Beyond Words
Trauma Recovery Through Art Therapy

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Honors Program Thesis
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Abstract: This paper provides a synthesis of research on Art Therapy, Posttraumatic Stress Disorder, and explains the unique benefit this therapy may provide for the refugee population suffering from PTSD.

Keywords: Bachelor of Science in Visual Arts, Minor in Psychology, Art Therapy, Posttraumatic Stress Disorder, Mental Health Counseling, Minority Health, Trauma, Refugee Crisis, Refugee Camp, Metalsmith, Metalworks, Art Exhibition.

Clarification: For the purpose of this paper, the general term refugee without further description refers to any displaced individual struggling specifically with PTSD. Veteran without further description refers to any veteran specifically struggling with PTSD. This paper uses the term PTSD (Posttraumatic Stress Disorder) as published in the Diagnostic Statistical Manual V, although some veterans prefer the label of Posttraumatic Stress Injury (PTSI).
Where traditional therapy treatment plans fall short, Art Therapy offers a unique path towards healing from traumatic events for marginalized people. While most forms of therapy rely on verbal communication, Art Therapy utilizes the universal visual language to enable the emotional, mental, and physical processing of PTSD, where words often fall short. The creative arts provide clinicians with countless courses of action to treat individuals from all cultural backgrounds, and within any non-traditional environment.

Facilitated by a licensed professional, Art Therapy pairs active art making with various psychology theories to support the personal and relational development of individuals and their communities.1

Through integrative methods, art therapy engages the mind, body, and spirit in ways that are distinct from verbal articulation alone. Kinesthetic, sensory, perceptual, and symbolic opportunities invite alternative modes of receptive and expressive communication, which can circumvent the limitations of language.2

How does this jargon translate into the real world? Imagine the conventional counseling session. Anyone seeking talk therapy would walk into a welcoming office space, furnished with a cushioned couch, fuzzy rug, bright windows, and a desk filled with plants and paperwork. For Art Therapy in this traditional setting, the environment could be much the same, but add in a row of art cabinets and a table filled with supplies. Perhaps some drawn or painted artwork hangs on the walls, intended to spark creative energy, or a minimalistic decor may invite the client to express their imagination and fill the blank slate. Art Therapy sessions within the private practice or clinical environment typically last for an hour, and are scheduled to fit whatever frequency meets the client’s need and financial ability: weekly, bi-weekly, or monthly. But what does the actual process entail? Here’s the difficult part: Every therapy session looks different for each client!

Stymied by this challenge, I interviewed local Art Therapists, inquiring, “What does a session look like in action?” Each replied, “That depends!” There are multiple factors that affect

2 “About Art Therapy”.
how a session runs. The age, gender identity, physical ability, cultural background, mental disorder, the severity of the disorder or traumatic event, and even the personality and creative interests of the client all affect the therapeutic process. Art Therapy provides a powerful path towards healing across all populations and all psychological or physical problems. While many people tend to think of creative therapies (including Music Therapy and Drama Therapy) as geared specifically towards children or those with previous artistic experience, Art Therapy is universally applicable. It takes place within hospitals, schools, veterans clinics (like the VA), psychiatric rehabilitation facilities, developmental disability rehabilitation programs, crisis centers, senior living communities, memory care programs, prison systems, community programs, and with refugee populations.³ It is used in treatment plans for a myriad of disabilities, disorders, and traumatic experiences. With this infinite amount of variables, it’s impossible to take a ‘one size fits-all’ approach, and it prevents any simple summary of Art Therapy in action.

Within the realm of accredited counseling, Art Therapy is a relatively recent theory of practice. The term ‘Art Therapy’ was coined in 1942, and the American Art Therapy Association was founded in 1969 with the Registered Art Therapist (ATR) credential following in 1970.⁴ This non-profit organization has worked tirelessly over the past 50 years for the professional license to be recognized and accepted around the United States and worldwide. Due to the varied methods and environments where Art Therapy is implemented however, it is difficult to demonstrate empirical efficacy and legitimacy for therapy sessions to qualify for health insurance reimbursement, and to exist as a credible form of care in the medical field. This creates financial barriers and limits general access to information regarding Art Therapy as a treatment option. Fortunately, recognition of this effective therapy is on the rise. As younger generations continue to destigmatize therapy and increase social awareness of mental health issues such as PTSD, more attention has turned to the versatile attributes of Art Therapy. PTSD

³ “About Art Therapy”.
⁴ “About the American Art Therapy Association” (American Art Therapy Association, 2014).
continues to be researched, largely among the American veteran population, and more data indicates that Art Therapy may provide an effective approach.\(^5\)

Our society has become overly familiar with the term PTSD, flippantly using it in reference to difficult exams, embarrassing mistakes, or even a regrettable night of drinking. In reality, a genuine diagnosis of Posttraumatic Stress Disorder is no light matter. The Diagnostic Statistical Manual for Mental Disorders (DSM) describes the cause of PTSD as resulting from directly experiencing, witnessing, or even hearing of a close relation having experienced a traumatic event that threatens death, serious injury, or sexual violation.\(^6\) Historically, PTSD has been known as soldiers’ heart, shell shock, or battle fatigue, among other names. It was originally understood to be something suffered by those in the military, resulting from proximity to large explosions combined with the stress and exhaustion of warfare and separation from home.\(^7\) Social movements, including advocacy by sexual assault and Holocaust survivors, helped the medical community recognize the wider variety of experiences that contribute to PTSD, including disasters.\(^8\) Currently, there is some debate from the VA community concerning the label of PTSD. Society tends to stigmatize those diagnosed with ‘disorders’. Veteran advocacy groups are pushing for the diagnosis of Posttraumatic Stress ‘Injury’ in the next DSM edition, to convey the biological changes the brain presents after experiencing a traumatic event. This may normalize people seeking help for their PTS Injury symptoms. The official diagnosis of Posttraumatic Stress Disorder was added to the DSM III in 1980, and has remained in the subsequent revisions of the DSM.\(^9\) This current edition, the DSM V, describes the symptoms of the disorder as follows.

PTSD presents with 4 clusters of symptoms in the following areas. Re-experiencing includes the most widely recognized symptom of flashbacks, as well as intrusive thoughts and recurring nightmares. Avoidance relates to the emotional and physical distance put between

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\(^7\) Friedman, Matthew J. “History of PTSD in Veterans...” (VA.gov, 2018).

\(^8\) Friedman, “History of PTSD”.

\(^9\) Friedman, “History of PTSD”.

this control center perceives that the emergency is ongoing (rather than a one-time scare), it

Negative cognitions and mood cause a distorted perception of self-identity, personal value, and responsibility for the event. This leads to relational conflict and lack of interest in social functioning and previously enjoyable activities. Arousal or hyperarousal results in heightened sensitivity to external surroundings and can lead to aggressive behaviors. This may appear as paranoia or self-destructive behaviors such as drug abuse and excessive drinking. These symptoms do not always occur immediately after the traumatic event, but can emerge days, weeks, or even years later. If they persist past four weeks and cause significant distress in work and daily functioning, it transitions from being labeled ‘Posttraumatic Stress’ or ‘Acute Stress Disorder’ to qualifying for the diagnosis of clinically recognized PTSD.11

In order to discuss how Art Therapy addresses some of the primary symptoms of PTSD, some neurological brain functioning must be explained. The central term is stress response, or more commonly known as fight or flight.12 This is the central nervous system reaction that kicks someone’s body into gear when confronted with an immediate emergency, such as an oncoming car, or reflexively pulling one’s hand from a hot stove top. These split second actions are the result of multiple brain functions communicating faster than the conscious mind can perceive. As information enters the brain through the senses, any detected threat sparks the amygdala into action. This region is known as the ‘emotional brain’. As its nickname suggests, the amygdala reacts without conscious reasoning. Instead of taking the slow road through the logical thought processes of the frontal cortex, the amygdala sends warning signals to the part of the brain, the hypothalamus, that controls the autonomic nervous system, which is responsible for bodily functions such as breathing, heart rate, and blood pressure.13 It signals the release of adrenaline to pump through the blood vessels, causing blood pressure and heart rate to increase: hence the pounding in one’s chest as they encounter a frightening event. If this control center perceives that the emergency is ongoing (rather than a one-time scare), it

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10 Torres, “What is Posttraumatic Stress Disorder?”
11 Torres, “What is Posttraumatic Stress Disorder?”
triggers the release of the primary stress hormone, cortisol. Because cortisol is a hormone, it is slower-moving, and lasts longer in the body.\textsuperscript{14}

The stress response works great for short-term self-preservation. However, it becomes a serious problem when it doesn’t shut off after the danger has passed.\textsuperscript{15} This is one factor at play in the physiology of those with PTSD, who have often been exposed to multiple or prolonged traumatic events. As a result, the amygdala feels as if it is under constant threat, prolonging the production of cortisol in the body. This is exhibited through jumpiness, sleep disturbance, panic, irritability, and self-destructive behaviors, which are all categorized under the hyperarousal symptom cluster. When cortisol remains elevated for long periods of time, it can cause physical brain damage in the parts of the brain responsible for memory function.\textsuperscript{16} Children are especially susceptible to life-altering changes as their brains are still developing. Unfortunately, there is not ample research on these physiological and psychological consequences.\textsuperscript{17}

What does cortisol have to do with Art Therapy? Some studies show that heightened cortisol impairs working memory and declarative memory, while facilitating the detailed encoding of implicit memory.\textsuperscript{18} This means that traumatic events are stored in the brain as vivid sensory memories, full of deeply negative emotions. However, the verbal component of memory is not encoded properly and does not become linked to the sensory memories. The continued state of heightened stress enhances the memory consolidation but impairs the retrieval process,\textsuperscript{19} so while someone can fully relive and see the event playing back in their

\textsuperscript{14} Godoy, “A Comprehensive Overview.”

\textsuperscript{15} Heim et al. (2000), (2008); de Kloet et al. (2005a); Juruena (2013); Nemeroff (2016) as cited by Godoy, “A Comprehensive Overview.”

\textsuperscript{16} Inka Weissbecker et al, “Psychological and Physiological Correlates of Stress in Children…” (Children, Youth and Environments, 2008), 35.

\textsuperscript{17} Weissbecker, “Psychological and Physiological,” 35.

\textsuperscript{18} Kirschbaum et al. (1996); Lupien et al. (1999); Newcomer et al. (1994), (1999); Oei et al. (2006); Payne et al. (2007) as cited by Luethi, Mathias, “Stress Effects on Working Memory, Explicit Memory, and Implicit Memory…,” (Frontiers in Behavioral Neuroscience 2008).

\textsuperscript{19} Luethi, “Stress Effects on Working Memory.”
head, they do not have the ability to verbally express what they’ve experienced. This disconnect between implicit and declarative memory creates emotional and sensory fragments lacking verbal and symbolic grounding for the mind to integrate into an individual’s life history. Instead, these fragments remain as current, threatening experiences that perpetuate the stress response in a destructive cycle. This is where Art Therapy offers a unique solution.

By their nature, traumatic memories are difficult to express in words alone. Non-verbal expression, as is used in art therapy, can facilitate both the shift to declarative memory and the creation of a coherent narrative.

Rather than requiring a client with PTSD to attempt to verbalize the painful memories, thoughts, and emotions trapped in their heads, Art Therapy invites a physical, visual creation in response to the traumatic pictorial memory. This type of work taps into the emotional elements that form someone’s inner world, that must be properly recognized, validated, and processed. Art Therapy often aligns with the Humanistic theoretical approach, where the end goal of self-actualization develops through personal introspection of understanding what is prohibiting someone’s current self from becoming their ideal self. In order to resolve the differences, one must work through the problematic experiences, along with developing coping strategies with behavioral and cognitive-based theories. The past traumas must be understood and accepted within an individual’s identity in such a way they can move forward “with these truths integrated in their reality”. By creating a physical work of art, the client can step back with physical and emotional distance, assuming the stance of an outside observer instead of

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20 This describes flashbacks, as mentioned in the intrusive symptom cluster of PTSD.
23 Dye, Loretta, Using Art Techniques Across Cultural and Race Boundaries... (Jessica Kingsley Publisher, 2017) 12.
24 Carl Rogers built upon Maslow’s Hierarchy of Needs to recognize the concept of an individual meeting their ‘ideal self’, where someone reaches their understanding of what their full emotional, spiritual, and mental potential is.
dwellings in the midst of disjointed experiences. Just as clients suffering from anxiety and panic attacks are advised to ‘ground’ themselves through their senses, working with tangible materials can provide enough stimuli to distract the mind from becoming overwhelmed as the client is processing those traumatic images. By safely expressing the visual and sensory components of the traumatic memory within the therapeutic relationship, the client can begin the process of re-integrating it into their reality and solidifying it as something that has occurred in the past. As the brain can form the correct connections, the body recognizes that the traumatic experience is no longer a present threat, and reduces the symptoms of hyperarousal resulting from the stress response cycle. Because trauma happens to both the mind and body, it makes sense that in order to process that experience properly, the therapy must work on both levels in the same way.

By communicating through a universal visual language, Art Therapy is the perfect tool to bypass the cultural and linguistic differences that often force disadvantaged communities, such as refugees, to the outskirts of society. Because of the non-confrontational nature of this therapy (as opposed to behavioral exposure therapies), it may be preferred as a more culturally and racially sensitive method for therapists, especially those working with clients outside of their own ethnic background. The social stigma associated with a PTSD diagnosis is magnified when applied to people from marginalized groups. Refugee trauma is not solely linked to experiences of warfare, as within the veteran population, but may also result from or be compounded by the difficult migration process and living conditions in refugee camps that lack basic necessities. This affects over 70 million people who have been displaced across the world, due to persecution, human rights violations, natural disasters, and political unrest.

30 Dye, Using Art Techniques, 13.
mental health crisis among refugees is intensified as they face cultural assimilation stressors in the resettlement process where they are without communal and institutional support systems. The symptoms of PTSD can exist alongside debilitating diagnoses of depression and anxiety disorders. Depressive symptoms present with loss of energy and interest in activities, feelings of guilt and worthlessness, and physical weight loss and exhaustion. Anxiety disorders bring sleeplessness, lack of ability to focus, irritability, and worrying. These symptoms amplify the barriers refugees face in adapting to a new culture, finding employment, and overcoming linguistic obstacles. This perpetuates the endless cycle where unemployment and financial instability heightens depression, anxiety, and PTSD symptoms. During the acculturation process, refugees face the conflict of fitting in to the dominant culture while maintaining their own cultural identity. For example, when a refugee seeks acceptance within society, they might struggle with feelings of guilt for betraying their origins, while someone who upholds their identity might feel inadequate when they are unable to secure jobs and social inclusion. It seems there is no way for the exiled person to find a welcome home within host countries without sacrificing their background or mental health.

Studies show that refugees face higher rates of mental illness, and are more than 10 times as likely as the general American population to struggle with PTSD. One clinical study focusing on refugee children within the American school system, the Burma Art Therapy Program Evaluation, noted that nearly all of the young participants in the school-based study had experienced, witnessed, or heard about a traumatic event, and 11% of the assessed refugee children fit the criteria for PTSD.

Eighty-three percent of participants had directly experienced a traumatic event, 90% had witnessed a traumatic event, and 97% had heard about a traumatic event. Commonly reported experiences of trauma included the

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34 Kartal (2016) as cited by Hameed, “Increased Vulnerability.”

35 Rowe, “Evaluating Art Therapy,” 2.

36 Rowe, “Evaluating Art Therapy,” 2.
following: lacking adequate food, witnessing rape, and hearing about combat. On average, participants had directly experienced two, witnessed four, and heard about eight traumatic events.\textsuperscript{37} Reports from case studies and expert opinions seem to indicate improvement in PTSD symptoms, showing Art Therapy as “helpful in decreasing reexperience, arousal, and less visible symptoms as avoidance and emotional numbing” when used in the field.\textsuperscript{38} Unfortunately, due to the difficulty of conducting clinical, scientific studies within refugee camps, it is impossible to present data that can undoubtedly demonstrate the efficacy of Art Therapy within this population. By working with refugees that had already settled into the American school system, the Burma Art Therapy Program (BAPT) was able to conduct evaluations through a more regulated format, recording the participants’ symptoms before, during, and after receiving the therapy sessions.

The BAPT worked with 30 adolescent refugees from Burma, ages 11-20, who had resided in the US an average of 5 years. They went through 4 baseline evaluations before receiving therapy, which tested levels of anxiety, depression, and behavioral problems.\textsuperscript{39} The participants received approximately 16, 50-minute-long, weekly sessions throughout the school year from trained professionals.\textsuperscript{40} For ethical reasons in this study, there was no control group. 60% of the participants worked individually with Art Therapists, and the other 40% received group Art Therapy.\textsuperscript{41} After the school year ended, the BAPT students reported statistically significant improvement in some symptoms such as: ‘feeling free from anxiety’, which increased from 50.0% at baseline to 65.4% at follow-up, decreased severe behavioral issues in school from 16.7% at baseline to 11.5% at follow-up, and overall increased positive self-concept from 26.7% at baseline to 38.5% at follow-up.\textsuperscript{42} It was interesting to note that there was a period of increased depressive symptoms (though not statistically significant) across the

\textsuperscript{37} Rowe, “Evaluating Art Therapy,” 5.
\textsuperscript{39} Rowe, “Evaluating Art Therapy,” 1.
\textsuperscript{40} Rowe, “Evaluating Art Therapy,” 4.
\textsuperscript{41} Rowe, “Evaluating Art Therapy,” 4.
\textsuperscript{42} Rowe, “Evaluating Art Therapy,” 5.
participants when they initially began to process and delve into their traumas. This study also demonstrated the unique difficulty in assessing the true benefits of Art Therapy, because “while the quantitative tools captured some of the effects of trauma and the impact of art therapy on their client population, they did not capture other effects, such as the unique experiences of growth and building of clients’ strengths.”

The Art Therapists in this study noted that because the measurements commonly used to assess mental health take a deficit-based approach, they cannot provide the full picture of posttraumatic growth (PTG) that recipients of Art Therapy often experience. PTG has been described as the positive psychological change, such as greater appreciation for life and increased perception of inner strength, in those who have struggled through and survived extremely challenging events. Additionally, the verbal and written based assessments created challenges with accurate reporting, especially working across cultural and linguistic barriers for these refugees. Instead, this study suggested that further research should employ art-based assessments that include a measure for PTG, so there are no probing questions and clinical terms (that may be lost in translation) about client trauma and difficult symptoms without the therapeutic support of the art materials.

Art Therapy is not reserved for just private practice or clinical environments. It can provide valuable disaster mental health counseling ‘in the field’, without requiring an office with set supplies. Art Therapists can adapt their practice within the often underfunded refugee camps, where even basic necessities can be hard to come by. There is no defined type of art medium to use within therapy sessions. Working with limited materials may also provide a better framework for emotional exploration, so the client does not become distracted by multiple avenues of creation, or overwhelmed by achieving some specific visual outcome. Using the materials, even broken or discarded items, from within the camp can develop a sense of familiarity that builds safety and openness between client (refugees in this case) and

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47 Dye, Using Art Techniques, 27.
Art Therapists can customize creative prompts through an understanding of the history and emotion behind cultural traditions and symbolism, so refugees can work within a comfortable, established visual language. Constructing sculptures from such materials that might have actually contributed to a refugee’s trauma empowers them to physically reverse those negative aspects and transform them into works of art that assist their healing process.

While many Art Therapists within private or clinical work spaces use the creative process to construct a vocabulary to apply to a client’s trauma, the spoken language is not required to initiate psychological healing. The act of expressing one’s trauma through creative materials can be enough for the individual to begin to process their own emotions and experiences. As they decide how to visually represent the various facets of their trauma, the client’s choices about material, texture, shape, size, and figural or abstract imagery, can inform them of their own inner world. Working through the meaning behind their creative decisions, the artwork becomes the mediator between the client and the therapist, and the client and their painful memory. They can detangle their frustrations, problematic behaviors, and overwhelming emotions as they sit before them.

"[I]t is the potential unlocked by an art product – the ability to dialogue with, change store, destroy, frame and rework the art – that places it in a unique position to access and effect change in a client’s inner world. These unsayables – the symbols, not the signs, of the internal experience – can be profoundly explored and altered through the process and product of art."

The therapeutic process continues as that creation can then be altered and placed within meaningful context. For refugees with PTSD, who are without social autonomy and are plagued by interrupting imagery and symptoms, having the ability to control the outcome of this externalized, concrete creation can help restore their sense of self-actualization and identity.

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48 Dye, Using Art Techniques, 18, 26.
49 Dye, Using Art Techniques, 30.
50 Dye, Using Art Techniques, 61.
51 Dye, Using Art Techniques, 61.
52 Dye, Using Art Techniques, 62.
They can choose to alter the work, hang it somewhere, or throw it away; they can reframe this creation within the scope of their reality, and understand it as something that no longer dominates their daily life. These actions may not erase the memory or pain of the traumatic event, but it can reduce the power that trauma holds over the individual, and decrease the debilitating symptoms of PTSD.

[Healing can be defined as the place where the individual is at peace with all the parts that make up who they are and there is full integration of all the different parts... This includes thoughts, choices, actions, and complex emotions.]

Art Therapy is a powerful, healing tool, uniquely able to break down linguistic barriers and locational and resource limitations, engaging the body and mind to overcome the debilitating effects of trauma. Through the infinite variety of physical material and visual expression, recipients can process and externalize the unspeakable emotions and thoughts they struggle with as a result of PTSD. In order to establish Art Therapy as a universally obtainable treatment option, more research and clinical studies must be conducted in medical and academic fields. These studies should employ measures that reflect the unique positive reframing skills and posttraumatic growth that recipients experience, and use art-based evaluation tools to avoid further language or cultural barriers. The social services industry and healthcare providers in the US and worldwide must respond to the positive outcomes of these case studies, expert opinions, and research, to ensure equal opportunity for access to this therapy across all populations, and especially marginalized peoples.

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Works Cited


Response to Research

*Works in Metal*

Rachel Brainerd
Visual Arts Capstone & Honors Thesis
With assistance from the New Paltz Metals Program, and Cheryl Wheat-Schmidt
December 18th, 2020
As a metalsmith, I juxtapose metal with mixed media to create pieces activated by the body, embedded with formal, theoretical, and literal imagery that spark dialogue about refugees within our society. The moving components within the jewelry captivate the wearer, inviting more intimate contemplation of the psychological traumas experienced by refugees, exiled to a culture devoid of empathy. I create wearable, metal forms that discuss the psychological effects of Post Traumatic Stress Disorder (PTSD) found among refugees. I translate the inequalities of our society into tactile jewelry that offers insight into the harsh realities of physical and psychological survival in exile. I recognize my position of privilege, and utilize the materials I have to highlight the lack of resources and validate the experiences of oppression these individuals face. My work challenges those with economic privilege to recognize the pain of others, rousing them to accept responsibility for their role in social transformation.

I delight in constructing intricate works of metal with various hinged and swivelling mechanisms that offer a doorway into my conceptualization of refugee trauma. I exploit the natural curiosity of viewers to wear and touch these moving elements, and thus briefly step into another’s experience. While my audience and I have the luxury of removing these external forms, refugees have no choice in carrying the burdens forced upon them. I developed a method to cast blue tarpaulin in resin, and embed photographs from newsreels of refugees in flight to visually reference the temporary building materials and living conditions found in refugee camps. The burned resin images evoke a sense of loss and longing, the memories of countless lives threatened by the disintegration of their homes, and the fragility of human life. The metal forms, tarnished by patinas and age, become a witness to this passage of time, and reside in a worn, familiar context that invites intimate connection and understanding instead of reverent distance.

These majority of the following works are labeled with two titles, the second being a direct reference to the symptoms suffered by those with PTSD (as explained on page 6 of Beyond Words: Trauma Recover Through Art Therapy).

Visit https://www.rachelelizabeth-studio.com/ for more information about these works.
ruptured shelter - social isolation / 2020
Copper. Liver of sulfur. WD40
18” x 3” x 3”
ruptured shelter / 2020
Copper. Liver of sulfur. WD40
18” x 3” x 3”
ruptured shelter gesture / 2020
Vine charcoal on paper
18”x 23”
Inescapable past - intrusive memory / 2020
4" x 4" x 2"
Inescapable past closeup / 2020
4”x 4” x 2”
hypervigilance - defensive irritability / 2020
3” x ¾ “
**hypervigilance gesture** / 2020
Vine charcoal on paper
18”x 23”
catching dreams of refugees - sleep disturbance / 2020
16” x 4” x 1”
catching dreams of refugees closeup / 2020
16”x 4” x1”
trauma in time / 2019
Variable length x 2.5"
trauma in time gesture / 2020
Vine charcoal on paper.
18” x 22”
lens of perpetual refuge - distorted perceptions / 2020
12" x 4" x 1"
lens of perpetual refuge closeup / 2020
12” x 4” x 1”