self include reappearing, revivifying, resuscitating, renovating, regenerating, reanimating, and reincarnating. The process is nonlinear and overlapping, often requiring work in more than one phase simultaneously. Working with a therapist who is doing their own inner work and having supportive relationships with self and others was found to be crucial to the healing

process. Impediments to healing were flashbacks, self-sabotage through old patterns of avoidance, and the difficulty in changing ingrained and outdated coping mechanisms.

In a study of 55 low income, predominantly African American women who experienced childhood abuse, Hall (2003) used a feminist narrative approach to explore themes which included the dynamics of life transitions which fostered positive outcomes and to identify themes in stories of positive life transitions after abuse. The data were organized into two process themes- epiphanies and maintaining momentum. Six elements were identified as elements which comprised the content areas for self-change: self-centering, ownership, interpersonal insulation (boundaries), willfulness, seeing options, and spiritual connection. Epiphanies were described as instantaneous moments of illumination and the most common form of self-transition in the stories. Positive transitions were dependent upon maintaining momentum and shortening the time between epiphanies. Clinical implications suggested that caregivers should realize that disruptions in the trajectory of healing are sometimes needed because they open up the opportunity for epiphanies, stability is sometimes not a desirable therapeutic goal when in transition, and intermittent therapy which fosters momentum and yet is frequent enough to acknowledge epiphanies is important. Positive transitions were related to career, own place of residency, financial self-esteem, and spiritual connection. Recommendations for care included complex and timely case management with referrals for vocational and occupational therapy, financial management, housing, and integrative spiritual counseling.

Kriedler's (2005) study of 121 women who were CSA survivors found that group therapy was equally effective for those with and without a comorbid chronic mental illness (CMI). A quasi-experimental design was used. Treatment (CMI) and control (non-CMI) groups were all CSA survivors. Both groups were assigned to weekly year long group therapy sessions. There were 25 therapy groups of six to eight participants over a six year period. Six groups of CSA had CMI, seven were women without CMI, and 12 were mixed. Scores on paired t-tests improved significantly for both groups on measures for depression, self-esteem, psychological symptoms, and responses to a childhood incest scale. There were no significant differences in scores based upon demographics or historical variables. This study highlighted the efficacy of group interventions in women abused as children as well as the need for survivor services for particularly vulnerable populations, such as those with CMI.

Martsolf and Draucker (2005) conducted an integrative review of 26 outcome studies and two meta-analyses that evaluated abuse-focused psychotherapy techniques in adult survivors of sexual abuse. Gender differences were not identified, but results found abuse-focused therapy was significantly beneficial in reducing distress, depression, and PTSD symptoms in adult survivors. All therapeutic methods were found to be beneficial across studies, with no difference between individual versus group therapy. No optimal treatment duration was found. Some of the studies included adults who had physical and emotional abuse, but studies were excluded if they did not include sexual abuse.

Research on Healing in Psychotherapy and Medicine Relating to Women Abused as Children

The research on healing in women abused as children outside of nursing overlaps between medicine and psychotherapy. The fields of psychology, biological psychology, psychiatry, social work, psychoanalysis, and counseling all contain biological, functional, sociological, and psychodynamic research on women who were abused as children. There is a large body of knowledge on healing and trauma, however most of this is not specific to women or to women abused as children. Most of this research addresses specific symptoms or phenomena, rather than healing as a process. Because of the overlapping nature of the research by discipline, this review of literature is organized by process phenomena such as group process, coping, interventions, and where found, healing across disciplines outside of nursing. Only one study was found specific to African Americans and was included in the literature review for ethnic diversity although the sample was mixed gender (Bryant- Davis, 2005).

Group Process

Research on group process for survivors of abuse suggests group therapy is effective in reducing intrusive trauma symptoms, processing emotions, and increasing positive coping and adaptive strategies in adults and adolescents (Hebert & Bergeron, 2007; Kruczek & Vitana, 1999; Palmer, Gadbois, Stalker, & Harper, 2004; Wallis, 2001). Wallis' (2001) study was with psychiatric outpatients, whereas the other studies were with psychiatric in-patients. The adolescent group (Kruzcek & Vitana, 1999) was all female, the other studies were mixed gender, but at least 75% of participants in both of

these groups were female. Two of these studies were international and one was in the US, suggesting therapeutic efficacy for group therapy cross-culturally. Additionally, a study of sexual assault survivors (n= 41) which included women abused in childhood or as adults found a feminist group intervention to be statistically significant in reducing blame/ stigmatization, sexual anxiety, and anxiety related to assertiveness at the end of the study and at three months post- intervention (Herbert & Bergeron, 2007).

Narrative

Narrative is used as both a research method and as a healing strategy. Kaminer (2006) conducted a review of the literature on the use of trauma narratives in healing. While the literature review did not specifically focus on women who experienced childhood abuse, the findings suggest this may be a powerful technique for trauma healing in these women. Six therapeutic processes were identified from the production of a trauma narrative as part of the therapy process. These included: emotional catharsis, the creation of linguistic representation of the trauma, the habituation of anxiety through exposure, an empathic witnessing of injustice, developing an explanatory account of the trauma which is cognitively meaningful, and the conceptualization of trauma as a source of personal strength and growth. Emerging techniques in therapy advocate for a new narrative co-constructed by client and therapist. The power of narrative for healing the effects of trauma was viewed as a function of the dynamic of a healing therapeutic relationship, not as an isolated technique (Kaminer, 2006).

In a feminist study of two centuries of Western narratives accounts of women abused as children from three continents, Marie Lovrod (1999) paints a portrait of women

struggling to make their outrage of childhood abuse known through their stories. Using the narratives for activism, healing occurs for the authors and for society through the breaking of the code of silence and through the elucidation of abuse as socially condoned injustice. These narratives reveal the attempts of the women to change the systems that allowed the abuse, and the responses of individuals and societies to subdue and invalidate the voices in order to maintain the cultural myths and status quo of patriarchy and dominance.

Body-Mind Therapies

Therapies that involve the body including massage, touch therapy, and Eye Movement Desensitization and Reprocessing (EMDR) especially in combination with therapy, imagery, or hypnosis have been beneficial in reducing trauma symptoms (Price, 2007; Edmond, Rubin, & Wamach, 1999; Stalker, Schacter, & Teram, 1999). Anecdotal reports from patients receiving physical therapy suggest that the patients often had spontaneous memories emerge during touch therapies. Patients reported the benefits of touch therapies in reducing physiological arousal, anxiety, and depression and improved body awareness. Many patients had accidentally discovered these benefits during periods in life when they were in counseling and had also separately sought out body therapies for relaxation and healing (Stalker, Schacter, & Teram, 1999).

In a two group repeated measures design, 24 women survivors of child sexual abuse were randomly assigned to a control group receiving a standard massage or an intervention group receiving body-oriented therapy, both over eight one hour sessions one week apart. All women had previous counseling for the abuse. Both groups had

significantly improved scores on psychological well-being, physical well-being, and body connection with decreases in dissociative experiences which lasted through the three month post-intervention evaluation (Price, 2005; Price, 2007).

EMDR (which includes support, information, cognitive restructuring, journaling and imagery) was compared to individual counseling (which incorporated integrated therapies such as hypnosis, dreamwork, imagery, art, and assertiveness training) and to controls which received delayed treatment (after the study period) in 59 women survivors of CSA for its effectiveness in reducing trauma symptoms (Edmond, Rubin, & Wamach, 1999). The EMDR and individual counseling groups had statistically significant reductions in trauma symptoms, anxiety, depression, and impact of events scores than controls which were maintained at 18 months post-study (Edmond & Rubin, 2004; Edmond, Rubin, & Wamach, 1999). Significant differences between the EMDR and individual counseling groups emerged at the 18 month study (Edmond & Rubin, 2004). While both groups maintained improved scores, the EMDR group scores for anxiety, depression, and PTSD symptoms fell within the normal range, while non-EMDR participants were improved but still within abnormal ranges on standardized measures. EMDR participants used significantly less counseling services than the individual counseling group over the 18 month follow-up period.

Isolated Interventions

Other research on healing in adults abused as children includes isolated interventions for specific symptom management. Imagery rehearsal (guided imagery plus CBT) was successfully used for the reduction of nightmares in male and female sexual

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assault survivors in three sessions and maintained improvement at six months post study (Krakow, et al., 2001). Forgiveness was found to be significantly more effective in improving self-esteem, hope, depression, and anxiety in 12 female incest survivors compared to controls in a structured intervention over a 14 month period (Freedman & Enright, 1996). Mindfulness was linked to depersonalization in childhood trauma survivors suggesting the need for mindfulness based interventions in a study of 163 men and women survivors of child abuse in Germany (Michal, et al., 2007). Art and music have been found effective in conjunction with psychotherapy, predominantly in children who have experienced abuse (Pilafo, 2006), but there was limited research found on adult or women victims of child abuse and art therapy other than Glaister's work noted above (1994, 1996). Art therapy in conjunction with psychotherapy was found effective in healing for both men and women victims of incest, however gender deconstruction is necessary for effective therapy (Hogan, 2003).

Conclusion

In overview, there is a significant body of literature on violence against women in psychology, sociology, nursing, and medicine but very little regarding this subset of women with experiences of childhood abuse. The state-of-science on women abused as children and healing shows advancing knowledge in the bio-psycho-social aspects of symptom identification and management. Many of the studies which focused on interventions with sexual abuse included women who had either been assaulted as children or as adults. Current PTSD theory suggests that the effects of childhood trauma may be more lasting and devastating psychologically if they occur at a young age and are

perpetrated by a family member. Not taking into account the age of the abuse and other factors of the situation of abuse could skew research findings in an intervention study (Naparestek, 2004).

There are few studies which specifically look at some of the life patterns in women who experienced childhood abuse and none that look at them holistically (Roman, Hall, & Bolton, 2008). Holistic and unitary theories of healing in women who have experienced abuse are absent. Recent attention has been given to spiritual theories of care, but these focus primarily on the spiritual and/ emotional dimension. They do not include the context of the whole life including physical, relational, or sociocultural patterns.

Healing has been confined to a narrow view of individual healing. Childhood abuse and its aftermath is a social illness and a public health issue (Roman, Hall, & Bolton, 2008). Research which addresses the individual within the community of origin is needed. Participatory, community action research is needed to identify and create social and familial mechanisms for healing childhood abuse on all levels.

Future research needs to address healing from a unitary- transformative perspective. There is a dearth of qualitative research and nursing research. Most of the quantitative and qualitative research on healing is limited to incest and sexual abuse survivors. The volume of research on women abused as children peaked between the mid-nineties and 2005, and appears to be decreasing. This may be related to funding, with major federal funding cuts across the board for the Violence Against Women's Act

since 2005 and dedicated funding streams diverted to sexual assault research (Biden, 2008).

There are healing modalities in the literature which are being used that show promise, but have not been researched. Women of color, immigrants, elderly, and disabled women are underrepresented. Like much of our current healthcare delivery system, research is piecemeal and fragmented on women abused as children and healing. Medicine studies the body, psychology studies the mind, continuing the Cartesian split. Research and healing methods that move beyond this dichotomy are needed so that the internal fragmentation perceived by women abused as children is no longer perpetuated by interventions or the research.

Methodological Issues in Research on Healing in the Lives of Women Abused as Children

Methodological issues are present in the current research with women abused as children. These are reviewed below. Additionally, there are issues related to designing a study with a vulnerable population such as women abused as children. The ethical issues involved will be delineated in Chapter 3. Other issues such as sampling and instrumentation are reviewed here.

In the research on healing and women abused as children, the quantitative research varied from randomized clinical controls designs to comparative and associational designs, primarily in the psychological and medical domains. Pre-test-post-test, repeated measures, and factorial designs were used in the psychodynamic research.

Cross-over designs may be difficult due to the treatment exposure effects which may be highly variable between individuals in psychotherapeutic techniques.

The qualitative research across disciplines addressed issues of transferability and rigor in their findings. Nursing research contained more qualitative research on healing than other discipline specific research. The one quasi-experimental study (Kriedler, 2005) found in the nursing literature varied controls and treatment groups by the presence or absence of chronic mental illness, with both groups receiving the intervention.

The existing research on healing and abuse is complicated by methodological redundancy. Finkelhorn (1997) states that although a large volume of research continues to develop, it is still focused on associations between childhood abuse and health outcomes, which are saturated. The focus of research should be expanded to multicontextual variables which address the policy and social infrastructure remedies for abuse prevention and treatment.

In the current literature on healing, the primary methodological issue appears to be the lack of qualitative data which gives voice to the nature of healing in the lives of women abused as children across cultural, social, educational, and economic strata within the contextual framework of their whole lives. Data collection and analysis methods are skewed by temporal and perceptual filters which are inherent in adult recall of childhood trauma, but this is to a great degree unaccounted for in the research reports. Research studies that focused on psychotherapeutic treatments tended to measure researcher defined variables such as stress, anxiety, depression. I am concerned that researcher and medical system induced bias creates a paradigm of disease and pathology which may be

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in itself traumatizing. Alternatively, researcher designed models which aim to appreciate the life patterns of women who have experienced childhood abuse may emancipate and promote a journey of self-discovery and healing 'through the dark emotions' (Greenspan, 2003).

Instrumentation Issues

Instrumentation in the quantitative research on healing and women abused as children tends to use standardized measures of symptom scales for both physical and psychiatric symptoms, depression, anxiety, PTSD, functioning, coping, adaptive skills, emotional mastery, social mastery, resolution of past symptoms, memory, self-esteem, parenting skills, life satisfaction, hope, forgiveness, dissociation, body awareness, social behavior, and other scales (Brier, 2008; Freedman & Enright, 1996; Kreidler, 2005; Kruczek & Vitana, 1999; Paivio & Laurent, 2001; Price, 2007). Instruments used were generally well described and psychometric properties were reviewed. Two instruments specifically designed for adult survivors of trauma are the Trauma Symptom Check-list 33/40, (TSC) with TSC-40 the latest version developed in 1996 (Briere, 2008). The TSC-40 is 40 item self-report measure which includes a partial measurement of the PTSD construct, sleep disturbance, anxiety, depression, sexual abuse trauma index, sexual problems, and dissociation. It is a Likert type scale taking 10 -15 minutes to complete and 5-10 minutes to score. Subscale alphas range from .66- .77 with full scale alphas ranging from .89 to .91. It is widely used in the literature. The Sexual Abuse questionnaire is a recently developed instrument to assess the presence of childhood sexual abuse in adults (Lock, Levis, & Rourke, 2005). The abstract reports good test-retest liability, internal

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consistency, convergent and discriminant validity scores in two studies done to assess the instrument, however the full article was unavailable for this review. Qualitative instruments used in the literature on healing and women abused as children are researcher designed structured and semi-structured interviews, participant drawings, and stories (Bryant- Davis, 2005; Glaister, 1996; 1994; Godbey & Hutchinson, 1996; Hall, 2003; Kaminer, 2006). Triangulated studies were predominantly quantitative with a one or two open-ended questions about the experience of the treatment (Price, 2005; 2006).

Evaluation of instrumentation issues demonstrate a lack of global measures scales that can assess the full impact of healing in the lives of women abused as children. Instruments that assess the existential and spiritual components of healing are the least used in the literature. There are few triangulated studies which may give a broader perspective about intervention efficacy and healing in childhood abuse. Sandelowski (2000) makes a case for triangulation at paradigm, method, and technique levels of inquiry. This is especially important if attempts are to be made at reconciling future research from the two primary philosophical paradigms of bio-psycho-social and holistic inquiries. Gender specific tools for evaluation of the effect of childhood abuse were not found. This may impair generalization of findings to women, especially given the relationship between the socio-cultural constructions of power and gender and narrative self- construction in women.

Sampling Issues

Sampling issues arise when trying to access vulnerable and hard to access populations (Martsolf, Courey, Chapman, Draucker, & Mims, 2006). Adaptive sampling

techniques are a two phase approach used to increase sample access in hidden populations (Martsolf, et al., 2006). It includes numerous subtypes including link tracing, using connections between people to find new participants, adaptive allocation in which conventional sampling techniques are followed by focused recruitment in areas with high concentrations of the study phenomenon, and adaptive cluster sampling designs which start with conventional sampling followed by sampling of people or areas in close geographic proximity to the first participant who has the variable of interest. Structured community nursing assessment was used by Martsolf, et al., (2006) to successfully enhance this technique to recruit a community based sample of sexual violence survivors, target individuals living in high risk situations, and collect a socioculturally diverse sample. Methodological sampling limitations found in the earlier review of literature included convenience samples, small sample sizes, and lack of socioculturally diverse samples limiting generalizability.

Recommendations for Future Research

Based upon the gaps identified in the literature noted above, there is a dearth of qualitative research on healing in the lives of women abused as children. Qualitative approaches which may be utilized in research on healing in the lives of these women include qualitative participatory design methods which focus on healing through participation and emancipation. Qualitative studies which use extended epistemologies through aesthetics, practical knowing, expression, and paratelic discovery would develop further areas of knowledge for exploration while expanding current theoretical models of healing. Methods such as unitary appreciative inquiry (Cowling, 2001) which focus on

wholeness should be explored for their potential in reframing the sense of victimization into an emancipatory appreciation of what exists. More qualitative research on gender and culturally based constructions of the effects and healing of childhood abuse is needed using grounded theory, ethnology, phenomenology, and narrative (Munhall, 2007).

The research on healing and women abused as children is heavily weighted by objective measures of specific and focused constructs about healing isolated symptoms or symptom clusters. Women of color, immigrants, elderly, and disabled women are underrepresented. Gaps in the quantitative literature include measurement of integrative and existential healing in women abused as children and intervention methods which are based upon women's own perceptions of what constitutes healing.

Research is needed to address healing as a community, and healing from a unitary- transformative perspective. Nursing research is very under-represented. Most of the quantitative and qualitative research on healing is limited to incest and sexual abuse survivors. The volume of research on women who experienced childhood abuse peaked between the mid-nineties and 2005, and appears to be decreasing. This may be related to funding, with major federal funding cuts across the board for the Violence Against Women's Act since 2005 (Biden, 2008). There are methodological issues with some of the research. Sample sizes tended to be small even in quantitative studies. There are healing modalities in the literature which are being used that show promise, but have not been researched.

Current theoretical models of healing with women who experienced childhood abuse are individually and bio-psycho-socially based. Shifting the focus of inquiry to a

unitary perspective within a participatory design will provide important knowledge and fill gaps in the current literature on healing with these women. A unitary model of healing which comes from a relational and appreciative vision of inherent wholeness offers a unique framework for this research study and for advancing nursing knowledge. UAI as a method for both research and praxis offers the opportunity to explore healing from a potentially transformative and emancipatory inquiry within the life patterns of women who have experienced childhood abuse.

Participatory Dreaming

Dreaming as a Beyond-Waking Phenomena

The literature on the use of altered states of consciousness (ASC) to heal trauma is vast, but there is little in the research pertaining specifically to dreaming in women abused as children (Putnam & Carlson, 2002). Dreaming, hypnosis, guided imagery, meditation, creativity, prayer, music, and ritual all encompass elements of expanded or altered states of consciousness which Rogers defined as 'beyond waking' (Rogers, 1992). The use of ASC's for healing extends as far as recorded history (Tedlock, 2005). Records of dream incubation for healing and divination were found in cultures from ancient Greece to China (Hoffman, 2004; Littlewood, 2004). Beyond waking states are used for healing in shamanic and indigenous healing ceremonies (Tedlock, 2005). Dream work, trance, art, and imagery is used for healing in medicine, psychology, and nursing (Lane, 2006; Moyers, 1993; Tedlock, 2005; Valente, 2007).

There is strong evidence that beyond waking states such as dreaming, trance, imagery, creativity, and meditation are very powerful adjuncts in recovering an integrated sense of self (Bensimon, Amir, & Wolf; 2008; Pantesco, 2005; Putnam & Carlson, 2002). Beyond waking states work in limbic, autonomic, and sensory-motor areas of the mind-body which affect memory, perception, emotion, and body awareness (Rossi & Rossi, 2007). Nuclear imaging studies suggest that traumatic and narrative memory are stored differently and are physiologically distinct processes (Hall & Powell, 2000; van der Kolk, 2006). Memory associated with trauma and any deep emotional state is stored in different areas of the brain than regular memory and bypasses normal memory processing circuits as a protective feature (Bartol & Courts, 2005). Theories of trauma suggest that this bypass mechanism (a self- protective feature meant to create super conductors bypassing the cognitive centers for instantaneous recall under attack) gets stuck in a repetitive feedback loop, creating many of the symptoms of PTSD such as hyperarousal, uncontrolled dissociation, anxiety, and fear (van der Kolk, 2006). Pain, affect, and emotions such as shame, grief, and fear are linked to this accelerated loop of perception, creating a roller coaster of physiological, emotional, and somatic arousal. Memories and emotions are triggered spontaneously, bypassing cognitive control, and often appearing irrational to the self and others (van der Kolk, 2006). Additionally, these memories are retained as fragments, rather than as aspects of an integrated holistic gestalt of understanding (van der Kolk, 2006). This can contribute to a sense of lost or buried parts of the self. Dreaming is a beyond waking state which works in the same right brain processing centers as the trauma processing centers, creating an accelerated and

integrative modality for reprocessing, reframing, and restoring neural circuitry to pre-traumatic arousal levels (Rossi, 2002; Rossi & Rossi, 2007). Dreaming is by nature holistic, holographic, and creative (Kremer, 2006; Mageo, 2004) and provides a metaphoric perception of patterns in which the dreamer can appreciate a larger perspective of the whole (Jung, 1964).

Dreaming is used for existential discovery and transpersonal exploration (Jung, 1964). Beyond waking states such as dreaming, art, play, and imagination are paratelic modes of cognition which offer solutions to pragmatic dilemmas in playful and analogical ways not apparent to the waking or teleological mind (Littlewood, 2004). Dreaming is a multisensory experience which is pandimensional and kairotic, extending beyond time and space to access the deepest wisdom of the psyche (Jung, 1964; Wilber, 2000). Expanded states of consciousness are associated with feelings of oneness and transpersonal unity, which arise in right hemispheric function of the brain (Tart, 2000). Art, spirituality, dreaming, creativity, intuition, and imagination are also right hemispheric functions (Tart, 2000). Survivors of abuse themselves identify meaning making, spiritual practices, relationality, and art as healing (Bryant- Davis, 2005; Glaister & Abel, 2001). The use of beyond waking states induced through art, trance, dreaming, ritual and ceremony, spiritual practices, and prayer may offer both symptom relief and transpersonal resurrection of the core self, lost during childhood trauma (Epstein, 2004; Naparastek, 2004; Sheikh, 2003). These methods inherently underscore the wholeness of the person by using the part of the mindbody that instinctively understands and perceives its wholeness.

While dreaming was used extensively for healing before the Renaissance period in Western healing traditions, the Cartesian influence on science has moved current healing paradigms into the realm of the empirical and rational, leaving the analogical and paratelic healing methods relatively unexplored (Epstein, 2004; Tedlock, 2005). Freud's work on dreaming (1900) changed the nature of the study of consciousness and renewed interest in beyond-waking phenomenon as worthy of scientific exploration (Harris & Lane, 2003). The study of dreams has to a great degree remained under the purview of psychology, which has deeply influenced our understanding of dreaming as an individual phenomena (Epstein, 2004). However, more recently anthropology and sociology have also contributed to the study of dreams and dream-states, expanding current conceptualizations of dreaming as a group or collective process and influencing psychodynamic theory and theories of healing (Jung, 1965; Lawrence, 2005; Tedlock, 2005).

Dreaming as a Beyond-Waking State in Psychology

Dreaming, once thought of as a discrete phenomenon separate from waking consciousness, is now understood by many researchers as a continuum of consciousness extending from beyond wakefulness (Epstein, 1992; Hartmann, 2000; Lawrence, 2005; Tart, 2000; Ulmann & Limmer, 1999; Wilbur, 1997). Hartmann (2000) developed a model of this continuum which moves through four levels of consciousness from waking thought to dreaming. The first level is described as waking awareness, in which logic, words, and a high degree of self- reflection (egoic thought) are characteristic of the mind processes being utilized. Level one is also characterized by serial processing and

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consequential thoughts (A→ B→ C). Boundaries between waking thoughts are considered thick, with discrete compartments and clear focus. Levels two and three are somewhat contiguous with each other and move from looser, less structured waking thought (level two) to reverie, free association, and daydreaming (level three). Words become less important, visual- spatial perceptions increase, and metaphoric constructions appear and increase as one moves toward full dreaming. The boundaries between thought constructs become thinner and move more freely between compartmentalized ideas. Creativity increases as thoughts flow more freely and self-reflection decreases. The daydreamer is more caught up in the flow of imagery and the process. The fourth level is dreaming which is almost pure imagery, with very thin boundaries as images float freely beyond time and space. Egoic or self- reflective thought disappears and the dreamer is simply 'there'. This level is comprised of almost pure metaphor. In this model, hypnogogic states such as those found in hypnosis, guided imagery, and shamanic trance would move between levels three and four.

There are many types of dreams. Dreams may be mundane and work simply to store memory or process daily events (Kramer, 2007; Occhionero, 2004). Other types of dreams may be used for healing. These are impactful dreams such as nightmares, existential dreams, and transcendent dreams which occur during sleep (Kuiken, et al., 2006). They are used for existential inquiry, cognitive restructuring, psychoanalysis, and spiritual discovery (Jung, 1965; Kuiken, et al., 2006). Dreams may be told to a therapist and the therapist assists the client in understanding the dream symbolism as it relates to his/ her personal life. Lucid dreams are dreams in which the dreamer awakens in his/ her

dream and participates knowingly in the dream while still asleep (LeBarge & DeGracia (2000), indicating a co-creative stance within the dreamer. Dream researcher LeBarge (1985) believes dreaming frees the dreamer from linear, logical, and egoic thinking to serve creativity, opening the psyche to ideas and new ways of seeing that bypass normal waking consciousness. Mutual dreams are dreams which occur almost simultaneously in two or more individuals and have a transpersonal dimension (Krippner & Faith, 2001). Research on these types of dreams have contributed to theories about the non-local nature of consciousness (Barrett & McNamara, 2007). This research used a waking dream process, therefore the rest of this review of literature will focus on non-sleeping dreaming as a beyond-waking phenomena and on dreaming as a participatory phenomena.

As early as 1930, methods of waking dreams were used for healing in psychotherapy (Epstein, 1992; 2004). Robert Desoille, a French psychotherapist developed a technique called "reve eveille dirge" or directed waking dream, wherein the patient was directed in an imaginal reverie in which he/ she was the hero (-ine) transforming subliminal blocks into new adaptive behaviors (Epstein, 1992). Italian psychiatrist Roberto Assagioli (1965) combined imagery with dreamwork, in which the patient would imaginally engage a person encountered in the dream or extend the dream in a beyond-waking state guided by the therapist (Epstein, 1992). Carl Jung (1965) used a technique he called active imagination to help clients finish an interrupted dream for insight and to foster individuation of the self. Psychiatrist Gerald Epstein (2004; 1992). developed a technique called Waking Dream Therapy where dreams are explored in a deeply relaxed state and then fulfilled in waking life. Waking Dream Therapy can be

used outside of traditional psychotherapy because the therapist acts as only a guide, assisting the patient into a relaxed state and facilitating the patient's inner exploration and reinforcing the patient's own inner resources when difficult emotions arise (Epstein, 1992).

Research on waking dreaming includes waking dreams, guided imagery, meditation, and hypnogogic states such as those during hypnosis as well as visualization used for healing. A review of CINAHL, PUBMed, EBSCO, and PsychInfo found no research articles specific to women abused as children and these topics. Research demonstrates the efficacy of these modalities in non-specific trauma, PTSD, autoimmune disorders, cancer, mood disorders, pain, stress, childbirth, cardiovascular disease, stroke, counseling, grief, and peri-operatively (Gruzelier, 2002; Menzies, Taylor, & Bourgignon, 2006; Punamaki, 1998; Rossi, 2005; Trakhtenberg, 2008; Valente, 2007). Guided imagery alone and in combination with various somatic therapies has been studied and found to be more effective than cognitive therapy alone in patients who experienced trauma (Naparestek, 2004).

In mixed samples which included women abused as children, imagery rehearsal treatment (scripting new dreams) was found to be significantly successful in reducing nightmares in 114 female sexual assault survivors with PTSD, 58% reporting childhood sexual abuse (Krakow, 2001). Germain, et al., (2004) also found imagery rehearsal treatment to be effective in increasing mastery over negative elements in nightmares in 44 female sexual assault survivors who were not delineated by type or age of assault. The successful use of imagery is described with case examples for the treatment of

dissociation associated with internal models of protection in child abuse survivors

(Thomas, 2005). Hypnosis has been used for memory retrieval and healing in adult

survivors of abuse with mixed results and concerns about the legitimacy or accuracy of

the retrieved memories (Hopper, 2005).

Dreaming as a Beyond-Waking State in the Social Sciences

Dreams are considered social and cultural phenomena which represent the

collective myth of a group or society (Stewart, 2004). These phenomena exist within the

historical and ecological constructs of the culture. The contextual study of dreams within

psychology has shaped our entire science of dreaming (Tedlock, 2007). By placing the

primary study of dreams within the individual, the collective understanding of dreams as

a function of society may be underrepresented in science and discovery (Tedlock, 2007).

Early Victorian understanding of dream relevance in primitive cultures reflected a

perception of superiority of civilized cultures over indigenous tribes, who were

considered fantasy- prone (Stewart, 2004). In the early 1900's philosopher and

anthropologist Lévy-Bruhl challenged this view by contending that aboriginal cultures

viewed dreaming as beyond waking, ". . . exceptional knowledge, sometimes more

significant than waking knowledge . . . and what mattered were the affective resonances

of experiences, which he termed mystical participation" (Stewart, 2004, p. 77). This

paradigm then moved from purely social constructions of dreaming to an anthropological

discourse which followed the psychoanalytical theories with the development of

ethnopsychology and ethnopsychiatry (Littlewood, 2004; Stewart, 2004). An increasing

focus on 'selfscape dreams' (Hollan, 2004) and the context of an individual's dream

meaning within a cultural perspective continued until the postmodern crisis of representation arose within qualitative domains of inquiry (Denizen & Lincoln, 2008; Tedlock, 2005). In the social sciences, dreaming is currently studied as complex psychodynamic and interpretive communication within the full social contextual field of the culture (Tedlock, 2005).

However, dreams are communal as well as individual. In indigenous cultures, dreaming is a process which continually creates and recreates the world each day (Wax, 2004). Dreams confer power through the strength of their relationship with the beings of the natural world. Shamanic dreaming is an intentional and conscious participation between the shaman, the spiritual and phenomenological worlds, and the community (Kremer, 2007; Tedlock, 2005). The shaman uses incubated dreams as an intermediary between the senses and the intuition, to transfer information and to restore balance to the patient and the community. Healing is a natural by-product of restored balance and harmony. The entire community may come together to support the patient and to share stories, music, dancing, and re-enactment of the dream. The dream is a participatory process used to predict future events, create new cultural myths, or to confer meaning to current events. Tibetan dream yoga and dream journeying are powerful methods used to travel in the spiritual realms for enlightenment and knowledge to be shared with the community (Hagood, 2006; Krippner, 2007).

Anthropologist and shaman Barbara Tedlock (2004) has proposed an enactive theory of dreaming in Native American cultures in which the dream is moved from a personal experience to an interactive social process. The dream field exists in sacred

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space, neither within the mind/ body nor the outside world. The dream is co-created through a process of living in and dialoguing with the world. Dreaming is considered both a waking and a sleeping process which occurs whenever energy flows toward the spiritual and the psyche and away from the perceptual senses:

> In Native American societies, dreaming and waking reality are not compartmentalized worlds, but rather overlapped experiences. Dreams provide an arena where human beings come into intimate contact with fused natural and spiritual worlds. This commonly occurs when one is fully within the landscape and social action of dreaming but on the edge of waking consciousness. All of a sudden one realizes that one is awakening to the outer world but still engaged within the images of the soul (Tedlock, 2004, p. 188).

Waking dreams may include visionary experiences of mythical or archetypical figures which inspire radically new or creative ideas (Wallaert, 2006). Ethnographic research shows that waking dreams may be specifically induced for creative inspiration in Native American bead-making (Wallaert, 2006); for hunting and protection by Sambian warriors (Herdt, 1999); to successfully raise chickens by Peruvian household women (Brown, 1999); and to spontaneously enter a trance by Quiche Mayan 'daykeepers' (Tedlock, 1999). A participatory relationship exists between the dreamer and the dream, an active engagement of imagination and future possibilities. In cultures who value dreaming as an extension of everyday reality, dream cultivation is a prominent feature of social and community life (Wallaert, 2006). However, the increasing acculturation into Western ideologies by indigenous groups has fostered a loss of communal dreaming as a way of being. This loss of a communal lifestyle has been proposed as a cause of cultural

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dissonance and socially constructed illnesses in these populations, such as Native

Americans and Australian aborigines (Wallaert, 2006; Wax, 2004).

A loss of reverence for dream sharing and enchantment with the

phenomenological world pervades Western culture, contributing to an increasing

disconnection with our ecosystem (Wax, 2004). Ullman (1999) calls for a sociology of

dreaming, a bidirectional use of dream imagery for both self and society. The

unidirectional focus on the individual's dreams in Western empirical traditions as a

discrete phenomena intended only for self use is both emblematic of and contributory to a

cultural ethos of separatism. In *Dreamwork, Anthropology and the Caring Professions*,

anthropologist Iain Edgar (1995) makes a case for the use of dream groups to foster a

unity of personal and social awareness and change, ". . . dreamwork is a culturally

specific process that changes over time and is a social, political, personal, and

professional source of intriguing and usually neglected potential" (p. 124). Group

dreaming sharing can be used for community healing, to re-examine social truths, and to

creatively explore and recreate a more humane and sustainable society (Hillman, 1999;

Lawrence, 2005; Ullman, 1999).

Jaenke (2006) proposes a communal relationship between dreamers and the rituals

which appear in dreams. Her belief is that lost fragments of collective consciousness

appear in the dreams of individuals, waiting to be brought back into the community. This

is the mirror image of Jungian thought in which the big dreams are given to individuals

from the collective consciousness for the personal process of individuation. These rituals

guide the community back toward balance and collective life. Marginalized voices, social

injustices, and community fragmentation are healed through the use of these powerful

and archetypical rituals dreamed by the individual for the community. The structure of

the community is mirrored in dreams and these dreams act as a template for higher

wisdom and ecological reconnection between the community and the environment.

Social dreaming was developed as a result of experiments in group dream sharing

by social psychologist Gordon Lawrence (2003). Drawing his ideas from dreaming and

group process developed by Foulkes (1973) and Bion (1961), Lawrence designed a

dream matrix, a collection of individuals who gathered to share personal dreams through

a socio-centric rather than an egocentric lens. The dream was seen as a mechanism to

synthesize fragments of emotions into a whole or gestaltic perception of meaning

(Lawrence, 2005). The focus of the work is the epistemic understanding of the social,

political, and cultural orientation of the dreams.

> From these thoughts the human mind culls elements that form a pattern the human
> binds together by a name or a number so they can be filled with meaning. Once this
> happens they become part of the culture of society, part of finite knowledge   . . . this
> apprehension of new patterns of facts become useful when the social dreaming matrix
> is used as a tool of action research (Lawrence, 2003, p. 611).

In this theory, dreaming is seen as essential for generating new knowledge and as

the source of creativity. Like UAI, social dreaming is participatory and draws from

extended epistemologies which are focused on knowledge development and

emancipation. In the matrix, a group of between six to 40 people convene and use free

association and dream amplification to make connections between personal dreams and

social reality. The concept of the matrix embodies connection and is conceptualized as a

web of extended mental processes which are the foundation of any social group. The emphasis is on the dreams and their social constructions, not on the personal dreamer (Lawrence, 2005; 2003). This technique has been used to assist organizations in bringing forth the unconscious aspects of the social consciousness of the group for the development and change in the system.

A holographic theory of dreaming is proposed by Mageo (2004). Personal dreams are viewed in fragments of holographic images which arise from within the culture. The purpose of the dream is to flesh out the contradictions and dissonances of the culture in order to bring meaning to the culture's symbolic psychological world. A participatory stance exists between the dreamer and the culture in which the dream acts as a catalyst for cultural interpretation and change. A holographic theory implies an inherent unity between the dream, the dreamer, and the community. This is consistent with the conceptual basis of the theory of social dreaming, wherein the purpose of the dream is to integrate disenfranchised emotional fragments into a meaningful gestalt for the dreamer (Lawrence, 2005).

Dream metadiscourse has been methodologically restructured in linguistic research (Graham, 2000). The nature of how dreams are expressed within a public domain and how they circulate within the community has taken precedence over the content analysis of dreams. This also signifies a shift from an egocentric to a sociocentric stance on the importance of dreams in the cultural metanarrative. Performance and language are the primary means of dream sharing and dream interpretation arises from the linguistic narrative of a culture (Graham, 2000). Metaphor is the imaginal basis of

dreams, myth, and art which is culturally defined and socially constructed (Rasmussen, 2002; States, 2003). A dream performed as an aesthetic expression extends the individual's dream into collective experience:

> Many language and performance-centered analyses emphasize relations and interactions between dream re-presentations and their discursive practices within communities. These studies stress that dream expressions and other narratives are part of a community's discursive field whose constituents interact and are mutually influential. . . Dreams are a source of creativity and innovation for a culture's expressive repertoire (Graham, 2000, p. 62- 63).

The relationship between dreamers and the environment was explored in a participatory dreaming study between individual dreamers and sacred sites in the United Kingdom (Krippner, Devereaux, & Fish, 2003). The individual's dream content and quality of dreams was the basis of analysis as a dreamed response to sleeping in a sacred place. This is echoed in the ethnographic literature which suggests a participatory relationship between the seascapes and the landscapes and the dreams of the people who inhabit them (Kremer, 2007; Littlewood, 2004; McNiven, 2004).

Dreaming as a Beyond-Waking State in Nursing

There is little research on dreaming or beyond waking states in the nursing literature. Disruptive dreaming during and after traumatic events such as after critical illness (Claesson, Mattson & Idvall, 2005; DE Papathanassoglou & Patiraki, 2003; Richman, 2000; & Roberts & Chaboyer, 2004) and during pregnancy after the loss of a previous pregnancy (Van, Cage & Shannon, 2004) are the primary foci of dreaming research in nursing. Spiritual transformation, perceptual in-body transformation, adverse

hallucinations and increased dreaming associated with extended (greater than 72 hours) stays in critical care, the use of narrative in understanding and transforming dreams of affliction experienced from catastrophic illness, and dreaming as a cause of sleep disruption and its effect on the health of pregnant women were emergent themes from the data. Interestingly, most of this research was done outside the U.S.

Watson (1999) developed an instrument, the Assessment of Dream Experience (ADE), using a Rogerian model to measure the beyond waking experience of dreaming. A four point rating scale was used to measure 20 words used to describe dreaming consistent with Roger's model of unitary science and human field patterns (Watson, 1999). Watson's definition of dreaming as a beyond waking experience was previously explored in this paper.

Studies in the nursing literature on dreaming that had a participatory focus were rare. Cohen and Bumbaugh (2004) did a phenomenological study with six oncology nurses participating in dream groups. Small dream groups were found to be beneficial in the oncology setting. Benefits included development and maintenance of team building within healthcare environments, feelings of support for nurses in their own search for phenomenological meaning, enhanced care-giver empathy with patients, and usefulness as a tool for participant self- reflection.

An organizational behavior model called appreciative inquiry (Cooperrider & Srivasta, 2000) was used by Carter (2006) to develop a best practices model for a complex organization which serves complex needs children and their families in the United Kingdom. Dreaming as waking imagination is used as a group process to

collectively dream new possibilities and create sustained change in organizational

structures and processes. The group successfully used appreciative inquiry to creatively

focus their energies into a unified plan for growth and change in delivery services to their

patients.

A report of six case exemplars of dreaming from a dream-sharing group was used

to demonstrate the power of a participatory format to foster spiritual awareness in

dreamers (Dombeck, 1995). Dream meaning was both specific to individual dreamers

and extrapolated by the group for group meaning. This mirrors a social dreaming format

discussed above. Donnelly and McPeak (1996) described three case studies in which a

Freudian theory of dreaming was successfully used for healing and self- development in a

clinical nursing practice. Dream sharing is considered an appropriate modality for nurse-

patient communication outside of a psychotherapeutic context. The value of enquiring

about and listening to patients' dreams is discussed as an important adjunct to holistic

patient care.

Participatory Dreaming: A Unitary Phenomena

Another proposed model of dreaming arising from a unitary appreciative

perspective is participatory dreaming (Figure 1). "The model of participatory dreaming is

conceptualized as a stream of universal consciousness which is at once the basis and the

field from which all dreams arise" (Repede, in press).

Figure 1.

Model of Participatory Dreaming
(Repede, in press)

Individual Dreaming
Cultural Dreaming
Ecological Dreaming
Societal Dreaming

UNIVERSAL
CONSCIOUSNESS

Daydreams
Free Association
Reverie
Focused Imagination
Art
Expressive Performance
Hypnosis
Shamanic Healing
Guided Imagery
Incubated Dreams
Lucid Dreams
Night Dreams
Transcendent Experiences
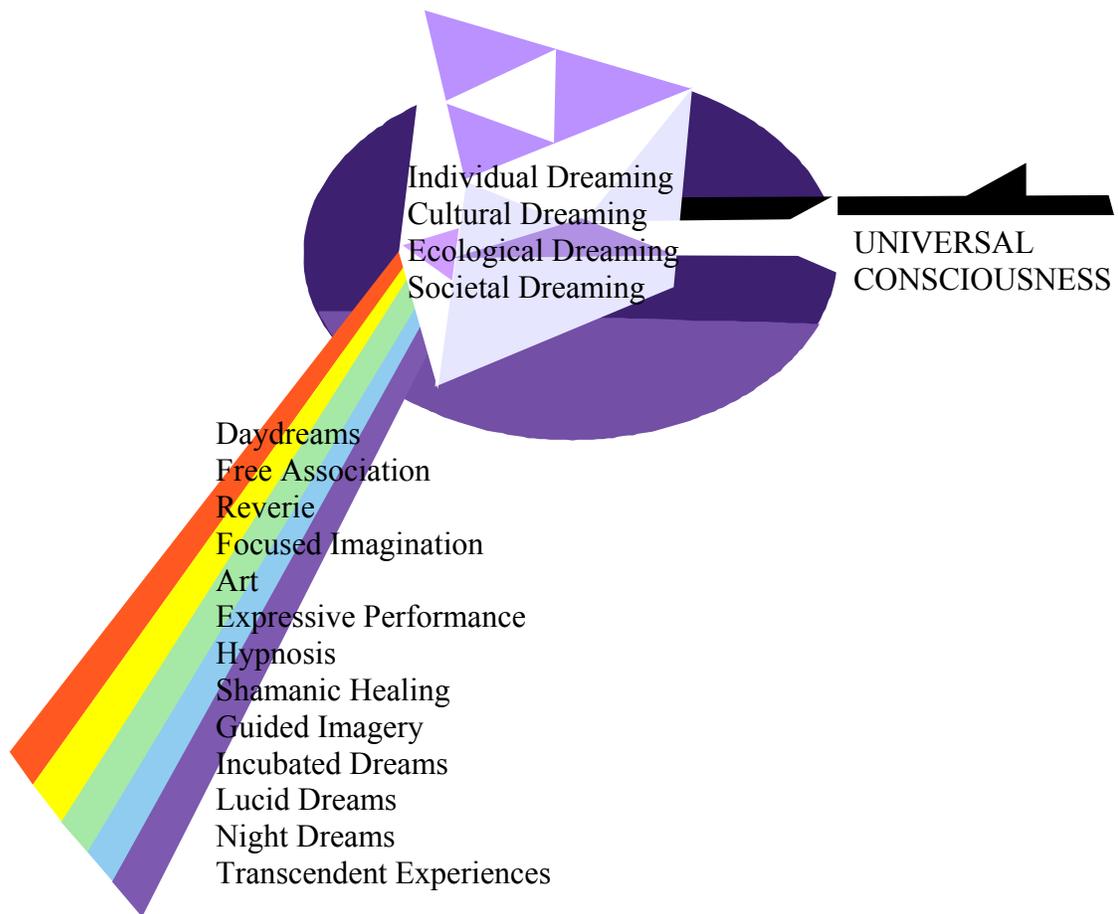
It is based upon the assumption of a relational and participatory universe which is

inherently whole (Cowling, 2001). The premise of this model is that while we exist in a

unitary cosmos, human perception is filtered through consciousness in the same manner

that a prism refracts and reflects white light into a visible full spectrum of color. Life

patterns are reflected through beyond waking states through such things as dreams,

imagination, imagery, art, expressive performance trance, and transcendent experiences.

Dreaming emerges from within this universal field of consciousness through individuals, cultures, societies and through the ecological relationships within and between them. Human consciousness acts as prism for universal consciousness which allows previously invisible patterns to become visible. There is a dynamic flux between and within all elements of consciousness, moving in ripple like waves through pan-dimensional space. The rays of refraction are symbolically used to categorize differing states of beyond-waking, however they are contiguous with the field and free flowing. Daydreams, free association, and reverie are states beyond waking with thinner boundaries, less self-reflection, and increasing imagery than full waking (Hartmann, 2000; Kahn & Hobson, 2004). Focused imagination, art, and expressive performance move into increasingly expanded perceptions and less egoic awareness than daydreams or reverie. These states are associated with more focused creative energy in paratelic modes of cognition than waking or daydream states.

Hypnosis, guided imagery, shamanic healing, incubated dreams, and lucid dreams are fully metaphoric but are interactive with the waking consciousness of the dreamer to some degree (Hartmann, 2000; Kahn & Hobson, 2004; LaBerge & DeGracia, 2000). Night dreams which are not lucid and spontaneous transcendent experiences are also fully metaphoric but lack the element of conscious awareness within the state (Windt & Metzinger, 2007). Movement is continual and fluid in consciousness, and a shift from daydreams to transcendent experiences can occur in the moment. Participatory dreaming is understood as simultaneously individual and collective, with elements of both personal

and transpersonal imagery. The dream state is a vehicle for moving information within the universal stream of consciousness through pandimensional space.

Participatory dreaming is a model which focuses on the communal aspects of dreaming, the flow between the dream, the dreamer, and the collective consciousness of humanity. It was theorized here for the purposes of this study that a waking dream can be incubated or guided with a group as well as with individuals for the purpose of discovery, illumination, and creative connection between the group members. While other models of social dreaming use individual dreams in a group process, this model was used to facilitate a group dream as a participatory exploration of wholeness in the life patterns of women who experienced abuse as children. This dream will be creatively expressed by participants through performance, story-telling, or an artistic representation such as a group collage using a sociocentric rather than egocentric lens.

Conclusion

Dreaming is understudied and underutilized in the nursing research in general and almost absent in the literature on healing and women abused as children, specifically. There are no studies on dreaming and healing in the lives of women abused as children in the nursing literature. Dreaming is a universal phenomenon across societies which reflects aspects of the life patterns of both individuals and cultures in a participatory dance between the dream and the dreamer. Waking dreams have been successfully used for illumination, for healing, and for transformation for millennia in every society. Research on waking dreams in the form of guided imagery, art, and trance has been shown to be significantly effective in healing with general trauma and PTSD in the

general population. A model of participatory dreaming was proposed which includes

waking dreaming as a beyond waking state. It was theorized that a waking dream may be

facilitated for the purpose of illumination, knowledge, and transformation in a

participatory research collaboration with women who have experienced abuse as

children.

Sensitizing Perspective on Unitary Healing and Women Abused as Children

The ontological and epistemological structure of unitary healing is the foundation

for a developing science and practice of wholeness (Cowling & Repede, 2009). In the

research on healing in women who experienced abuse as children, the current

paradigmatic umbrella arises from an existentially opposite viewpoint in which

wholeness is to be found or developed as a result of the healing process. There is a

parallel between left and right hemispheric functions of the human brain and the

perceptual framework of these two differing ontologies of healing which provides a

useful metaphor for understanding the need for two distinct types of knowledge

development. The mechanisms of discovery and epistemological methods will

necessarily be quite different within these paradigms.

The right hemisphere of the brain provides the gestalt of human understanding

(Bolte Taylor, 2008). It is holarchical, spatial, visual, boundaryless, analogical, and

creative. Patterns are revealed through metaphoric language, dreams, imagery, intuition,

art, aesthetics, and imagination which are the primary ways of knowing for the right

hemisphere of the human brain. Relationality is the core function of the right hemisphere-

relationship to self, to other, to the collective, and to the universe. The essential functions

of the left hemisphere are linear, logical, categorical, boundaried, and individualistic. The

left hemisphere is hierarchical, goal directed, and task focused. Its purpose is to take the

larger understanding of the right hemisphere and create the structural components

necessary to function in daily tasks of living. Language in the form of narrative and math

are the primary ways of developing, perceiving, and communicating ideas or knowledge

that is developed within this teleological mode of operation. Ways of knowing will both

emanate from and reveal knowledge in conceptually congruent patterns according to the

paradigm one wishes to explore (Chinn & Kramer, 2004). The current research in nursing

is highly underrepresented in the intuitive, aesthetic and relational ways of knowing often

considered to be feminine ways of knowing (Mckinnon, 2005) and highly suitable for

research with women (Chinn & Kramer, 2004).

Research on women abused as children has predominantly occurred in the

equivalent of the left brain tradition, an empirical model which has existed for several

hundred years. Specific symptoms, patterns, and life style dysfunctions have been

isolated and ranked hierarchically by the amount of pain, lifestyle disruption, and

disability they cause and how each alone or in some combination can be remedied. The

goal of interventions is a return to an improved functional status, reduced symptoms, and

better health or health patterns. The individual is the focus of treatment, but the research

aims to discover what helps the most women the most often in one or more parameters of

measurement. Research methods are primarily quantitative, measuring outcomes in

statistically oriented and categorical ways of knowing. Based on this research which has

had limited success with achievable and reproducible interventions, the focus of treatment has been talk therapy, a function of narrative left brain cognition and understanding.

A recurring theme in the qualitative research on healing in women who have experienced childhood abuse is the relational quality of their life patterns, with themselves, with their families, within their communities, and with their spiritual connection to the universe (Beveridge & Cheung, 2004; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Hall, 2003). Disruptions in a sense of core self, fear of imposing wounds on their children, repeating patterns of abuse, addictions, and feelings of alienation from family, friends, and community are consistent throughout both the qualitative and quantitative literature (Beveridge & Cheung, 2004; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Hall, 2003; Martsolf & Draucker, 2005). In the reports of women who felt they had achieved a measure of healing, a sense of emergent wholeness was a consistent theme related to feeling healed (Beveridge & Cheung, 2004; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Hall, 2003). Facilitators of healing were identified by the women themselves as information, relationships, experiential activities such as groups, art, spiritual practices, developing a sense of inner strength and beliefs, life skills, and acceptance of themselves and their experiences (Beveridge & Cheung, 2004; Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Hall, 2003). Healing was associated with appreciation of themselves and their lives by creating meaning (Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Hall, 2003). Emancipation came through knowledge and knowing participation in their life patterns. Change occurred as

they began to understand and release old unconscious patterns of thoughts and behaviors, as they expressed feelings, and as they became visible to themselves and others. The healing journey was described as nonlinear, intuitive, and as a metaphoric journey of the soul (Glaister & Abel, 2001; Godbey & Hutchinson, 1996; Hall, 2003). Healing occurred in epiphanies (a gestalt of understanding which would emerge intact) followed by an active engagement with the enactment of the newly revealed information through embodied actions (Hall, 2003).

The theory of unitary healing is conceptually congruent with a qualitative study of healing in women who have experienced childhood abuse. It provides a unique and novel method of discovery that speaks to the nonlinear, holarchical, metaphoric, and intuitive ways of healing described by the women themselves. It is based in a participatory framework which:

> flows from a unitary perspective of a world which that is in continuous, mutual process. Participation is a mode of appreciating wholeness capitalizing on the mutual and communal nature of the world enabling a unitary participatory knowing that goes beyond analytic knowing, although it may encompass aspects of analytic thinking (Cowling & Repede, 2009).

The embodied ways of knowing which are participatory in unitary healing are relational, representational, and reflective (Reason & Bradbury, 2001). They include extended epistemologies which are interdependent and include experiential, presentational, propositional, and practical knowing (Heron & Reason, 2001; Reason, 2005). This offers the possibilities of illumination through understanding, consciousness raising, and envisioning new ways of being and acting in the world with conscious

intention and reflection for women who have experienced childhood abuse. A participatory framework is ideal in restoring a sense of control to women whose lives have been negatively impacted by prior power imbalances.

The core focal dimension of unitary healing is wholeness and the core process dimension of unitary healing is an appreciation of wholeness without boundaries, without limitations, and without essentializing labels or diagnoses (Cowling, 2007; 2001; Cowling & Repede, 2009). This awareness of appreciating wholeness as an aspect of healing was noted by the women in each of the qualitative studies. In the current healthcare system, wholeness is an objective to be achieved. Replacing this perceptual filter at the beginning of a woman's journey of discovery with a reflection of wholeness which is shared in process with another may offer new ways of appreciating healing for these women.

The patterns of epiphanies and maintaining momentum described by the women in Hall's (2003) study is contextually congruent with the idea of right hemispheric cognition, a paratelic quality of knowing. Guided imagery has been found superior to talk therapy in healing with victims of PTSD (Naparastek, 2004). In fact, talk therapy is often contraindicated initially because the narrative type of language (a left hemispheric function) used often reinforces the compartmentalized fracture of the psyche. It is within the holistic and unitary perception of the paratelic, (right hemisphere) mind that synthesis and integration is able to be perceived. So imagery, dreams, metaphor, art, spirituality, and creativity act as the synthesizing functions of the human psyche and may be superior to more analytical ways of knowing and healing in women abused as children

(Naparastek, 2004). These are also the elements of extended knowledge development in unitary healing (Cowling & Repede, 2009). These ways of knowing reflect the uniqueness of each individual and group and ". . .create a patterning of knowing and knowledge" (Cowling & Repede, 2009) that is consistent with appreciating the wholeness inherent in individual or group.

The emanicpatory nature of unitary healing is reflected in the freedom to participate fully in life which comes with an increasing awareness of self and self in relationship. Only with awareness can enlightened change and transformation occur. The facilitation of this freedom originates within the ontological and epistemological foundations of unitary healing as a theoretical framework and UAI as a method of research and practice (Cowling, 2007; 2001; Cowling & Repede, 2009). Unitary healing provides a radically new theory from which to situate a research study in the lives of women abused as children. It offers an opportunity to understand healing in these women from a relational, participatory framework, as well as to offer new insights into the study of healing with an expanded epistemological toolbox. Because it comes from an appreciative understanding of inherent wholeness, the potential for emancipation and transformation through illumination and knowing participation in change exists in the moment by moment unfolding of the research process and practice.

CHAPTER III

METHODOLOGY

Unitary appreciative inquiry (UAI) is a unique methodological tool which is both research and practice focused. The previous chapter addressed the theory of unitary healing which is the conceptual framework for this study. Because this is a new process of inquiry, the methodology chapter of this paper addresses both the specific methods which were used to answer the research questions as well as provides an overview of the unitary design in terms of its research and praxis elements. The background of the unitary design and its use in previous research is explored. A description of the unitary design as praxis is given through the core process dimensions of appreciation, participation, and emancipation. The actual methodology for this study is presented under the Elements of Design and Methods section of this chapter. The core focal element of wholeness and the process element of knowledge through extended epistemologies are addressed as components of the actual research design for this study. The process element of change/transformation is addressed here as an outcome measure and is explored more fully in the presentation of the findings of the study.

Background of the Unitary Design

UAI is a unitary healing praxis model which evolved initially from Cowling's research with women in despair and despair as experienced by abused women (Cowling,

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2000; 2004a; 2004b; 2006). The UAI model is currently being further developed in his

ongoing study with women who have experienced childhood abuse (Cowling & Repede,

2009). Based upon a unitary orientation, UAI is a participatory action research method

which has a simultaneous practice focus (Cowling, 2006). The UAI inquiries are ". . .

constructed for and devoted to creating new forms of understanding through action and

reflection (Reason & Bradbury, 2001) grounded in a unitary perspective" (Cowling,

2006, p. 123). As a participatory action research method, UAI has the potential to both

generate and enact new practical knowledge for healing in participants as well as in

researchers (Cowling, 2004a; 2004b; 2006; Cowling & Repede, 2009). This occurs as

each person gains an appreciation of their respective life patterning and the potentials for

knowing transformation and change. The ultimate intention of UAI is human

emancipation through a process which generates multiple forms of knowledge about the

unitary human pattern (Cowling, 2004b; 2005).

     The six ways in which UAI is grounded in a unitary perspective are: (1) the focus

of the research design is on understanding the wholeness inherent in each person's unique

life pattern through appreciation of what is; (2) data is sourced from the mutual process

of human- environment interactions; (3) knowing participation in change is the

fundamental praxis component which is also the primary method of achieving the results

of the inquiry; (4) a synoptic rather than purely analytical process is used to construct

knowledge of the whole; (5) the aim of the study is to uncover or illuminate unknown

potentials for growth and change moving the researcher/ participant away from pre-

constructed realities or limiting thoughts; (6) the results of the inquiry are

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representational constructs of unitary knowledge portrayed through experiential, presentational, and propositional methods which culminate in practical knowledge for the researcher/ participant (Cowling, 2006). Unitary pattern appreciation was developed as a method for embodying research and practice within the above unitary theoretical perspective (Cowling, 2000). In contrast to other holistic research or practice methods in which healing is achieved through an integration or rebalancing of parts of the whole, the attention in UAI is placed upon appreciating the wholeness that already exists in the pattern emergent in the human experience which exists in mutual exchange with the environment (Cowling, 2000; 2004a; Cowling & Repede, 2009). The conditions for healing which are created by pattern appreciation are the synoptic, participatory, and transformative elements which lead to practical knowing and emancipation (Cowling, 2000; 2004a).

Pattern is the basis of the appreciating process. The Rogerian ontological assumptions of unitary theory which are explicated by Butcher (2006) are the basis of understanding fields, pattern, and change. Humans are contiguous with their environment which is the universe and everything in it. The human- environment dyads are irreducible energy fields which are dynamic, pandimensional, and constantly in flux. These energy fields are characterized by patterns which are unique, boundaryless, and unpredictable. Perceptual reality is nonlinear, nontemporal, and nonspatial. Change is continuous, creative, and evolves toward increasing diversity and innovation. Humans are engaged in mutual processes of unfolding potentials with the universe. Each pattern is unique and cannot be appreciated or perceived directly (Cowling, 2006). Rather, pattern is reflected

in the experience, perceptions, and expressions of the participants (Table 2) (Cowling, 2001; 2007).

Unitary pattern appreciation inherently seeks to understand the wholeness within the life patterning of participants (Cowling, 2000; 2001). The researcher seeks to be sensitive to the full manifestations of each person's unique pattern through perception and recognition of the human expressions which reflect pattern. The pattern is reflected in a profile- a meaningful representation of life patterning which emerges through metaphoric constructions such as stories, art, dreams, and/ or music.

Table 2.

The Three Elemental Features of Field Pattern
 (Adapted from Cowling, 2001; 2007)

Expression	Perception	Experience
1. Meaning	1. Apprehending	1. Sensing
2. Manifestations of experiences and perceiving	2. Contiguous with experiencing	2. Feeling in a natural, unprocessed way
3. Internal/ external expression	3. Includes observing, reflecting, knowing, constructing	3. Encountering self
4. Pattern grasped only through its expressions	4. Making sense of	4. Raw encounters with phenomena of life
	5. Requires some capacity for pattern awareness	

Description of the Unitary Design as Research

A description of the unitary design as research is presented through a review of three studies on despair in the lives of women done by Cowling (2000; 2004a; 2004b). A review of other studies using UAI is also included. This review demonstrates the UAI research methodology, how it is used, and the findings of the studies. A synopsis of the elements of the unitary research design as it relates to this study is included.

The initial work with UAI was developed as a case method research- praxis project with six women experiencing despair (Cowling, 200; 2006). This study aimed to both study and ameliorate despair in a project with six individual women. Despair was examined within a broad life context which also generated knowledge useful in understanding despair. Researcher developed narratives were generated as the result of every other week meetings of one to two hours between the researcher and the participant. Study participation ranged from six to 18 months.

The narratives, called pattern profiles, synthesized major themes and patterns within each individual's story of despair in the context of her individual life. The use of imagery, music, and metaphor was the primary feature of the narrative construction which reflected the researcher's appreciation of the meaning of despair for each participant. One case is presented as an exemplar in which a researcher written story is interspersed with music especially selected to represent the feelings expressed by the participant over the study period (Cowling, 2000). The ending of the story was developed to suggest both the inherent possibilities of appreciating the wholeness of the participant's life and to acknowledge her power by being able to write her own story. A

key component of the unitary appreciative pattern process is for the researcher to let go of expectations of change (Cowling, 2000). In this exemplar, the participant Karen was tearful as she expressed gratitude for being understood. The following excerpts were captured on recorded transcripts:

> This is such a gift…this is so much better than being diagnosed…you make it so you validate my experience. That's something I've never had. Its always been wanting to change or what I did wrong. This felt a whole lot more about what went on instead of, 'Oh Lord. I have to change that now' or, ' If I would only. . .' (Cowling, 2000, p. 24).

Sessions were recorded and transcribed. The data were collated synoptically from participant drawings, dreams, and narratives, from researcher experiences with the participant, and from the unfolding dialogue which reflected the expression and experience of despair in the lives of each of these women. Each participant was given an opportunity to reflect on the pattern profile created specifically for her. Other methods of UAI suggested by Cowling (Cowling, 2000; 2004b) include having the participant create the profile or doing it collaboratively with the researcher or other participants in a group setting.

Despair: A Unitary Appreciative Inquiry (Cowling, 2004a) is a report of a qualitative, participatory study of the concept of despair in 14 women participants. A unitary appreciative case study method was used to illuminate the understanding of despair within the context of 10 life situations: major depression, addiction, sexual abuse, child abuse, homelessness, loss of a loved one, terminal illness, spinal cord injury, infertility, and chronic illness (Cowling, 2004b, 2006). The study design was open-gendered, however all respondents were female and 10 of the 14 described some history

of abuse. The methodology incorporated the use of two dialogical, appreciative interviews between each participant and the researcher. Each interview lasted from one to two hours, and was audiotaped and transcribed by a professional transcription service. The process of synopsis " . . . the deliberate viewing together of aspects of human experience which for one reason or another, are generally kept apart by the plain man and even by the professional scientist or scholar" (Cowling, 2000, p. 8) was used rather than analysis to find emerging patterns of despair. The author reports the creation (by the author) of four documents from the data collection process. These were 1) the original transcript of the interview; 2) a synopsis of despair prepared by the researcher using the participants own words and written in the first person for the participant; 3) a pattern profile written in the form of a story using metaphor, images, and music from the themes and content of the transcriptions; 4) a summary document of general information about despair from the individual view point of each participant. Key questions and information which guided the data collection were descriptions of despair, the context and the features of despair, transformational processes in the life of the person with despair, helpful and unhelpful ways of living with and dealing with despair, and experiences of the participant with the healthcare system. These were included in the summary document given to participants. The four documents were shared with each participant two weeks before the final interview. The participants were asked to review and edit the documents for representational accuracy. This was felt to be very important as there was an institutional delay which resulted in a one year time frame between the initial and final

interviews. The study report presents three cases as exemplars which demonstrate the unitary appreciation of despair.

The findings of this study were conclusions that were drawn from the author's examination of the three exemplar cases and their representation throughout the study group. Despair was embedded within the life fabric of each woman. The shifting of focus from the study of despair to the life pattern of despairing women was essential to the process of uncovering the richness of despair as a transformational opportunity for appreciating wholeness in all of its complexity in the lives of each woman. The use of story, metaphor, music and images was helpful in assisting women to move beyond despair as a symptom of something wrong toward an opportunity for deeper understanding of their life pattern or story. Pattern profiles were found to be helpful in assisting the participants in a journey of self discovery and knowledge. Some common features identified in the life patterns of these three women with despair were hopelessness, powerlessness, isolation, lack of coherence, a narrowing of the life scope in some manner, a sense of being unable to be understood or to express clearly what they were experiencing, and pervasive and constant feelings of despair. The contextual features of despair remained unique to each woman and distinct from any generalizability. This is consistent within a unitary- transformative framework. The author makes a case for shifting from a symptom based model of nursing to a pattern based model of nursing which combines research and praxis ideals that speak to the richness of individual experience and guide the client toward self-knowing.

The third project by Cowling (2004b) using UAI was a cooperative inquiry group which focused on the connection between despair and abuse. The inquiry group consisted of six women in a community domestic violence program, a staff member, a graduate nursing student and the researcher (Cowling, 2004b, 2006). A UAI group process was used with six three-hour sessions over a 10-week period. Rather than a phenomenological approach which would have looked at the lived experience of despair, the researcher used a patterning focus to explore the various ways in which despair was embedded in the life fabric of these women who had experienced abuse (Cowling, 2004a). The exploration included both general discussions about the context of despair in relation to abuse in life patterning as well as on the specific focus of living in despair.

The study findings were synthesized in an appreciative pattern profile that was developed and reviewed by study participants (Cowling, 2006). The findings described by participants included: (1) benefit from working cooperatively with other women who had experienced both abuse and despair; (2) finding both individual uniqueness and a common ground of experience that was shared as helpful in the healing process; (3) participant guided discussion and dialogue as extremely helpful to the appreciative and learning processes; (4) the positive effects of using artistic expressions such as poetry, music, stories, and movies to represent the nature of despair; (5) words, images, and stories were successfully used to convey vulnerability, fragility, and anger; (6) practical knowledge was generated by lists of strategies that ameliorated feelings of despair (Cowling, 2006). Congruent with unitary theory, no consensual agreement was obtained which spoke to one broad conceptual definition of despair.

A review of PubMED, CINAHL, and EBSCO for studies using UAI found one article and three doctoral dissertation abstracts in addition to the above studies. Rushing (2008; 2005) used UAI to explore the unitary life pattern of serenity in a group of nine people (five women and four men) from 12-step addiction recovery programs. Participants were interviewed individually and a matrix of manifestations of serenity shared among the group of participants was developed through a data synthesis method. Four pattern facets were identified with common experiences, perceptions, and expressions which were shared among participants: addiction, turning points, early sobriety, and serenity. A unique appreciative profile which used storytelling in a creative format was developed by the researcher for each individual participant and validated by participants as well. Serenity was found to be

> . . . a way of living and being, an orientation to life, and a transformation of personality. . .a healing quality that seemed to emerge as each person as each experienced a spiritual awakening or a transcendence of experiences (Rush, 2008, p. 204).

Duis- Nittsche (2002) used the UAI methodology to examine nursing presence from both the patient and the nursing perspectives. Interview guides for nurses and patients were developed in a participatory group process with the researcher/ participants and interviews were completed with seven nurse- patient dyads. Results were obtained through data synopsis, and themes were identified from data analysis. Nurse participants were included in the synopsis/ analysis process. Nurse themes of nursing presence included knowing the patient, responding to needs, nurse/ patient attitudes and beliefs, bonding between nurse and patient, influencing others, and relationships. Patient themes

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of nursing presence included knowing me, bonding, supporting me, encouraging me/ others, accessibility, and healing. Nursing presence was felt to be more important than technical care by patients and healing was a strong theme which evolved spontaneously without researcher suggestion. The synopsis of data was presented in a descriptive narrative which was validated by participants for authenticity and accuracy of reflection.

Cox (2004) used UAI to explore the impact of insurance risk transfers (managed care, cost shifting, diagnosis related groups [DRG's], and healthcare financing on registered nurses and the care they provide to clients. A participatory approach was used with eight bedside nurses to develop seven appreciative profiles of their experiences of professional caregiver despair related to healthcare financing. Results included the perceived effects of current healthcare system financing which adversely affected workplace staffing, equipment, and material resources. Data synopsis and synthesis was used to validate an apriori theory of professional care-giver despair related to insurance risk transfers (cost- shifting). Strategies were cooperatively developed to reduce professional caregiver despair and improve working situations for the benefit of clients and themselves.

Alligood (2007) used a UAI design to understand the life patterns of persons with spinal cord injuries. Synopses were developed and pattern profiles were created by the researcher with eight persons who had incurred spinal cord injuries at least two years prior to the study. Three shared pattern manifestations were identified: depersonalization, loss, and hopelessness. These manifestations (validated by participants) were the basis of despair in persons with spinal cord injury in this study.

Prospective pattern profiling was done with eight female Gulf War veterans in order to express their future hopes and dreams following deployment in a UAI dissertation study (Kemp, 2004). The premise of the inquiry was to explore the life patterns of women who were returned from deployment during the first war in the Persian Gulf. The needs and wants of the women included relief and cure from a variety of physical and emotional symptoms incurred during the deployment period. Woundings from social limitations, military sexual trauma, and a loss of trust in persons and institutions occurred which were associated with the traumatic patterns they were experiencing. The researcher and the participants initially co-created metaphorical stories of the women's lived experiences of being deployed. Subsequently, the prospective pattern profiles of future hopes and dreams were co-developed by the participants and the researcher. Implications for nursing practice, research, and education were developed by the author but not explicated in the abstract.

There are processes and procedures of UAI that have been implemented in the above research, however the UAI method is open to new and creative ways of achieving the aims of the research. Inquiries can be initiated by either a researcher or by participants seeking a researcher to undertake a study process of mutual concern (Cowling, 2006). Sampling is purposive and done by linking researchers and participants who are interested in a unitary understanding of the research topic. Participants are considered co-inquirers or co-researchers. The primary mode of data collection is mutually engaged dialogue, reflection, and action among individuals and the researcher(s) or as a group process (Cowling, 2006). Participants are invited to participate in dialogue, reflection,

aesthetic expression, and action as indicated by the participant-researcher dyad (this may

be a collective dyad). Cycles of reflection and action are used to achieve specific aims.

The reflection and action can occur in either an individual or group format and between

dialogue sessions. The data includes dialogue, experiential descriptions, expressive

products, journals, and whatever is felt by participants to be reflective of life pattern

(Cowling, 2006). The study may have an informative or a transformative aim or both.

Participants may experiment with some desired change. Participants are involved to the

degree they wish in the data collection, evaluation of the inquiry process, and in

developing or validation of the final report (Cowling, 2007).

The elements of UAI as a research method which lend itself to this study are

based upon the above literature, the literature review of women who experienced

childhood abuse, and the review of healing in these women. To date, most of the research

on women who experienced childhood abuse has focused primarily on finding the

commonalities of the effects of the abuse experience in adulthood. Since the research

design of UAI is based upon understanding the uniqueness of each person, a new and

fresh perspective will be explored which can illuminate possibilities for healing and the

potentials for transformation in the lives of these women, moving the researcher and

participants away from pre-constructed realities or views.

Because the nature of the effects of childhood abuse is pervasive and impacts

multiple dimensions of women's lives, a unitary approach which can accommodate a

pandimensional perspective is an ideal method for understanding the gestalt of living as a

woman who has experienced childhood abuse. Since the focus of the inquiry is on unitary

patterns rather than phenomenon, the larger aspects of the human experience of childhood abuse can be explored as it relates to both the individual and the collective aspects of human existence (Cowling, 2004b). Since data are sourced from the mutual process of human- environment interaction (Cowling, 2005), the reciprocal aspects of childhood abuse as it relates to both the women and their environment (internal and external) can be explored. This is in contrast to most of the previous research on women abused as children using traditional quantitative or qualitative methods which have by nature limited the exploration to one or the other as a mechanism of study control.

As a research method, the participatory nature of the design allows for a remediation of the power imbalance that existed as a childhood experience, as well as those inherent in more traditional research designs. A common thread in Cowling's ongoing research with women abused as children is the feeling of invisibility, which seems to be ameliorated to some degree in many of the participants in the cooperative nature of the group research/ praxis setting of UAI (Cowling, 2004b; 2008). The action component of the UAI design also has been reported in all of the studies to have an emancipatory effect (Cowling, 2000; 2004a; 2004b; Cox, 2004; Duis- Nittsche, 2002; Rushing, 2005; 2008), also a recurring theme in women who have reported a degree of healing from childhood abuse (Glaister & Abel, 1996). A common finding of the UAI research described above was the ability of the method to allow for the appreciation and perception of the self as a whole in the moment. This would have an inherent healing potential for women abused as children who report feelings of being broken or losing their soul (Glaister & Abel, 2001; Hall, 2003; Godbey & Hutchinson, 1996).

Synoptic analysis is a deliberate viewing together of data. The synoptic process of reviewing the data in the unitary research method allows for a unique understanding of the experiences, expressions, and perceptions of the participants as they unfold in patterns which reflect the whole. This is in contrast to current research which again aims to reduce or quantify the experience of childhood abuse as a measurable construct.

Aesthetic ways of knowing and transpersonal explorations have been shown to be helpful in healing with women abused as children (Bryant- Davis, 2005; Glaister & Abel, 1996; Hall, 2003). The research on dreaming has demonstrated that the dreaming state is a paratelic function which works in the same neurophysiological, somatic, and emotional pathways common to many types of trauma patterns and healing from trauma. Dreaming is an extended epistemology- a way of knowing which works on both personal and transpersonal levels simultaneously. Dreaming has been proposed to be a participatory phenomena (Repede, 2008). Because UAI uses these expanded epistemologies as part of a participatory research process, UAI provides an ideal and unique methodology for exploring the use of participatory dreaming in women who have experienced childhood abuse.

Description of the Unitary Design as Praxis

The ability to enter into an evolving patterning process with clients over time is viewed as particularly relevant to nursing as it seeks to integrate the empirical, interpretive, and critical dimensions of a practically oriented theoretical foundation for nursing science (Newman, 2002). UAI has been described by Newman (2002) as praxis because it is an active synthesis of theory, research, and practice. As praxis, UAI creates

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opportunities for participants to open themselves to new unitary understandings of their

lives in process with an appreciative stance toward what is, rather than what should be

(Cowling, 2006). Emancipation occurs with the freedom from a preconceived set of

expectations, allowing the energy of transformation to be creatively mobilized toward

practical ways of doing and being in the world that support growth. Inquiry projects

which encompass reflection and participation support 'generative theorizing' wherein

action and knowledge are simultaneously informed (Cowling, 2006; 2004b). The critical

reflection inherent in UAI requires a critical examination of one's own practices as well

as an awareness of what maintains the status quo (Cowling, 2006). This is participatory

both within the individual and within the collective. The generative capacity of praxis

(Cowling, 2006) allows for the development of propositional knowledge (theory),

experiential knowledge (group encounters and endeavors), presentational knowledge

(imaginative and creative ways of comprehending the life pattern and illuminating new

possibilities), and practical knowledge (actions or practices which evolve from the first

three ways of knowing and which advance change and transformation). The foundation

of UAI as praxis lies in the core process components of appreciation, participation, and

emancipation (Cowling & Repede, 2009).

Appreciation

Appreciative knowing incorporates perceiving, being aware of, being sensitive to,

and expressing the ". . . full force and delicate distinctions" of life pattern through an

attitude of gratefulness (Cowling, 2000, p. 17). Appreciation implies an empathy or

resonance of the perceiver with the pattern perceived as it manifests in its entirety

(Cowling, 2004b; 2000). As a healing practice, the focus is on appreciating the wholeness within this pattern. In UAI, pattern is appreciated through the intimacy of the encounter with self and other (Cowling, 2004a; 2004b).

Appreciating is the antithesis of essentializing (Cowling, 2004b). Essentializing implies stereotyping or generalizing, whereas appreciation in UAI refers to the deliberate process of seeking out of that which is unique for the individual or group. Essence, the root of essentializing, is a static phenomenon. This is in direct contrast to the appreciation of life patterns as ever-changing and fluid in their relationship between the individual and the cosmos. Essence in UAI refers to the dynamic flux of patterning versus a more static dimension of phenomena (Cowling, 2001).

In Cowling's work with despairing women (2004a; 2004b), the appreciation as praxis evolved in four directions. Describing what worked, reflections about adversity and power, envisioning possibilities, and contemplating life patterning as an informational resource for change were the foci of appreciation for participants as they reflected upon wholeness in their lives. These four dimensions have become the structural framework for the development and sustainability of healing outcomes in UAI processes.

Encouragement and support through journaling, dialogue, and creativity are provided in order to illuminate the ways in which participants have known or felt personal power, made positive life changes, or influenced others (Cowling, 2004a; 2004b). Individual and/ or mutual reflection provides opportunities for understanding the relationship between personal power, life choices, and personal sustenance in the midst of

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adversity. Dreaming of new possibilities is accomplished through creative expression, collages, imagining, imagery, writing, and dialogue. Goals or desired outcomes may be written, expressed, drawn, or performed. Contemplation of life patterning through the above techniques can provide a source of information for both individuals and groups about what currently exists and the desire for knowing transformation and change.

Appreciative knowing is distinct from critical knowing (Cowling, 2001). Appreciative knowing assumes a stance of mystery which can never be fully known. Critical knowing seeks to answer a question or answer a problem. In UAI, the mystery is something to be caught up in rather than a problem to be solved. Knowledge cannot be categorized with diagnoses or language. The researcher is an inquirer who comes into relationship with the co-inquirers through an act of affirmation based upon mutual trust in the absolute integrity of universal wholeness. Thus, UAI as praxis is a theoretical precept of wholeness, a research method centered around the appreciation of what is and what could be, and the opportunity to find practical ways of appreciating and transforming life patterns through knowing participation in change.

Participation

The concept of participation in UAI is as much a metaphysical stance as a method of inquiry (Cowling, 2001; 2005). There is the assumption of a participatory consciousness in which each person has a personal relationship with the universe in UAI (Cowling, 2001). As an inquirer- participant, each individual is a direct participant in the co-creation of the cosmos. In unitary nursing and research, this is reflected in mutual relationship, an openness to discovery without preconceptions, negotiation of process,

and the release of predicted or proscribed outcomes (Cowling, 2000; 2001). The human

capacity for knowing participation in change and patterning is a central tenet of unitary

theory. The participant is considered as the expert on and the author of his/ her own life

in UAI. Change may be the outcome of knowing participation, however the researcher/

practitioner releases the *expectation* of change for the participant (Cowling, 2000; 2001).

The relationship of pattern, participation, power, and knowledge, and praxis has

been developed in a matrix by Cowling (2004b) (Appendix A). Participation is described

as engagement, shared reflection, cooperation, and dialogue which brings sense- making

through experiential knowledge (Cowling, 2004b). The mutuality of participation inspires

and encourages imagery generation and creative expression for presentational knowledge.

Propositional knowledge arises from and is grounded in the mutual reflection inherent in

a participatory design. And practical knowledge is developed as skills through

participation in the inquiry process (Cowling, 2004b).

Participation can be between individuals and researcher or between groups and

researcher. A case has already been made for a participatory approach in women abused

as children. Creating a safe and comfortable space for women to share life experiences

and to collectively dream about wholeness is necessary to provide women who

experienced childhood abuse an opportunity to participate in a UAI study on healing. A

group encounter offered the opportunity for dialogue and helped to create the social space

needed for shared exchanges about experiences and information, the formulation of both

common and individual meanings, and the basis for collective action (Cowling, 2004a;

Reason & Bradbury, 2006). A novel approach using a participatory dreaming approach

to envision healing and wholeness was proposed for this UAI study with a group of women who have experienced childhood abuse.

Emancipation

Cowling (2001) makes a case for UAI as both interpretive and emancipatory. Hermeneutic inquiry is the exemplar of the interpretive paradigm of nursing science. The ontological assumptions of both UAI and the interpretive paradigm include a complex, holistic, and contextual reality (Monti & Tingen, 1999). However, the goal of UAI is not to understand and interpret the meaning of human experiences. Rather it seeks to ". . . illuminate wholeness, uniqueness, and essence of human life, or what is conceptually labeled " unitary pattern' in theoretic terms, as a referent point for nursing knowledge development, both theoretical and practical" (Cowling, 2001, p. 44). Emancipation arises from the praxic nature of UAI as a potential rather than as a specified end-point as it is in critical inquiry. Emancipation is also a function of newly perceived possibilities, visionary innovations, and personal explorations in unboundaried potentials.

Praxis through power is also a feature of emancipation (Cowling, 2004b). Power is experienced through the experiential component of UAI as a result of being in process with other(s) in the inquiry. Power lies in the creative expressions of an appreciated life. The propositional or theory generating capacity of UAI lends power to participants through expanding knowledge, and also creates a venue in which their voices are heard through research and activism within the community. And finally, practical skills are developed through the UAI process which provide emancipation through the discovery of tools for personal and collective transformation and change.

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In conclusion, UAI is grounded in cooperative inquiry and uses repeating cycles of reflection and action (which may be dialogic action) which culminate in four ways of knowing; experiential, presentational, propositional, and practical. The unitary nature of healing, the pandimensional nature of the life patterns associated with childhood abuse, and the creative potential for transformation and change through the illumination of inherent wholeness and future possibilities made UAI the best choice for a methodology for this study. In women abused as children, UAI was an ideal method for combining unitary theory, research, and practice in order to answer the research questions for this study:

(1) What changes/ transformations occurred, if any, with participatory dreaming as a unitary healing approach in women who have experienced childhood abuse?

(2) What is the nature of unitary healing examined through participatory dreaming from the perspective of women abused as children?

Elements of Design and Methods

Research Design

The research design for this study was a qualitative exploratory study utilizing the participatory methodology of UAI. The purpose of the study was to explore the potential of participatory dreaming on unitary healing in women who have experienced childhood abuse. The conceptual framework for this study was unitary healing, a new theory of healing grounded in Rogerian science and described in an earlier section. Although this is a qualitative study, the use of the term 'variable' was used representationally to give

clarity to the constructs under study (Gliner & Morgan, 2000). The variable definitions given in chapter one are reviewed here.

Unitary healing, conceptually was defined as the appreciation of the inherent wholeness reflected in the life patterns of women abused as children and the illumination of possibilities for transformation and emancipation through knowing participation and change. Unitary healing was defined as the appreciative reflections of both participants and researcher portrayed through a participatory group aesthetic creation and synopsis of individual participants' journals through a facilitated participatory waking dream research group of women abused as children. Participants were asked to journal the answer to the following question at the beginning of the study immediately before the first cycle of reflection and action:

(1) How would you describe your current perception of healing in your life as it relates to the experience of childhood abuse?

After the final round (and immediately prior to the closing ceremony), and two weeks after the study intervention period, participants were contacted by telephone, mail, or email depending upon their preference and asked to answer the following open-ended questions:

 (1) How would you describe your current perception of healing in your life as it relates to the experience of childhood abuse?

(2) What effects (skills/ knowledge) if any did the participatory dreaming research project have upon your appreciation of the healing process(es) in your life? If yes, how did these effects occur in your opinion?

Participatory dreaming was conceptualized as a beyond waking process invoking the collective imagination and creative action of women abused as children to illuminate the possibilities for healing, transformation, and emancipation in their lives and in society. Participatory dreaming was defined as a researcher facilitated group process using communal dialogue, imagery, and incubated daydreams to envision healing in women abused as children using the participatory action research method of UAI. The script for an incubated day dream (Appendix B) was developed by the researcher, who is a nationally certified family nurse practitioner and hypnotherapist with over 1,000 hours of extended clinical training in guided imagery, hypnosis, meditation, and group trance work. The script was developed using research guided principles of facilitating healing through appreciation, awareness, presence, and imagination in trauma survivors (Epstein, 1992; Naparstek, 2006; Sheikh, 2003). The script was tested on three female volunteers who have experienced childhood abuse and was found to need no revisions before the study period. After the first day of the study, two of the participants made comments regarding some frustrations with being unable to imagine what had been suggested at various times in the dreaming. Some very minor changes were incorporated in the language of the script to be more permissive ('imagine yourself' was changed to'…and I wonder if it would be possible for you today to imagine yourself…') for the second and third rounds of the dreaming.

The study procedure was a two day process which occurred over two weeks. The first day entailed an opening circle of introduction and orientation to the study process followed by a researcher led participatory dreaming sequence using imagery and soft

music. Participants then wrote in journals about their experience of the dreaming. This was followed by a group discussion facilitated by the researcher about the dreaming process and experiences which had occurred. This sequence was repeated in the afternoon after a lunch break and concluded with a closing circle on the first day. The second day of the study occurred two weeks later and followed the same format as the first day in the morning session. The afternoon session was the creation of a group aesthetic project, described in detail below.

The group process was facilitated through an introduction of the participants and researcher, a discussion of the UAI research/praxis process, and through three cycles of discussion and reflection about healing in the lives of women who have experienced childhood abuse which culminated in a presentational product developed and created by the women. Each cycle lasted about two to two and a half hours. Participants decided how much time was needed in each round as they occurred. The study group was led in a researcher facilitated incubated daydream read by the researcher at the beginning of each round of the retreat before the discussion and reflection, except before the aesthetic expression. The timing was decided by the majority consensus of the group. In the opening cycle, each woman was given a journal for writing reflections throughout the reflection periods offered throughout the day. These were collected by the researcher at the closing event of the study. Participants were given a new journal as a gift as well as a $20.00 gift card to keep after the final closing ritual.

Initially, there was some discussion about everyone in the group doing the same art project. The final consensus was that this group project would have two forms of

expression that were acceptable to the group combined into one hanging mobile. These would take the form of a mobile combined of either the individual decoration of paper face masks or a two sided collage representing the internal and external expressions of women healing from childhood abuse. One participant did a collage and the other 10 created face masks. Both the masks and collage were hung together by four of the participants and myself into a group mobile. The group titled the artwork, *The Expressions of Women Healing from Abuse.* The final cycle included the individual presentation of their art (mask or collage) to the group and the hanging of the mobile. A ritual of closing was led by the researcher with the participants in an expression of gratitude and appreciation for the experience, expression, and perceptions shared within the group. The fourth cycle of reflection and action was considered the two week period following the study. This was felt to be a long enough period (four weeks from the beginning of the study) for participants to become aware of any changes in life patterning while still maintaining a sense of potential momentum from the study by the research committee.

Following the study protocol, an aesthetic portrayal of results from the initial analysis and synthesis of data was created in the form of three music videos by the researcher. This format was selected because of the power of imagery and music to transcend linear expressions of communication and was consistent with the metaphoric nature of the study design. Additionally, the images described by individual participants were able to be synthesized into a group montage of pictures coordinated with songs that seemed to represent the emergent patterns found in the study. These music videos and my

explanations of my perceptions and feelings about the group process were presented to those in the group who could stay after the study. Seven participants were able to stay. Results will be reviewed in Chapter Four. Participants were offered the opportunity to participate in doing the data synthesis and to read the final report for accuracy and validity before it is disseminated. None were interested in participating in data analysis, but one woman asked if they could be present at the defense of the dissertation

A research assistant with a Master's degree in nursing who had been involved in the previous research with Cowling's ongoing study with women who have experienced childhood abuse was the research assistant for this study. Her role was to provide support for the women in the event of any abreactions or distress while the researcher continued the study and to provide organizational support to the researcher. Field notes were kept by the researcher and the research assistant during the process. This served to maximize accurate data collection and minimize researcher bias by anchoring the data within a contextual field. Additionally, the researcher kept a reflection diary to minimize researcher bias in a process Munhall (2007) describes as decentering yourself and unknowing. This allowed for a more reflexive intersubjective stance with both the participants and the data.

It was assumed that participants might develop new knowledge, insights, skills, and relationships that promote unitary healing from experiences of childhood abuse. It was also assumed that the participatory process might help participants feel freer and have a deeper connection or awareness of the core self as they share with others in a supportive setting. The final assumption was that the participatory dreaming process

would facilitate the sociocentric aspects of healing within and between participants which may lead to a broader vision of healing for the community.

Setting

The setting for this study was two days of group process in a retreat-like setting at the Sanctuary. The Sanctuary is a not-for-profit center in central Greensboro which offered a reduced price to the researcher because the type of study done was in alignment with its mission, which is the facilitation of healing through the arts. A large studio with comfortable seating at one end of the room and art tables at the other end of the room was available for use. An additional room was opened for more space and there was also space for participants to go outside or sit in waiting areas with fountains for individual journaling and reflection in a beautiful and natural setting, consistent with a unitary healing framework. The two full day, four week study design was developed to allow for appropriate time for follow-up reflection. Two one-day sessions with a two week follow-up were also decided to be more conducive to follow-up and participant convenience than four two- hour sessions over a period of four weeks.

Lunch and snacks were provided for participants. The facility was easily accessible to all participants, including one participant who traveled from over 100 miles to participate in the study. The study was conducted on days that were mutually convenient to the participants and the researchers. Scheduling was also arranged to provide backup consultation and support from the dissertation chair who is a clinical nurse specialist in adult psychiatric mental health nursing and has extensive experience working with this population.

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Sampling Plan

The unitary appreciative design is based upon a participatory framework known as Cooperative Inquiry (Heron & Reason, 2001). An inquiry group less than six is considered too small and lacks the variety of experience needed for an inquiry group. More than 12 participants makes the group unwieldy and dilutes the richness of responsiveness needed for an in-depth inquiry. Thus this study used a purposive sampling technique aimed at obtaining a small but diverse group of six to twelve women (Heron & Reason, 2006) who self-reported a history of childhood abuse. An adaptive sampling technique designed to access hidden populations was used (Martsolf, et al., 2006). Initially, previous participants who had expressed interest in future research with women who have experienced childhood abuse were contacted to see if they would be interested in participating in this study. Snowballing was used to recruit from previous participants. IRB approved flyers (Appendix C) and cover letters (Appendix D) were mailed to Jungian therapists, healthcare providers, and healers in the Greensboro region of North Carolina known to be receptive to holistic healing modalities by the researcher and any informants. Flyers were also sent to local women's groups, churches, and the two known support groups for women with a history of childhood abuse in the Greensboro area as well as other areas of concentrations of women abused as children verbalized by contacts and potential participants. Abuse shelters and domestic violence centers were not contacted as the study design required women who had a relatively stable level of functioning for their safety and the group's safety. To obtain a diverse sample which would reflect the diversity of women in the study population, flyers were posted in

diverse socioeconomic areas across the central North Carolina area. Study exclusion included less than 18 years of age, involvement by participant report in an on-going violent relationship, history or visible evidence of recent or on-going mental illness, substance abuse, cognitive impairment, and/ or suicidal thought or intention in the last year.

Although participatory dreaming was considered an intervention, it is not therapy and exceptionally vulnerable women were screened out through an interview with the researcher prior to being accepted into the study through a researcher developed pre-interview questionnaire (Appendix E). Even though this research approach is gaining in popularity, there was no appropriate brief pre-screening questionnaire found. A researcher developed prescreening tool was used to screen for exceptionally vulnerable women. The final questionnaire was an eight item questionnaire addressing psychotic symptoms, history of severe mental illness, suicidality, current drug or alcohol abuse, involvement in a currently abusive relationship, and cognitive dysfunction which would interfere with obtaining study results. This questionnaire was adapted from the Diagnostic and Statistical Manual of Mental Disorders [DSM-IV] Guidelines for Mental Health Assessment (American Psychiatric Association, 1994) and the Basis-32 Behavior and Symptom Identification Scale (Eisen, Normand, Belanger, Spiro, & Esch, 2004) with revisions made according to IRB suggestions. These two instruments have been widely used in research for screening large populations, but both instruments were felt to be too unwieldy and insufficient by themselves to use for this study.

The researcher, a certified family nurse practitioner and certified hypnotherapist, used the interview process to ascertain exceptionally vulnerable women prior to obtaining both the informed consent and demographic information if the woman qualified for the study. Before scheduling a face-to-face interview, potential participants were asked specifically about the exclusion criteria listed on the flyer and told if they had not met the criteria for inclusion. Two potential applicants were excluded on the basis of telephone interviews in which they did not meet inclusion criteria. The study was filled within three weeks of beginning recruitment.

An IRB stamped informed consent (Appendix F) was given to each participant to read and was reviewed with her before being signed after the pre-screen questionnaire was obtained and the participant was qualified for the study. A researcher developed demographic sheet was then completed by participants (Appendix G). Directions to the study site and a list of appropriate area crisis hotlines and therapists were given to each woman at the time of the interview and again at the beginning of each day of the study. A wait-list for qualified potential participants was created in case there was any pre-study attrition and one woman was placed on this list at her request on the list. All women provided their own transportation, although the study site was within walking distance of a city bus route.

Sample

Thirteen women were screened through face to face interviews in a variety of private settings of their choosing. These included secluded spots in coffee houses, restaurants, the Greensboro library, and one participant was screened in her home. One

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woman withdrew a week before the study due to a sudden schedule conflict. She contacted me by telephone and email to apologize and to make sure that she would be kept on a list for future research. Three of the participants screened had been diagnosed with depression, anxiety or PTSD several years ago and one currently in therapy had a stable mild clinical depression and was encouraged by her therapist to be in the study. None had any current suicidal thoughts or attempts within the last two years but some had had suicidal thoughts or attempted suicide several years ago. All other responses on the pre-study questionnaires were negative (no).

Twelve women completed the first day of the study and eleven completed the second day. One woman called me the morning of the second day to say that her mother had been admitted to the hospital and asked if she could come for the afternoon only. She was told that if this was a project instead of a research study, that would have been fine, but since it was research, having her come in the afternoon only could skew the results. She apologized for any inconvenience to the group and withdrew from the study.

The final sample was a diverse group of 11 women. The women completed a brief demographic questionnaire (Appendix G) and eight self described as white or Caucasian, two as black or African American and one as Hispanic- African American. Ages ranged from 24- 58, with all but one of the women age 35 and older. Seven of the women described their current health status as good, fine, or better than ever. One woman responded that she was healthy except for fibromyalgia and chronic fatigue, one wrote simply "(HIV positive)", one wrote fair, and one left it blank intentionally saying she didn't want to get into it. Eight women had at least some college, one woman wrote high

school graduate, one had a GED, and one wrote 'certifications and workshops'. Two of the women had Sexual Abuse Leadership Training and lead area workshops for women abused as children. During the group discussion, it became apparent that there was a diversity of socio-economic status, although this was not formally ascertained in the demographic survey and was not problematic during the study. The participant who withdrew before the study was a 28 year old, African American with a bachelor's degree in good health. The participant who withdrew during the study was a 54- year- old white woman with a bachelor's degree in good health.

Participant Protection

This study underwent a full review and was approved by the University of North Carolina at Greensboro Institutional Review Board (IRB #08-0148) on January 15, 2009 (Appendix H). IRB stamped consents (Appendix F) were reviewed with participants and signed during the pre-interview and process consent was maintained during the study by reminding participants of their ability to withdraw at any time if they chose. Group confidentiality was addressed at the beginning and throughout the study in order to protect participants. Because of the group nature of the study, anonymity could not be offered and this was made clear to participants from the first telephone interview and throughout the research process. In order to further protect confidentiality, participants selected pseudonyms for their journals and were told that they could choose whatever name they wanted to use face-to-face during the group process. All but one used their real first name for the group, one used her journal name as her name of address within the group. A list of pseudonyms that were selected by participants during the pre-interview

process was brought to the study to remind those who had forgotten what names they had selected.

A confidentiality agreement (Appendix I) was signed by the participants and the two researchers at the beginning of the first day to try to establish protection of confidentiality during the group discussions. Based upon IRB recommendations a Secret Ballot (Appendix J) was developed and given to participants at the beginning of the second day to allow for the use of the art project (the mobile) in the dissemination of findings through photography, display, or videography. A unanimous agreement to the photography and use of the mobile was given. Participants stated that the researcher could have the use of the mobile for the dissertation defense and for photos for dissemination. The participants then directed the researcher to either display the mobile in the Women's Resource Center where women who understood would see it or give it to the two women who held sexual abuse survivors groups for use in their group. Otherwise the masks and collage were to be separated and returned to their respective owners. All data were stored and protected according to the IRB protocols with identifying information locked and stored separately from data.

Because of the vulnerability of the women, during the study period, both the researcher and the research assistant actively worked to maintain a sense of privacy and safety within the group. Individuals who seemed tearful or anxious were sought out individually at breaks and reminded that they should do whatever was needed to feel safe and remain as comfortable as possible. Offers of support were given and special needs were accommodated as possible. One woman was breast feeding and would leave the

room to get her infant and breastfeed her during the breaks (this was supported by the entire group). Two women wanted to lie on the floor during the dreaming sequences and were supported with pillows. One of the women had some mild gastric distress the first day and was brought herbal tea. After the first day of the study, all of the participants were contacted by the researcher within 48 hours to ensure that they were doing well. While some felt that they were experiencing physical and/or emotional discomfort, none were unduly distressed and none wanted to withdraw from the study. Most expressed relief and comfort in knowing there would be a second session and a contact two weeks later. Journal entries were specifically scanned immediately after each session to ascertain unusual or extreme distress. One case was reviewed with Dr Cowling in which one of the women said that she had had a severe stomachache after the first session, but that she was feeling better. Her journal drawings were rather dark, so she was contacted a second time, but had seen her therapist and was feeling better. She stated that her therapist had felt she would be fine to continue with the study. It was left that the participant would contact the researcher if she needed any assistance. She did not contact the researcher until the day before the second data collection, at which time she had called to confirm the time for the next day. She stated she was doing fine at that time. She called the researcher the next day to say that her mother had been hospitalized for a stroke and she would need to withdraw from the study. She did want to return for the afternoon only, but was told that would not be possible due to the study design.

Data Collection

The data collection methods were aimed at the four epistemological results of the study which are experiential knowing, propositional knowing, presentational knowing, and practical knowing. The data designed to capture experiential knowing came from the in-process engagement within the group. Researcher and participant reflections were gathered from observation and participation in reflection and dialogue cycles. The actual dialogue was not digitally recorded as the focus of the study was on the dynamic effect of the group process, however the researcher took notes during the group discussions which were entered into the data set. The responses to the qualitative questions from the one month follow-up were also used for data collection about the experience of being within the group and its association with healing, if any.

Propositional knowing emerged from the journal entries collected the day of the study intervention, the group process, the results of the research questions, and from validation of the study results with the women. During each cycle of reflection and action, participants were asked to reflect on their thoughts and feelings with either words or pictures in their journals. The researchers took this time to write notes of their observations and reflections. Presentational knowing was collected as the aesthetic data from the fourth round of the group process. With agreement by all participants, the aesthetic expression was photographed as both a whole and as individual masks/ collage. Practical knowing evolved from the culmination of the three previous data collection methods and emerged through the lived lives of the participants and through the data synthesis done by the researcher/ participants. The final data collection point was at one

month post- project and was used to assess new participant competencies or skills to facilitate and promote healing which resulted from the research study.

The integrity of the data was maintained throughout the study process by the researcher and the research assistant (RA). All journals were logged into a notebook kept by the researcher. The journals were collected at the end the first day by the RA and given to the researcher. They were redistributed to individual participants by the RA at the beginning of the second day and recollected at the end of the second session. All journals were accounted for before the final closing ceremony by the RA and given to the researcher. The qualitative data obtained through journal notes, log notes, and follow-up interviews were double checked by both researcher and research assistant for accuracy and audited by Dr Cowling. The journals were photocopied, so any visual images or changes in intensity or emphasis in handwriting was maintained to refer to as needed. The journals were returned to participants by mail or in person at their request at the completion of the study period after the final interviews. Additionally, several women requested a copy of the participatory dreaming recorded on a CD for their personal use and a photo of the group art work, which was mailed to them one week after the final data collection point along with their journals. The mobile was photographed by the researcher as an entire piece and each mask/ collage was photographed individually after the study period for use in data analysis/ synopsis and for the dissemination of findings. The only instruments that were used were the researcher created pre-screening questionnaire and the brief demographic survey (which was intended to create a portrait of this particular group of women as a collective).

Data Analysis

Data were typed by the researcher and loaded into Atlas-ti, a software package used for data management, storage, and for ease of analysis. The researcher kept a reflective journal during the entire analysis/ synopsis period. Using Atlas-Ti, line by line 'in vivo' coding using the participants own words as quotations was done across and within each of the four cycles and the final interview data. The quotations were collapsed into codes and themes were extracted from the categories using a form of thematic content analysis (Denizen & Lincoln, 1998; Graneheim & Lundman, 2004) consistent with a UAI study. Patterns and changes in patterns were assessed for both individuals through journal entries and follow-up interviews and across the groups through participation and experience of the groups by the researcher and through her field notes.

Data analysis in UAI is done through both analytical and synoptic processes (Cowling, 2001). Data from each of the three times of data collection (day one, day two and follow-up interviews) were analyzed both separately and together in both a step-wise fashion as the data was collected and in reiterative cycles going between analyzed data and the synoptic viewing of the whole. The analysis of data was done through a review of participant journal notes and session notes taken by the researcher during the group discussions. Data were analyzed using the line by line in vivo quotations to identify both themes and patterns which emerged from the words of the women about healing and life patterning as they related to the experience of childhood abuse and about the participatory dreaming process. These patterns were then contextualized into the six

tenets of the unitary healing theory: (1) wholeness, (2) appreciation, (3) participation, (4) knowledge, (5) emancipation, (6) change/ transformation (Cowling & Repede, 2009).

Data synopsis (seeking the contextual patterning of the group data as a whole) was done through in-depth dwelling with data, reading and reflection upon the journal entries, researcher field notes, and the appreciative viewing of the group aesthetic creation. The data was reviewed for individual and group expressions, perceptions, and experiences, and for the effects of the participatory dreaming process on healing from a unitary lens. The researcher reviewed across all the data points, both within and across groups, to explore potential expressions of patterning that occurred within the individual, the group, and in relationship to the participatory dreaming process. The synoptic viewing of the data gave a sense of the patterning which reflected the wholeness, uniqueness, and essence in the life (Cowling, 2004a) of the individuals and within this group of women. This type of review was consistent with a focus on healing from a unitary perspective and with a UAI methodology (Cowling, 2006).

A group pattern profile comprised of a narrative/ aesthetic synthesis of the data sources noted above was developed by the researcher and shared with participants to validate the perceptions of the researcher about the data. This group pattern profile consisted of three music videos (two created by the researcher and one commercially prepared and purchased) which seemed to express three overlapping patterns in the lives of women healing from childhood abuse as they emerged in this group. The images, words of the songs, and contextual meaning all arose from the journal entries, the voices

of the women in the group discussion, and the researcher's participatory (situated and reflexive) stance within the group (Reason & Bradury, 2001).

Legitimacy and Credibility

The four tenets of legitimacy and credibility developed by Cowling (2001) for a UAI study are: (1) the quality of the data, (2) investigator bias, (3) the quality of the research process, (4) the usefulness of the study findings. The quality of the data from a unitary appreciative perspective is evaluated from an interpretive paradigm, in which the voice of the participant is held to be the final authority on the phenomenon or area of interest under study. The quality of the data was enhanced by using thick descriptions and the metaphoric language of participants which contributed to the fuller expression of and uniqueness of each individual within the group. These findings were also validated by the participants. During the presentation of the findings to the group, most of the women were emotionally touched-crying, nodding their heads in agreement, and hugging each other. When asked if the findings given and the aesthetic presentation captured their voices and the voice of this group, all were in agreement that it was. When asked if there was more, or anything left unexplained, all stated that there was nothing else they could add at that time. Additionally, the dissemination of the authentic voices of the participants through direct quotations and themes developed from the actual words of the text was used to reduce researcher bias. Having a research assistant who was present throughout the study and acted as a peer-reviewer of the data analysis assisted in maintaining the integrity of the data, monitoring the quality of the research design as it unfolded, and reduced investigator bias. The research assistant/ peer reviewer who

worked with this study is familiar with the conceptual system and the UAI method which was a distinct advantage in achieving legitimacy and credibility given the newness of the system (Cowling, 2001). The quality of the research process was monitored through out the study using a combination of peer-review, oversight by Dr. Cowling, and the development of an audit trail using field notes and software where applicable.

The quality standard of the usefulness of UAI study findings is similar in some aspects to the interpretive and critical theory perspectives (Cowling, 2001). There is similarity to the interpretive perspective in the desire to obtain transferability to other contextual situations through rich descriptions of data. In this study, this was done through data analysis and synthesis which include rich data descriptions using the words of the participants themselves and through the aesthetic presentation developed by the women.

UAI standards of usefulness are similar to critical theory research in the usefulness of the project in making a positive difference in the lives of the participants (Cowling, 2001). Additionally, the ability of the participants to facilitate personal knowledge development and increase process skills through participation in the study is a measure of the usefulness of study findings as they are reported by participants. The inquiry process, reflective journals, presentational expression, and qualitative questions asked at the end of the inquiry and at the one month follow-up period were used to answer the question, ". . . to what extent do the study findings illuminate the wholeness, uniqueness, and essence of these human lives that would inform knowing participation in change?" (Cowling, 2001, p. 46). While a UAI inquiry differs from critical inquiry in that

it does not target the elimination of oppression as a social activist project (Cowling, 2001), it is believed that the nature of this study highlighted and informed the participants about the social ramifications of childhood abuse.

This study uncovered information that could not be ascertained from other approaches because it focused on healing, rather than on the experience of abuse. This study also created the conditions which allowed for the reflections of wholeness in several ways. First, the participatory nature of this dreaming process was designed to assist participants in finding both an individual and collective image of personal and group healing (the word healing derives from the Anglo-Saxton word haelos, meaning whole) through the childhood abuse experience. Secondly, the group process was engaged in such a way as to be inclusive of people, thoughts, ideas, feelings, and remaining respectfully open to both differences and similarities. Thirdly, the group was supported throughout the study period in a safe, nurturing, and feminine-relational manner consistent with appreciating what is, no matter what it looks or feels like. And finally, the use of music, metaphor, dreaming, imagery, and art was used to facilitate the appreciation of extant wholeness in a manner in which linear, logico-rational processes by their very nature cannot.

CHAPTER IV

PRESENTATION OF FINDINGS

There are three topical areas of findings which arise from this study. These are the

thematic analysis/ synthesis of data, the reflection- synopsis of the emergent patterning of

the group, and the unity within the findings which represent the inherent wholeness of the

study process. The thematic analysis is reviewed from the perspective of answering each

of the two research questions. The reflection- synopsis component of the study is situated

within the patterning framework of experiential, presentational, propositional, and

practical knowledge. Chapter Five includes the discussion of the unity within the findings

from the contextual framework of the six tenets of unitary healing (wholeness,

appreciation, participation, knowledge, emancipation, change/transformation), the

relationship of the findings to the literature and to nursing science, and the

methodological considerations of the study.

Thematic Analysis

Themes related to the experience of childhood abuse about (1) unitary healing and

life patterning and (2) participatory dreaming as they emerged from the data were

grouped into three main areas: healing from the inside out, dreaming, and a circle of

healing. These themes were distilled from the in-vivo quotations and codes of the journal

entries, the group discussions, the researcher field notes, and the follow-up responses of

the participants at the four week data collection point. A general discussion of each theme is presented along with in-vivo quotes which support the theme. The unitary nature of the findings demonstrate that these themes are not isolated, each is woven like a thread into the tapestry of the whole fabric of the study. Some of the quotations, therefore, often appear to represent more than one theme or sub-theme. Quotations were from participants unless otherwise specified. Journal quotations were reproduced as they were written, including spelling, punctuation, spacing, emphasis with capital letters, and symbols.

Healing from the Inside Out

Healing from childhood abuse was the primary focus of this research and "healing from the inside out" emerged as the predominant theme of this study. Healing was described by participants in many ways throughout the study, but healing as an inside process contextualized within the group, within community, and within a grander vision of the universe often emerged in different ways. Thus several sub-themes for healing from the inside out occurred. These included time, journeys, feelings, finding lost keys, and engaging paradox.

Healing from the inside out implies a process that deals with recapturing a lost sense of self. Much of the literature on childhood abuse deals with this sense of disruption to the deepest regions of the psyche along with a sense of isolation, fragmentation, and despair (Cowling, 2008; Hall, 2003; Roman, Hall, & Bolton, 2008; Scott, 1999; Thomas & Hall, 2008). The women in this study described themselves as being in varying states of the healing process. This was characterized by the length of time they felt they had been actively working on healing, their personal perceptions of

being on a journey and where they were on that journey, the sense of seeking/ finding

keys to unlock inaccessible or lost parts of themselves, the feelings and emotions that are

bound with both the abuse and the healing from the abuse, and their intrapsychic capacity

to hold paradoxical beliefs or feelings. These subthemes are intricately intertwined and

can be seen as both uniquely expressed and unitarily shared. Examples of these

expressions are presented in Table 3.

Table 3.

Healing from the Inside Out

	Time	Journeys	Keys	Feelings	Paradox
Participant A	This is an unusually dark time for me in my life with my healing process.	I feel like I was on that path, but than I took time off to make sure that was what I really wanted… I want to get back on the healing journey.	I feel like I'm slowly remembering how to be that person again, and what I liked about her.	Oh god. This is so hard. I feel like I'm ready to feel again. I feel like I want my life back.	I want space, I want no space…I want to be alone with someone else.

	Time	**Journeys**	**Keys**	**Feelings**	**Paradox**
Participant B	But I don't think I'll ever be done with this and that's not what I had thought in the past.	My perception of healing at this point is I'm realizing that more in-depth that this is such a process and that is a spiral, that it is helical. Each time it gets a little easier and easier.	I'm at the point in my healing that I have dealt with the anger, rage, tears, guilt, old patterning, etc. What I am left with now when I am faced with challenges is: do I do what's in my own best interest?	The biggest differences are: now I am strong; I feel safe; I have emotional support; I am willing to stand up for myself and take an unpopular position in order to take better care of me.	Things looked great on the outside but inside was completely different.
Participant C	I have been sexually abused for what feels like my entire life. First at the hands of others and later at my own hands by poor choices .	I am on a very clear healing journey and I can't wait to experience all that entails.	The key is patience. My inner self smiles because it knows the secret and has power to unlock any and all doors.	Accepting that emotions are good regardless of the connotations or implications I, society at large or others have attached to them.	New beginnings…then blackness… void… Nothingness.

	Time	Journeys	Keys	Feelings	Paradox
Participant D	It took me a long time to be ok in my own skin. Today I feel a hold lot better about my life. Things are not where I would like them to be. But better then it has been in a long time.	All of the dreams that were stolen from me when I was a child, I'm trying now to live, now that I'm comfortable in my skin.	If I can trust in something I can not see, but feel thing how empowering it become and so the hurt go away yet for that day….And the possibility to believe new thing are then open.	I had a lot of fear going on in my life. I think it was a direct result of being sexually molested and I didn't really figure that I would amount to anything, that I could do anything.	Abuse did stuff to us and I don't want to be that person no more.
Participant E	The journey began so long ago, it seems now that it started the day I was born into this life.	I don't know if I've said this before but, to me the journey has been in a- its not been a constant forward, one, two, three, four, five, six, steps in a row, its been two steps forward, one step back, three steps forward, one step back.	The "destination" for me is being present.	…when I first opened up those issues and became willing to examine them, it was so painful. It felt like I was one big raw nerve walking around. I didn't want anybody to touch me. Don't hug me, don't blow on me, don't look in my direction because it hurts.	But just that, its being ok being different. And there was a time when I never would have bucked the system. Then there was a time I would have bucked the system just to be defiant and different.

	Time	Journeys	Keys	Feelings	Paradox
Participant F	I think that the abuse that was suffered as a child will live inside me until the day I die.	It is ongoing the older I get the longer I strive to free myself of the old memories, (the Bad ones anyway).	Its all just a tool to help you to get all the pieces to fit together.	It let me share something with others that know how I feel.	This mask represents feeling plain and empty on the inside and realizing the real Goddess within on the outside.
Participant G	Because It Never Really Goes Away	My perceptions of healing (from abuse) have changed many times and in many ways.	I want to learn to soothe myself…the real growth will come when I am centered and strong in myself everyday.	Anger paralyzed me. I felt it in my spirit, in my heart.	Somehow paralyzed as to what to do- but very excited to be going!
Participant H	Learning to live as joyfully fully as I can at this point in my journey, which will be different from past and future.	Words have been a means to chronicle both my abuse and pain and my healing journey.	I am learning to let my true self come out to live, love, play and not allowing the tyrant child to rule.	I'm tired of being numb. I want more of life.	That is my ambition – to grow up to become a child – the person God created me to be. That is healing – becoming the real me.

Time

Healing from the aftermath of childhood abuse was described as a lifelong

process. The concept of time was relative and contributed to the sense of healing as a

journey and a process. This participant expressed her frustration with people who do not

understand the pervasive nature of the effects of the abuse on the life patterning of

women who experienced abuse in childhood. In this description, time is unitary- past and

future merged into the now:

> Don't talk about it- its back then. But back then is NOW for you and back then and
> tomorrow for the victim-its everyday, every WAKING day of their life that they have
> to deal with the fact that somebody, somewhere did some horrible things to them
> that's stopped them from living to their full potential.

Many of the participants expressed frustration with others for not understanding,

but also with themselves for not reaching a destination of healing as an end point. This

often contributed to a sense of despair which was related to self-esteem, ability to project

into the future, and anger or frustration. "There is an automatic wall . . .I keep banging

away, trying to get a chink."

Journeys

Every woman in the group verbalized healing as a journey, but some understood

at a deeper level the helical nature of healing as a spiral, while others began to see it

through their work in the group. "Another turn on the spiral and another opportunity to

recognize what really works for me and doesn't." Understanding did not necessarily come

with a release from frustration:

> My resources and support are different than they were when I first started the healing
> process. I'm a big believer in chaos theory though, so what's on the other side of
> whatever is getting ready to happen is at a minimum another fucking growth
> experience. I guess I just know now that there always is another side and a healthier,
> happier, and better understanding of myself when I'm done wading through the muck.

I've done it before and can and will do it again, a lot less scarier this time because of course I'll be okay.

Another described her journey as starting later in life:

Being that I have only began the healing process just awhile ago I really still have a way to go. But for right now I am beginning to see small changes in my life. I [am] able to understand more about me and why my life was the way it had been in the past. It is a very scary feeling facing certain issues as part of this healing journey, but is the best and most important thing in my life. Without it I would be stuck Someplace I Never want to be again.

The above quotes are from a woman in her mid-thirties and one in her fifties. The journey into healing was dependent on multiple patterns in the lives of women beyond age. Catalysts for healing came through internal processes, feelings, turning points in awareness or life circumstances, and from environmental cues. "I have been able to except [accept] the little girl who went through all she did. I have been able too forgive her for some of the things she was put in a position to do. I am able to tell her I love her and understand what I say and feel." The environmental cues were often seen as a cue to practical action, an emancipatory process leading to hoped for transformation.

I never make impulsive decisions yet decided to join this study if possible as soon as I finished reading the flyer – I set out to research "dreaming," "creative visualization" and other mind body spirit therapies. That resulted in my finding a wealth of information that helped me to understand many of the physiological things I experience as they related to the abuses and my response to them emotionally as well as physically.

Both physical and emotional feelings were processed by the women and expressed verbally and nonverbally, and provided the underpinning for much of the work the women did during the study. Every woman in the group described some measure of

emotional healing from the safety of the group as it provided a safe space. "In a group like this, it allows me to let go some of the shame that is not mine." Some of the healing came through a catharsis of emotion for being witnessed. This woman was crying as she told the group, "My daughter was a victim also. The only difference between her and me is that she has no idea what it was like not to be able to tell, to be seen and heard." One participant told the group angrily that she was tired of not being believed by others such as family, even by health care practitioners. Another participant very compassionately told her, "I believe you and every woman here believes you." The women all nodded or verbalized agreement.

Emotion was a catalyzing force in the healing process. "I was not motivated to heal from my abuse by how good it felt- it was the PAIN that motivated me to heal." Anger and rage appeared to be a huge mobilizing force for healing. The metaphor of a volcano erupting emerged in one woman's imagery and was the focal point of a discussion around the need to find a psychic container strong enough to hold the intensity of emotion that emerged at times during the healing process. Many described the need for a sense of internal and external safety before they could deal with the powerful emotions triggered by the healing process. "The only way I can get this out is to get it out of my body. No amount of anything works if there is not a safe place…when I learned I could scream, cry, and be an activist, it was a huge part of the healing process for me."

Dealing with the emotions did not mean they were gone. But when they were experienced in the presence of a more developed sense of self that comes with healing,

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they were perceived differently, perhaps more as ripples on the surface of a pond than a

tsunami:

> So I am living the aftermath of making a decision in the best interests of me that
> <u>certain</u> other people don't like. I am supporting myself in that decision and in the
> process experiencing <u>ALL</u> the emotions that have previously gotten in the way of me
> taking care of myself in the way that was best for me:
>> guilt
>> shame
>> judgment
>> fear
>> doubt
>> criticism
>> caretaking
>> I'm a bad person
>> anger
>>> etc. etc. etc…
>
> Only now I am standing in my power, standing up for myself, making a decision and
> getting in the VERY UNCOMFORTABLE aftermath. But I remind myself – the dust
> will settle and I will again see the moon and stars reflecting in my being – it's just
> that the water hasn't stilled yet. ♥

Throughout the study many of the women would reach over and touch or hug

one another during intense emotional moments. One participant felt mothered in a good

way when some of the older women would reach out to physically comfort her during

times of distress. Physical sensations were often experienced during the dreaming

sequences or after that gave a cue to emotional states as well as providing needed

information about a pattern that was "coming up to be healed." One of the women

became aware of a chronic pain in her shoulder that was related to a later and secondary

abuse by a chiropractor when she was 21 years of age. Correlating the pain of the

shoulder to the abuse was an epiphany for her and provided a cue for action that she felt

was needed to clear the pain.

Another woman who had been sexually violated from early childhood had intense vaginal pain during the second dreaming sequence. She was able to sit with the pain and breathe into her body to soften it. Her response was to embrace her feelings rather than numbing them out. "Numbing out" was described by several of the women as a mechanism for coping with intense rage, fear, shame, anger, or pain. Many of the women were in recovery from addictions. Healing was seen as choosing to be awake to all of life's fullest expressions. Feelings both physical and emotional which were attributed to the abuse were often described as recurring life patterns. One woman stated that she knew that both her migraine headaches and fibromyalgia symptoms were a direct result of her childhood abuse.

Finding Lost Keys

The subtheme of finding lost keys recurred several times. Many of the women described this feeling as blocked, locked in, locked down, fenced in, blocked down, or being behind a gate or a glass wall with no way to get in or get out. Over and over the women described this sense of being blocked. One of the women approached the RA at lunch and said, "its so interesting. Its like we've all lost our keys [to healing] and can't find them." The metaphor of lost keys was replayed in the study itself. In a unitary understanding, there is a reflexic relationship between the environment and the people within it (Cowling, 2007). From the very first day of the study, the research assistant and I each lost our car keys several times. I misplaced the keys to the study site the first day and it took over an hour to find them. The RA got locked out of the building in a comical interlude with the lunch delivery man, and I was locked out of the building the morning

of the second day of the study with no one to call for help. In every case, help arrived

unexpectedly and from unusual sources. Many of the women described this same sense of

unexpected help arriving or being gifted in their healing journey in some way.

> I keep feeling like I don't even now fully realize how much I am supported by the
> universe. How much I am cradled and held in it's arms, how much I am cared for and
> protected. I didn't know – and I'd really like to know. I am asking to know and feel
> the depth of love and connection so that I may live more fully from that place of
> inherent wholeness.

Healing seemed to be related to finding, replacing, restoring, or unlocking parts of

the self that had been buried as a result of the life patterns which evolved from being

abused. Tools and techniques (keys) often included reaching for a transcendent grace

through prayer, meditation, music, spiritual readings, writing poetry, activism, art,

writing, doing healing work through therapy or alternative means, being out in nature,

and connecting with others, including pets. Some moved deeper into solitude for healing

trying to hear their own voice, while others looked to other and community for help.

Embracing Paradox

Paradoxical feelings were described frequently. "I want to be alone with

someone." These feelings may originate in the paradoxical feelings that women develop

with their childhood abusers (love- hate, dependence-fear) creating an internal tension

that is both psychically and physiologically stressful (Phillips & Frederick, 1995). Higher

power and expanded awareness into a transpersonal dimension seemed to offer the gift of

being able to hold greater amounts of cognitive and emotional dissonance (paradox) with

a lesser tension. The ability to hold diametrically opposing feelings was an indicator to

some of the women that their healing process was evolving. This lesser tension appeared

to offer a sense of healing (wholeness) that moved them to increasing awareness and

freed them up to make new choices.

> My understanding of healing is not the forgetting nor suppression of my experiences
> but rather the embracing of all that is me. I have begun to view any feelings – anger,
> despair, hopelessness, happiness, joy, hunger, excitement, anxiety all as proofs that I
> am alive! That I am here! That I matter! That I count!

Higher power as spirituality was a recurring discussion during the study. Many

women described relationship with a Higher power as central to their appreciation of the

healing in their lives. One woman who self- described as atheist, remarked at the end of

the study, "It definitely had me personally questioning again, it has been sort of a theme

for a few months now- questioning spirituality and how I feel about it, how it relates to

my healing process and if or whether I am missing some aspect of that in my life."

Perceptions of Healing from the Study

Participation in the study did influence many of the women's perceptions of

healing in their lives. While journal notes and responses to the two research questions on

days one and two of the study indicated some changes in awareness, most of the

perceptual changes were noted on the follow-up interview two weeks later. Eight of the

eleven women specifically reported a change in their perception of healing in their lives

between the first and third data collection points. These changes included new tools, the

ability to visualize new possibilities and to daydream, incentives to see differently,

change toward an active pursuit of healing, a recommitment to stay engaged and avoid

distancing or numbing out, actually using tools to set boundaries, seek out information, new awareness of the healing as a journey or a destination, feelings of clearing out old patterns and consciously creating new ones, the creation of new connections with the self and other women, insights into physical symptoms and how to clear them, the ability to face scary feelings and move through them with the support of the group, and intense personal transformation.

There was one participant who stated that she "couldn't say yes or no" as to whether her participation had influenced her perception of healing. Yet her work with the mask demonstrated to her in a profound way her own transformation from the dark to a new life. She also stated during her final interview that the study was an empowering thing for her because it allowed her to share with others and identify with the hopelessness they were feeling. This participant was told by another in the group how powerful and solid she seemed. This moved her to tears and offered her an opportunity to share her own healing journey and how she came to a point in her life that she had never before dreamed possible.

One of the women in her final interview stated that her perception of healing had not changed during the study, "its going to take time to heal. I think that just all it needs is time." Interestingly, her previous response to the research question about her perception of healing in her life on day two of the study two weeks earlier was, " I think that the abuse that was suffered as a child will live inside me until the day I die. I have been damaged and all the praying and meditating does help some. Temporarily." This woman told the group that her mask represented feeling plain and empty on inside and

realizing she was a real goddess on the outside. This may indicate that healing may be subtle or actually be occurring without the conscious perception of the woman, which is consistent with the literature review on women who have experienced childhood abuse.

Another woman stated in the final interview that her perception of healing was still the same, but she had gained a new awareness about the healing process:

> I think my view of healing is still the same, that I think that healing, true healing takes place in community and I think a really important part of that healing I've come to realize would probably be relaxing and getting quiet and listening to what your body and mind are saying. I don't think I realized how important that was before. Just how important that is. You know everyone says that, but until you actually experience it I would say that you don't get the gist of it.

The above discussion speaks to the perceptions of healing from the perspective of women abused as children examined through the lens of participatory dreaming. It suggests that healing is a process that arises from within the woman but emerges within the context of community. The subthemes of time, journeys, feelings, finding lost keys, and engaging paradox overlap in ways that suggest that there are no discrete components to healing. Every pattern is enfolded within another creating a non-hierarchical round of increasing complexity and fluidity. Boundaries are non-existent, person and environment are contiguous, and healing is relational within the self, with others, and in community: "I really am whole and I really do have all that I need. What is dim is only my awareness at times. . ."

Dreaming

The participatory dreaming sessions were designed to offer the women a safe, imaginal space in order to find whatever tools, insights, or discoveries were needed to envision healing for themselves, for each other, for their families, and for their communities. The dreams were first expressed in writing and then discussed. The aesthetic component of the study was added because art helps to ground active imagination in the body senses and can offer other avenues of perception and awareness that extend beyond conscious thinking patterns (Norman, 2001; Rhyne, 2001). "When you engage in an art activity, you are experiencing yourself: what you produce comes not from a 'depersonalized' it but from a very personal you" (Rhyne, 2001, p. 112). This is extremely important because depersonalization has been found to be a recurring problem in women who have experienced childhood abuse (Scott, 1999). This section of the paper describes the findings regarding both the dreaming and the women's discussions about the creation of the masks and their personal interpretations of them.

There was an incredible diversity in the dreaming experiences of the women. The experiences ranged from transcendent to sublime and some of the women even had intense physical and/ or emotional sensations, sometimes pleasant, other times painful or unpleasant. Each woman was encouraged throughout the study and especially during the dreaming to do what was necessary to feel as safe and as comfortable as possible. The women were told they could leave the room if the session became intense or if they did not like the dreaming, and that the RA was available for support if needed. Even women who were intensely uncomfortable during the dreaming made the choice to remain during the sessions. Suggestions for breathing into, softening around, and changing body

position to ease discomfort were given by the researcher. All of the women who

expressed discomfort felt there were deeper understandings to be gained from staying

with the unease and used the container and safety of the group to stay with feelings that

had been previously submerged or numbed.

> I couldn't go anywhere…I blocked…there is an automatic wall…I keep banging
> away, trying to get a chink…finally I got a glimpse…finally, I got to space where I
> felt warm and comfortable…a eucalyptus steam room…it cleanses the negative
> energy…I focused on the sound. I always feel like I'm observing life from the
> outside…at one point I saw death and destruction, there were buildings…then I got a
> short glimpse of the sun radiating, the sky was ablaze…always on the periphery and
> no way to get there (to the sun). I'm on the way up. My emotions are a way for me to
> know that I'm alive…. I'm not ready, but I am desperate to take that leap.

After each dreaming and journaling session when the group would convene in a

circle for the discussion, the researcher would simply ask, "So what was that experience

like for you?" After a few moments, one of the women (it varied as to which woman

would start) would begin to talk about her experience of dreaming. The rest of the

discussion would then flow within the group uninterrupted except if or when the

researcher made a space in the conversation to allow the quieter participants an

opportunity to share if they so desired. Often the recounting of the dream would lead to a

discussion about issues, patterns, and feelings about living in the aftermath of abuse. The

following exchange about dreams was started after one of the women described her

experience of the dreaming.

> Man, that was really 'out there', I didn't really remember nothing you said, but I felt
> a sense of freedom by myself without children. . . awesome to me to be just me. I
> pray I can cut loose the things that tie me down. [Crying] The first time [abuse]
> altered everything. We have our baby dreams and it goes down the drain. I wanted to

be a stewardess. I can't be a stewardess no more. If I had my way, I wouldn't have four children, maybe not any, maybe one. . . I'm trying to see if I can have my way now.

After awhile, another participant returned to this discussion about lost dreams and said to the above woman:

I can't be an airline stewardess, but I'm not a victim anymore. I remember sitting on the front stoop as a little girl and asking God, what is my purpose, why am I here? When you were talking, I was just trying to find that little girl (self as child). The God I grew up with was an angry God….Now if I'm not a stewardess, I'm not a victim, I'm just lazy…I'm not that girl no matter, I'm 50 years old…I have a friend that is a mirror and that helps me….Abuse did stuff to us and I don't want to be that person no more- I'm not a victim no more."

In this manner, the women would gently engage each other, exchange stories and feelings, and offer up wisdom to each other. Throughout the discussions there was a rhythm and flow that mirrored the dreaming process, nonlinear, fluid, contextual, and circular. After the first dreaming session, three of the twelve participants declined to share, but by the second round all of the women participated in the discussions, which seemed to reflect the safe space that the group had created for each other.

Each woman's experience of participatory dreaming was unique. Many experienced each of the dreaming sessions differently within themselves. The following notes from the final interview with one participant reflect her awareness of how she experienced differing aspects of personal transformation as a unity of flow that moved with her as she progressed through a decision-making process during the four week study period. The script read was the same at all three sessions.

The 3 sessions of participatory dreaming in succession were helpful because I got to witness the progression of healing [of] this particular situation from one side of the continuum to where I am now. I saw how differently I perceived what was said based on where I was in my process. The dreaming sequence itself was very relaxing and it was very gentle and allowed- if my memory serves me right there was a part that was- well there were several different aspects- was there a part about seeing yourself as healed or being healing? (Researcher; yes- what would it look like if you felt healed, whole) and there was also a part of what would you need to do or who would you need to help you, that kind of thing. I thought those were very helpful because each of the three times I got different answers which allowed me to focus on whatever aspect was really "up" for me. It was- I got new information based on doing the sequence and it was also deeply relaxing, so one time, the first time it was me seeing all the support that I had in my childhood that I didn't realize and it felt like a lot of comforting and nurturing and I had just come from that other emotional/somatic release session so that's what I needed and Mary was there (Mother of Christ) and how can you argue with that? And the second time, there were more tools involved and was more of specific how-to's like XXXX (name of art teacher) showing up (in the imagery) was speaking to creativity, so the message was that that is an opening for you (for participant), and the third time was the chair, I don't remember exactly but there was that being in a difficult place and acting on what I needed to act on and sitting in an uncomfortable place but feeling solid and stable and strong (the chair), so it was more awareness about me personally. So it almost goes through a progression. It was like feeling support around me initially and then it was things to do, and then it was me having taken action and me feeling consequences of that but knowing that I was ok. Knowing that even though it was particularly challenging that that was ok, that no matter what I was going to be alright.

Like the participant above, many women heard different things at different times during the guided portions of the dreaming sessions depending upon several things, such as what was emerging at that time in the imagery, how they were personally feeling, different aspects of the group process, and how deep they could go into the imaginal space in general. In beyond waking states, current research suggests the ability to more deeply enter into a trance or dissociated state may be a state trait, however this is often enhanced in women who have experienced childhood abuse (Rossi, Erickson- Klein, & Rossi, 2008; Hall & Powell, 2000). "Did you really say the word 'chrysalis' the last

time?" After the second session, one woman said that when I had said to visualize herself as beautiful, she immediately thought, "I can't do that" and she did not remember those words in the script from the first session. One of the benefits of imagery is that often the logical egoic mind can be bypassed to get 'below' an entrenched or embedded pattern of thought or behavior that is no longer desired or wanted (Naparstek, 2006). It can also (as it did for this woman the second time she heard it), highlight an area or need that she deems needs more personal work (Baer, Hoffman, & Sheikh, 2003). Interestingly, healthy self image in women abused as children is often problematic (Cloitre, Stovall-McClough, & Han, 2005), yet most of the other women in the study did not notice or have difficulty with this section of the dreaming.

Despite discomfort or difficulty getting into a relaxed dreaming state, all of the women stated that the dreaming was an important part of the study and contributed in some way to their awareness of a particular pattern or patterns and of action or change that was needed in their respective healing journeys. This woman described her second dreaming session and was amazed that her safe place in the imagery had shifted to a place that was never before safe for her because of her experience with childhood sexual abuse. This passage also demonstrates the fluid nature of the dreaming for her and indicates how she became aware of her current feelings during the group process and how she dealt with them using the dreaming:

> I have been more cognitively aware of my surroundings and the persons in this room – knowing more about each – and having given/received hugs from some of them. Perhaps that's why initially my "diseased thinking" went to the judgment piece – "what are others thinking of me?" It took a couple of good deep breaths and really focusing on Liz's voice and the words to get centered again. I could not see anything

in particular until the vibrant colors. Sparkling? glistening? glimmering? <u>And</u> what I saw was a kaleidoscope. No, <u>the</u> kaleidoscope – the one I grew up with. Purchased just for me by some of the folks who loved and nurtured me. Mom? Dad? Grandma and Grandpa? Not sure but one or more of them. Occupied my fascination for many hours as a child, seeing into the tunnel, toward the light, turning the base which rolled the colored pieces…
My being is a fluid and translucent but contained energy field. Able to move wherever. . .
My current home, the safest place in the world. Filled with bright and happy colors, wonderful scents, beautiful flowers, safety, comfort and most of all a feeling of being loved and nurtured. Encouraged to do, be, say, think, feel, explore whatever I need. The most beautiful part of this particular visualization is that when I was asked to "go deeper" – it happened in the <u>our</u> bedroom. This is <u>truly</u> a first. I have never visualized safety in the bedroom setting. But, today our bedroom <u>is</u> a safe place. For <u>both</u> of us.

Dreaming is a metaphoric language. One participant who experienced great difficulty being able to be still and relax for the dreaming, even though she had piled pillows on the floor said during the group discussion, "I had a hard time with this. As a child I went outside because the chaos was on the inside." She described how the metaphor of the chaos inside was still playing itself out in her life patterning. She talked about seeing a sandpiper in her images, "the little bird that runs between these huge waves and big sand dunes, both of which are so vast to the little bird, but the bird is not afraid, the bird is so calm. I wish I had all that courage and no fear."

Others found the dreaming difficult at times. Feelings of frustration would emerge.

Well, that sucked. There was nothing. I couldn't leave this room. I couldn't dream. My head hurt, my lips are chapped. I feel heavy and uncomfortable. I became aware at some point that I wasn't even hearing Liz talking or paying attention to what she was saying, but then I would hear her say one or two words and be aware that I was still just sitting here, feeling uncomfortable. I also became aware of the feeling of being lost in general, unsafe in general.

Others wondered if they were doing it right. Feelings of despair would emerge and be replaced with hope. The following participant was too afraid to talk about her experiences on the first day because they were not as pleasant as some of the others, but by the second day of the study she verbalized this to the group and was validated for sharing that. The women were reassured over and over that there was no wrong way to experience this and that every feeling was valid and important.

> I don't know how to write, I don't want to write. I hope that this stream of consciousness is okay. Bag russels. Water falls. Cramps. Relaxing in not relaxing or the other way around. Not sure what I should be writing. Its hard to find that safe space. I'm not sure which one is right. Who's suppose to be there. I don't want to be there alone. How long are we suppose to write for. I'm so sorry that you are reading this. Maybe I'm doing this wrong, and its not supposed to be a free write. Yeah I don't that it is, but I get the most out of my feelings this way. I want to find a safe space. I know that, that beautiful water fall or wheat field is our there somewhere. I just need to reach for it. My head feels so heavy. This is harder than I thought. I feel like there is so much sludge and gunk clogging the clear parts of my brain that are free and full of light. Slowly the gunk will dissipate and the light will shine through once again. I can see the light, I know that it's there.

Dreaming, with its relaxed boundaries between concrete thinking and analogical thought processes was a way for some of the women to experience or perceive the paradoxical nature of their desires:

> I just want to sleep on in a warm cave filled with lambs ears and moss. I want rest. I want warmth. I want sunshine. I want space. I want no space. I want warmth. I want heat. I want hot air. I want earth. I want orange. I want green. I want quiet. I want rest. I want to be alone with someone else. I know that some of this seems to be a contradiction. I want safe. I want warm orange glow. I want the glow. I want eyes close and mind at ease. I want this iodine to wash off and skin to show. I want skin. I want warm hearts pounding. I want rhythm. I want rust. I want peeled birtch

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bark. I want bark. I want crunch sweetness. I want home. To want to be a home. I want to feel at home. I want warm.

The dissolution of waking boundaries was also evident as some of the women described their imagery as a merging of senses, "I found peace, seeing the colors, catching the greens. I was trying to catch the greens." Another woman wrote,

I am a fountain of lights. Like a prism all colors shine up through me. At the top a beautiful orange sunrise graduating to corals, pinks, lavanders. Then at the base dark purple for strengthening and grounding. At the end of my fingers droplets are clear crystal like. It's as if I've absorbed the beauty let it ran through me, heal me strengthen me used it up and clarity is what I have to let out.

And another wrote, "There is no 'noise' but it is not silent. The liquid light is filled with beautiful sound that soothes and comforts and at the same time invites us to revel in the beauty around us and in us." This merging of senses allowed for an expanded awareness of the unitary nature of all things, a place outside of time and space that can reduce the sense of isolation, fragmentation, and disconnection that many women experience with abuse.

Often the dreaming sequences would take the women deeper into a process until a synthesis of conflicting perceptions or feelings would emerge into something new and very surprising to the woman. The participant who was not sure if she should have had four children or one or any experienced the first dreaming session as a release from feelings of being overwhelmed with responsibility.

There so many emotions that I feel. Right now for this moment safe from responsibility. Calm somewhat surreal as if I am in another life, body did something really happen to me. Felt good for that moment and I needed that. So what about

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now how many times a day a week can I have that moment back with my life as it is now.

Her second dreaming session took her deeper into the process of allowing her to feel a sense of freedom:

I saw the colors I was able to breath them in and exhale them out a beautiful feeling the softness of the skin that even stronger feeling of being free like the colors I was breathing in and out light like a butterfly coming out of their cocoon Spreading there wings and flying for the 1st time standing on a mountain top saying I can do this I can fly and just doing it spreading those wings and flying do I really have to come back or can I just keep on flying This was a beautiful experience. To take a ride to anywhere.

Her third dreaming session surprised her as she found herself inviting her children into her dream.

I was able this time to listen to hear everything that was being said where 1st time I went to a place where I no longer heard. I felt a different kind of peacefulness. I was able to see myself as the person I would love to be, the person I am working on becoming. The free to be me person. I was able to go to that place where peace compassion and love. I even took my children there to a island in the middle of nothing but water just me and them in love and peace. Beautiful colors. To be able to give love to them to have that true inner peace was a wonderful feeling. Just being quiet talking with your eyes and heart not speaking a word, but being understood just from looking at each other with love. Being able to do that in my mind was one of the most gradifying feelings. Again being that free person no chains, bars, locks, nothing but beautiful colors space love.

The above story demonstrates the power of the dreaming to assist in first identifying a life pattern, then to go deeper into the self to find inner resources, and finally to use those resources for desired transformation and change. By the third session of dreaming, this woman had found a way to integrate her reality with her dreams of

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feeling free by appreciating the wholeness that existed as it was in her life. By the final follow-up, this is what she said,

> The dreaming thing helped me know I could put my mind at ease for a period of time. I was able to embrace myself, my life in a different way. The dreaming showed me I could go where I want and take who I want by making decisions for me and only me. This has helped me in learning how to take care of me and make me a priority. I used what I learned to set boundaries in a situation that came up last weekend.

Another element that emerged during the dreaming was the transpersonal nature of the dreaming process. After the third session of the dreaming, at least six women said that they had had images of Hawaii or a tropical Hawaii like place. To my knowledge there had been no discussion or mention of Hawaii before this. The women were astounded that their images would merge so much. One of the participants who is a holistic nurse told the group that the earth is considered to have an energy system of its own and that Hawaii is the energetic space of the second chakra for the earth. Chakra is a Sanskrit term that means wheel of light and is considered in the esoteric literature to represent and embody certain qualities, emotions, and physicalities that correlate with specific life tasks (Judith, 2002). In the human chakra system, the second chakra resides in the pelvis, just below the navel. The second chakra represents sexuality, relationship with others, creativity, generativity, and the ability to provide for oneself in the world (abundance) (Judith, 2002). The group of women immediately contextualized this in relationship to their abuse issues and took this as further confirmation of a collective awareness and connection to a space that that is neither temporal nor boundaried.

Several of the women had dreams about community. One woman had dreams about a place of peace. She described it to the group.

I was someplace… don't know where…it was peaceful…it was a town…it was clean…everybody, all kinds of people…everybody was carefree…there was a Chinese lady holding a baby of a different race…I felt like I was in the spirit…saw some colors- burgundy, green grass, trees… thee was no confusion… everybody was just ok, everybody was just everybody, everybody was happy….I was moving through…I started feeling awful hot- that's new for me- I'm always cold, so I embraced it… a really warm sensation.

Another woman who felt that she had spent most of her life rejecting help and needing to do things on her own was amazed when she found herself wanting people for the first time ever.

I am energized and with every moment I disperse and distribute the liquid light to those around me. In fact, the light is only dispersed when others are there to soak it into their being. But the light is poured into me constantly as I want it. It empowers me. It soothes me. It is a gentle power that flows out of me, a liquid essence that unites me with the one filling me and with those who are with me. We join hands to dance and dispense the light to one another. We play together in a place filled with beautiful animals, birds, fish and flowers. We are not hungry. We are just present in the beauty. We are part of the beauty.

The Aesthetic Process

The aesthetic component of the dreaming was the masks and the collage done by one of the women (Appendix K). The discussion around the decision making process involved in the art is described in the next section of this paper. The collage became the centerpiece of the mobile of masks, providing a point of connection. The quotes are from the notes taken during the group presentation of the art.

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When I started cutting I was going to do a mask, but there were too many pictures, so I did a collage…it was women, all women, women…on the outside, come to the carnival, on both front and back, a hand giving a gift, back side- 'see things differently', 'rare' 'precious', lots of eyes, 'even before I had words I could see'.

The masks were created with an inside and an outside expression of healing from abuse, but no direction was given as to what the inside or outside meant. This, like the dreaming, also varied from woman to woman. "Inside-rocks are the fears and dark part of my life, then I saw pieces of my heart so I put little stars and hearts. Outside- its brighter, I can dream sometimes, I have a lot of colors on the outside." (Appendix K-X) Another woman's mask was not painted (Appendix K- IX). She cut and pasted words onto the front and inside of her mask and decorated it with ribbon, butterflies, and sparkling stickers. She described her mask to the group.

Words have always been my thing, for first 18 years of my life I didn't speak. Front- qualities I'm able to give and receive. What I got here in this circle, I've got chains being broken here for a lifetime, inspired breath- letting it motivate me…Inside- all tools I've picked up along the way, journey to self…reflection by design…proactive, playing air- seeing past the outside…pink pom poms- being responsible for me doesn't have to burdensome…what I see has to guide me…not trying to fool you…grounded but flying…I jus opened, taking charge….fresh start….

Another woman expressed the duality of feelings on both the inside and the outside of her mask (Appendix K- VII). Here are excerpts from what she said to the group:

A lot of double meaning on both sides…kicked around, beaten up, confused, pretty dark that in the middle of all that is music and beauty…straight pins inside, duct tape over my mouth outside, eyes covered, I wasn't told what was true…a lot of rough edges…I'm not done yet, but I am on my way…the notes inside are scattered and fractured, outside the notes- the song is coming together.

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Some masks were more clearly delineated as inside from outside, yet the confusion of duality emerged in the linguistic expression. One woman painted the inside as a simple red face inside with a shell for a nose and two square beads for eyes, her mouth was a simple smiling ribbon (Appendix K-VI). The outside was a beautiful, vibrant yellow face surrounded by shells and gold beads, with full red lips and long white hair made of tissue. She wrote on a card, "this mask represents feeling plain and empty on the inside and realizing the real goddess within on the outside." Her 'goddess within on the outside' was a mermaid.

Before healing was the outer expression of one woman's mask (Appendix K-VIII). A very large over-painted red mouth was a caricature of, "in my home you had better smile and pretend to be happy OR you would find yourself smacked across the room, sliding down a wall." The inside represents her transformation after healing, "I now see life in color. It is exciting and exploding with possibilities. I can cry. I am a new creation represented by the gorgeous butterfly."

The choice of materials and colors was often intentional, but also could be quite subconsciously chosen. "Inside, is who I used to be- I have rocks, I was closed minded., I didn't let nobody in. Outside I have sweet sleep. It feels like massive transformation" (Appendix K- III). Some of the women weren't sure what the mask represented.

> I brought colors I like messing with (from home)..the inside- represents what I see, what's around me, words I heard told to me and my mom growing up. Outside- trees and butterfly tied to string to the word SLUT on the inside. I'm not sure what any of it meant. (Appendix K- II).

The masks were metaphorically representational. One woman had a mask over her outer eyes (Appendix K-VII), another duct tape over her mouth (Appendix K-V), yet another had cellophane covering the garbage she had collected for two weeks which was glued to her face (Appendix K- I). One woman named her mask and attached a card to the mask with a slender green ribbon with the following words (Appendix K- X):

> I finally got the courage to speak!!! I went over 50 years holding on so tight. I finally got the courage to speak. It hurt. But I spoke, I cried. Boy!!! I cried. I spoke. I yelled. I rocked. I spoke. "Speak".

Many of the women loved what they created but a few were expressed some dissatisfaction with their final creation. One said she didn't want to finish, she wasn't 100% thrilled with it, but it would do for now, suggesting again the idea of a process in the making. One woman was frustrated with the amount of time required for two masks, so she decorated the inside and outside of one mask instead. Yet another had been worried about finding the space within herself to create what she wanted in a group setting. She later stated that she had enjoyed the art project and enjoyed discussing it with the other women, but felt it did not add to the study. All of the other women felt the art project contributed to their awareness, their connection with each other, and their appreciation of the healing processes in their lives.

Overall, the women felt the dreaming gave them new skills including the ability to relax, to go within and be present with themselves, to understand or unlock parts of themselves that were hidden or inaccessible, and to understand and transform patterns that were entrenched or no longer served them. Dreaming and the aesthetic creations

helped them to visualize themselves in new ways, to envision new possibilities, and to

appreciate the wholeness of themselves in the moment. Some of the women received

insights about the deep and intimate connections between mind and body or mind, body,

and spirit. Many of them realized places where they felt stuck or lost. This often came

with cues for action, directing them to healthier or more conscious decision-making or

choices. Others came away with a deep appreciation and gratitude of how far they had

come on their journeys, how much help they had received along the way, and they

realized a deep joy in sharing their stories in order to help others. For the group, the

dream sharing demonstrated that healing was a mutual process, rather than a solitary

destination.

> Yet another example of the very multifaceted healing process that can occur as long
> as I am open to it. Yes, I have healed, yes I am healing, yes, I will continue to heal
> and in doing so I become a part of the force of healing in the world, in the universe, in
> the. . .

A Circle of Healing

"This research has opened doors to therapies for me and given me a circle of

healing that has been remarkable for me." From the beginning, the participatory nature of

this study was designed to create a reflexive space that simultaneously acted as a safe

space, a container in which to hold the intensity of thoughts, feelings, and expressions of

women who had experienced the trauma of childhood abuse and which also created an

opening for new thoughts, ideas, and patterns to emerge as the women interacted with

themselves and with each other. Every participant commented at least once and often

many times on the power of the group to offer a healing space which fostered a sense of

safety, sharing, and connection that went beyond the mundane into a true intimacy and communion of spirit, which is often very difficult for women who have experienced childhood abuse (Cloitre, Stovall-McClough, & Han, 2005; Phillips & Frederick, 1995). One woman expressed it like this, "The strongest bond is the bond of human suffering." And another participant said, "And this is beautiful- the power of the group- it makes it such a relief, I don't have to hold it alone."

After lunch during the second session of the first day, one woman remarked to the group, "This space feels like everybody's spirit has come together in one spirit. Very seldom does that happen where everybody's spirit comes together as one." Even the study setting fostered a sense of healing. One woman said, ". . . the day long retreat- like setting is helpful I believe in creating the IMPORTANCE of the work. It gives the feeling that healing matters. I matter. No matter what."

The power and intention of the opening circle was to create a sacred space- an intentional space in which all of the participants physically, emotionally, and spiritually could come together in a unified purpose dedicated to exploring healing and to seeking a new vision of healing from childhood abuse. "During the healing circle I had a vision of me, the bigger me, the Higher Self me." The circle of healing included the creation of space for participants to express both their unique, individual desires for the outcomes of the study as well as their intentions for healing for the group and the community. In unitary healing theory, outcomes are viewed as emergent and unfolding through the desire of the women in concurrence with the unitary inquiry process (Cowling, 2005). They are determined by the women's views alone as to what makes a difference in their

life patterning. And outcomes are framed as healing potentials as they are envisioned by

the women. In a unitary worldview, outcomes are not indicative of causality, but rather

indicate a reflexive systematicity (Cowling, 2005). One participant stated,

> I think it is so empowering when I hear people say, 'this is what I experienced'. If
> they tell me what I need to do, I get really pissed" and " When somebody tells me
> how to heal or writes a book about it, I get angry. **I** (emphasis) decide how to heal.

Circles may be used as nonhierarchical, relational modes of cooperative inquiry

(Heron & Reason, 2001). The power in the use of circles for healing, activism, and for

empowerment for women has been addressed in both the anthropological literature on

healing (Tedlock, 2005), feminist discourse on relational theory and how women relate

(Surrey, 1991), and in nursing and social activism (Chinn, 2008; Peace x Peace, 2009).

Group therapy has been found to be effective in the treatment of issues resulting from

childhood abuse, such as PTSD (Classen, Koopmen, Nevill-Mannng, & Spiegel, 2001;

Parker, et al., 2007; Wallis, 2001). This is especially important in women who have

experienced an extreme abuse of power such as that which occurs during childhood

abuse. The women found the participatory group to be conducive to feeling safe,

supported, understood, and empowered. One woman who had been repeatedly sexually

abused since infancy and who described herself as being unable to trust even to the point

of an aversion to individual therapy wrote at the end of the study,

> The changes [from the study] were affected first because I was given a safe place,
> people who connected with me and whom I was able to connect with in turn and there
> was an interchange of support, compassion, empathy, fellow-feeling and love.
> Secondly, we were so in tune with one another that the healing power of the human
> spirit was obvious. Here we were with differing lives and backgrounds and different

paths in life converging for this time together with one goal; unification of action, and thought focused on healing. It was beautiful and extremely empowering.

The stories of the effects of the abuse were a common link between the women which offered comfort and healing. "It was comforting to be around other people in similar situations . . ." In fact, the women verbalized a sense of healing from the sharing.

> It was so helpful to see that no matter what race, age, or socioeconomic status, sexual orientation, religious preference- the issues are the same. And everyone brought their own special perspective to the process. I greatly appreciated that.

Another woman expressed it even more powerfully, "Facing the shame, rage, and horror of my abuse has been life giving. Sharing it with others has been life changing." Another participant wrote in her journal,

> the judgment and grief I am experiencing are real, however in speaking of the [healing] effects- I think they occur by providing safety, a group environment that's loving, and the opportunity to speak out openly and honestly (without judgment) about exactly where I'm at in the process.

The age difference for one participant was a block to speaking in the group on the first day, but she was able to open up in the group during the second day of the study. She at first found the age difference to be intimidating, but finally found strength and a sense of empowerment through speaking her own truth:

> It was really amazing to be in room of women sharing such intense parts of their lives with me. I am by at least 12 years the youngest person in this room, and it has been very powerful to be able to find a voice within myself with all of these older women, who are so much like myself. I feel like the main side effect has been my willingness to open myself up for big new change. These women have given me the strength. It has been amazing.

The women used the group process to facilitate the discussion of issues and highlight aspects of abuse. One of the issues that came up for discussion early was the sense of secrecy, shame, and isolation that surrounded the abuse. During the initial discussion on confidentiality, the researcher facilitator used the phrase, "it's the idea that what is said in the group stays in the group." After the first round of dreaming during the discussion, one of the women brought this up as scary and uncomfortable for her because that type of thinking perpetuated the abuse in her home, "what goes on in the family stays in the family…this is family business." She stated, "that thinking perpetuates it [the abuse]". While this participant understood the rationale for confidentiality, she also felt that those words were a trigger back to the silence, the solitude, and the loneliness of the childhood abuse. Another participant responded that in contrast, those words had given her comfort and offered the sanctuary of a safe place to speak without feeling vulnerable or exposed. A third participant stated that ten years earlier when she had begun confronting her abusers, her mother had said, "Did you have to tell people?" This woman then told the group that, "Empowerment comes when I break the cycle." Another participant found solace in the group. "It was wonderful hearing the others share because I know I'm not alone in both my pain and my experience of wanting to heal, and struggling with finding that safe place." The first participant who had initially brought up the issue of 'family business' also found a sense of connection within the group that was healing for her sense of isolation. Her journal notes at the end of the second day of the study reflect this:

Talking with the ladies gave me a sense of belonging. I felt so connected with the other ladies and their experiences how they used different things. . . it showed me how women from every walk of life, no matter what color you are, you can come together to heal.

Another issue that came through the circle of sharing was the pervasiveness of the wounding from abuse within a culture of silence. "This was probably the first time out of therapy that I've ever really said a lot of stuff that I've felt- just the way my family was always like the elephant in the room- like don't talk about it." One participant described activism as her spirituality doing political and social justice work around abuse. Another participant likened sexual abuse to slavery:

Remember sexual abuse is a real taboo- nobody wants to talk about it. Its just like slavery, its just like everything people just don't want to talk about it. Oh God- leave that alone- get over it- get over it. How do you get over something and you never remember where you came from? If you don't remember, how do you get to the other side? How do you ever connect the dots?

The time of the group space over two full days allowed the participants to go deeper into the process.

Its like in therapy its only like 45 minutes and you don't always get to what you need to get and you're afraid to cry cuz then you'll have to pass all those people in the waiting room when you leave. I never cry in therapy, never, ever, ever, but I was crying there. I was even crying when I was driving away because I'm going to miss these women.

Even the discussion about the group art project lent itself to the empowerment of individuals within the group. When the group was ready to decide upon a group aesthetic

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piece, four of the participants thought they would like to do a collage and the other eight

thought they would like to decorate the masks. When I opened the possibility of everyone

choosing their own, there was immediate and strong reaction from a few of the women

that it should be one project. All but one of the women agreed. This particular participant

very gently but firmly stated that she would like the opportunity to choose for herself.

There was resistance from some in the group. The dynamic of the group was such that

when I suggested that perhaps what this woman was asking was this- could the group

support her in her need to decide for herself what was best if we could find a way to

incorporate the collage and the masks together? The response was an immediate,

unqualified, and unanimous 'yes, they could.' This response was indicative of the support

the women were giving to each other in their call to be authentic to themselves first and

then to each other.

> Deciding what the art project would be was such a valuable experience to have everybody give their input and then find a way to make it work…You know it really allowed people to be heard. And there's such a trust that it always comes together for the Highest good and you really let that BE. And let it emerge rather than saying, "well, we're all doing masks together, period. And at the end when you looked at the finished product, you're like, 'Wow, its really perfect'.

This circle of women opened their arms to each other in a spirit of community

dedicated to healing from childhood abuse. Every woman expressed how powerful this

group was in supporting her on her journey of healing.

> Thank God for your dissertation. Really, really, there was great connection made in this and there are women healing as a result of this and there are women giving women invitations to other things for more healing as a result of that. I know that for a fact.

The above presentation of findings from the thematic analysis/ synthesis of data illustrates our understanding of healing in the life patterns of women abused as children as it occurred in this study. Participatory dreaming was a useful method which offered access to the individual, the imaginal, the transpersonal, and the collective expressions of healing in women who have experienced childhood abuse. The group process was instrumental in creating a healing space for the women in the study and indeed contributed to the healing process in its own right. The aesthetic, propositional, presentational, and practical knowledge gained from this study was woven throughout the above narrative but is explicated in the following section of the paper.

<center>Reflection- Synopsis of Findings</center>

The next section of this chapter uses a group unitary pattern profile to describe the emergent patterning of the unitary healing process within the group from the researcher's perspective. A case exemplar is used to demonstrate the unity within the findings for this study. The summary of findings are presented through the framework of the extended epistemologies- experiential knowing, propositional knowing, presentational knowing, and practical knowing.

Unitary Pattern Profile

A unitary pattern profile for the group was created that was based upon a process of synthesis and synopsis (Cowling, 2006) of what emerged during the study regarding

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healing in the lives of women abused as children. This process was a reflective aesthetic creation developed by the researcher in both a reflexive and participatory capacity as a member of the study as well as a researcher. The group pattern profile created by the researcher was an aesthetic creation of three music videos which represent three overlapping patterns that emerged during the study. While these patterns are contiguous and can be appreciated throughout the study, for the researcher they emerged perceptually as a flow of experiences. Music videos were selected because they used imagery and music consistent with the visual and auditory modes of inquiry used in the study design. These modes of presentation were felt to encompass all of the elements of the extended epistemologies- propositional, experiential, and presentational culminating for me in practical ways of knowing. The two researcher created music videos also allowed for the integration of unique, individual expressions of the participants to be woven into a unified whole, demonstrating the findings within a unitary healing framework.

My experiences of the study resulted in a perception of three field patterns. The first morning of the study there was a sensation of expectancy. The RA wrote in her field notes, "12 women controlled but open to what emerges." All of the women expressed their personal intentions and I added mine for the group, for healing, for a safe and beautiful space for mind, body, spirit, and for healing for all women everywhere on the planet. The first participatory dreaming session seemed to contain more elements of joy, lightness, expectancy, sensations of freedom, novelty of experience.

This transitioned to increasing emotional intensity as the women shared and each of the dreaming sequences took the women deeper into their healing processes and into themselves. The group discussion became very emotionally intense as stories of pain that never resolves, the pervasiveness of the effect of the abuse on all areas of their lives, and the desire to "be healed" emerged. One woman had to leave the group to walk outside. When she returned, she was asked by a participant if there was anything she needed or wanted to share since she appeared distressed. She was crying and gratefully and graciously said no, while another woman leaned over to rub her arm and hold her hand, which she seemed to find comfort in. Those further along in the healing journey (those who described many years of active searching for healing) offered advice to those who were more recently exploring their healing. Their advice reflected a sense of process rather than destination. Some reacted to this with a sense of heaviness or despair, while others verbalized a sense of freedom from having to be anything but where they were now. It was my impression that the journaling combined with the discussion lead them to deeper places in the second and third dreaming sequences and that is perhaps why the later dreaming sessions were more uncomfortable to some than others. I had told them repeatedly that each time they did this, the experience may be quite different and that each person would experience it uniquely, but many verbalized surprise at the nature of the differences between each other's experience and within their own. By the third session and after the art, there was a sense of things coming together, of new realizations just beginning, and of old perceptions either shifting or taking on new meaning in a different way. There was also a sense of renewed hope which came with an awareness of

resilience, strength and a deepening commitment to what was increasingly perceived as an ongoing journey.

Researcher Developed Aesthetic Works

The aesthetic pieces I created and selected reflect three field patterning movements. The term movement implies the flowing, changing nature of these three patterns as they emerged from the data and from my participation in the group. The first movement was a researcher developed music video taking images gathered from the stories of participants about their dreaming, their feelings, and from the group discussion. The music is called *Flying*, a song by Celtic artist Cait Agus Sean (2002a), and the images were gathered from the internet. The first field patterning movement is called Dreaming. Dreaming represents a patterning of hopeful expectancy, a need to transcend old patterns, old feelings, old wounds. The music video represents the coming together of the group to dream, to reach for newer, expanded visions of themselves and of their experiences of abuse as they try to fly above the loneliness and despair of the abuse. The music is more ethereal, invoking an awareness of transcendent unity and fostering a sense of shared exploration. But even in the midst of this lightness, the underlying loneliness and solitude of the journey runs like a thread throughout the video. This movement represents the call to the journey. It is starting over, gaining higher perspectives, seeing differently, an awakening of spirit and a longing for a return to lost dreams and a sense of wholeness.

The second field patterning movement is called Fire and Ashes. This movement represents the power of emotions to burn through another layer of psychic debris and act

as the fertilizer for new growth. Like a volcanic eruption, it is cyclical and transformational. This movement is represented by the music video, *Not Ready to Make Nice* by the Dixie Chicks (2006). While this video was not about childhood abuse, the images and lyrics were so aligned with what emerged as the second field patterning movement that it was chosen to be used as it was. The power of this choice was evident in the responses of the women when it was shown to them. They held each other, cried, rocked, and nodded in affirmation all the way through the video.

This movement is characterized by several things. First there was the power of anger and emotion as a catalyzing force for healing. This was echoed in the imagery of one of the study participants as a volcano spewing ash and fire, erupting under intense pressure and then when the ash settled becoming fertile ground for new growth, a rich tropical paradise. In the black and white music video, the starkness of the journey and the paradoxical nature of the healing process is highlighted. The contributing forces to abuse and to the silence of abuse are evident in scenes about the patriarchal nature of the culture and through the complicity of society, of other women (even mothers), of families, of authorities, of teachers, and of the healthcare system. The women in the video are simultaneously innocent in their white dresses and tainted with ink that won't wash off. The freedom comes in recognizing and using the intense anger and emotion to throw off both individual and collective patterns, roles and even outmoded ways of healing that only serve to reinforce that the patient is the sick one, not the family or the system. The Dixie Chicks (2006) use music and activism to speak out, to end the silence, to come together to throw off the oppression of a colluding collective. The music is strong,

powerfully moving, and the images are vivid and stark. This is consistent with the movement in the group after the initial movement of Flying and seemed to represent engaging reality on an even deeper level as new awareness and feelings emerged. Finally, the overriding theme and refrain of the video (Dixie Chicks, 2006) speaks to the very heart of what emerged in this study as the effects of abuse on the life patterning of these women, "Forgive, sounds good. Forget, I don't think I could. They say time heals everything. . . I'm still waiting."

The third patterning movement is called Journeying, Coming Home to the Self. The music is called *Rivers and Dreams,* by Cait Agus Sean (2002b) and the images were obtained from the internet and drawn from participant's expressions of healing. This movement represents a synthesis of Dreaming, the call to transcendence of the abuse, and Fire and Ashes, the internal power and deep, painful emotional/ psychic work needed to catalyze the healing process. The words of this song speak to the ongoing work of the journey. The lyrics of the song speak to all of the 'places gone, battles won, and rivers run' bringing one home to one's self. This represents the transition from victim/ bully to true feminine power. It also speaks to the women's use of everything they have experienced to heal themselves and help others.

The refrain, "I will make the journey, I will find a way", speaks to the full engagement in the journey of healing, of coming home to self (Sean, 2002b). The music and images speak to the stamina, strength, and the commitment that the women in this study have made to themselves for their healing journeys. There is an increasing awareness of transcendence as a perspective rather than a destination. Transcendence

comes in truly being present with what is, whether it is raw emotion, physical pain, or gratitude and appreciation for who they are as a result of where they have been. Dreams call from the past, but they have been gentled and tempered with a new awareness of reality and a deepening of the sense of self and where they are headed. The songs and images speak to ongoing doubts and darkness, but they are no longer feared as they once were. They are viewed as reminders of how far they have come or ways to feel alive as they spiral to new levels of perception. The music in this song changes crescendo from slow and sweet to full and powerful, reflecting the simultaneous beauty in the gentleness and softness, and power and strength in this circle of women.

These three patterning movements seemed to be present in both individuals and the group as a whole. There was no discrete distinction between the patterning movements. All were present simultaneously, but manifested in unique ways in the group and among individuals. However, there did seem to be a rhythm, if you will. All seemed to flow unidirectionally, consistent with Rogerian theories of patterns as ever changing and evolving in increasingly complex ways (Rogers, 1992). Together these three patterning movements provide a synoptic vision of the study findings.

Exemplar

The following exemplar is a synoptic expression of one woman's journey during this study. This is a story of appreciation, perception, knowledge, and profound transformation which evolved during the study which was reflected in the journal notes, the field notes, the aesthetic representation, and the follow up interview with this

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participant who will be called Julie. The three patterning movements are reflected in this exemplar as are the thematic elements of the findings.

Julie was one of the more quiet participants. She shared in the group, but she had a soft voice and took time to frame her thoughts before speaking. Day one when asked about her current perception of healing, Julie wrote of her perception of healing:

> Ability to feel safe. . . Have very little trust in myself, it only comes to me a few minutes a week that I feel worthy. If I read spiritual publications it seems to ground me where I can feel safe and loved like I have a right to be part of life. My goal would be to move in the direction of my goals and life's work and trust in myself in all situations. To be the best of myself to present to all other beings and all situations.

After the first dreaming session on day one, Julie's notes reflected a new space of unity and beauty. She expressed the dream in the first person. Julie becomes her dream.

> I am a fountain of lights, like a prism all colors shine up through me. . . its as if I've absorbed the beauty and let it run through me, heal me, strengthen me, used it up and clarity is what I have to let out. . . My safe places are all up high. . . my journeys to safe places tell me to let go. . .there is safety and renewal in letting go.

Afterwards, Julie told the group that she came to feeling safe up high, in an airplane, then in a hot air balloon. Being up high made her feel powerful, she was able to leave her worries below. She experienced beautiful spaces and colors, and a lot of energy. Julie said that in her dream she let her worries go and was not in her house like a hermit. During the second dreaming session on day one, an image of her father (her abuser) appeared in a split screen. Julie's verb tense changed to present time, she merged with the imagery. She moved through her tension to find a safe space and an internal image of approval.

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I'm myself playing in a pool with my friend. I feel safe in knowing who I am and being able to laugh and have fun. Afterwards her father cooks dinner for us and speaks to his daughter with love, tenderness and respect. There is a split screen and my father's face is gray black and white. He is giving me that disapproving look his eyes narrowed his teeth clenched. My stomach sinks. . . I search in vain for something to comfort me- I'm at a horse farm. Then I'm riding the horse, I feel its muscles, smell its body, run my fingers through its mane, we are like one unit. The horse doesn't disapprove of me.

After the third dreaming session which occurred on day two, Julie dreamt of transformation. Her work with the circle of women created a safe space to go deeper into her own processes and experience herself in a new way.

The color I'm feeling is pink because I'm surrounded by women and I'm safe. It blends in with lavender a color that is safe and healing for me. It travels down my body and I have the sensation of birds flying free from my body. My limbs turn red like flowing lava and it just circles inside. I feel like toxins want to come out but just tears come to my eyes but they don't flow out. Something comes up to my throat but stays stuck. My cheeks and jaw are tight. I am on amusement park on the wildest ride just letting go. Not worrying about anything just experiencing exhilaration. Afterwards I walk to a lake and watch swans float by. I am totally in peace and comfort. My safe place is somewhere I have never been before, tropical winding expanding. I am safe ready for new experiences. I can't go back to familiar it carries old pain and worries. I feel vulnerable exposed. My stomach has butterflies in it. I feel like I am walking ahead and shedding a skin which stays behind dark and colorless (dormant self). My sense of worry and apprehension is no longer there. When I look up in the sky there are small white birds flying overhead.

After this dreaming session, Julie was very eager to share with the group and became more animated than she had been previously. She told the group that this session was very powerful for her. She described the dream vividly and said she " . . .felt like the real me coming out". From my field notes that day,

At lunch [Julie] approached me and told me that it is so hard for her to talk to people and to share in groups and this whole experience had been opening to her in a huge way she could not even describe, she was crying as she told me. I am amazed. This from a woman who said she never cries. I cried with gratitude for her, for me, for every woman here.

Julie's mask (Appendix K- I) demonstrates her inner and outer expressions of living in the aftermath of childhood abuse. Julie told the group that she had saved trash around her house for two weeks to put on the mask that represented all the garbage she had been fed in her life like being told over and over who do you think you are? She wrote on a card which described the outside face of her mask.

I was brought up to be the nice helpful girl. Taught to accept the garbage as normal. If I tried to defend myself and my sister from an insane childhood I was beaten up. If I wanted a better life I heard the constant refrain "Who do you think you are?" The bubble wrap shows my weight gain and need for protection. Since I moved South I hear the same accent as my father had and I'm terrified another man will emotionally and physically abuse me again.

The inside of Julie's mask was painted purple, her favorite color, with the words well-done" across the inside of her mouth. The mask is decorated with opalescent stones, feathers, sparkling stars and stickers, and sea shells. This is what she wrote:

My inner self is learning to be grounded and spiritual. Nature is my biggest inspiration and healer. At night I go outside and meditate with the stars and know I am safe and loved.

During her final interview, this woman was excited, amazed, and aware on a deep transpersonal level of the power of her transformation.

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My current experience of childhood abuse has changed a lot since I started the study. Right after the last Saturday, I was kind of emotionally wiped out for two days. Its like I had to absorb it all and I had to release so many emotions that I don't normally feel. I kind of separated from people for a few days and since then I've been on an upward spiral, taking better care of myself, standing up for myself, being more true to myself. How I see it differently is I'm definitely eating better. I'm wanting to be the person I was meant to be before I was abused. I had dreams where I went back to my old house, my mother's heart was there (deceased mother- died when participant was 12 years old). I woke up and I cried, I never cry. I never cry. Liz, that was a huge breakthrough. I had gotten back from that Saturday. I went to the bathroom and happened to look at my face in the mirror, and I said, "Oh my gosh!", my face looked totally changed- this is what I'm supposed to look like- I can't describe it! I look like the future me- I look like I'm in control of my life and not scared. I'm like this is what I'm aiming for- what I'm shooting for. The study definitely helped me, I guess, be more willing to….I told you before, I lost so much of myself because I kept repeating what my father told me. And I tried to like fit into everyone's mold and make nice-nice. Now I've started a new path. Now I'm from the North and I'm going to act like who I am, because it's the real me. Its just so funny because its working for me. Its like I'm not bending over backwards to be like another person. I'm just trying to be who the real me is. And its just funny (laughing) because I'm like, Oh that worked out! I never thought it was going to work out. Its kind of, I know its going to be a long haul, but another thing from the study, the music- I've been listening to Native American music all the time now. And one thing I really got from that study is that its ok to be who you are supposed to be, to be who you are. And to want what you want, because its always been drummed into me you're selfish for wanting anything- you're selfish, you're selfish, you're selfish. And that was from my father and from my grandparents- don't ask for anything, don't want anything and you sort of like turned on the light bulb where, where its not selfish. Its- you're supposed to be here for a reason. And if you just like throw everything away that you care about and that you like what good is your life?

All the parts of the study (dreaming, journaling, discussion, art) were all necessary. I've even started doing visualizations- I have used that when I'm getting real fearful or when I wake up in the middle of the night. If I can't sleep I'll try and visualize something positive- beautiful Light and it just engulfs me and makes me feel safe. And another thing, I don't know if you have found this, because of all of the stuff about the Chris Brown abuse (in media), on all the talk shows, its like brining to light women are bused by people that love them. And its healing me because there's books out there that I've written down and need to go buy and its like 'Oh this is real, its not just hidden in the background like its always been'.

Consistent with unitary healing theory, these dreams are not analyzed for content.

The outcomes are viewed as emergent and determined by the women's views alone as to

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what makes a difference in their life patterning. What can be understood is that the three elements of (1) experiential knowing obtained from the experience of participation in the group, (2) propositional knowing that emerged from Julie's engagement with others, from reading, from the media, and through self exploration, and (3) presentational knowing from her creation of the mask and sharing of it with others has led to a practical knowing that has transformed her vision of herself and her ways of being and acting in the world. Julie's expressions, perceptions, and experiences exemplify unitary healing (wholeness, appreciation, participation, knowledge, emancipation, change/transformation) and are revealed through the life patterning illuminated through Julie's words and images.

Summary of Findings

These findings represent the culmination of the propositional, experiential, presentational, and practical knowledge developed from this study. Cowling (2006) states that the overarching attempt of a UAI study is to generate both informational and transformational knowledge. Propositional, experiential, and presentational knowledge culminate in the fourth type of knowledge which is practical (Heron & Reason, 2001). Practical knowledge is the skills that have to do with transformative and emancipatory mechanisms or processes by which individuals or groups create or sustain new ways of enhancing quality of life.

The propositional knowledge gained from this study was substantial. First, healing from the experiences of childhood abuse was a unitary process that involved every aspect of life because it involved the core self of the woman. Second, this healing

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was visible in the whole life patterning of the women as evidenced through the journals, discussions, reflections, art, and experiences of the women in this study. Third, healing for women abused as children was a process and a journey without a final destination. Fourth, participatory dreaming was a valuable tool in assisting women to appreciate their life patterning, to find new ways of healing from childhood abuse, and to transform their lives in ways that enhanced their quality of life. Fifth, healing has a participatory component, that was engaged and enhanced in the women of this study. And finally, healing and dreaming had both unique and collective expressions in these women.

The experiential knowledge gained in this study occurred as a result of group dreaming, shared discussions, self-reflection, and group creative expression. The time between the two study periods and the final interview also was a component of the experience as the women took what they had learned and experienced out into their daily lives. The processing of the experience added to their knowledge, their skill sets, and to the emancipatory results of the study experience. There were unique and collective expressions of the experience as well. A shared sense of community as well as the individual perceptions and expressions of the participants contributed to a sense of unitary wholeness throughout the study.

The presentational knowledge came from both the aesthetic creative process and the sharing of the process. This knowledge was instrumental in helping some of the women to synthesize and integrate what they had learned about themselves and from each other. For many the knowledge came in the form of realizing how much healing they had accomplished and how much there was left to achieve. For some, it was an

affirmation of what they already knew. And for others, it was a return to a joyful, childlike state of engaging themselves in life and creativity.

The practical knowledge developed by the women included personal skills in self-soothing, relaxation, self-discovery, imagination, and new knowledge that resulted in changed behaviors and healthier patterns of self-care and in relationships. Some gained insight of where they wanted to transform their lives and received cues to the practical actions needed to accomplish them. Some of the women found news ways to aid their community activism with women who have experienced childhood abuse. All of the women gained new relationships that have continued to nourish and sustain them in their growth processes since the study and are extending that healing to others in the community through groups, Facebook, and educational programs. The researcher gained knowledge about healing for herself and for future research and projects to assist other women on their healing journeys from childhood abuse.

In conclusion, the findings answered the two research questions and supported the study assumptions discussed in chapter three. Initially, it was assumed that participants might develop new knowledge, insights, skills, and relationships that promote unitary healing from experiences of childhood abuse. It was also assumed that the participatory process might help participants feel freer and have a deeper connection or awareness of the core self as they share with others in a supportive setting. The final assumption was that the participatory dreaming process would facilitate the sociocentric aspects of healing within and between participants which may lead to a broader vision of healing for the community. The implications for these findings are addressed in Chapter Five.

CHAPTER V

THE STUDY FINDINGS IN CONTEXT

This chapter presents a discussion of the unity within the findings from the contextual framework of the six tenets of unitary healing (wholeness, appreciation, participation, knowledge, emancipation, change/transformation). The relationship of the findings to the literature and to nursing science are presented. This chapter concludes with a discussion of the methodological considerations of the study.

Unity within the Findings

Wholeness

Unitary healing encompasses the appreciation of human wholeness through a knowing participation in change which is simultaneously emancipatory and transformative (Cowling & Repede, 2009). This change or transformation is defined by the participant and unfolds through an appreciative stance which reflects the inherent wholeness that already exists. Using consciousness and knowing in unitary ways creates a space for the participant to learn, to reflect, and to engage her own power and to appreciate extant life patterns. This in turn fosters a creative, dynamic force which can mobilize inner and outer resources creating an opportunity for knowing participation in change (Barrett, 1997).

While the ultimate aim of unitary research/ praxis is assisting the participant to free themselves from perceived limitations and restrictions in life patterning, it is

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understood that the researcher has no expectations of change for other (Cowling, 2008). The intentional space created for this study included a psychic space held by the researcher that reflected this assumption of inherent wholeness and appreciation for the processes which were allowed to unfold in whatever way was necessary for the participants to experience themselves directly. Using only qualitative data collection methods fostered this sense of 'no expectations' for preconceived outcomes or a hierarchical measuring of self against an externally determined tool. This did cause some angst among one of the participants who wondered in her journal at first if she was 'doing it right'. But when she surrendered to the process, she became aware of a recurring pattern held over from her childhood abuse in which she was constantly seeking approval outside herself. This allowed her to recognize the pattern and consciously transform it by moving into the discomfort, sitting with it, verbalizing it to the group, and then going deeper into her own processes to begin validating her self by finding her own voice.

Even the metaphoric language of the women validated the unitary nature of healing as a process, a journey without a destination, as a helical spiral, another turn on the spiral. The dreaming journals often reflected this awareness of themselves as whole in process with the environment in a merging of self with color, light, and sensation. Prisms, kaleidoscopes, energy fields, and patterns are unitary descriptions and emerged spontaneously in the personal reflections of participants. The aesthetic creations were fusions of inner and outer manifestations of healing from abuse that the women joined together, a symbolic reconstruction which fostered a sense of synthesis and appreciation for their inherent wholeness.

Feelings of fragmentation or limitation are common in women who have suffered from childhood abuse (Scott, 1999) and this group was not different. The creation of an intentional space which focused on wholeness did not actively seek to diminish or minimize these feelings. Rather, by accepting all of the feelings and perceptions as part of emerging patterns of awareness which reflected the 'all of them', the women in this study were able to use the environment, the space, the study, and each other to see their own reflections as perfect in the moment. This validation of everything that was unique to them and common to the group also mirrored the perception of wholeness as a unified field. The field was both energetic and perceptual, contiguous with the environment and everyone in it. This field operated much like a net, which created a sense of connection and safety that allowed the women to explore new ideas and even new feelings. One participant's journal notes were a reminder to herself that she knew herself as already whole, it was only her awareness of the wholeness that occasionally dimmed.

Appreciation

In unitary healing theory, appreciation is a method of viewing that would lead the nurse away from a problem solving mentality in which one is trying to fix something that is inherently not broken (Cowling & Repede, 2009). Adjusting a mind set to one of wholeness allows the participant to move toward an appreciative stance with increasing self knowledge that allows for an exploration of possibilities through compassionate self awareness. Some of the women came to the study with a deeper appreciation than others for all of who they were and how their entire life's experiences were a part of that appreciation. Some came with very little appreciation of their own inherent beauty and

strength. Yet, by the end of the study, every woman there had expressed an increased

appreciation for parts of themselves that had been previously unrecognized, or heretofore

thought of as negative or bad. Many of the women found inner resources that were

waiting to be tapped. Some even came to a deeper appreciation for their experience of

abuse and the strengths, lessons, and tools they had gained from it. This appreciation

often led to healing or changes and transformations in their experience of themselves as

in the woman who was presented as an exemplar case.

Knowledge

The knowledge the women developed through this study emerged from the four

avenues of the extended epistemologies which were intentionally created as part of this

study. Propositional knowledge was gained through the shared discussions, self

reflections, and through seeking new information outside the study itself based upon what

was learned in the group. The experiential knowing came from direct confrontation with

the group and inner experiences. Many of the women found news ways of understanding

old patterns and new perceptions as a result of their experiences with dreaming,

discussing, reflecting, and creating. The aesthetic process offered the space for the

development of presentational knowledge. Some of the women stated that they had no

idea what they would even say about their masks until they actually presented it to the

group. The practical knowledge emerged from the three previous ways of knowing and

led to both profound and sublime changes as reported by the women following the study

period. Consistent with the previous literature review and these study results, some of the

women appeared to be unaware of the changes in their knowledge or understanding of

healing from the first session to the final interview. For example, one participant stated that she had not gained much from the dreaming, yet reported somewhat offhandedly that for the first time she could remember in her entire life, she was daydreaming about her future.

Participation

Participation is a concept of unitary healing which implies a relational stance with a world that is mutually in process with the individual or group (Cowling & Repede, 2009). The goal of the researcher is to capitalize on this, ". . . mutual process to mobilize strengths and possibilities available to the client for change and transformation" (Cowling & Repede, p. 35). The purpose is for the researcher and participant together to broaden their appreciation and understanding of the participant's patterning of wholeness within the context of the experience of childhood abuse. This understanding then acts as a catalyst for change or transformation as the participant recognizes new patterns or ways of relating to herself, to other, and to the environment. The study was designed to create a field of inquiry which allowed for participation on all levels between the researcher and the participants, the participants and each other, the participants and themselves, and the participants in their environment. The findings support that this deliberate and intentional stance allowed for a deep and profound engagement within a relational field that aided the women and the researcher in their appreciation of patterning and healing in the lives of these women. The entire nature of these findings would have been diminished by using a method that did not allow for the capturing of the essence of wholeness in the lives of these women.

The nature of knowledge development in unitary healing is expanded through the fourfold extended epistemological inquiry method. These four ways of knowing (propositional, experiential, presentational, and practical) greatly enhanced the ability to understand and generate new knowledge in this study because they did not limit the type of information that emerged from the data collection. What needed to emerge was captured in the expressions, perceptions, and experiences of the women in a natural setting. This allowed for in process interactions which changed throughout the study period as women learned new things about themselves and each other. In turn, this allowed for the capturing of data as it evolved through participation in the study. Every woman in the study expressed that she had gained some new knowledge for herself, for her family, or for her work with other women. This knowledge was often transformational and emancipatory. Like a domino effect, the knowledge gained from participation in this study continued to evolve after the study period as the women continue to interact and seek out yet more information based upon what they had learned in the study.

Emancipation

Emancipation was defined by Cowling (Cowling & Repede, 2009) as a sense of freedom that moves through all of life's expressions and is experienced through a process of discovery and appreciation of the person's wholeness. Many of the women in this study experienced a sense of freedom for the first time through the expanded consciousness encountered in the dreaming state. The dreaming allowed them to transcend their ordinary consciousness in a manner that illuminated new possibilities for

transforming feelings and perceptions into a new and differing reality which they actively created within themselves. This new reality was often translated into actions and changes in their lives as outer manifestations of the new reality. This occurred as they found and explored new techniques for self healing, developed new knowledge, and participated in different ways with significant others and the community.

Transformation/ Change

Transformation and change involves the awareness of patterning, the realization of a need for change, and the power to make the desired transformation (Barrett, 1997; Cowling, 2007). Change as defined by Rogers (1992) is inevitable, unpredictable, and constant. Transformation is a form of change that encompasses an entirely new view of reality, a change in the lens of consciousness, if you will (Cowling & Repede, 2009; Newman, 2003). As the case exemplar demonstrated, the dreaming, reflection, group participation, and art allowed for a space in which the transformation of consciousness could occur if the participant was ready and willing to embrace that change. This was not as much a result of 'doing', but a more a result of 'being' in a receptive stance which allowed for an appreciation of the inherent wholeness and uniqueness of the individual to emerge into awareness.

In a unitary worldview, everything is infinite potentials and possibilities which are waiting for the proper moment to be seen or appreciated (Cowling, 2001). Like the prism of participatory dreaming, the light is whole and already present. It exists in every moment in a state of wholeness and incipient completion. Consciousness acts as a prism in which different patterns or wavelengths of light can be seen and appreciated by the

naked eye. The participatory dreaming and the UAI methodology were ideally suited for a study of unitary healing. This study supports the theory of unitary healing as a framework which allows for the understanding of the uniqueness and wholeness inherent in the lives of women who have experienced childhood abuse.

<center>Relationship of the Findings to the Literature and to Nursing Science</center>

The research findings from this study are supported by the literature on the exploration of the physical and psychosocial effects of childhood abuse on adult women (Bonomi, et al., 2008; Gibson & Hartshorne, 1996; Hyman, Gold, & Cott, 2003; Renck & Rahm, 2005), on specific therapies in women who were abused as children (Kreidler, 2005; Martsolf & Draucker, 2005; Meekums, 1999; Talbot, et al., 1999), and through qualitative research on the lives of women who have been abused as children (Bryant-Davis, 2005; Draucker & Madsen, 2005; Hall, 2003; Thomas & Hall, 2008). Music and guided imagery have been found useful in trauma in general (Blake & Bishop, 1994, Menzies & Taylor, 2004, Naparstek, 2006).

Corroborating findings from this study about the physical and psychosocial effects of childhood abuse with the other literature suggest that the effects of childhood abuse are pervasive with overlapping features across all areas of life patterning (Bonomi, et al., 2008; Bryant- Davis 2005; Hall, 2000). Therapies which recognize and support the person in the context of these multiple effects, which treat the whole person, and which include an element of spiritual or transpersonal framing of the abuse within a life context have better outcomes as defined by the traditional research paradigm (Baer, Hoffman, &

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Sheikh, 2003; Beveridge & Cheung, 2004; Bradley, Maschi, & Gilmore, 2007; Cloitre, Stovall- McClough, & Levitt, 2004; Gall, Basque, Damascene-Scott & Vardy, 2007). The women in this study validated the importance of a broader perspective, a spiritual framework, and a holistic approach as the only way to truly heal from childhood abuse.

The qualitative research (Bryant- Davis, 2005, Hall, 2003, Thomas & Hall, 2008) supports the nature of healing from childhood abuse as a non-linear journey or process, which must be choreographed by each woman in a manner consistent with her unique life path. However, these women can be assisted with a unitary healing approach.Therapeutic benefits seen in this study also found in the literature included the acquisition of new knowledge such as that found in cognitive- behavioral therapy and educational processes (Palmer, Brown, Rae-Grant, & Loughlin, 2001), the power of the imagination and art in healing (Blake & Bishop, 1994; Glaister, 2000; Naparestek 2006; Sheikh, 2003), the power of the group process in healing from childhood trauma (Morgan & Cummings, 1999; Kreidler, 2005; Parker, Fourt, Langmuir, Dalton, & Classen, 2007; Talbot, et al., 1999), and the healing power of healthy relationships for these women (Roman, Hall, & Bolton, 2008). These correlate with the propositional, experiential, and aesthetic knowledge women verbalized which led to practical knowledge as a result of their participation in this study.

Loneliness and negatively constructed social networks were found to be higher in women who had experienced childhood abuse (Gibson & Hartshorne, 1996). While this study did not explore this specifically and had women who had experienced other types of abuse as well, loneliness and isolation were recurring themes for many of the women,

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predominantly those who had started the healing process more recently than others. Women who had been actively exploring healing for a longer time had developed powerful networks of friendships or had peer groups which seemed to ameliorate feelings of loneliness. Women in this study who described a strong relationship with themselves also seemed to verbalize less feelings of loneliness or isolation. Hyman, Gold, & Cott (2003) found that social support, in the form of self esteem support and appraisal or advice-giving support, significantly buffered PTSD development and reduced symptoms in women sexually abused as children. Findings from this study support the power of affirming each other and sharing strategies for healing was instrumental in healing for these women.

Other findings about healing from abuse that are consistent with the literature include the inadequate interface with an uninformed and often uncaring healthcare system (Palmer, Brown, Rae-Grant, & Loughlin, 2001). This includes the re-enactment of trauma that can occur in a power dynamic between client and provider, the lack of available resources, and the nature of the healing relationship which is often relegated to therapeutic management with medications (Bass & Davis, 2008). Despite all of the research about the effects of childhood trauma and the importance of the healthcare relationship, physicians often remain unaware or anxious about opening a discussion about childhood abuse (Weinreb, 2007) and there is a huge gap between service delivery settings and trauma-informed services for women (Elliott, Bjelajac, Fallor, Markhoff, & Reed, 2005). Many of the women in this study verbalized their negative experiences with the healthcare system both locally and from other areas of the country.

Findings about the unitary nature of healing from this study did not support other theories of healing from childhood abuse that suggest a fragmented a multiplicity of selves as a normal phenomena of consciousness (Goulding & Schwartz, 1995), or a psychopathological framework of diagnosis and treatment (Pascual- Leone & Greenberg, 2007) . Schwartz developed internal family systems theory [IFST] (1995) in response to the need for a systematic method of caring for survivors of severe trauma and abuse. IFST is based upon a theoretical view of consciousness in which any perception of unity is illusion. The psyche is considered a menagerie of multiple fragments which are all vying for recognition or power. This theory is supported in part by Jungian thought which states that complexes of the psyche do not support a unitary consciousness. Goulding and Schwartz (1995) describe a continuum of adaptive and maladaptive multiplicities, which in extreme cases are multiple personalities or dissociative identity disorder (DID). In this study, the appearance of unity states of consciousness during the dreaming was associated with an inherent sense of 'returning' to a state of wholeness. IFST is in direct contrast to other research on altered states of consciousness, in which this perception of wholeness is the field of quantum consciousness which is the very basis of Jung's collective unconscious and all other energetic manifestations of matter, time and space (Tart, 2000; Wilbur, 2000).

Pascual- Leone & Greenberg (2007) used experiential therapy to treat unhealthy emotion described the therapy as 'the only way out is through'. This model corroborates the findings from this study which suggests there is an element of healing as a synthesis of paradoxical and extreme emotions. The authors report a healthy dialectical

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construction of surviving and coping as a synthesis of previously unmodulated anger and

hurt/ grief with the ability to self soothe and express assertive anger. However, they

define emotions as categorical and linearly moving from stage to stage. My perception of

the emotions expressed in this study was a gestaltic representation which moved fluidly

in the moment without discrete boundaries or categories. The emotional expressions in

this group of women were much like a kaleidoscope, another turn of the wheel and the

pattern shifts. Their emotions were the normal reaction to severe abuse and the responses

of an unsympathetic or unknowledgeable healthcare system and served in some ways as a

catalyst for further growth.

New findings in the study of women abused as children also emerged that were

correlated with the nursing literature. These were healing through intentionality

(Zahourek, 2005), power as knowing participation in change (Barrett, 1986), resilience

(Dyer & McGuiness, 1996), and transition (Kralik, Visentin, & van Loon, 2006). Self-in-

relation theory (Blenky, Clinchy, Goldberger, & Tarule, 1997; Surrey, 1991a), although

not specifically arising from the nursing literature, also informed the findings of this

study and is reviewed here. Zahourek's (2005) theory of intentionality states that healing

and intent to heal are mutually occurring processes which occur in three phases.

Intentionality is choice or need driven, related to thought and action. It is multifaceted

and paradoxical, and it underscores a belief or faith in healing as leading to a greater

good. The three phases of intentionality are the generic intentionality phase, the healing

intentionality phase, and the transforming intentionality phase. The generic phase which

is inherent in all beings, evolves over time and is a reflection of a person's unique life

patterning. It is the intent to perceive, think, and act, or in other words, to make choices. The healing intentionality phase is need driven and is characterized by skill building and the development of new knowledge. Transforming intentionality is a response to a deep spiritual and emotional call for a transcendent worldview, which can accommodate the paradox of opposites and create a psychic space for suffering as meaningful and purposeful. Zahourek envisions the transcendent phase of intentionality and healing as mutual processes which merge without a predictable or defined end. But this phase confers a greater sense of unity and oneness in relationship with a participatory and benevolent universe. Although discomfort or physical illness may remain, a serenity, trust, and peace with the process emerges These phases of intention were evident in the women in this study in overlapping and non-exclusive forms. The call to heal in the women of this study emerged from profound psychic, physical, and emotional distress, creating an intentional space from which to transform their lives.

The theory of intentionality is consistent with Barrett's power as knowing participation in change theory (Barrett & Caroselli, 1997). Power is ". . . the capacity to participate knowingly in the nature of change characterizing the continuous patterning of the human and environmental fields" (Barrett & Caroselli, 1997, p. 17). The pattern manifestations of the theory are awareness, choices, the freedom to act intentionally, and the active involvement in creating change. This was evident in this study of unitary healing and dreaming in woman abused as children. The propositional, experiential, and aesthetic knowledge generated an intent for transformation which was evident in many of the woman and made explicit in the case exemplar. Also, many of the women defined the

intent to heal as creating the interior space needed to transform or inform life patterning related to the abuse. Even the intention to join the study was described as a powerful tool for highlighting what needed to be brought forth next in the healing journey.

Another concept in the nursing literature which correlates to the way in which people create change is transition (Kralik, Visentin, & van Loon, 2006). In a Rogerian worldview, change is continuous, unpredictable, and inevitable (Rogers, 1992). Transition is a response to change. It involves the ability to change across developmental, personal, relational, situational, societal, and environmental patterns. Women abused as children demonstrate a remarkable ability to cope with adversity. However, these adaptations are often construed as maladaptive and unhealthy (Pascual- Leone & Greenberg, 2007) and result in the labeling of diagnostic categories that imply and infer disease. This is in direct contrast to the remarkable complexity and versatility of these women to cope under enormous stress over long periods of time. The is evident in the poignant question asked by the woman in this study who was repeatedly abused by her churchgoing parents, "Why am I the one labeled as crazy?" In contrast, identifying these adaptations as healthy but no longer useful or needed could impact the way these women view themselves. Identifying places and times when transition is imminent may also assist the women in creating a smoother transition as change inevitably unfolds. Many of the women in this study also understood the inevitability of change and thus transition. This offered a higher perspective from within which to work consciously and removed the sense of healing as an endpoint which was constantly out of reach.

Critical attributes to the concept of resilience (Dyer & McGuinness, 1996) are a sense of self, determination, and a prosocial attitude. This was repeatedly demonstrated by the women in this study and directly correlated to the three patterning profiles for the group- dreaming, fire an ashes, and journeying home to the self. It requires resilience to allow oneself the capacity to hope and dream when so many dreams have been stolen or buried. It takes great resilience to withstand the pressure and heat of the volcanic emotional cleansing that must occur to get to a new space which is self-nurturant and offers the possibility and hope for new growth. And it requires enormous resilience to commit to a conscious journey that is life-long, full of perils and pitfalls, and risks everything to be able to sit in one's own skin. Again, where is the appreciation in the healthcare system and social environment that recognizes the strength and power it takes for these women to heal?

The answer to that question probably lies in the relational theories purported by the feminist epistemological literature, specifically as they relate to the development of a sense of self within the current culture and the concept of empowerment. One of the core constructs which has emerged through this study and others is the perceived disruption in a healthy sense of self which occurs in the presence of childhood abuse. The self-in-relation theory of women's development (Surrey, 1991a & b) postulates empathy as a critical feature of both women's development and the ongoing relationality at the core of women's sense of self. In contrast to the prevailing patriarchal model of development and way of being in the world which is objective, hierarchical and solitarily defined, women develop a sense of self in relationship to themselves, to other, and to the environment

which is more subjective, reflexic and non-hierarchical (Belenky, Cinchy, Goldberger, Tarule, 1997, Surrey, 1991a). It is characterized as a web which is flexible and reciprocal. Surrey states that women's primary role model is through the mother-daughter relationship. In almost every household with childhood abuse, there is a disruption in this relationship, even if the mother is not involved in the abuse. This has tremendous implications for healing in women abused as children. We have a current healthcare paradigm which is hierarchically focused and often patriarchal to a great degree. Most of the research and theories of healing from abuse have evolved from within this paradigm. Studies such as this which are intentionally created within a circle of relationality and which foster a sense of self knowledge as the ultimate authority on self are necessary to shift to models of research and care-giving that foster empowerment for all women, not just those abused as children, but especially for those who have been abused as children.

Empowerment in a relational model is power with or mutual power rather than power over (Surrey, 1991b; VanderPlaat, 1999). In more traditional views of empowerment, the ability to empower others arises from the privileged power holders who confer their power on the less privileged (Vanderplaat, 1999). This is echoed in pyschological and family systems theories in which one part of the self or family overpowers or assumes control of other disparate internal components of the psyche or family (Goulding & Schwartz, 1995). The concept of relational empowerment suggests empowerment as the capacity to move or be moved into action and which emerges through interaction with the other (Vanderplaat, 1999). This is in direct contrast to much of the previously discussed literature on healing in women who experienced childhood

abuse, wherein knowledge is conferred or transferred to other with the expectation that this will offer what is solely necessary for conscious change. It minimizes the process of interaction with the environment and within the self that is inherent and intrinsic in a unitary paradigm wherein all healing comes from within. The job of the practitioner is to assist the client in creating an environment conducive to healing through a safe space to explore her own processes in her own time without judgment as a treatment failure or non-compliant patient.

Methodological Issues

The methodological issues in this study include those involved when working with a vulnerable population and the complexity of disseminating synoptic and experiential processes in a manner that speaks to rigour and credibility. The ethical considerations in the current research on healing in the lives of women abused as children are multifaceted. The sensitivity required when working with a vulnerable population whose injury has come through the abuse of power is tremendous (Draucker, 1999; Flaskerud & Winslow, 1998). The researcher may be viewed as an authority figure and may be presented with antipathy, displaced anger and fear, or contrarily projected with an exaggerated sense of control and power (Stovall- McClough & Cloitre, 2006). This could make it difficult for the participant to leave the study even if she wanted to and could also exaggerate the potential for researcher expectancies threatening the construct validity of findings (Polit & Beck, 2008). Feelings of depersonalization, already an issue in women who have experienced childhood abuse may increase if the participant is viewed as an

object of research rather than a participant in research (Beveridge & Cheung, 2004). Certain study designs such as experimental or quasi-experimental involving large groups and standardized testing may augment the depersonalization. This study aimed to reduce this effect by giving the participant a voice in which she could express her uniqueness and personal beliefs.

For this reason, the participatory and unique nature of UAI as an appreciative inquiry and open process reduced the likelihood of depersonalization and feelings of power imbalance, further victimization, or researcher expectancies. Research which aims to empower the participant was helpful in reducing actual and perceived threats and promoting a sense of safety and support, such as the participatory UAI design which is inherently emancipatory (Reason & Bradbury, 2006). Each cycle of reflection and action began with a re-affirmation of the participants' right to speak her own thoughts and feelings within a safe environment and the researcher worked to actively create a supportive group process that actively encouraged open dialogue. Group conflict was minimal and was easily managed by the group itself for the most part with minimal intervention by the researcher. This consisted of gentle reminders to speak only for oneself and redirecting the energy of the group toward meaningful consensus. The presence of a research assistant was also helpful in managing and maintaining the smooth flow of the group process.

Although confidentiality is imperative in all research, anonymity may be especially important in women who have been abused. A review of the literature about this aspect of research with women abused as children demonstrated the following

findings. Physical safety, emotional protection, and social ramifications exist for women who disclose a history of abuse, especially incest (Rahm, Renk, & Ringsberg, 2006). Sexual abuse is a socially constructed taboo and personal disclosure can lead to familial and social ostracism (Rahm, Renk, & Ringsberg, 2006). For this reason, potential study participants were informed by telephone during the pre-interview contact period of the lack of anonymity conferred by the study design. Confidentiality was discussed repeatedly as part of the group process to attempt to ensure privacy. The issue of confidentiality also triggered the childhood admonitions to keep secrets for some of the women, while conferring a sense of safety for others. This line must be tread carefully in studies with women who have experienced childhood abuse.

The simple act of recounting the abuse is considered a therapeutic technique and in a research study in which participants are telling their story of healing, the line between research and praxis may not exist (Draucker, 1999). However, in a unitary model of research, this is expected as the assumption is that research and praxis are unitary phenomenon (Cowling, 2001). This also posed the ethical question of asking trauma related questions and exposing participants to emotional distress during a research study (Carter- Visscher, Naugle, Bell, & Suvak, 2007). Women who have not previously remembered trauma and are involved in research which asks questions about childhood abuse may experience precipitant memories which were previously unconscious and have mild to severe abreactions either in the research setting or days later (Draucker, 1999; Fivush & Edwards, 2004).

In this study, one of the participants developed some depression after the second day of the study. When she was contacted by email for the follow-up questions, she mentioned that she'd had some depression earlier in the week. I immediately phoned her and was told that she had had a emotional distress due to a traumatic recall of a previous (years earlier) negatively experienced therapeutic relationship and involuntary hospitalization for mental distress. The participant had denied any previous mental illness or hopitalizations for mental illness on the prescreening instrument. She experienced about a week and a half of increasing emotional distress following the study but was afraid to get professional help because of her previous experiences with healthcare prfessionals. The participant was contacted daily for a week by phone or email. Contact then decreased to every few days as she verbalized improved mood and terminated when she left town for a conference she was scheduled to attend. At that time she reported she was doing better and would make contact with a therapist and with the research team if she needed more assistance. Efforts were made to support her in her process, suggest counseling and/ or emegency assistance through HELP lines, counseling agencies, and even the emergency room as needed. She was offered a consultation with the PI, a psychiatric mental health clinical nurse specialist to explore other options for counseling, but she declined. The PI was notified the morning after the initial contact with the participant (the initial incident occurred late on Friday evening) and the situation was reviewed with him daily until the participant terminated contact stating she was doing better. She was assessed for suicidal ideation, family and community support, and exploration of available resources throughout the process. The particpant was also given support and encouragement throughout the process.

An IRB adverse event form was submitted, although the participant did not perceive the occurrence as adverse. Rather, she expressed that the study had opened her in a beneficial way to getting help she desperately needed but was afraid to get. She expressed gratitude to the researcher for acting as a tether until she could mobilize the necessary resources to get help.

The study design was extremely useful in gathering data from a unitary perspective. However, communicating unitary findings can be challenging since language by its nature seeks to communicate through semantics and constructs that are more narrowly defined. The ability to display the photographs of the art creation and the use of the participants language in full context quotes was helpful in surmounting this issue. The current trend in research is to find commonalities in the findings. One of the primary goals of UAI is to capture the unique essence and voices of the women, which still lies outside of mainstream research. Finding ways to make stories as valuable to the scientific community as numbers remains a challenge to qualitative research in general and to UAI particularly, as it seeks to avoid the reduction of differences into a synthetic abstraction of the whole.

The ability of the UAI process to be both research and praxis was evident in the findings, particulary exemplified by the exemplar case. The fact that the attrition rate was so low and the participant selection process was completed within three weeks speaks to the call for research that women who have been abused find useful and meaningful. The fact that it only took three weeks to recruit for the study speaks to the need for community based research and resources for women who have experienced childhood abuse. The retreat setting was costly and labor intensive, except when one remembers that you are not only

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collecting data, you are practicing nursing in a manner which blends science and art and

research and praxis in ways that this circle of women found healing and transformative.

CHAPTER VI

EVALUATION OF THE STUDY

The importance of any study must be defined by its contribution to the discipline and as well as its contribution to the good of the human condition. In this chapter, the findings of the study as they contribute to both nursing science and the general human welfare were reviewed. Study limitations and the need for future research were discussed. In addition, a brief overview of the projected future research as it evolved from this study was offered.

Contribution of the Findings to the Advancement of Nursing Science and Human Welfare

The findings of this study have contributed to the advancement of nursing science in several ways. First, the theory of unitary healing was supported by the study results. Healing from childhood abuse occurs in nonlinear and often painful or disruptive ways for the woman. Rather than pathologizing these disruptions, a unitary healing presence offered these women the opportunity a safe space in which to creatively explore their life patterning and consciously begin to select strategies which resonated with them in unique ways. Unitary healing offered each woman a way of seeing their inherent wholeness which in itself contributes to healing by reducing or diminishing a sense of brokenness or as one participant said, "damaged goods". Unitary healing also offers a method for women to see themselves in context with other women, with themselves, and with the

environment. It allowed each woman an opportunity to connect with a higher perspective that illuminated possibilities. I believe even the fluid nature of the UAI process contributed to an awareness that change is possible and that many potentials previously unexplored were now available to them. This is a major finding in a nursing paradigm which increasingly measures results and outcomes in a linear and rational way, bypassing the need for unique and self-defined ways of healing.

Participatory dreaming was a useful method for accessing hidden or lost keys to healing from childhood abuse and for offering an appreciative or higher perspective from which to view the journey. Every woman in the study wanted a copy of the dreaming sequence on a CD for personal use. The participatory dreaming model was found to be an accurate representation of dreaming in this group of women. One woman even visualized herself as a prism of light which allowed her to illuminate patterns previously unacknowledged or resistant to change. The unitary, fluid nature of beyond waking states was described by many of the women and was associated with a sense of previously unexperienced inner connection and peace. This suggests the power of using beyond waking states for exploration and healing, especially in trauma and supports the need for further nursing research in this area.

The collective and individual expressions of the women were both reflected in the dreaming journals. This is very important in nursing and speaks to the nature of healing from childhood abuse as a social process which cannot be accomplished by individuals without the participation of a social collective which supports the woman as she journeys. Participatory research designs are ideally suited to this purpose and create an opportunity

for nurses to combine research and praxis in ways which are both healing and emancipatory.

There are implications for nursing practice derived from this study. Nursing practice which includes unitary models of healing, group processes which target specific domains of healing which affect women who have experienced childhood abuse (i.e. fibromyalgia, substance abuse, and PTSD), and practices which support women's ways of healing need to be explored and developed. Creating back doors to therapy and practice offices so patients can express emotions freely without having to exit full waiting rooms are important to facilitate the emotional processing of abuse and trauma. Talk therapy alone may be insufficient for women who have suffered childhood abuse and should be augmented with creative opportunities for healing. Trauma centered services should be standard practice with all patients, especially in light of the numbers of childhood abuse victims which continues to increase.

Human welfare is advanced through the propositional, experiential, presentational, and practical knowledge generated by this study on how women heal from childhood abuse using a unitary theoretical framework. Scientific studies which do not address the wholeness of the experience of healing from childhood abuse can only offer a fragmented picture of what healing entails for these women and may in fact contribute to the sense of isolation and inherent sense of fracturing of the core self many of them experience. Additionally, the practical knowledge that was generated by this research suggests that women's ways of healing, like women's ways of knowing, may be in direct conflict to the current hierarchical healthcare system. Human welfare which is viewed

through a more masculine lens may benefit only half of the human condition. Taking that a step further, women's ways of healing may be inherently more relational and therefore more conducive to creating a community of healing which is ecologically, environmentally, and socially more conducive to the health and welfare of the entire planet. This study highlights the need for studying women's ways of healing through a relational, participatory stance which can accommodate a vision of healing within the context of wholeness and appreciation for that which is both unique and diverse.

Future Research

More studies are needed which explore the meaning of healing in women abused as children, especially across cultures, demographic variables, and in disabled women. Further research on the interface between health care providers and women who experienced childhood abuse is needed. Interventional studies aimed at changing existing models of healthcare delivery and provider attitudes toward women who have experienced childhood abuse are needed to change the existing split between what women need and what they are receiving from the current system. A modified Adelphi technique (Keeney, Hasson, & Mckenna, 2005) which combines experts of both nursing practice and practical knowing of abuse, using providers and survivors or perhaps using providers who themselves have been abused as children could be developed. Triangulated research is needed to begin bridging paradigmatic boundaries in nursing with women who have experienced childhood abuse. Because of the gendered nature of the nursing profession, and the rates of childhood abuse experienced by women, studies which

explore the rates of childhood abuse in nurses compared to other professions may give insight into the power dynamics of the current healthcare system.

Individual quantitative studies using health beliefs and change models could be tested using experimental and correlational methods, as well as community organization and community building models, which would be studied using epidemiological methods of research (Gliner & Morgan, 2000; Minkler & Wallerstein, 2002). More research is needed to assess gender, cultural, economic, and ethnic differences in healing. This could be done through experimental designs in which the manipulated variable is the ethnicity, age, gender, or socioeconomic status of the participant. A very important focus of future quantitative and qualitative research should address the lack of knowledge regarding abuse by type or mixed types of abuse. Most of the existing research has been done with sexual childhood abuse and incest.

A grand multi-stage project which includes quantitative and qualitative community based research would be ideal. Involving all stake-holders at policy levels, provider levels, and community levels will be necessary to address the foundational basis of healing in women abused as children which is a social health problem (Minkler & Wallerstein, 2002). Interdisciplinary research which explores healing in women abused as children from a unitary theoretical framework would be the next projected step from this study. This will be a participatory action model designed by both the women and providers, which includes a community action project aimed at raising consciousness and mobilizing resources which may reduce current childhood abuse and offer healing for those who have experienced it themselves as children.

Study Limitations

The primary limitation for this study is that the sample size and purposive sampling frame do not allow for generalizability to all women who have experienced childhood abuse. A potential study limitation was researcher bias. In aesthetic research designs, the researchers allow themselves to fulfill the relationship of artist and audience through fully experiencing the performance and recording their own emotional responses to the experience (Duffy, 2007). This intimate connection offers an appreciation of a life story as a form of art and ". . . is the heart and soul of artistic and aesthetic [narrative] analysis" (Duffy, 2007, p. 416). Every effort was made to authentically record and reflect both a non-biased process inquiry and yet emotionally engage the process within a reflective and appreciative stance. This required an open and participatory stance on the part of the researcher and an awareness of both self and other for emotional, somatic and dialogic processes and external events. Using the language of the participants and validating the patterning profile with the participants was also instrumental in minimizing researcher bias.

Another study limitation was the inadvertent absence of music for the third round of dreaming. The same music (Ocean Dreams) had been used for the first two sessions of the dreaming. Part way into the third dreaming sequence, I realized it was off and felt it would be too disruptive to start it at that point. The participants were questioned later and some felt that it had made a difference in their ability to relax. This may have impacted the study findings from the third round of dreaming.

Conclusion

A science of nursing must be able to reflect both the unique path of healing for each individual and the collective nature of healing within the sociocultural collective. This research was relatively distinctive in that it approached healing in this group of women from both individual and collective perspectives. This study also demonstrated that an interventional qualitative study has much to offer the discipline of nursing by combining research and praxis, and science and art in ways that contribute to our understanding and support of women healing from childhood abuse. Overall, the participants in this study developed new knowledge, insights, skills, and relationships that promoted unitary healing from experiences of childhood abuse. Secondly, the participatory process was useful in helping participants feel freer and connect with themselves and each other in ways that supported the healing process. And finally, the participatory dreaming process facilitated the sociocentric aspects of healing within and between participants which may lead to a broader vision of healing for the community.

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Appendix A

UAI Pattern-Participation-Praxis-Power Matrix & Knowledge Model

Unitary appreciative inquiry	Pattern	Participation	Praxis	Power
Experiential knowledge	Pattern is known through immediacy of perception in encounter, resonance, and empathy among participants.	Participation is engagement, dialogue, cooperation, and shared reflection that bring sense-making to experience.	Praxis brings to life the integration of theory, research, and action within experience.	Power resides in the process and products of the firsthand experience of joining together in the inquiry venture.
Presentational knowledge	Aesthetic imagery and imaginal symbols in art and words represent, convey, and portray life pattern.	Imagery generation and creative expression are inspired and encouraged through the mutuality of participation.	Creation and expression are vital modes of praxis that link theory and action.	Power resides in creativeness and expressiveness that portray and convey the fullness and context of one's life.
Propositional knowlege	Informative and theoretical statements concerning life pattern and how one might understand life pattern are generated.	Propositions are grounded in and derived from dialogue and mutual reflection that comprises participatory inquiry.	Praxis provides the context and method for the action-theory dialectic that informs propositional content.	Power resides with the participants who shape the propositional content on the basis of their experiences, concerns, and values.
Practical knowledge	Practical skills develop in relation to knowing life pattern through inquiry and using this knowledge for transformation.	Skills related to the inquiry process and to the focus of the inquiry emerge through participation in the form of dialogue, action, and reflection.	Praxis offers a context and method from which experiential, presentational, and propositional knowledge can be used for skill development.	Power resides in the development of practical skills that are relevant to the experiences, concerns, and values of all participants.

Cowling, 2004b, p. 211

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Appendix B

Participatory Dreaming Script

Become comfortable and relaxed and allow your attention to rest lightly on your

breathing. Remembering to do whatever you need to stay very comfortable, to feel very safe…As

you notice your breathing perhaps you can become aware of the sensation of the breath as it

passes your nostrils… cool as it enters, perhaps warmer as it leaves… and as you notice your

breathing, you can allow the sensations to carry you into a deeper state of focus and awareness

inside your body. (Pause) Breathing deeper now, perhaps imagining or pretending that you could

breathe a light or a beautiful color down through the crown of your head… and as you breath this

light, this color, this sensation even deeper, your body begins to soften just the right amount for

you here in this moment… softening your scalp and easing any tension over your eyes… in front

of your ears… that's right… doing whatever you need to soften, to feel safe, to be very, very

comfortable…As you continue to breathe, using the breath to pull the light, the color, the

sensation deeper and deeper …softening the muscles in the face, the neck, the back of the

neck…notice that your breath carries you even deeper into the awareness of the body… as the

breath begins to flow into your shoulders, softening, releasing tension, releasing anything you no

longer need to hold, flowing out effortlessly on the outbreath…until this light, this color, this

beautiful sensation is flowing from your fingertips…and your arms are very soft and

comfortable…Beautiful…

Now allowing the breath to pull the light, the color, the sensation deep into your chest,

filling your lungs… filling your heart with this healing and beautiful light, or color or

sensation…softening the spaces around your heart, perhaps softening the spaces inside your heart

and allowing it to overflow with beauty…light…color….healing…And now allowing the heart to

pump all of this beautiful, healing presence into every cell and space of your body… each

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inbreath bringing in new ideas, new thoughts, new awarenesses, …and every outbreath releasing what you no longer need…right along with the carbon dioxide…so effortless… just softening and allowing the body to heal in just the right way for you…in just the right time for you…remembering to stay very comfortable and do whatever you need to stay and feel very safe…

And now allowing your awareness to drift to your back as the sensations, colors, or light is circulating in your body…softening…healing…relaxing…good….now into the belly…every organ glowing, swirled, bathed in this healing awareness…carrying away that which is no longer needed…making room…space…for new ideas…new images…creating new patterns and ways of being that are more in line with who you are now or who you want to be…in the times to come…and the sensations, colors, or light moving deeper into the belly and flowing into the legs, the right leg….the left leg…down the calves….healing…softening…creating new spaces…flowing even into the very marrow of your bones…down into the feet…and flowing in a beautiful stream of light…of awareness… through the soles of your feet…allowing yourself for just a few moments to experience yourself as pure… beautiful… radiant …light… color… sensation… love…floating on waves of breath…(pause)…crystal clear breath…(pause)

Once again, doing whatever you need to feel safe, to feel soft…comfortable…and deeply relaxed…And now I am going to ask you to keep relaxing…and at this time you may have a dream…a real dream...much like when you are sleeping…but very aware…that you can be a participant in the dream…or you can just observe without being in the dream, but you can guide this dream…first into a place you have always imagined, a beautiful, fun, or relaxing place…perhaps somewhere you may have been that you loved…where you felt safe…where you were FREE to explore…to daydream… to create…or someplace you have always wanted to go…somewhere so beautiful, so colorful, so exotic…with new sights…and smells… where the

air feels like a soft glove caressing your skin…and the colors sparkle and shimmer in the light…let yourself be here for a few moments…experiencing the sights, the sounds…what can you hear…the sensations, even the tastes, but always safe…always comfortable… (Pause for 1 minute)…

And now perhaps taking yourself into a new dream…a beautiful and very safe place…a place of healing for yourself…or maybe for your children.. or even for your community…and what does this place of healing …or wholeness…look like? (pause)…are there road signs or signposts along the way to guide you?…is there someone here …or elsewhere…who can help you…to create this dream…to turn this dream into a reality of …appreciation…of wholeness…of understanding…perhaps even gratitude…of everything you are…are there tools you may need?…what are they?…lessons you are ready to understand?…people you need to meet…can you expand your vision…perhaps make it grander…broader…can you create it for the world?...Allowing yourself the space you need…knowing that if nothing comes…that too is perfect…understanding and trusting just for a little while…that everything happens in its own time…no need to rush…unfolding just like a small bud…transforms itself at the right time into a beautiful flower…or a caterpillar who enters the cocoon…knows intuitively…instinctively… how to emerge from her chrysalis into a beautiful butterfly of many colors…

And now, in a few moments…and whenever you are ready…bringing back everything you need…leaving behind what no longer serves your highest good…feeling your hands and feet as they begin to move, becoming more aware of your surroundings…taking some deep breaths…feeling light and refreshed…ready to play and to talk, to enjoy and to create, and…coming back completely into present time…ready to journal whatever you have found for yourself…for the group…

Flyer

ARE YOU A WOMAN WHO HAS EXPERIENCED ABUSE AS A CHILD?

WOULD YOU LIKE TO PARTICIPATE IN A STUDY TO EXPLORE HEALING THROUGH AN INNOVATIVE APPROACH CALLED PARTICIPTORY DREAMING?

Participatory dreaming is a process that uses imagination to explore healing with a group of women who have experienced childhood abuse. This is not a therapy or treatment group. We will focus on healing and ways to heal together and individually. You will be asked to write about, talk about, and create art which reflects the healing process. We will also use daydreaming to understand healing after abuse.

There will be 6-12 women in the group. You will be asked to come to two group sessions each lasting a full day (9am – 4 pm). These will be held two weeks apart in the North Greensboro area. In addition, I will phone, mail, or email you two weeks after our last session to get your responses to two questions about healing. For each day you attend the group you will be given lunch and a $20.00 gift card. You will be contacted two weeks after the study by email, mail, or telephone for a brief follow-up questionnaire. There will be two questions about the process of healing in your life (as it relates to your history of abuse) as a result of the group meetings.

In order to be part of this study, you must be at least 18 years of age, indicate that you were abused as a child, speak and write English fluently, and have telephone or email access. You cannot have an ongoing mental illness, be currently using drugs or alcohol, or be in a violent relationship.

If interested & for more information CONTACT: Elizabeth Repede, FNP, MS, CMH
PhD student in Nursing, University of North Carolina at Greensboro.
(803) 517-0302, ejrepede@uncg.edu

Appendix D

Recruitment Letters to Psychotherapists

Recruitment Letter

Elizabeth Repede, MS, FNP-BC, CMH
School of Nursing
University of North Carolina Greensboro

Addressee
Dear (NAME):

This letter is to inform you about a research opportunity for women who have experienced childhood abuse. I am recruiting 6-12 women who have experienced abuse as children for a participatory study to explore the nature of healing using a facilitated waking dream approach. Data collection will be done on two separate days which are two weeks apart in a retreat-like setting in the North Greensboro area. The study will use four cycles of researcher-facilitated day dreams, participant journaling, and discussion. The culmination of the two days will result in a group aesthetic creation which reflects their perception of healing from childhood abuse. Participants will be asked to journal their responses to two open ended questions regarding healing in their lives and about the effects, if any, of the research process itself. There will be a follow-up contact with each participant to ask the same questions two weeks after the second session. The two research questions are: (1) How would you describe your current perception of healing in your life as it relates to the experience of childhood abuse and (2) What effects (skills/ knowledge) if any, did the participatory dreaming project have upon your appreciation of the healing processes in your life?

The participants will receive lunch and snacks on both days of the study and a $20.00 gift card each of the two days. The ideal participant must be a woman over 18 years of age, self-describe a history of childhood abuse, be comfortable in a group setting, NOT be in a currently abusive relationship, and be free of current substance or alcohol abuse and any mental illness which would impair cognition, reading, or writing ability. The participant must also be fluent in written and spoken English. The participant should have telephone or email access for consideration in this study.

The potential benefits of this study for the participant include an increased sense of understanding, new knowledge and skills for self-healing from the experience of abuse, and support from other women who have had similar experiences.

I realize that this is a potentially vulnerable population and multiple safeguards have been built into the study to protect the women. This study has been approved by the Institutional Review Board at the University of North Carolina Greensboro.

If you have any questions please feel free to contact me. Any women who you feel would benefit from participation in this study can contact me directly. I am enclosing a flyer for your consideration as well.

Thank you for any assistance in recruitment for this study.

Sincerely,

Elizabeth Repede, MS, FNP-BC, CMH
PhD Student
School of Nursing
University of North Carolina Greensboro
803-517-0302, ejrepede@uncg.edu

W.R. Cowling, III, RN, PhD
Director of Doctoral Studies and Professor
School of Nursing
University of North Carolina Greensboro
336-334-4785, WRCowlin@uncg.edu

Appendix E

Pre-Study Questionnaire

1. Have you ever been diagnosed by a healthcare professional with a mental illness such as severe depression, anxiety, post-traumatic stress syndrome, bipolar disease, thought disorder such as schizophrenia, or personality disorder?

2. In the past year, have you had any of the following: intense anxiety, severe depression, disturbing or unreal thoughts, heard voices, seen things which weren't there, uncontrollable mood swings, severe outbursts or anger, violence, impulsive or illegal behavior, uncontrollable compulsive thoughts, manic or unusual behavior?

3. Have you had any history of attempted suicide or suicidal thoughts?

4. Have you ever been hospitalized for a mental illness?

5. Are you currently in a violent or abusive relationship (experiencing physical, emotional, or mental abuse)?

6. Are you having any current suicidal thoughts?

7. Do you have any current problem with substance abuse such as alcohol, prescription medication, or illegal drug use?

8. Are you having any difficulty with your memory, confusion, or problems concentrating that are unusual or out of the ordinary?

Appendix F

Consent

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORM

Project Title: Women Abused as Children and Participatory Dreaming: A Study of Unitary Healing

Project Director: W. R. Cowling III

Participant's Name: _____

What is the study about?
This research project for which I am seeking your participation has 2 purposes:

1. To look at the relationship between a shared waking dream method (discussed below) and healing in women who have experienced abuse as children in a two day small group setting.
2. To describe healing through a shared waking dream group method from the viewpoint of women who have experienced abuse in childhood.

Unitary healing is defined here as giving people time and space to explore and appreciate the wholeness of their lives to give them a greater sense of freedom and health.

Why are you asking me?

You are being asked because you either have shown interest in a shared research study about healing and dreaming with women who have experienced abuse as children, or you have responded to a letter or flyer posted in your community.

What will you ask me to do if I agree to be in the study?
If you agree to participate and you meet study criteria, you will be given the dates of the study and the location (with directions) where the study will occur. It occurs on two full days (each lasting about six to eight hours) that are two weeks apart. The first day of the study (9am- 4pm), you will be given materials for the study. You will be given an opportunity to select a pseudonym to protect your identity throughout the study period. You will be asked to answer questions throughout the day and to write your answers in a journal which will be provided for you. The procedure will be similar on the second day which occurs approximately two weeks after the first day. During the afternoon of the second day you will be asked to help in creating a group art project. Each day will include one or two sessions of guided daydreaming focused only on healing and ways to heal together and individually. You will be guided only to safe and pleasing images which allow your imagination to explore what healing looks and feels like for you personally. Day one will consist of two rounds of individual journaling, group discussion, guided daydreams in a group setting. Day two will consist of two similar rounds but the second round will result in a group presentation or art which may be one of the following: story, play, collage, poetry, mime, song, or dance decided by the group. These rounds will each last about two to three hours. Also, you will be asked to journal the answer to one question about healing in your life as it relates to your history of abuse as a child at different times during the study. You will also be asked to journal about the effect, if any, of the research method on healing in your life. These questions will be asked at the end of the first day of the

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study and at the beginning of the second day of the group. In 2 weeks after the study, you will be contacted by telephone or email and asked the same two questions. While you may experience therapeutic benefit from participating in this study, the study activities should not be viewed as a replacement for any counseling or therapy you may be receiving.

You will not be asked to discuss your experiences of abuse. However, you may do so if you wish to discuss them in relationship to how you have experienced healing in your life during the discussion groups. After the group project is created and discussed, the researcher will present a short art work such as a story, art, or video which will be her reflection of the group healing process. Two weeks after the study, you will be contacted by email, letter, or phone (however you wish). You will be asked to answer the same two questions which will be linked to your first answers by the name you created earlier in the study. You will be given an opportunity to review the study findings if you wish by mail or email and asked for your opinion about them before they are published.

Is there any audio/video recording?
The group discussions during the study will not be recorded. If the group consents as a whole, the group art creation (art, story, dance, or other media created by the group) may be audiotaped, videotaped, or photographed depending on the nature of the project for the researcher's use in data analysis (a secret ballot will be used to vote for or against the taping , photography, or recording). Because you may be able to be identified in the group art creation by your voice or appearance in video or photos, all tapes, photos, or videos will be locked up and they will be destroyed after five years. However, due to the sensitive nature of the material, if all participants do not consent, there will be no audio taping, video, or photos made at any time.
If any participant removes her consent, the artistic material will be destroyed at that time.

What are the dangers to me?
There are few side effects from shared waking dreaming; however there may be a risk of slight headache, sleepiness, or emotional upset during or after the session. These are usually very short, lasting just a few minutes, and you will be given suggestions during the imagery to prevent or reduce any distress. Most people feel wonderfully relaxed, but wide awake after imagery. However, because of the nature of the topic, you may experience some mental, emotional, or physical distress. You will be encouraged throughout the project to do what you need to be comfortable and feel safe. The setting is especially chosen to offer the opportunity to leave the group if you need to and be out in a beautiful setting. You should be able to drive or return to normal activities without any difficulty after this research project. A specially trained research assistant will be available at all times during the group sessions should you have any problems and there will be a number to call following the study if you are experiencing any difficulties from the research method.

Are there any benefits to me for taking part in this research study?
You may experience positive feelings from being in a beautiful setting with other women who have experienced similar life events. You may feel freer, more hopeful, and more connected to yourself and to others. You may be more open to new possibilities in your life after this research experience. You may learn new things and develop a new appreciation of your life through the method of group discussion, creativity, and individual reflection.

Are there any benefits to society as a result of me taking part in this research?
The potential benefits to society from this study are the increased understanding of healing in the lives of women abused as children, the evaluation of the research method used for future studies, and knowledge related to healing and the group dream method.

Will I get paid for being in the study? Will it cost me anything?
You will be paid with a gift card (Target $20.00) after each day of the two days of the study. You will receive lunch, and snacks on the two days of the study. It will cost you the gas for transportation to the

study site and the time for the study which is two full days plus the time of the follow-up interview which will be done by phone, email, or mail and should take no more than 10- 15 minutes.

How will you keep my information confidential?
Confidentiality:
All information and data will be kept stored separately from identifying data. Because this involves group discussion, your anonymity cannot be maintained. You will be asked to create a false name that only you know, but which will be used to link all of your data. When the results of the study are published, you will not be identified by your real name. Any material such as quotations, or video, photos, or audio recordings of the artistic presentation will be de-identified as possible. In the case of the photos, video, or audio recordings of the artistic presentation, no material will be released for publication without the written consent of every participant. All data records, storage, and records of verbal communication will be kept locked in a file cabinet in the researcher's home office, data will be typed and stored in a password protected computer in the researcher's home office, and there will be no access to patient health records in this study. Data will be stored for 5 years, at which time it will be shredded or destroyed. All information obtained in this study is strictly confidential unless disclosure is required by law. If you choose to do your follow-up questions by email, **absolute confidentiality of data provided through the Internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.**

What if I want to leave the study?

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data which has been collected be destroyed unless it is not identifiable. Since the journals will not be identified by name, they are not considered identifiable data.

What about new information/changes in the study?

If new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

Voluntary Consent by Participant:

By signing this consent form, you agree that you understand the procedures and any risks and benefits involved in this research. You have had the research method explained to you by the researcher to your satisfaction. You understand that shared dreaming is a relaxed state of awareness which can be used to imagine new ways for healing and exploring your life. You understand that you are completely free to refuse or to withdraw your consent to participate in this research at any time without penalty or prejudice; your participation is entirely voluntary. Your privacy will be protected because you will not be identified by name as a participant in this project. You agree not to divulge any information about the identification of other participants in the study group. You understand there is no way to insure that other participant group members will not divulge any information outside the intervention group, thus confidentiality cannot be completely assured.

The University of North Carolina at Greensboro Institutional Review Board has approved this research and this consent form.

Questions regarding your rights as a participant in this study can be answered by calling Eric Allen at (336) 334- 4700, the University of North Carolina at Greensboro. Questions regarding the research itself can be answered by calling Elizabeth Repede at 803 517-0302 or email at ejrepede@uncg.edu.

The principle investigator is Dr. W. R. Cowling, III, a PhD prepared nurse researcher and a board certified Clinical Nurse Specialist in psychiatric mental health nursing and advanced holistic nursing. He has over 12 years of research experience with women who have experienced abuse as children. The person conducting the intervention is Elizabeth Repede, a Family Nurse Practitioner with 30 years of nursing experience, certified in medical hypnosis with 6 years of experience in clinical hypnosis and over 1,000 hours of advanced training in imagery, dream work, and mind-body healing. She is also a PhD student at the University of North Carolina at Greensboro and has assisted Dr Cowling with his research with women abused as children for the last two years. Dr. Cowling will be off-site, but available to respond during the intervention if needed. In addition, there will be a Master's prepared registered nurse who is familiar with the research on site during the intervention who will be available for assistance as needed.

By signing this consent form you are agreeing that you read and you fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By signing this form, you are agreeing that you are 18 years of age or older and are agreeing to participate, or have the individual specified above as a participant participate, in this study described to you by Elizabeth Repede.

Signature: _____ Date: _____

Appendix G

Brief Demographic Survey

Please write in the responses to these questions and cross out any questions which you do not wish to answer.

What is your current age?

To what race/ ethnic group(s) do you belong?

What is your current health status?

What type of educational experiences have you had as an adult?

Appendix H

IRB Approval

THE UNIVERSITY *of* NORTH CAROLINA
GREENSBORO

OFFICE OF RESEARCH COMPLIANCE
2718 Beverly Cooper Moore and Irene Mitchell Moore
Humanities and Research Administration Bldg.
PO Box 26170
Greensboro, NC 27402-6170
336.256.1482
Web site: www.uncg.edu/orc
Federalwide Assurance (FWA) #216

To: William Cowling
Community Practice
101 320 McIver Street

From: UNCG IRB IRB

Authorized signature on behalf of IRB

Approval Date: 1/15/2009
Expiration Date of Approval: 1/13/2010

RE: Notice of IRB Approval by Full Board Review
Submission Type: Initial
Study #: 08-0148 (Former IRB Number 089148)

Study Title: Women Abused as Children and Participatory Dreaming: A Study of Unitary Healing

This submission has been approved by the above IRB for the period indicated.

Study Description:

This is a descriptive, exploratory, qualitative study to examine the potential of participatory dreaming (a waking researcher-guided daydream
) on unitary healing in women abused as children.

Investigator's Responsibilities

Federal regulations require that all research be reviewed at least annually. It is the Principal Investigator's responsibility to submit for renewal and obtain approval before the expiration date. You may not continue any research activity beyond the expiration date without IRB approval. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.

When applicable, enclosed are stamped copies of approved consent documents and other recruitment materials. You must copy the stamped consent forms for use with subjects unless you have approval to do otherwise.

You are required to obtain IRB approval for any changes to any aspect of this study before

they can be implemented (use the modification form at ohre.unc.edu/forms). Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB using the adverse event form at the same website.

Confidentiality Agreement

Confidentiality Agreement

Women Abused as Children and Participatory Dreaming: A Study of
Unitary Healing

I am member of the research project, *Women Abused as Children and
Participatory Dreaming: A Study of Unitary Healing* being conducted by
W.R. Cowling, III and Elizabeth Repede. The group will be discussing
healing as it relates to the healing of women who have experienced
childhood abuse. I agree as a member of the research group to respect the
privacy of all group members by keeping in confidence any personal matters
discussed group sessions. I will do this by not discussing any personal
matters discussed in group sessions, outside group meeting times with
anyone.

I agree to this requirement of group participation and I understand this form
will be destroyed at the completion of this study.

Signature_____   Date_____

Secret Ballot

Women Abused as Children and Participatory Dreaming: A Study of Unitary Healing

I agree to the videotaping, sound recording, and/or photographing of the group art creation made as part of this study. I understand that these tapes or recordings will be used to share knowledge about the study findings and will be de-identified for names, faces, voices, or any identifying information as possible.

Please circle your response.

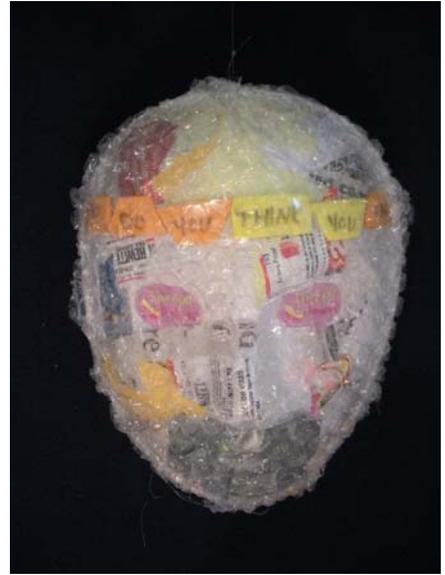YES, I agree   NO, I do not agree
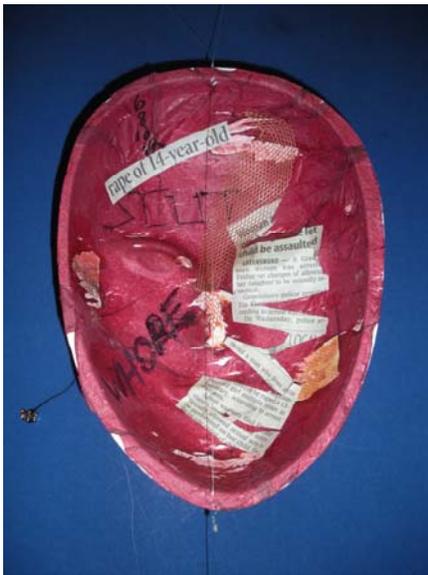
Appendix K

Expressions of Women Healing from Childhood Abuse

Mask I, Inner

Mask I, Outer

Mask II, Inner

Mask II, Outer

Mask III, Inner

Mask III, Outer

Mask IV, Inner

Mask IV, Outer

Mask V, Inner

Mask V, Outer

Mask VI, Inner

Mask VII, Outer

Mask VII, Inner

Mask VII, Outer
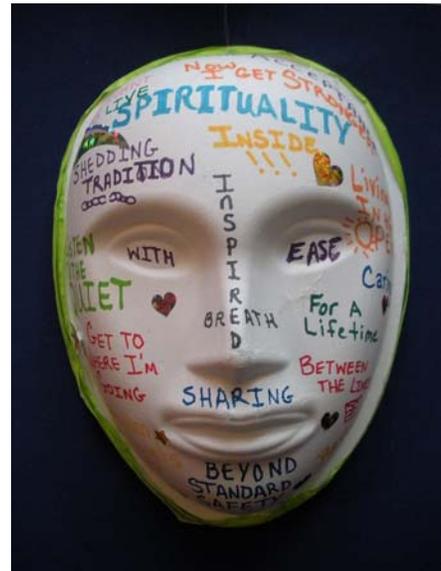

Mask VIII, Inner

Mask VIII, Outer

Mask IX, Inner

Mask IX, Outer

Mask X, Inner

Mask X, Outer

Collage, Side A

Collage, Side B

Mobile, Side A

Mobile, Side B

Appendix L

Copyright Permission:
UAI Pattern-Participation-Praxis-Power Matrix & Knowledge Model

**WOLTERS KLUWER HEALTH LICENSE
TERMS AND CONDITIONS**

Jun 12, 2009

This is a License Agreement between Elizabeth Repede ("You") and Wolters Kluwer Health ("Wolters Kluwer Health") provided by Copyright Clearance Center ("CCC"). The license consists of your order details, the terms and conditions provided by Wolters Kluwer Health, and the payment terms and conditions.

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Volume Number	27
Issue Number	3
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Title of your thesis / dissertation	Women Abused as Children and Participatory Dreaming: A Study of Unitary Healing
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Appendix M

Copyright Permission:
Model of Participatory Dreaming

From: Hutchinson, Adele
To: imago@comporium.net
Cc: wrcowlin@email.uncg.edu ; Fried, Katja
Sent: Wednesday, June 17, 2009 12:51 PM
Subject: FW: Copyright needs

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> Thanks, Richard, the only thing I need copyright permission for is the article contents and model of participatory dreaming that is in n NSQ accepted manuscript entitled, *Participatory Dreaming: A Conceptual Exploration from a Unitary Appreciative Inquiry Perspective.* I have attached the manuscript in case there are any questions. It was accepted last September after minor revisions. This is for use in my dissertation. Thanks so much. My cell is 803 517-0302 for any questions.
> Liz
>
> Elizabeth J. Repede, PhD, FNP-BC, CMH
> www.imagohypnosis.com