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Emma Brenner-Malin
Art as a Clinical Tool in The
Treatment of Complex PTSD:
A Theoretical Study

ABSTRACT

This theoretical thesis explores how art-making can be used as a clinical tool in social worker's psychodynamic treatment of complex post-traumatic stress disorder. A theoretical thesis was chosen in order to address the gap in the social work literature discussing the integration of creative action into trauma-informed care. D.W. Winnicott's object relations theory and Trauma-informed art therapy theory are the two theoretical lenses applied and discussed. A review of the literature indicates that art created during therapy can function as a transitional object, facilitating the client's ability to learn how to regulate their affect, recall dissociated affect and memories, bolster their ability to trust and establish a more cohesive sense of self, all of which are primary goals of therapy for clients with significant trauma histories. Implications for clinical social work and recommendations for future research were discussed.

**ART AS A CLINICAL TOOL IN THE TREATMENT OF COMPLEX PTSD:
A THEORETICAL STUDY**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2015

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CHAPTER I

Introduction

This thesis explores the ways art can be integrated into social work practice as a clinical tool for the treatment of Complex Post-Traumatic Stress Disorder (Complex PTSD). Complex PTSD is a diagnostic term used to describe the symptoms of individuals who have experienced some kind of prolonged abuse or neglect. Often, this abuse has occurred in childhood, and has hindered the individual's ability to cope with stressful situations, regulate their emotions and self-esteem, and maintain relationships with others (Chu, 2011). Without proper mental health treatment, these individuals are at greater risk for future re-victimization, high risk behaviors, co-occurring disorders, and physical illness (Allen, 2001, Chu, 2011; Herman, 1992), and have often faced stigma by mental health professionals (Herman, 1992). Clinical social workers will benefit from increased research into the phenomenon and treatment of Complex PTSD, since so many of the clients entering the mental health system have complex trauma histories.

Research indicates that effective trauma treatment must involve the body as well as the mind in an effort to calm the nervous system's perception of, and response to, stress (Cozolino, 2014; Duros & Crowley, 2014; van der Kolk (1994). While art therapy has been identified as one type of body-oriented therapy that shows promise in this regard, there is a lack of empirical evidence supporting this claim.

The fields of social work and art therapy have a great deal to learn from one another and would benefit from increased cross-pollination. My review of the art therapy literature has demonstrated a gap in the literature pertaining specifically to the research and clinical treatment of adults with Complex PTSD. There is extensive research and writing on the treatment of PTSD, but very little on the unique needs of clients with Complex PTSD. These art therapists

integrate neurobiology, trauma theory, psychodynamic and cognitive-behavioral theory into their practice. While the social work literature includes a more comprehensive discussion of the treatment and research of Complex PTSD, it is lacking in critical discussion of the use of visual art in clinical practice.

The aim of this theoretical study is to explore how art-making can be used as a clinical tool in social workers' treatment of individuals with Complex PTSD. I've chosen to conduct a theoretical inquiry in order to include a more in-depth, exploratory examination that involves multiple theoretical perspectives. I've chosen to examine D. W. Winnicott's contributions to object relations theory in order to help the reader conceptualize how early relationships affect the subjective formation of the self. Winnicott's recommendations for therapeutic treatment are also examined and discussed.

The second theory will be through the lens of trauma-informed art therapy. This theory was chosen to illustrate the ways art therapists perceive the creation of artistic images to be healing in a way that words cannot.

Summary

The following chapter elaborates on the methodology and theoretical lenses selected for this thesis. Chapter Three is an overview of the phenomenon of Complex Post-Traumatic Stress Disorder, which includes a historical overview of the treatment of trauma disorders in the West, as well as a discussion of common treatment modalities. Chapter Four explores object relations theory, with a focus on D.W. Winnicott's concepts of the true and false self and transitional phenomena. Chapter Five reviews the literature on trauma-informed art therapy. Chapter Six discusses how the two theories can be applied to the phenomenon and treatment of Complex PTSD. Recommendations are made for social work practice and future research.

CHAPTER II

Conceptualization and Methodology

In this chapter I will provide a conceptual introduction to this thesis, as well as a discussion of potential biases, strengths and limitations. The aim of this study is to explore how art-making can be used as a clinical tool in social workers' treatment of individuals with Complex Post-Traumatic Stress Disorder (Complex PTSD).

I became interested in this population through my social work field placements at a mental health clinic for teenagers and an inpatient psychiatric hospital for adults. Working with clients who had complex trauma histories was clinically challenging. I felt privileged to witness their resilience, as well as disappointed to learn how frequently their trauma histories were not accounted for in psychiatric treatment plans or school disciplinary and academic conferences. It seemed this population was particularly prone to slipping through the cracks and not receiving the care they needed to thrive. My longstanding passion for the arts was another factor in the development of this thesis question: is art-making a beneficial clinical tool for social workers to integrate into the treatment of patients who have Complex PTSD?

Complex PTSD is a relatively new diagnostic category that will benefit from more research on treatment efficacy. While it is not a unique diagnosis in the DSM-V, a growing number of mental health practitioners and institutions are starting to consider the unique needs of patients with Complex PTSD, and are changing their programming accordingly. Research has substantiated art therapists' intuitive belief that trauma must be resolved through stimulation of body *and* mind to engage both the left and right hemispheres of the brain (Cozolino, 2014; Duros & Crowley, 2014, p. 9). There are numerous art therapy publications that address the treatment

of PTSD through art interventions such as the *American Journal for Art Therapy* and *The Arts in Psychotherapy*. Only a few of those articles specifically address the needs of individuals who have experienced prolonged interpersonal trauma. Additionally, I could only find two articles published in the journals accessed by the larger population of social workers and psychotherapists that addressed the use of visual art as a clinical tool.

Dr. Bessel van der Kolk, an internationally renowned leader in trauma studies and director of the Trauma Center at Justice Research Institute, argues that the resolution of trauma and complex PTSD must involve a somatic component. The Trauma Center has published research on the use of yoga and drama therapy for the treatment of PTSD and Complex PTSD. Unfortunately, it has not yet initiated an investigation of the efficacy of any type of visual art intervention.

I've chosen a theoretical investigation that utilizes object relations theory and trauma-informed art therapy to contribute to the social work literature existing research in art therapy literature on the efficacy of art as a clinical tool, and to fill a noticeable gap in the social work literature about the potential value of integrating creativity and art-making into a trauma-informed therapeutic intervention. A theoretical methodology was selected in order to conduct an exploratory review of the existing literature, since there is very little currently written about this topic.

Object relations theory and trauma-informed art therapy will be the two theoretical frameworks used to guide this investigation. Chapter Four will explore D.W. Winnicott's contributions to object relations theory. This theory was selected in order to explore how one's earliest childhood relationships significantly shape the formation of the self and the ability to cope with life's stressors. Winnicott's notion of the true and false self will be explored to discuss

the life long difficulties individuals with Complex PTSD experience as a result of growing up without a supportive and safe environment. His concept of transitional objects and transitional spaces will be explored in order to explore the role art and art-making may have in a client's treatment. Winnicott's views on the therapeutic nature of play will be identified and applied.

Chapter Five will explore trauma-informed art therapy. This theory was selected in order to investigate how the process of making an artistic image can itself be therapeutic, and how art allows clients to explore their unconscious and experience their emotions in a less threatening way than traditional talk therapy. The ways art therapists integrate neurobiology and psychodynamic theory into their practice will be discussed. This chapter will include a historical overview of the field, and explore the way art can assist clients identify feelings and memories, contain and soothe their affects, and restore attachment patterns that were previously shattered by trauma.

In Chapter Six, I discuss how these two theories complement and conflict with one another, as well as how they can be applied to the phenomenon of Complex PTSD. The benefits and limitations of utilizing art interventions in one's practice will be evaluated and discussed, as well as suggestions for further research.

The intended audience of this study is clinical social workers. Other mental health clinicians and researchers in the fields of Marriage and Family Therapy, Clinical Psychology, Counseling and Art Therapy may also be interested in reading the results of this study. Individuals who have experienced prolonged and complex traumatic experiences may also find this study of interest in their quest for more literature surrounding their treatment.

Strengths and Limitations

A benefit of this investigation is that it has allowed me to investigate and integrate texts from different fields. It is my hope that the results of this study offer a strong introduction to the ways artistic images can be utilized in social work practice, and can be utilized by other researches hoping to conduct empirical research on the use of art and creativity in a therapeutic session.

The main limitation to this study is that it does not include voices and opinions of the client population I am aiming to serve. While that was not within the scope of my study, I believe it will be beneficial for individuals with Complex PTSD to have the chance to speak freely about their treatment experiences, so that they are not further marginalized. While I did not interview art therapists, their voice is more present in this study through the literature and case studies they published, that I have summarized in chapter five. Art therapy is notoriously difficult to evaluate since it is not a standardized practice. For this reason, most published art therapy literature is in a case-study format, rather than as a generalizable study. Another limitation of this study is that it does not investigate the impact that race, gender, sexual identity or class has on clients' treatment outcomes for the resolution of Complex PTSD.

My personal experience with art making locates me in a space of potential bias in the evaluation of this study. I chose to research art-making as a social work intervention due to my own interest in the healing and protective qualities of art and of body-oriented therapy. I've grown up appreciating and making art, and have found drawing, painting, writing, yoga and meditation to be essential components of my own self-care. Art therapy is a field that often encompasses all sorts of modalities of art making, including photography, poetry, film and video,

sculpture and more. For the purposes of narrowing this study and due to my own bias and personal preference, I chose to narrow my research to two-dimensional art interventions.

In the following chapter, I will define the phenomenon of Complex PTSD, provide an overview the history of treating and diagnosing patients with trauma, and discuss current preferred treatment methods.

CHAPTER III

Complex Post Traumatic Stress Disorder

This chapter will address the phenomenon of complex post-traumatic stress disorder (Complex PTSD). This disorder describes the experiences of individuals who have experienced a range of interpersonal abuse(s), generally originating in childhood, and who often continue to struggle with interpersonal relationships, a cohesive sense of self, and emotional regulation in their adult life (Basham, 2011, p.454). The chapter will illuminate key diagnostic terms and explore the history of treating and diagnosing traumatized individuals in the West. Current treatment modalities will be discussed, as well as the role that somatization has played in the processing and conceptualization of traumatic affect.

Defining Trauma and Related Disorders

It is impossible to speak of complex post-traumatic stress disorder without first establishing a basic understanding of what trauma is and how it affects people. The following descriptions aim to provide information so that the reader is able to fully grasp how Complex PTSD differs from PTSD or other responses to extreme stress.

Trauma.

A traumatic event significantly disrupts a person's life and their ability to function for a period of time. The Merriam-Webster dictionary defines trauma as "a very difficult or unpleasant experience that causes someone to have mental or emotional problems usually for a long time." Examples of acute trauma could be the unexpected death of a loved one, a natural disaster or surviving a rape. While traumatic events are common, most individuals are able to respond resiliently and not go on to develop post-traumatic stress symptoms (Basham, 2011, p.433; Harvey, 2007, p. 6). The National Comorbidity Survey (NCS) that was conducted in the 1990s

corroborates this resilience to traumatic events. The study determined that approximately 61% of males and 51% of females would be exposed to a severe traumatic event, (Chu, 2011, p. 26). However, just 7.8%- 8% of the population would actually develop a post-traumatic stress disorder response (Bremner, 2008, p.11; Chu, 2011, p.27).

Traumatic stress response.

A traumatic stress response is a neurobiological response, often described as 'fight or flight mode' that is activated within the body during a time of perceived threat. The adult brains' functioning temporarily regresses to a more primitive state (Miehls & Applegate, 2014, p.151). The amygdala, located beneath the temporal lobes, is the part of the brain involved with attention, physiological arousal, learning, memory and emotion. It appraises events and connects meaning and emotion to experience (Cozolino, 2014, p.47). When a person is interacting with their environment, the amygdala identifies what information should be codified into memory and sends that information to the left hemisphere of the brain. This communication links the new material with the part of the brain involved in logical decision making, language and memory. Thus, it becomes a part of explicit, declarative, memory, meaning that it can be remembered and discussed.

When the traumatic stress response is activated, the connection to the left hemisphere of the brain is temporarily disrupted so that more resources can be put towards reacting to the threat. This is a healthy and natural part of human experience, and generally subsides when the threat dissipates. Due to this process, memories from the time of the stressful event are not processed in the normative way, and often become stored in the body, leaving the individual with no way to assign language to their experience or memories (van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996).

Post-traumatic stress disorder (PTSD).

This diagnosis was first included in the Diagnostic Statistical Manual of Mental Disorders (DSM) III in the late 1970s as a response to the overwhelming number of veterans returning from the Vietnam War with acute symptoms. To be diagnosed with PTSD, an individual must be exhibiting symptoms for a full month after the traumatic incident has occurred (Basham, 2011, p.450). Symptoms developed before a month has passed are better classified as part of Acute Stress Disorder. If an individual with Acute Stress Disorder does not see their symptoms resolve within a month, then they may fit criteria for PTSD. Additionally, the symptoms must not be the result of a medication, substance abuse or other illness.

The DSM-V now classifies PTSD in the Trauma and Stressor Related Disorders category, removing it from its previous classification as an anxiety disorder. The first criterion that must be met is that the individual experiences a severe stressor. A Stressor is defined as:

The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)

- Direct exposure
- Witnessing, in person.
- Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
- Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures. (APA)

The criteria for being diagnosed with PTSD in the DSM V must meet criterion within four clusters:

1. Intrusion symptoms: The traumatic event is persistently re-experienced in the following way(s): (one required)
 - Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.
 - Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).
 - Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.
 - Intense or prolonged distress after exposure to traumatic reminders.
 - Marked physiologic reactivity after exposure to trauma-related stimuli.
2. Avoidance: Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)
 - Trauma-related thoughts or feelings.
 - Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).
3. Negative alterations in cognitions and mood: That began or worsened after the traumatic event: (two required)
 - Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
 - Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
 - Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
 - Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
 - Markedly diminished interest in (pre-traumatic) significant activities.
 - Feeling alienated from others (e.g., detachment or estrangement).
 - Constricted affect: persistent inability to experience positive emotions
4. Alterations in arousal and reactivity: that began or worsened after the traumatic event (two required)
 - Irritable or aggressive behavior
 - Self-destructive or reckless behavior
 - Hypervigilance
 - Exaggerated startle response
 - Problems in concentration
 - Sleep disturbance

Additionally, symptoms must result in significant distress or “functional impairment.’

There is an option to specify if dissociative symptoms are prevalent, or if symptoms came with delayed onset after the traumatic event. There is also now a preschool subtype for ages six and younger.

Often, individuals suffering from PTSD will feel a sense of disconnection from others, and an increased sense of apathy and helplessness. PTSD also affects memory. When a traumatic event occurs, the event is often stored implicitly in the body rather than following the typical process and being converted into declarative memory (van der Kolk, 1994). This explains the reason that amnesia is a common response to trauma. For others, hypermnesia occurs, resulting in vivid flashbacks and the feeling of re-experiencing the event (van der Kolk, 1994, *The Symptomatology of PTSD*, para. 1).

While this diagnosis was originally created to describe the experience of soldiers and veterans, it is now applicable to anyone who fits the diagnostic criteria after experiencing a shocking and often violent acute experience. Individual with post-traumatic stress disorder generally suffer from an overactive amygdala, which frequently misidentifies something in the environment as a threat, and sends the body into hyperarousal.

Complex Post-Traumatic Stress Disorder

Complex post-traumatic stress disorder (Complex PTSD) is a diagnostic category first conceptualized by psychiatrist and scholar Judith Herman, MD in 1992. It is used to describe the plight of individuals who have had chronic exposure to traumatic experiences, which are typically interpersonal (Slayton, 2012, p.180; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005).

Often, individuals who fit this diagnosis have experienced some type of repeated victimization in their childhood, such as sexual, physical, emotional abuse and/or neglect, or witnessing community or domestic violence (National Child Traumatic Stress Network, 2015). The diagnosis “disorders of extreme stress, not otherwise specified” (DES NOS) has also been employed to describe complex post-traumatic stress reactions, and was used by the DSM IV-PTSD taskforce to explore if and how DES NOS differed from classic post-traumatic stress disorder (Luxenberg, Spinazzola & van der Kolk, 2001, p. 375).

In addition to classic PTSD symptoms, individuals who suffer from Complex PTSD struggle daily with emotion dysregulation and self-esteem modulation. They are often overwhelmed by their feelings and struggle to cope with intense shame, sadness, anger, guilt and suicidal ideation, among other emotions (Chu, 2011, p. 36). While they develop adaptive coping mechanisms for their situation, this often comes at the expense of their ability to learn, concentrate, develop a healthy self-image and control their impulses (National Child Traumatic Stress Network, 2015). These individuals often have other co-occurring mental health concerns or diagnoses, including post-traumatic stress disorder, dissociative disorders, substance abuse, anxiety, depression, borderline personality disorder, eating disorders, and obsessive compulsive disorder, as well as a weakened immune system (Allen, 2001 p.205; Chu, 2011, p. 221; Herman, 1992; National Child Traumatic Stress Network, 2015; US Department of Veteran’s Affairs, 2015; van der Kolk et al., 2005, p.396). Often they have encountered various traumatic events in their lifetime since they are more likely to engage in risk-taking behaviors and re-victimization is unfortunately common (Chu, 2011, p. 113; Cloitre, Tardiff, Marzuk, Leon & Portera, 1996, p.473).

Although Complex PTSD currently remains a subsection of the PTSD diagnosis in the DSM-V, it is gradually gaining recognition in the mental health community. The U.S. Department of Veterans Affairs describes individuals struggling from complex PTSD as experiencing difficulties with emotion dysregulation, consciousness (including dissociation), self-perception, distorted perceptions of the perpetrator, relationships with others, and altered system of meaning and recommends establishing a safe therapeutic relationship to promote healing and empowerment for patients (2015).

I became interested in working with individuals with complex post-traumatic stress disorder during my second-year placement at an adult inpatient psychiatric hospital. I noticed a certain subsection of the population that would cycle in and out of the facility, which the staff referred to as “frequent flyers.” Despite their chronic suicidal ideation, these patients were not fully convinced that they could be helped by the psychiatrists and inpatient staff due to the somatic nature of their complaints. They were convinced that it was physical pain, rather than emotional distress, that had caused them to be admitted to the hospital. I will further elaborate on the treatment of these patients in my discussion chapter.

Demographics.

Gender, race, ethnicity, age and class are all risk factors in who becomes afflicted by different types of trauma. In the United States, women and children are known to be at a greater risk for experiencing physical and sexual abuse in their home than men (Harvey, 2007, p. 4). In fact, childhood abuse is the most prevalent cause of traumatization in women (Kessler, Sonnega, Bromet, Hughers & Nelson, 1995 as cited in van der Kolk et al., 2005, p. 389), and 61% of rapes occurred before the victim turned 18 years old (p. 390). Societal marginalization also affects what resources a trauma survivor is able to access, which in turn affects their ability to respond

resiliently. Miller (2012), a social worker whose research focuses on resiliency and disaster response notes, “a lack of resources, whether it is economic, social or personal, affects the vulnerable and their capacity to recover” (p.16).

Child abuse.

Individuals with Complex PTSD are frequently found to have suffered in childhood (Herman, 1992). The American Psychological Association (APA) estimates that around three million children in the United States experience some kind of abuse and/or neglect annually, and that the abuse is typically from a family member or caregiver (APA, 2014). Another research study determined that over one million children in the United States qualify as complex trauma survivors (Slayton, 2012, p. 180). The APA research also found that children with emotional abuse and neglect had similarly severe, if not worse, mental health problems than children who had experienced physical or sexual abuse (2014). Both Garbarino, Kostelney, and Dubrow’s (1991) study and Bell and Jenkins’ (1991) study found that children living in inner-city neighborhoods in the United States reported symptoms similar to children who grew up in war zones (Bragin, 2005, p. 297)

Herman (1992) argues that most psychiatric inpatients have histories of childhood abuse (p.122). In 2003, an estimated 71% of children institutionalized in residential treatment programs had been exposed to trauma (Jaycox, Ebener, Damesek & Becker, 2004) of which neglect is the most common (an estimated 51%-69%) followed by physical abuse (an estimated 42%-63%) and sexual abuse (estimates ranging from 18% - 47%) (Dale, Baker, Anastasio, & Purcell, 2007 as cited in Spinazzola, Rhodes, Emerson, Earle, Mornore, 2011, p.432; Hussey & Guo, 2002 as cited in Spinazzola, et al., 2011, p.432). Clearly this population is one deserving of academic and clinical attention.

Herman's diagnostic criteria for complex post-traumatic stress disorder.

Judith Herman found that survivors of prolonged abuse are often misdiagnosed and/or given a diagnosis that carries great stigma, such as somatization disorder, borderline personality disorder and multiple personality disorder (1992, p. 123). She argued that even a PTSD diagnosis was not an "accurate" description of their full situation, and called for a new diagnosis of complex post-traumatic stress disorder (p. 119). The criteria of this new diagnosis, complex post-traumatic stress disorder includes the following:

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.
2. Alterations in affect regulation, including
 - persistent dysphoria
 - chronic suicidal preoccupation
 - self-injury
 - explosive or extremely inhibited anger (may alternate)
 - compulsive or extremely inhibited sexuality (may alternate)
3. Alterations in consciousness, including
 - amnesia or hypermnesia, for traumatic events
 - transient dissociative episodes
 - depersonalization/ derealization
 - reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation
4. Alterations in self-perception, including
 - sense of helplessness or paralysis of initiative
 - shame, guilt, and self-blame
 - sense of defilement or stigma
 - sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)
5. Alterations in perception of perpetrator, including
 - preoccupation with relationship with perpetrator (includes preoccupation with revenge)
 - unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
 - idealized or paradoxical gratitude

- sense of special or supernatural relationship
 - acceptance of belief system or rationalizations of perpetrator
6. Alterations in relationships with others, including
 - isolation and withdrawal
 - disruption in intimate relationships
 - repeated search for rescuer (may alternate with isolation and withdrawal)
 - persistent distrust
 - repeated failures of self-protection
 7. Alterations in systems of meaning
 - loss of sustaining faith
 - sense of hopelessness and despair
- (Herman, 1992, p. 121)

Disorders of extreme stress not otherwise specified (DESNOS).

A DSM-IV field trial was conducted between 1990 and 1992 to determine “whether victims of chronic interpersonal trauma as a group tended to meet diagnostic criteria for PTSD or whether their psychopathology was more accurately captured by another constellation of symptoms.” They used the terminology Disorders of Extreme Stress Not Otherwise Specified to represent the phenomenon of complex PTSD. The study conclusions indicated that individuals who experienced trauma before age ten were more likely to have symptoms in addition to classic PTSD symptoms, such as struggles with aggression, dissociation, affect regulation, somatization and character pathology, and that trauma becomes “more like “pure” PTSD, with age” (Luxemberg, Spinazzola & van der Kolk, 2001, p.3; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005, p.395). The American Psychiatric Association (2000) included Complex PTSD symptoms in the “associated features” section of the DSM-IV as a result of this study (Cloitre, Courtois, Charuvastra, Carapezza, Stolbach & Green, 2011, p. 615).

Presentation.

Individuals who had experienced chronic and/or repeated traumatization were found to struggle to regulate their emotions or calm themselves in times of stress. Fearing the return of

violence or threat at any moment, they frequently experience hyperarousal symptoms found in patients with PTSD, often displaying an anxious demeanor, easily startling and overall fear and vigilance of their surroundings (Herman, 1992, p. 86). Herman states that her clients with complex trauma often speak of somatic complaints, including “insomnia and agitation...Tension headaches, gastrointestinal disturbances, and abdominal, back or pelvic pain are extremely common. Survivors may complain of tremors, choking sensations, or rapid heart beat.” (Herman, 1992, p.86). Many abused children focus the majority of their attention on survival, and learn to please/appease their caregiver to minimize abuse (Kinniburgh, Blaustein, & Spinazzola, 2005, p. 424). When this happens, the child may struggle to develop a cohesive sense of self, an ability to trust others (Basham, 2011, p. 454) and may demonstrate different cognitive and behavioral deficits in functioning (Kinniburgh et al., 2005, p. 424).

A diagnosis of Complex PTSD actively acknowledges that the cause of distressing symptoms (for instance acting out, self-harm) is based in the client’s trauma history rather than a pathological personality. Basham (2011) notes that the diagnosis also alerts the therapist that dissociation will be employed as a coping mechanism and that there will likely be “(1) a full range of somatic, psychological, and emotional symptoms; (2) reenacting of traumatic relationships in the present; and (3) distorting identity and diminished self-esteem” along with the typical post-traumatic stress symptoms of re-experiencing, numbness and hyperarousal (p. 455).

Historical Overview

The study of trauma and dissociation has waxed and waned in popularity over time. Our current conceptualization of trauma is just over thirty years old, as scientific interest was reignited in response to the overwhelming number of soldiers returning from the Vietnam War in

great mental distress, and Post-Traumatic Stress Disorder was added to the DSM III in 1980 (Chu, 2011, p.3). In the following section, I will briefly illustrate the ways this conceptualization has changed over time in Europe and the United States.

Hysteria.

In the 1900s, a number of French neurologists began to research and treat hysteria. Hysteria was a common disease in the Victorian era that affected women. Common symptoms included unexplained epileptic convulsions, anorexia, nausea or vomiting, visual hallucinations, amnesia, paralysis in a specific body part or unexplainable physical cramp, Numb body parts, an inability to speak or other variations on disturbed speech, such as the ability to speak in only one language when the patient previously knew three (Freud & Breuer, 1895; Herman, 1992). Neurologist Jean-Martin Charcot found that often symptoms could be temporarily relieved through hypnosis (Herman, 1992, p.11). *Studies in Hysteria*, first published in 1895, was a collaboration by Freud and Breuer and included five case histories, including the famous case of Anna O. Through their therapy with these women, they determined that the true cause of hysteria was real experiences of sexual trauma. They explained, “sexuality plays the principal role in the pathogenesis of hysteria as a source of psychic traumas, and as a motive of “defense” of the repression of ideas from consciousness (1895, p. vii). Their radical idea was that these women were reacting to real memories of childhood sexual abuse that felt unbearable to them. As they repressed the memory of the overwhelming event into their unconscious, it became “converted” into a bodily symptom that was perhaps more socially acceptable. “In the therapeutic work, one is led to the conception that hysteria originates through the repression of an unbearable idea as a motive of defense, that the repressed idea remains a weak (mildly intensive) reminiscence, and that the affect snatched from it is used for a somatic innervation,

that is, for conversion of the excitement. By virtue of its repression the idea becomes the cause of morbid symptoms, that is, pathogenic” (Freud, 1895, p. 216). They found that having these women free-associate allowed them to bring repressed memories into consciousness, which proved to relieve their symptoms (Freud & Breuer, 1895; Herman, 1992, p.12)

This is now known as Freud’s seduction theory.

Freud’s seduction theory was met with great resistance by his peers and fellow scholars. Herman (1992) argues that this is because if the seduction theory had been accepted, it would have meant publicly acknowledging the rampant reality of childhood sexual abuse in their own communities. In 1987, Freud replaced this theory with his theories of psychosexual stages of development and the Oedipus complex. Freud believed that there were five developmental phases that a child progressed through; the Oral Stage (birth to one and a half years), the Anal Stage (one and a half to three years), the Phallic Stage (ages three to five), Latency (ages six to eleven), and the Genital Stage (adolescence). The Phallic Stage was an indication that children in this age range were experiencing the Oedipal Complex. Freud believed that in this phase, children’s unconscious sexual desire was directed towards their parent of the opposite-sex, while their aggressive drive was aimed at their same-sex parent (Berzoff, 2011, p.37). This led him to reason that childhood sexual *fantasy* was the route cause of hysterical symptoms, rather than an actual event (Basham, 2011, p. 441). Freud’s enormous impact on the practice of modern psychiatry meant that until the late 1980s, many doctors and psychiatrists viewed patients’ reports of childhood sexual abuse as mere fantasy (Chu, 2011, p.4).

War veterans.

Soldiers on the battlefield are faced with life-threatening situations. They witness horrific events and are at times required to participate in extreme violence. Kathryn Basham, PhD, states

“combat exposure is one of the most severe stressors that a person can experience in life” (2011, p. 447). Doctors have conceptualized these stress response symptoms differently over the years. Commonly noted symptoms were mood swings, hyper-vigilance, vivid nightmares, increased heartbeat and blood pressure and a startle response after joining the military. In the Civil War these symptoms were referred to as “soldier’s heart syndrome,” while in WW2 they called it “Shell Shock” (Chu, 2011, p. 5).

Kardiner and Rivers’ writing on trauma and repression during WW1 helped guide psychologists in the 1970s as they struggled to define and understand the overwhelming number of soldiers returning home from the Vietnam War in distress. Kardiner (1941) found that soldiers returning from WWI would return home, often with amnesia of the trauma, but act as if they were still in a threatening environment. He also observed their preoccupation with establishing safety was so strong that “their interest in the world generally shrinks” (p. 249) and believed that the men were re-enacting dissociative fugue states in an attempt to resolve their trauma (van der Kolk, et al., 1996, History and Background, para. 5). Rivers (1918), also observed that, while traumatic repression can be a natural and healthy process, it becomes pathological when “it fails to adapt the individual to his environment” (para. 3). Like Freud and Breuer in the early studies on hysteria, Rivers believed that soldiers who had repressed their traumatic memories during the war developed other symptoms at home or in the hospital that were a response of unresolved affect (para. 5).

Soldiers returning from the Vietnam War struggled tremendously to reintegrate into civilian society, especially one that criticized America’s involvement in the war. Many of them returned to their homes without control of their emotions or actions. The visibility of the suffering soldier led to the American Psychiatric Association finally recognizing the existence of

post-traumatic stress disorder as a legitimate mental illness. They included the phenomenon in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (Basham, 2011, p. 442). Up until now, soldiers faced great stigma for having mental health problems and were encouraged not to speak of their emotional stress; the inclusion of PTSD in the DSM-III helped to decrease stigma and legitimize the very real struggles these men faced. It also helped open the way for others who had been previously invisible, to be seen and connected to resources.

Feminism.

The feminist movement in the 1970s radically changed the dialogue about what constituted a traumatic event (Basham, 2011, p.443). Women attended consciousness-raising sessions to publically speak out about their experiences of sexual assault and rape that they had previously felt too ashamed to voice (Herman, 1992, p. 28). The first rape crisis center was formed in 1971, and mental health professionals began to realize that their patients who had experienced domestic abuse and/or rape were exhibiting symptoms with a striking resemblance to soldiers returning home from war (Herman, 1992, p.32). These early rape crisis centers provided crisis intervention, advocacy and peer-counseling and were often established as an alternative to professional counseling services which were male dominated and often based in classical Freudian theory (Woody & Beldin, 2012, p. 96).

The false memory debate.

In the 1980s and 1990s, many therapists encouraged their patients to vocalize their memories of childhood abuse, believing that the act of bringing those repressed memories to consciousness could be curative. Chu (2011) reflects that this might have been harmful at times, because it left the patient facing painful memories without first establishing a secure therapeutic

relationship or developing strong coping skills. He found that this too often “resulted in a fixation on the trauma as the central theme of the lives of some patients, with their identities becoming organized around their traumatization” (p. xiv), and that this too often left patients feeling disempowered and victimized. While this was a monumental time for many individuals to begin the work of healing from their painful pasts, there were also some patients who struggled with reality testing or who for some other reason falsely claimed that they were victims of child abuse (p. xiv).

The False Memory Syndrome Foundation (FMSF) was founded in 1992. Composed of parents who stated they had been falsely accused of abuse, as well as clinicians and academics that were skeptical of the number of individuals claiming to have recovered memories of abuse, they cited Dr. Kihlstrom’s definition that these patients were suffering from “A condition in which a person’s identity and interpersonal relationships are centered around a memory of traumatic experience which is objectively false but in which the person strongly believes.” (False Memory Syndrome Foundation, 2015). They credited therapists and self-help books for planting the suggestion that child abuse occurred when it had not and funded law suits to this aim.

While this debate is ongoing, many empirical studies have found validity in the existence of traumatic amnesia and later recall (Chu, 2011, p.91). Furthermore, advancement in neurobiological research has confirmed that patients with childhood abuse and a PTSD or other stress-related diagnosis have memory deficits (Bremner, 2008, p. 19). Clinicians have learned from this heated debate to be aware of the suggestibility of memory, and to conduct their assessments in ways that are straightforward and neutral (Chu, 2011, p.17). Treatment plans have also been refined in order to support rather than further exacerbate patients’ symptoms.

Treatment Options

While there is a growing body of literature addressing the phenomenon of complex post-traumatic stress disorder, in reality, individuals are too-often misdiagnosed or treated for their co-occurring diagnoses without an assessment of how complex trauma should factor into their treatment plan.

The U.S. Department of Veterans Affairs recommends two types of evidence-based cognitive behavioral therapy (CBT) for the treatment of PTSD: Cognitive Processing Therapy (CPT) and Prolonged Exposure therapy (PE). They state that individuals with Complex Trauma will benefit from their PTSD recommended treatments, but that additional work following Herman's phase based treatment may be necessary. CPT is a 12 session manualized treatment that consists of four stages. The first stage is psychoeducation, where patients learn about PTSD symptoms. The second and third stage consist of processing the trauma through cultivating an awareness of thoughts and feelings and learning skills to identify and challenge maladaptive thought patterns. In the final stage, the patient reflects on how their beliefs changed following the traumatic event, and creates a safety plan for relapse prevention (US Department of Veterans Affairs, 2015, National Center for PTSD; Center for Deployment Psychology, 2013, Cognitive Processing Therapy).

PE is an evidence-based type of cognitive behavioral therapy that aims to decrease avoidance and distress through exposure. It includes psycho-education about symptoms, breathing exercises, in vivo experiences, and repeated discussion of the traumatic event. The in vivo experiences allow the patient to practice confronting something that they have been avoiding (ex: taking showers for someone who avoids being wet). Repeated retelling of the

trauma is used to desensitize the patient to the extreme reactions they fear (US Department of Veterans Affairs, 2015, National Center for PTSD).

Additionally, they espoused Eye Movement Desensitization and Reprocessing (EMDR) and the use of a selective serotonin reuptake inhibitor (SSRI) medications. EMDR therapy has patients recall troubling memories while focusing on guided eye movements, hand taps and sounds. The National Institute of Mental Health also recommends CBT and PE as well as cognitive restructuring and stress inoculation training, as well as medications. They do not list recommendations for those who have a complex type of PTSD.

In 2012, The International Society for Traumatic Stress Studies, published *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD In Adults*. The task force interviewed fifty “expert clinicians” and found that that an overwhelming number of the, 84%, recommended a phase-based approach as the most effective treatment modality for complex PTSD (Cloitre et al., 2011, p.3). There is clearly a need for more studies of this nature to be conducted, because the task force found only nine published studies of adult Complex PTSD treatment to be assessed (p. 6). They found just one study, Cloitre et al., 2010, that compared phase-based treatment with CBT treatment such as prolonged exposure treatment.

Phase-based treatment.

The phase-based treatment recommended by the *ISTSS* is the same one proposed by Herman in *Trauma and Recovery* (1992), in which she introduced the concept of complex trauma to the public. Phase One is about establishing safety. This is a time for the therapist and client to establish a secure therapeutic rapport and work on the client’s ability to regulate their emotions and responses to stress. A client will be diagnosed and referred to a psychiatrist for medication if deemed necessary. New coping skills will also be developed and practiced, and the

patient will learn to tend to basic bodily needs such as eating, sleeping, curbing self-harm activities, and finding a safe place to live (Herman, 1992, p.160). Since these patients often have difficulty trusting others, self-soothing and taking care of basic needs, work in phase one can take quite a long time. This is also a time for social supports outside of the therapeutic relationship to be identified (p. 160). In this phase, Herman states, the patient “must regain the ability to take initiative, carry out plans, and exercise independent judgment” (p.166).

In phase two, the patient mourns their past by remembering their memories and the feelings associated with them (Herman, 1992, p. 175). This could be considered a type of exposure therapy as well, since the patient is encouraged to tell their story “completely, in depth and in detail” (p.175) until telling it doesn’t bring up the intense emotional response that it used to (p. 195). This is where the patient learns to mourn and express their anger and despair, and is validated and supported by the therapist.

Phase three is where the patient begins to look towards the future and reconnect with their community. Sometimes, this means they must work to “develop a new self” (Herman, 1992, p. 196) that they now feel ready to embody. Some patients will disclose their story to friends or family, take legal action or begin social activism in hopes of helping others (Herman, 1992, p. 207; ISTSS, 2012, p.5). This is also a time for individuals to learn to forgive themselves and to make plans for the future (p.204).

Mind-body modalities.

Recent developments in the study of trauma and neuroscience have disproven the common believe that trauma must be recalled and spoken aloud in order to be resolved. For this reason, a number of practitioners and researchers have called for body-based practices to be incorporated into treatment regimens (Spinazzola et al., 2011, p.433). Duros and Crowley (2014)

argue that “because trauma is actually something that happens deep in the core of the brain and the body, the most effective treatment approaches integrate traditional therapy modalities with those that focus on calming the nervous system such as yoga, mindfulness, imagery, expressive arts, and eye movement desensitization and reprocessing” (p.1). Franklin (2010), who comes from an art therapy background, and Ogden, Pain, Minton and Fisher (2013) who study the sensorimotor processing of trauma, are all concerned with how the intersubjective space co-constructed between the therapist and client allows non-verbal, unconscious messages to be communicated (Franklin, 2010, p. 161). Sensorimotor therapy shifts focus back and forth from the body to the narrative, and aims to bring awareness of how patients’ bodies react to different emotional states (Fisher & Ogden, 2011, p.6). Due to the relational aspect of this therapy, Franklin argues that the therapist must cultivate their own mindfulness practice while doing this work, as well as the importance of cultivating an attuned relationship so that the client could use the therapist as a “third hand” in similar ways to how clients use therapists as auxiliary egos in psychodynamic therapy (Franklin, 2010, p.163). Ogden et al. support this statement by recognizing the work done in the treatment of traumatized individuals is not the work between two minds but between two bodies’ affective states (Ogden et al., 2013, para. 2).

In light of this recent research, I believe it is beneficial to investigate the utility of integrating the arts into treatments geared towards resolving Complex PTSD. In the following chapter, I will provide an overview of object relations theory and Winnicott’s theories of the transitional object, true and false self, and play.

CHAPTER IV

Winnicottian Object Relations Theory

In this chapter I will explore some of Donald W. Winnicott's main theoretical contributions to object relations theory. I will discuss his thoughts on transitional objects and transitional phenomena, define true/false self development, and explore his views on the necessity of creativity and play. I believe his theories will be relevant to my study on the treatment of Complex Trauma survivors that will be detailed in Chapter Six of this study.

Object Relations Theory

Object relations theory is a school of psychoanalytic thought primarily interested in examining how the self develops *in relation to* others. Laura M. Flanagan, PhD (2011) explains that the word *object* is used to denote “the thing outside of the self that the self perceives, experiences, desires, fears, rejects, or takes in” (p.120). Proponents of this theory diverged from the Freudian belief that humans contained inherent sexual and aggressive drives that became tamed over time through the development of the ego and superego (Mitchell & Black, 1995, p. 112). It was also a shift away from exploring the adaptive and repressive functions of the ego, as was the focus of ego psychology (Flanagan, 2011, p. 118).

Historical Context

Shortly after Sigmund Freud's death in 1939, the British Psychoanalytic Society split into three factions that differed ideologically, but shared equal power within the Society. This was due to increasing tension between Anna Freud, Melanie Klein and their followers (Rayner, 2000). The first faction was a group of clinicians who followed Freudian theory and ego psychology, led by Anna Freud. The second faction was composed of the Kleinians, who supported Melanie Klein's radical theory that a baby was already born with great anxieties

directed at an object (primarily the mother's breast). Klein's theories differed greatly from Freud's. Rather than adhere to Freud's psychosexual theory of development, she believed that babies and adults frequently shift between the paranoid-schizoid position, where the defense of splitting is employed, and the depressive position, where feelings of love and hate can be integrated and held together. Klein believed it was the mother's task to provide an environment that would help soothe these anxieties in hopes of the best psychological outcome, the depressive position (Mitchell & Black, 1995, p. 94).

The third faction consisted of individuals who saw theoretical value in both Freud and Klein's viewpoints. They chose to not take a side, first calling themselves the 'Middle group' and later changing their name to 'The Group of Independents' (Rayner, 2000). This group included W.R.D. Fairbairn, Michael Balint, John Bowlby, Harry Guntrip and Donald Winnicott. While individuals in the Independent Group had differences in opinion, they are considered to be object relations theorists (Flanagan, 2011, p.124; Mitchell & Black, 1995, p. 94). Rayner (2000), of the British Psychoanalytic Society, wrote that the Independents shared the common belief that one should approach any situation or theory with curiosity and doubt rather than with certainty.

Donald Woods Winnicott (1896-1971) was an English pediatrician, psychoanalyst and a prolific writer. Although he was supervised by Melanie Klein herself and trained as a Kleinian, he ended up forming a unique theory of psychoanalysis and child development based on his observations of the thousands of mothers and babies he attended to at the Paddington Green Children's Hospital in London (Mitchell & Black, 1995, p.124). Winnicott was especially curious about how the relationship between a baby and its mother impacted the formation of that baby's personality and its ability to thrive in adulthood. While Winnicott contributed many new theoretical concepts to object relations theory, the rest of this chapter will focus primarily on key

concepts, such as the true self, false self, transitional objects, and use of play, most relevant to psychotherapy with Complex PTSD survivors.

When considering Winnicott's theories, it is necessary to situate them in historical context. Winnicott lived during an era with greater fixed gender roles and gender stereotypes than are present today. He wrote about the mother being the infant's primary attachment figure (or object), and does not consider children who are raised primarily by a father, grandmother or other dedicated adult. When Winnicott references the role of the mother, he is referring to the primary caretaker of the child, the latter of which I adapt for my own purposes in this study.

True Self (and the Capacity for Object Use)

Winnicott believed that an infant would develop either a true self or a false self presentation depending on the quality of the environment and the mothering it received. The true self is described as an authentic, self-assured, unique and creative self, that allows the individual to focus on being rather than on defending against anxiety. Winnicott (1971) described it simply as an "expression of I AM, I am alive, I am myself" (p. 75). He believed that the true self could only be developed in the context of a secure "holding environment" which allowed the baby to feel safe enough to explore authentically. This holding environment initially consists of the mother actually holding her infant, and gradually transitions to a psychological form of 'holding' and making her child feel safe as the child ages (Choi & Goo, 2012, p. 20). An attentive, caring mother provides a strong holding environment and regulates her infant's strong affect until the baby learns how to regulate itself independently from her.

An essential component to true self expression is the ability to self-soothe and manage anxiety. This skill, which Winnicott identified as the "capacity to be alone" can only be developed in relationship with another person, typically the good-enough mother (1958, p. 29).

Winnicott applied these same concepts to the practice of psychotherapy, believing that the therapist must work to create a secure “holding environment” for the client in order for their true self to emerge. He believed that a good-enough therapist could help an adult develop their ability to self-soothe if they had not learned to do so in childhood, through the experience of an attuned therapeutic relationship.

Development of a true self.

Winnicott wrote that the healthy development of a child is a fundamentally relational process, dependent on a caring and attuned, “good-enough mother,” who at times does not meet the baby’s needs but is constantly present and able to withstand the child’s aggression. When the child is an infant, this requires the mother to be as present and as attentive to the baby’s needs as possible, consistently putting her child’s needs before her own. Winnicott (1956) described this devotion a “primary maternal preoccupation” and as a “normal illness” (p. 302 as cited in Flanagan, 2011, p.127). This creates conditions for the baby to feel safe, loved and comfortable when it is most vulnerable. Winnicott realized that the mother only needs to be “good-enough” because no individual can consistently meet the baby’s every need. Gradually, she responds less to her child as the child learns to be more self-sufficient and learns to tolerate frustration (Winnicott, 1971, p.13). As long as she is able to attend to the baby’s needs enough to make her child feel safe and cared for, she has succeeded in creating the “holding environment” necessary for the baby’s development of a true self (Flanagan, 2011, p. 127).

A person who has a true self presentation has also mastered object constancy. Object constancy suggests that the child and mother have formed a secure attachment to one another, and the child is not filled with abandonment anxiety or ambivalence about the caregiver. This allows the child full freedom to focus on playing and interacting with the world. He believed that

object constancy was achieved through the mother's successful survival of the child's destructive impulses.

Winnicott (1971) viewed the infant's destructiveness to be something that emerged out of a healthy relationship with a caregiver. In essence, it is only through this experience of having the mother survive the child's destructive projections that the child learns to experience the world as "other-than-me" (1971, p. 119). A "shared reality" is created, and the child can be comforted knowing that his fears will not always come true. He calls this ability to see others as separate people (rather than projections of the self), *object use* (1971, p. 119). In a therapeutic setting, this happens when the patient recognizes that the therapist is able to tolerate their worst fantasies and projections, so the *projection* of the object is destroyed, while the actual object (the therapist) becomes both more separate and reliable (Winnicott, 1971, p. 121). This shift allows the patient to feel safer and able to take more creative risks in session since they are not preoccupied with conforming to their therapist's presumed needs or expectations.

In summary, Winnicott (1971) lays down the following conditions for the development of a true self:

- a) relaxation in conditions of trust based on experience;
- b) creative, physical, and mental activity manifested in play;
- c) the summation of these experiences forming the basis for a sense of self (p. 75).

False Self (and Object Relating)

When a baby develops in an inadequate holding environment with a misattuned, neglectful or abusive caregiver, a false self adaptation occurs. Winnicott viewed many of the symptoms that patients came to therapy with as emerging from this false self-adaptation. This false personality is always created through the child's attempts to comply and adapt to their

environment. For example, someone with a very depressed parent or a parent who was quick to anger may learn to develop a reserved and compliant personality in order to thrive in their environment. However, a life based on compliance is also generally one of dissatisfaction. Winnicott (1971) stated that this compliance “carries with it a sense of futility for the individual and is associated with the idea that nothing matters and that life is not worth living” (p.87).

In Winnicott’s theory of personality development, children who develop a false self adaptation are more anxious, less engaged in play, and unable to achieve object constancy with their primary caretaker or other important figures. Thus, they are unable to make the necessary switch from object relating to object use. This means that every relationship this individual has is steeped in their own fantasies and projections. A patient who relies heavily on the defense of splitting is a prime example of object relating, since they can so quickly perceive the object as their fantasy of that person (for example, loving and compassionate on one day, and full of hate and judgment the next). When a person views all of their relationships through a projection, they unintentionally obscure the reality of how the other actually feels.

Winnicott recognized that there were times that utilizing a false self adaptation was necessary, such as obeying the instructions of a school teacher or boss. The false self, in opposition to the spontaneity and creativity of the true self, can also be conceptualized as the “caretaker self” (Eckler-Hart, 1987, p.684). This ability to be able to conform to society’s social demands is protective; it protects the true self from having to adapt and change. A healthy use of the false self replicates the protective response of the good-enough mother (Eckler-Hart, 1987, p.684).

A maladaptive use of the false self results in the individual feeling stuck or lost, without a clear sense of self (Mitchell & Black, 1995, p.129). Winnicott viewed individuals with

personality disorders, such as Borderline Personality Disorder, as experiencing a psychotic anxiety arising from their reliance on the false self. He states “the core of the patient’s disturbance is psychotic, but the patient has enough psychoneurotic organization always to be able to present psychoneurosis or psychosomatic disorder when the central psychotic anxiety threatens to break through in crude form” (1971, p. 117). Clients who experienced early and prolonged childhood victimization fit this description well, since they are often preoccupied with an anxious psychotic anxiety and are often hypervigilant, prepared for the worst. Winnicott believed that there was hope for those with a false self adaptation. He believed that every individual with a false self also had within them a “secret life” of an authentic true self lying dormant, waiting to be uncovered through a strong therapeutic holding environment and relationship (1971, p. 92). The therapeutic relationship would serve as a corrective emotional experience for the patient’s environmental deficiencies.

Transitional Objects

Perhaps Winnicott is best known for his theory of the transitional object. The transitional object is an object that the child uses and relates to as it transitions from object relating to object use. The object itself is chosen by the child and given a special significance and symbolic meaning. It often is a stuffed animal, special blanket, or song that the child needs to hold on to and relies on consistently for soothing and help falling asleep. The transitional object acts as a stand-in for the comfort and security provided by a parent, and allows the child to begin to tolerate feeling separate and alone. The parents, too, recognize the value this object has in comforting their child, and ensure to make it available at all times (Winnicott, 1971, p. 5). The transitional object, also described as a “not-me possession” (p.6), helps the infant learn how to internalize the soothing qualities of the mother when she is not available (Flanagan, 2011,

p.128). This helps the child learn how to self-soothe and tolerate being alone, which is a quality associated with a true self adaptation.

The inherent paradox of the transitional object is that it is not perceived by the child as an extension of the self, but is also not perceived as a separate object the child has no control over. It exists in a transient space between self and other; and further, this paradox is accepted by both the child and parent (Mitchell & Black, 1995, p. 127). Eventually, when the child learns to internalize the love and soothing they experience from the mother, the object loses meaning and is remembered but no longer needed to fend off the child's anxiety (Winnicott, 1971, p.7).

Play & Transitional Phenomenon

Winnicott equated mental health with the ability to play and create. The ability to play sets the condition for the child or adult to experience pleasure and to be creative. This ability to play is cultivated through the realm of transitional experience. Like the transitional object, the transitional experience of play is a special time when the child is engaged in his environment but is free to express himself rather than comply to any outside rules or conditions (Mitchell & Black, 1995, p.128). Play involves the body interacting in space, so it does not exist purely in the child's internal world, as a fantasy does. A child deeply involved in their play is intensely focused, creative, excited and satisfied. Winnicott saw this experience as "always creative" and as a "basic form of living" (1971, p. 67). It is a way of integrating objects from the external world into the individual's own inner world, where the child attaches emotions, dreams, meaning or feeling onto the object (1971, p. 69).

An ability to play also involves an ability to trust, which Winnicott believes is first cultivated through the relationship between the baby and the "good-enough mother" (1971, p.69). The transitional experience of play, similar to the transitional object, requires that all

involved accept and tolerate the paradox of its existence as both a real experience and a made-up one (Winnicott, 1971, p. 71).

Play and Psychotherapy

As stated above, Winnicott (1971) believed that creative action was what made individuals feel their life was meaningful and worth living (p.87). He viewed a strong therapeutic relationship as the primary mechanism for change, and wrote that the essence of psychotherapy was the facilitation of an environment where people can play or learn to play. Creating this therapeutic holding environment would allow the patient to cultivate a more authentic and creative sense of self, which would relieve the great mental stress of individuals who constantly felt they must to adapt to their demanding environment. He wrote, “psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play (p. 51). Thus, he found it essential that a psychotherapist know how to play and create himself before trying to help someone else develop their truest sense of self (p. 73).

The transition from *learning-to-play* to being *able-to-play* parallels the transition from object relating to object use. Thus, the therapist needs to withstand the client’s projected hate and destruction the same way the mother withstands her infant’s projected hate and destruction in order to create a reliable and secure therapeutic relationship based on two separate people relating to, and playing with, each other (Winnicott, 1971). The good-enough therapist, like the good-enough mother, models her ability to self-soothe and to express herself authentically throughout the tumultuous process of therapy. Over time, the client ‘learns to play’ partially through internalizing these qualities from the therapist.

Contemporary Critique

Winnicott believed that a therapeutic holding environment would provide a safe enough transitional space for the client to learn to play, express himself creatively, and allow his true self to emerge. Contemporary relational psychotherapists, on the other hand, dispute the idea that there can ever be one cohesive true self. Proponents of this theory view the self as composed of numerous self-states loosely strung together to form the illusion of one self. Health, in this conceptualization, is understood as “the ability to stand in the spaces between realities without losing any of them – the capacity to feel like one self while being many (Bromberg, 1996, p.513). Relational theorists such as Phillip Bromberg, PhD, would view Winnicott’s conceptualization of a false self adaptation to actually be an over-reliance on dissociation to ward off self-states that cause too much anxiety to be acknowledged (Bromberg, 2000).

Conclusion

Winnicott’s concepts of the true and false self adaptations, transitional objects and phenomena, and the role of play and creativity in psychotherapy and in mental health have been outlined in this chapter in order to demonstrate how the earliest years of one’s life deeply impact the rest of their psychological development, and how therapy can be used to rectify longstanding feelings of emptiness, stuck-ness, and difficulties relating to and trusting others. Winnicott’s enthusiastic belief that play and creativity are an essential component of healthy self-expression and of the work of therapy will be beneficial to the discussion of how art therapy could be beneficial to CPTSD survivors’ treatment in chapter six. The next chapter will expand on the second theoretical framework of art therapy theory.

CHAPTER V

Trauma-Informed Art Therapy

This chapter will review contributions from various art therapists who have contributed to the literature on the therapeutic treatment of trauma. While each therapist uses slightly different terminology, all of the protocols that will be discussed draw heavily from both trauma theory and neurobiology. Thus, I will designate this chapter as focusing on the theory of Trauma-Informed Art Therapy.

Art Therapy

The American Art Therapy Association (2015) defines art therapy as “a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem.” Practitioners must become knowledgeable in theories of human development, psychology, counseling, and visual art (AATA; Gantt & Tinnin, 2009). Since art therapy’s goal is primarily therapeutic, clinicians learn to focus their attention on their clients’ emotional experience during and after the creation of a work of art. The focus is on the process rather than the quality of the final product. As with psychotherapy, the relationship established between therapist and patient is an essential component of the process (Avrahami, 2006, p.6).

Art therapists choose a theoretical orientation to ground their practice in a similar way that social workers do. They are familiar with psychodynamic, humanistic and psycho-educational theory, among others (Rubin, 2010) and have acquired training at an accredited school where a master degree or certificate of completion was obtained.

Art therapy can be directive at times, for example when conducting an assessment, but generally follows a more open-ended structure, where clients take the lead in selecting materials and project content (Malchiodi, 2007). It can be distinguished from arts and crafts or the type of artistic project used in occupational therapy because the focus is on therapeutic exploration and healing rather than the acquiring of a new skill or way to pass the time (Fleshman & Fryrear, 1981, p. 8).

Art therapy is a young and growing discipline. For the purposes of this paper, I will be focusing specifically on visual art therapy, which includes the use of drawing, painting, sculpture, clay and collage for therapeutic means. This is the most common type within the profession (Rubin, 2010, p.45). Other types of creative therapies offered use poetry, music, dance, drama, sand play or a combination of different modalities. The multi-modal format is generally termed expressive arts therapy. (Malchiodi, 2005; Rubin, 2010, p. 41).

Basic Tenants of Contemporary Art Therapy

It is beyond the scope of this chapter to cover all the components that art therapy entails. The following section represents some basic assumptions art therapists believe to be true.

Art is empowering.

Art therapists, regardless of theoretical orientation, believe that art making is empowering and enhances one's quality of life through (Konopka, 2014, p.73). The website of the American Art Therapy Association (2015) states that art therapy improves relationships and interpersonal conflict, reduces stress and increases insight while providing "an opportunity to enjoy the life-affirming pleasures of art making." At times, making art can be soothing, cathartic and even pleasurable for clients. The experience of creating something tangible allows clients to have a "dialogue with themselves" that they can later return to and reflect on (Liebermann, 1986,

p.30). It can also be a valuable coping skill for clients who experience overwhelming feelings or memories, since it offers a sense of containment, distance and control to the person creating the art. (Malchiodi, 2005, p.9). Avrahami (2006), an Israeli art therapist, believes that art “calls to the creative, healthy part of the client, which enables an authentic, non-threatening expression, opening new possibilities for change and growth” (p.6).

Anyone can benefit from art therapy.

Art therapists work with individuals of all ages, from young children to seniors in nursing homes and rehabilitation centers. They practice in schools, psychiatric facilities, hospitals, prisons, mental health centers and private practices. Since it does not rely solely on verbal expression, art therapy can be practiced with clients who have developmental disabilities or severe mental illness. It is also appropriate for individuals who are functioning highly in society but seek greater insight into their inner experience (AATA, 2015).

Art can express the unspeakable.

Artistic expression allows individuals to share a part of their inner world with the viewer without needing to rely on words. Malchiodi (2006) states that individuals who have limited access or no access to language, such as a selectively mute child or a person recovering from a stroke, can use art to express themselves. Individuals who have experienced trauma and dissociation and cannot find words to express or understand their experience can also benefit from this alternate means of communication (Malchiodi, 2005, p. 4). Art helps people, especially those struggling with a mal-adaptive use of dissociation, “to “see” what they are *feeling or thinking*” (Rubin, 2010, p.1), as it makes the unconscious conscious. I will further elaborate on this concept in another section of this chapter.

The art therapist helps clients express themselves.

Edith Kramer, one of the founders of American art therapy, developed the idea of the ‘third hand’. This is where the art therapist uses their knowledge and expertise to assist the client in expressing their intent. Kramer (1986) described this as “a hand that helps the creative process along without being intrusive, without distorting meaning or imposing pictorial ideas or preferences alien to the client” (p.71). This prevents the client from feeling discouraged, is collaborative, and helps the client build confidence in their piece.

Historical Context

In the late 1800s and early 1900s the moral therapy movement changed how psychiatric patients were treated in Europe and America. Previously, psychiatric patients were institutionalized without any focus on rehabilitation. Moral treatment offered a more humane and compassionate model of care, and many hospitals encouraged patients to express themselves artistically and musically as part of their treatment plan (Malchiodi, 2005, p.5). Adrian Hill, for instance, was a pioneer of art therapy in Europe. He developed his artistic practice in a sanatorium where he was being treated for tuberculosis (Malchiodi, 2007, p.37).

American art therapy was developed in the 1930s and 1940s. It was deeply influenced by the influx of European immigrants fleeing World War II who brought psychoanalytic theory and practice with them to the United States. Roosevelt’s New Deal also created a number of new teaching jobs for artists in schools, hospitals and community centers across the nation (Rubin, 2010, p. 57). The Menninger Clinic in Topeka, Kansas hired a number of artists to teach lessons to their psychiatric patients starting in the 1930s (Malchiodi, 2007, p.38; Rubin, 2010, p.58).

Margaret Naumberg and Edith Kramer the two women most frequently identified as the pioneers of American art therapy. Naumberg was a scholar and educator who founded the experimental Walden School with her sister Florence Cane. Having experienced Freudian and Jungian analysis, she viewed artistic expression as a form of ‘symbolic speech’ that unearthed messages from within the unconscious (Rubin, 2010, p.58). Her practice of “dynamically oriented art therapy” utilized art-making as an alternate mode of communication. She viewed art as a therapeutic tool, and often had her patients draw their dreams for psychodynamic interpretation (Malchiodi, 2007, p. 36; Vick, 2003, p.5).

Kramer, an Austrian refugee who had fled WWII, worked in New York City as an art teacher and later in a psychiatric ward for children. She, too, was interested in Freudian psychoanalytic theory, but she differed from Naumberg in that she viewed the act of art making itself as a form of sublimation (Rubin, 2010, p.58). To her, the process of creating art was therapeutic in itself (Vick, 2003, p.6).

Art therapists began to professionalize their practice in the 1960s, developing educational programs, credentials and academic journals of their own. In 1961 the first journal was established, and the American Art Therapy Association was founded in 1969 (Fleshman & Fryrear, 1981, p. 79; Vick, 2003, p. 6). Starting in the mid-1980s the field began to become more accepted and has continued to grow in numbers (Vick, 2003, p.7). One common criticism of art therapy is that it is difficult to measure efficacy due to the eclectic ways practitioners work and document their results. There is a lack of published studies examining whether art therapy can be (or should be) an evidence-based practice (Kennedy, Reed & Wamboldt, 2014, p.22).

Trauma-Informed Art Therapy

Many art therapists believe that their field is uniquely suited to help clients process traumatic memory and affect. Trauma-informed art therapists integrate trauma theory, psychodynamic theories, cognitive-behavioral theory and relevant studies in neurobiology into their art therapy practice. For example, Kathy Malchiodi, PhD, is a well-known art therapist, writer and educator dedicated to promoting the use of trauma-informed art therapy with children. While she grounds each of her sessions in an artistic exercise, her recommendations for others who wish to practice with youth who have experienced complex trauma resemble Judith Herman's (1992) stages of recovery. The main difference is that her recommendations also include consideration of how to best work with a traumatized brain, with a highly overactive amygdala. She writes:

1. **Establish a sense of safety.** This includes helping children establish both an internal sense of safety and identification and support for safety within their homes, neighborhoods, and communities.
2. **Regulate affect.** Help children understand that what has happened is “not their fault,” and assist them in learning methods to regulate and moderate arousal [limbic system] with the long-term goal of restoring emotional equilibrium.
3. **Reestablish attachment.** Chronic, complex trauma disrupts basic trust because it is often caused by dysfunctional or abusive interpersonal relationships; our goal as helping professionals is to help children reestablish attachment with positive adult role models and to learn how to empathize and productively interact with peers.
4. **Enhance the brain's executive functions.** Serious and repetitive trauma impacts cognition, disrupting cortical functioning; our goal is to help children effectively engage attention, comprehension, and problem-solving skills to allow for the experiences of mastery, self-esteem, and self-efficacy.
5. **Reframe and integrate traumatic experiences.** Chronic, complex developmental trauma cannot be erased from memory; however, with our help children can learn to how to manage their reactions, enhance adaptive coping skills, and cultivate present-oriented responses to current stresses. Our ultimate goal in intervention is to help these youth transform, incorporate, resolve, repair, and construct meaningful lives, post-treatment.

(Malchiodi, 2010, Part One: Developmental Trauma)

I use this example to highlight the ways that art therapists are frequently integrating multiple theoretical orientations together, depending on the needs of their client population. The following section provides a review of how trauma-informed art therapists theorize art therapy is uniquely beneficial to this client population.

Containment, control & coping.

Trauma-informed art therapy holds that art can be a useful grounding and coping tool when one is experiencing overwhelming emotions. Recent developments in neuroscience have shown us that the brains of traumatized individuals function differently than someone who has not been traumatized. Healthy brain development occurs when an infant is in relation to an attuned caregiver. This experience of traumatic childhood stress indicates that the amygdala and hippocampus of an individual who has been exposed to chronic stress are smaller than that of a securely attached counterpart. Cortisol is a stress hormone that is released in order to shift the body's response from homeostasis to the alert fight-or-flight mode. Clients with Complex PTSD's hypothalamic-pituitary-adrenal axis (HPA) have been found to release a higher level of resting cortisol, even when the situation does not warrant it (Cozolino, 2014, p. 271). This means their body responds more severely to minor stressors than is typical.

The first stage of Herman's (1992) stage theory for the treatment of trauma is establishing safety, which includes learning how to regulate emotions through the development of coping skills. Art therapy is uniquely suited to accomplish these tasks simultaneously. Art therapists believe that art can help individuals with PTSD and Complex PTSD feel safe because it contains and creates a tolerable distance between the patient and their overwhelming feelings (Avrahami, 2006, p.32). Art that is created on a piece of paper has physical boundaries and is a tangible representation of the patient's internal world. Once a piece of art is created, the client can

become introspective. This allows the client to reflect on their experience visually, perhaps gaining a new perspective when they see their overwhelming emotions contained to a page they can choose to keep or discard. In this case, there is less likelihood of the client's amygdala perceiving a threat and activating fight-or-flight mode. In fact, Hass-Cohen (2006) states, the quiet, alert state of the artist is thought to stimulate "hippocampal processing of new information," which is not possible when the amygdala is on high-alert and assessing for danger (p.2).

A client who is afraid to express their feelings may be relieved to see that they survived the process of creating a piece of art, and that the expression has been confined to the limits of the piece of paper (Avrahami, 2006, p.11). A client who is too dissociated to know what they are feeling can become more grounded and present in their body through the sensory act of drawing, painting etc., and can gain access and insight into what they are feeling by looking at the manifestation of their unconscious on a piece of paper (Estep, 1995).

After clients have learned to use art to contain and safely distance their intrusive thoughts and memories, they can begin to develop it as a coping mechanism, to use for self-soothing in times of stress. Cozolino (2002) and Sapolski (1998) also suggest that It can also be called upon as a useful distraction that allows the client to regulate their body as they focus solely on the art on the page, rather than on intrusive thoughts or impulses for self-harm (Hass-Cohen, 2006, p. 2) This affords clients with a sense of agency, when previously they felt only helplessness. Estep (1995) documented how her client developed a routine where she would choose drawing to disclose painful memories of her childhood and watercolors when she wanted to relax and calm herself. This client explained that she chose watercolors instead of markers because she didn't want to feel upset. A client with a trauma history who is able to use art therapy for containment,

self-expression, and self-soothing is also able to experience a sense of control, choice and agency.

Working with traumatic memory and dissociation.

Interpersonal Neurobiology is a field of study that examines how the brain develops and changes in response to interpersonal relationships and patterns (Siegel, 2003). It aims to integrate research from attachment theory, neurobiology, mindfulness studies, psychology and other fields in order to explain how changes in emotions and relationships alter the brain throughout one's life (Cozolino, 2014, p.12). Recent research in neurobiology and interpersonal neurobiology propose that trauma temporarily disrupts the communication between the left and right hemispheres of the brain. This disruption means that the left side of the brain, which is known to be in control of language, linear thought and rationality, is cut off from the right hemisphere, which addresses non-verbal communication, emotions, and self-regulation (Siegel, 2003). These researchers believe that for traumatic experiences to be truly integrated and processed by an individual, *both* hemispheres must be engaged in the therapeutic work (McNamee, 2005, p.546; Siegel, 2003, p.15). In this view, talk therapy is just one component of the treatment, which must integrate both body and mind. EMDR is grounded in this belief, as it aims to stimulate both hemispheres of the brain (Talwar, 2007, p.27).

Trauma-informed art therapists have created their own protocols in attempt to stimulate bilateral integration in their clients' brains. They believe that creating art stimulates the non-verbal, body memories within the right hemisphere, and that discussing and processing the art and memories afterwards stimulates the left hemisphere (Hass-Cohen, 2006, p.1; McNamee, 2005; Talwar, 2007, p.23).

Talwar's (2007) Art Therapy Trauma Protocol (ATTP) is aimed at reaching the "non-verbal core of traumatic memory" (p.22), and influenced by how "studies in neuropsychology, art and PTSD...present significant findings for art therapists engaged in accessing traumatic memory through image making" (Talwar, 2007, p.26). It is influenced by EMDR and McNamee's (2003) bilateral art protocol. In phase one of this intervention, she gathers the client history and has the client recall a memory of a traumatic event. Then, the client is asked to focus all their attention on painting. The paints are on the other side of the room, so the client must continuously walk back and forth across the room as they work. When they are finished, the client is asked to explain the "dominant emotion associated with the painting." Talwar explains that this emotion is generally a negative one, and associated with the traumatic memory. Phase two involves the client coming up with a phrase that identifies that negative cognition (ex: "I am not valuable" and then counter it with a positive cognition ("I am valuable"). The client is then asked to rate how true those statements feel to them on a scale of 1-10. Talwar also asks the client to identify where in their body the negative belief is located. They then paint that feeling with their non-dominant hand while feeling and remembering the negative memories (Talwar, 2007, p. 30).

In phase three, the client is asked to keep painting and switching between dominant and non-dominant hands, until "there are no longer any feelings of disturbance at the recall of the traumatic event" (Talwar, 2007, p.31). In some ways, this protocol evokes Prolonged Exposure (PE) therapy used by the military and VA. It also perhaps draws from sensorimotor psychotherapy, as one of the therapeutic aims is to help the client grow to identify and observe their own thoughts and bodily sensations moment-to-moment. Talwar associates the choosing of

color, brushes and design with left brain functions, and the right brain with emotional, special and sensorimotor activity (2007, p. 34).

Talwar has had great anecdotal success implementing this method in her private practice. In one of her case studies, she reports a client felt a shift from “feeling trapped to feeling free” (Talwar, 2007, p.33). However, it should be noted that the client in Talwar’s case study sought her out specifically to explore her trauma history through art. The client chose art therapy after engaging in years of talk therapy, and stated “I need to work with the image. Words are not enough” (Talwar, 2007, p.31). This raises the question of how much the placebo effect is relevant to the success of therapeutic interventions. I also wonder if there were other therapeutic modalities that were recommended to this patient or if other body-based therapeutic modalities would have had a similar effect on her mental health.

The “Check, Change What You Need To Change and/or Keep What You Want” protocol (Check art therapy protocol), is another art therapy trauma intervention established for the treatment of PTSD. It was modeled with Herman’s stage-oriented treatment in mind (Hass-Cohen, Findlay, Carr & Vanderlan, 2014, p.73) and was tested with a woman who suffered from the aftermath of September 11th. The protocol has five art directives offered in sequence. They are:

- a) Autobiographical trauma timeline
- b) Trauma image drawing and narration
- c) Image alteration
- d) Self-strength image
- e) Optimistic future image

The first directive helps the client to begin placing their traumatic memory in an autobiographical order, helping the client to place it in the past (p.73). In the second step, the client expresses a memory, titles the drawing, and describes it. The third directive allows the client to check-in internally, and respond to the question, “check in; if you could change or keep one aspect of the drawing or painting, which aspect would you choose and what does it look like?.” A digital picture is taken of the drawing to document it, before the client alters the image through cutting, drawing, painting or altering the image in another way. The client also has the option to start over on a new piece of paper. Once the alteration is complete, the client describes what alterations are made, and why. The authors explain that this is done to reinforce the client’s perception of regaining control, as well as of minimizing dissociated states by having them reflect and be active in the present (Hass-Cohen et al., 2014, p. 73). Finally, the last two directives are conducted to cultivate resiliency. The client is asked to depict one of their strengths, and then draw an image of hope for the future. They are directed to pick the art materials that they wish to use, allowing the client to remain in control of their work and with a focus on the positive future ahead of them (Hass-Cohen et al., 2014, p. 73).

Like Talwar’s ATTP, this protocol focuses on processing negative cognition and affect *and* developing new, hopeful experiences and ways of being. It also teaches the client to observe and reflect on their emotional state, which aims to help them learn how to self-regulate their body. The authors of the Check art therapy protocol argue that creativity breeds optimism, and that helping clients envision an optimistic future is helpful in their quest to feel a solid sense of selfhood (Hass-Cohen et al., p.72).

Skeffington and Brown (2014)’s case study of an alcoholic adult who grew up in a family where incest occurred to a sibling, states that art therapy may be a beneficial way to reach clients

who try to manipulate the therapy and avoid the most painful subject matters. They argue that this is especially true with clients who have complex trauma and who are likely to be riddled with shame and/or dependent on avoidance through substance abuse (p.119). Working with images instead of words, they argue, allows the client to start expressing themselves more authentically in an environment that feels more tolerable (p. 119).

Re-establishing attachment.

Trauma-Informed art therapists are focused on using their sessions to re-establish a client's ability to form trusting and meaningful relationships with others. Malchiodi (2014), acknowledges that complex trauma disrupts a child's ability to trust others, and realizes that an essential component of her role as a therapist is to be a consistent, positive force for her clients. She cites research on how sensory interventions like art, dance and play, may reach a patient's pre-verbal body memories of infancy, before their amygdala became hyperaroused through the experience of trauma. Repeating this experience can re-wire neural pathways, helping the brain to become less hyper-vigilant (Malchiodi, 2003; Riley, 2002).

Hass-Cohen (2006) cites research by Mead (2001) and Main (2002) that states that the quiet, focused intimacy of making art in the presence of another "mimics the reiterative dynamics of approach and avoidance observed in mother-child play" (p.1). As the therapist and client build rapport, the art therapist's office becomes a safe place for the client to conjure up imagery within themselves, share it with another, and receive attention and feedback (Hass-Cohen, 2006, p.1). Creating and sharing a piece of art then becomes a cathartic experience, as the trauma victim vulnerably shares a part of herself that has previously been kept secret or repressed (Avrahami, 2006, p. 32)

Estep's (1995) case study detailing art therapy with an adult survivor of childhood incest cites a turning point in the middle of therapy when the client called her in distress. This was a sign of progress, Estep argued, because it demonstrated her client's shift from isolation to trust in the therapeutic relationship.

Transference and countertransference.

Research by Johnson (1987) and Schaverien (1995) demonstrates that art therapy mitigates the intense transference between a client with PTSD and their art therapist (Avrahami, 2006, p. 12). A piece of artwork expresses a client's feelings, and can become a target for the client's powerful projections. A client can also indirectly express their feelings about their art therapist through a piece of artwork. Avrahami (2006) reflects, "with the help of the image, the patient makes a statement about the self – but also makes a statement that is aimed at the therapist" (p.12). Transference and countertransference with patients who have experienced trauma is known to be particularly intense, as the patient vacillates between the poles of trust and mistrust, idealization and devaluation, and an overarching helplessness (Avrahami, 2006, p.11; Herman, 1997). After a client creates an image and expresses a feeling state, they have the opportunity to take control and manipulate it further (cutting, tearing, putting away, adding to), which potentially counters a feeling of helplessness or allows the patient to shift their perspective and experience something new. It seems that Avrahami is arguing that a focus on the artwork facilitates the maintenance of healthy boundaries for both therapist and client. She states that strong countertransference can also be mitigated through a discussion of the symbolic messages within the artwork (2006, p. 12).

Commentary

It is important to recognize the potential limitations of this therapeutic modality. Certainly, as Avrahami (2006) discussed, the use of art in therapy significantly alters (and diffuses) the transference and countertransference between client and therapist. I was unable to identify literature critiquing trauma-informed art therapy, perhaps because the field is still so young. I wonder if this is also because literature discussing the efficacy of art therapy has generally been written by other art therapists, and limited to art therapy publications. I imagine there are numerous mental health professionals who are skeptical about the efficacy of trauma-informed art therapy relative to other treatment options.

Conclusion

In conclusion, there is a growing body of literature exploring how art therapy can benefit patients with trauma histories. The next chapter will include a discussion synthesizing D.W. Winnicott's contributions to object relations theory, trauma-informed art therapy, and the treatment of individuals with complex post-traumatic stress disorder.

CHAPTER VI

Discussion

The objective of this thesis has been to explore how visual art can be used as a clinical tool in the treatment of clients with complex PTSD. This chapter provides a general overview of the research presented as well as a discussion on how the lenses of object relations theory and trauma-informed art therapy help to conceptualize the development and treatment of symptoms associated with prolonged exposure to trauma. Implications for social work practice and future research will also be discussed.

Complex PTSD

Complex PTSD is a diagnostic term used to describe the symptoms of individuals who are exposed to consistent, prolonged trauma, lasting from months to years. Often, individuals with this diagnosis have experienced childhood victimization in the form of abuse, neglect or the witnessing of violence (National Child Traumatic Stress Network, 2015). Other forms of repeated victimization are experiences of hostage situations, concentration-camps, some religious cults, prisoners-of-war, and domestic violence (Herman, 1992).

Judith Herman (1992) identified the following six categories that individuals with Complex PTSD suffer from: alterations in affect regulation, consciousness (ex: flashbacks and dissociation), self-perception, perception of the perpetrator, relationships with others, and meaning making (p.121). Individuals with Complex PTSD are filled with great anxiety about their relationships with others and their sense of self-worth. They are often chronically suicidal and struggle with issues of trust, despite a desire for intimacy. In identifying with their aggressor, they tend to turn their destructive feelings against the self (Chu, 2011, p.34).

The DSM IV field trial indicated that 92% of individuals with Complex PTSD also qualified as having PTSD (US Department of Veterans Affairs, 2015, National Center for PTSD). This indicates that while PTSD treatment can be beneficial for clients with Complex PTSD, additional treatment is required to address the full spectrum of these clients' symptoms. Clients with Complex PTSD also may differ from ones with PTSD because some may have not been able to recall or call upon ego strengths from a time *before* the onset of trauma.

The International Society for Traumatic Stress Studies' Complex Trauma Task Force recommends Herman's (1992) phase-based treatment as the treatment of choice for this population (Cloitre et al., 2012, p.5), which includes establishing safety, remembering and mourning their past, and reconnecting with society. They also recommend implementing alternative treatments that integrate the use of the body to increase awareness of the *mind-body connection* and facilitate healing (Cloitre et al., 2012, p.13). They have called for more studies to be conducted that investigate best practices for treating this population.

My research asserts that there is a strong correlation between Winnicott's concept of the false self and the concept of Complex PTSD. Furthermore, it indicates that helping a client express him or herself spontaneously and creatively is an essential component to heal from a traumatic childhood. A review of object relations theory and trauma-informed art therapy literature indicate that the art created can function as a transitional object, facilitating the client's ability to learn how to regulate their affect, recall dissociated affect and memories, trust another person and establish a more cohesive sense of self, all of which are primary goals of therapy for clients with significant trauma histories.

Early Childhood Relationships and the Development of Complex PTSD

Winnicott's theory of the development of the true and false self offers a useful framework to conceptualize the development of Complex PTSD in cases of childhood abuse and neglect. This theory emphasizes the importance of attentive and attuned parenting in the child's life, arguing that children develop their sense of self *in relation to* their caretaker. Winnicott observed that children who receive attentive, "good-enough" parenting grow up feeling safe in their homes and curious about the world around them. These children learn to tolerate their feelings through the transitional space of focused, curious play (p.71). "Good enough" parenting allows the child to develop healthy self-esteem and view their place in the world as meaningful.

Winnicott's concept of the maladaptive false self is an adaptation that occurs in the context of a deficient holding environment. He describes individuals with a false self as overly compliant, depressed, stuck and dissatisfied (1971). The deficient holding environment is one where the child is in some way emotionally neglected, which produces anxiety and fear in the child.

This false self description seems to adequately describe the experience of individuals living with Complex PTSD. Herman (1992) indicates that clients with Complex PTSD struggle with affect regulation, alterations in consciousness, perception of the perpetrator, relationships with others, and meaning making (p.121). Clients with a false self are described in a similar way. They have not learned how to tolerate being alone or how to comfort themselves when emotionally dysregulated (Winnicott, 1971). They struggle to form close, reality-based relationships with others, since they view interactions through the lens of their projections (object-relating) rather than being able to pick up on cues of how the other person actually is feeling about them (object use). Since they are overly concerned with meeting the needs and

expectations of others, they lack a feeling of agency and the conviction that their life is personally meaningful (Winnicott, 1971, p.87). While Winnicott does not specifically address what Herman deems “alterations in consciousness” (1992, p.121), such as re-experiencing a traumatic event through a flashback or dissociation, he does note the severity of clients’ anxiety, stating that “the core of the patient’s disturbance is psychotic” but they have enough ego strength to keep this anxiety repressed or somaticized (1971, p. 117). This acknowledgement of the patient’s ability to somaticize their anxiety also resembles descriptions of the ways individuals with Complex PTSD frequently report of an array of somatic symptoms (Basham, 2011; Chu, 2011; Herman, 1992).

Is it problematic to equate the false self with Complex PTSD? Does this mean that every person Winnicott and other object relations practitioners treated for false self disorder could accurately be diagnosed as suffering from Complex PTSD in current parlance, or does the false self adaptation exist on a sort of diagnostic spectrum, with Complex PTSD being on the more extreme end? While this warrants further research, trauma researchers have cited the high rate of child abuse in contemporary society, and suggested that diagnoses such as borderline personality disorder, dissociative identity disorder and somatization disorder might be better conceptualized as Complex PTSD (Chu, 2011; Herman, 1992, p.123). Finally, a conceptualization of a client’s symptoms as stemming from either false self disorder or Complex PTSD calls for the practitioner to approach their client with compassion, acknowledging the impact of their early relational experiences on their coping mechanisms and sense of identity in the present.

Transitional Objects and the Transitional Experience of Play

Winnicott’s theory of the true self emphasizes the importance of a safe holding environment that affords the child the opportunity to express their emotions and grow through

play. If the true self is not developed in early childhood, it can be cultivated through a strong therapeutic relationship, which Winnicott viewed as, in essence, “two people playing together” (1971, p.51). Play is such a valuable experience because it integrates the mind and body in a focused, creative and satisfying activity, where the individual is free to be active in the world but without any of the usual rules or constraints (Mitchell & Black, 1995, p.128). This capacity to express oneself freely is an essential component of living a meaningful life (Winnicott, 1971, p.67). Creating art can be viewed as a form of play, since it involves focus, trust, and the integration of mental, creative and physical activity. Art therapists believe that this act of creating can be therapeutic (Vick, 2003, p.6) and that that act of creating activates a healthy, authentic part of the client, that was perhaps previously dissociated or kept latent (Avrahami, 2006, p.6).

In object relations theory, both the transitional experience of play and the transitional object (such as a beloved stuffed animal, or in this case, a meaningful drawing), help the child learn to tolerate the experience of being separate from his mother. This is the space where coping skills are developed and the child learns to tolerate complex feelings and express himself. My review of the literature in Chapter Five has demonstrated the many ways that the creation of a piece of art during therapy can serve as a powerful transitional object.

A picture created during a particularly emotional therapy session can serve many functions as a transitional object. A client who struggles with anxiety can carry it with them throughout the week, serving as a physical reminder of the therapist’s care and support. When the client looks at the art made in session, she can remember the soothing moments that occurred and begin to practice internalizing them. It can also serve as a reminder of how creating a piece of art can be soothing or distracting in itself, as the act of putting emotions and memories onto a

piece of paper is reported to offer containment of the overwhelming feelings, as it creates a visible distance between the client and their pain (Avrahami, 2006, p.32). Looking at a piece of art can also remind the client of any feelings of safety or peace they might have felt at the time they were making it.

The holding environment that can be formed when a therapist and client are involved in a creative activity also resembles the transitional space of play. Winnicott (1971) viewed this space as a place that was safe enough for the subject to take emotional risks and try out new ways of being. This offers an exciting opportunity for clients to take safe risks exploring traumatic memories or feelings, communicating transference, and relating to the therapist in new ways. Mead (2001) and Main (2002)'s research that demonstrates how creating art in the therapeutic holding environment mimics the relational patterns of mother and infant at play (Hass-Cohen, 2006, p.1) is an example of this restorative risk-taking for clients whose extensive trauma history has made them distrustful of others.

Discussion: Why Integrate Art?

In the previous section, I outlined many potential benefits of utilizing art as a therapeutic tool. I argue, building on the findings outlined in Chapter Four and Five, that art can be a useful way to engage a client with Complex PTSD—functioning as a transitional object that helps them to feel safer relating to the therapist, experiencing their feelings and memories, and regulating their own affect. Anecdotally, art therapists and their clients with histories of trauma and child abuse have shared their positive feedback on the use of art as a therapeutic tool (Avrahami, 2006; Estep, 1995; Malchiodi, 2006; Rubin, 2010; Talwar, 2007), however there is still a lack of ample empirical evidence to support this as an *evidence-based* practice (Kennedy, Reed & Wamboldt, 2014, p.22).

Recent discoveries in neuroscience and trauma theory indicate that in order to address the implicit memory of trauma stored in the body, the use of the body must be integrated into traditional talk therapy (Duros & Crowley, 2014; Ogden et al., 2013; Spinazzola et al., 2011). While more research is needed, the integration of art therapy has been indicated as one such body-based practice. Since this is a relatively new and growing field, it is unclear whether art is more or less effective than another form of expressive or body-based therapy. A clinical social worker interested in integrating the use of art into their practice could do so with relative ease, since basic materials of paper, markers or paints are relatively low-cost.

The question remains, if there is only theoretical and anecdotal evidence supporting the use of art as a clinical tool for the resolution of trauma, why should readers consider art instead of another body-based modality? Is it worth exploring trauma-focused art therapy protocols such as Talwar's (2007) and Hass-Cohen et al.'s (2014), when they are modeled off of EMDR, which has a greater body of evidence supporting it? And if Winnicott believed that the therapeutic relationship was a form of play sufficient to aiding the development of the true self, why suggest the integration of a new element?

I believe that there is no "one-size fits all model" of treatment that works for all clients. My education has taught me that people are diverse, and it is essential that we as clinicians remain flexible and resilient, able to tailor our interventions to our clients' unique needs and strengths. Rather than arguing for a greater prevalence of art therapists, I am merely suggesting that social work students and clinicians are exposed to more information about the integration of art as a clinical tool, so they are able to draw from it when a client is too fearful or traumatized to express themselves with words, or as a new and innovative attempt to create a safe holding environment for a new and cautious client.

The clients I mentioned in Chapter Three, who were hospitalized time and again for suicidal ideation and subsequently triggered by physical pain psychiatrists deemed psychosomatic, voiced feeling angry, helpless and dismissed during their hospitalizations. One client who reported an emotionally abusive home environment, had learned how to speak intellectually about the effects of trauma and relevant coping mechanisms, but was consistently able to conjure these modes of self-soothing when she found herself in emotional or physical pain.

While I recognize that the primary goal of a psychiatric hospitalization is the stabilization of acute symptoms, rather than longer-term therapy, hospitals do exist that offer complementary alternative medicine sessions that include art, music and yoga therapy for psychiatric inpatients during an acute stay. One study on such a hospital indicated a 96% positive patient response rate, where respondents indicated that the complementary therapy improved the quality of their care (Kennedy et al., 2014, p.21). The integration of art into their treatment would have perhaps allowed these disenfranchised clients an opportunity to tune into their bodies and emotions and safely explore the depths of their unconscious. It would also afford them the opportunity to quietly enter a creative and playful zone, where they could perhaps begin to assign meaning to their hospitalization. Or, it could have simply provided them with another outlet to express their frustration and anguish in a socially acceptable and non-violent way.

Jon Kabat-Zinn (2012), in a personal communication with Duros & Crowley (2014), approached the multiple options of body-based therapies to choose from as “different doors into the same room” (p. 9). This means that they each have different modes of bringing attention to the sensations within the body as well as the mind, and are perhaps safer ways for clients to

access unconscious materials without triggering the amygdala's alarm system (Duros & Crowley, 2014, p.9).

Object relations theory and trauma-informed art therapy both support the assertion that creative action is an essential mode of meaning making, and enhances the quality of one's life. While the art therapy protocols that draw from EMDR may mimic its format and mode of bilateral stimulation, they differ by allowing clients to take a more active role in creating their own piece of art, embedded with personal symbolism that could only come from them. These protocols also allow the client to create their own, personalized transitional object, which they can choose to frame, destroy, leave in the art therapist's care, or carry with them at all times. Looking at the art work may help them feel a sense of emotional distance from their traumatic memories. A client who has not yet mastered object constancy would likely benefit from this physical reminder of the safe and attuned therapeutic relationship.

Implications for Social Work Practice

While this thesis strived to examine and correlated ideas through existing literature, it is by no means exhaustive. There is a considerable need for increased empirical and theoretical research on the treatment of Complex PTSD (Cloitre, et al., 2012, p. 3). Involving clients' voices in qualitative research would be potentially empowering for participants, as well as inform the field about trauma survivors subjective experience of their treatment.

In choosing to investigate object relations theory and trauma-informed art therapy, I had to omit other theoretical lenses also worthy of investigation. This thesis is also limited by its privileging of Euro-centric literature, and the viewpoint of individual differentiation and expression as a sign of health. I recommend a future study that draws on literature from other cultures around the globe. Due to time and scope limitations, I also was not able to examine how

race, class, gender, sexual orientation and culture may impact an individual's experience of Complex PTSD, and what implications intersectionality has for their treatment.

I chose to primarily focus my attention on the most common reason adults find themselves in therapy for the treatment of Complex PTSD, which is child abuse. This largely omits an important examination of how a prolonged experience of subjugation in adulthood, such as a severe domestic violence or political hostage situation, alters the experience of symptoms and recommendations for treatment. This, too, would benefit from future research studies.

I propose that clinical social workers gain more educational exposure about how creativity can serve as a valuable coping mechanism and transitional object in therapy, and specifically for the treatment of individuals with trauma histories. The utilization of art-marking in sessions allows for clients to express themselves in new ways, and can be integrated into a session when a client is struggling to speak, is in need of a grounding activity, or wants to work on a particularly terrifying memory or feeling.

Clinicians who find this thesis compelling and are interested in introducing art into a future therapy session would benefit from first establishing their own comfort-level with the art materials and creative process. Winnicott (1971) states the necessity of a therapist learning to play themselves before trying to help a client engage in play (p.73). This is because creative expression in therapy is a relational one: clients must feel supported and connected to their therapist if they are to take a risk and expose themselves in a new and vulnerable way. It is important for the curious clinician to be cautious when beginning to support a client explore their creativity, and heed Franklin's (2010) advice of cultivating a mindfulness practice of their own (p.163). This will allow them to be aware of their own somatic and emotional responses while

making art, so that they can be more attuned to their client's affective state from moment to moment (p.163).

Finally, social workers who wish to gain proficiency in trauma-informed art therapy techniques should seek specialized training through a graduate level master's degree or certificate program. Like any specialized therapeutic technique, it is unethical to practice as an art-therapist without obtaining the proper training and certifications.

REFERENCES

- Allen, J. (2001). Substance abuse, eating disorders, and self-harm. In J. Allen (Ed). *Traumatic relationships and serious mental disorders* (pp. 204-233). New York: John Wiley & Sons, Ltd.
- American Art Therapy Association (2013). *What Is Art Therapy?* Retrieved November 1, 2015, from <http://www.arttherapy.org/upload/whatisarttherapy.pdf>
- American Psychiatric Association. (2013). *Diagnostic and Statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.
- American Psychological Association (2014). Childhood Psychological Abuse as Harmful as Sexual or Physical Abuse. Retrieved September 28, 2015, from <http://www.apa.org/news/press/releases/2014/10/psychological-abuse.aspx>
- Avrahami, D. (2006). Visual art therapy's unique contribution in the treatment of post-traumatic stress disorders. *Journal of Trauma and Dissociation*, 6(4), 5-38.
- Basham, K. (2011). Trauma theories and disorders. In J. Berzoff, L.M. Flanagan, & P. Hertz (Eds.) *Inside out and outside in: psychodynamic clinical theory and psychopathology in contemporary multicultural contexts*, (pp. 440-474). Lanham: Rowman & Littlefield.
- Berzoff, J. (2011). Freud's psychoanalytic concepts. In J. Berzoff, L.M. Flanagan, & P. Hertz (Eds.) *Inside out and outside in: psychodynamic clinical theory and psychopathology in contemporary multicultural contexts*, (pp. 18-47). Lanham: Rowman & Littlefield.
- Bragin, M. (2005). To play, learn and think: Understanding and mitigating the effects of exposure to violent events on the cognitive capacity of children and adolescents. *Journal of Infant, child, and adolescent Psychotherapy*, 4(3), 296-309.

- Bremner, J. (2008). The neurobiology of trauma and memory in children. In: M. Howe Goodman & D. Cicchetti (Eds.), *Stress, trauma, and children's memory development: Neurobiological, cognitive, clinical and legal perspectives*. (pp.11-49). New York: Oxford Universities Press.
- Bromberg, P.M. (2000). Potholes on the royal road: Or is it an abyss? *Contemporary Psychoanalysis*, (26), 5-28.
- Bromberg, P. (1996). Standing in the spaces: The multiplicity of self and the psychoanalytic relationship. *Contemporary Psychoanalysis*, (32), 509-535.
- Carr, S. (2014). Revisioning self-identity: The role of portraits, neuroscience and the art therapist's 'third hand', *International Journal of Art Therapy*, 19(2), 54-70.
- Center for Deployment Psychology (2013). *Cognitive Processing Therapy (CPT)*. Retrieved October 16, 2015, from <http://deploymentpsych.org/treatments/cognitive-processing-therapy-cpt>.
- Choi, S., & Goo, K. (2012). Holding environment: The effects of group art therapy on mother-child attachment, *The Arts in Psychotherapy*, 39, 19-24.
- Chu, J. (2011). *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders*, Hoboken: John Wiley & Sons.
- Cloitre, M., Courtois, C.A., Charuvastra, A., Carapezza, R., Stolbach, B.C., & Green, B.L. (2011). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of Traumatic Stress*, 24, 615-627.

- Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B., Van der Hart, O. (2012). The ISTSS expert consensus treatment guidelines for complex PTSD in adults. Retrieved October 2015 from <http://www.istss.org/treating-trauma/istss-complex-ptsd-treatment-guidelines.aspx>.
- Cozolino, L. (2014) *The neuroscience of human relationships: Attachment and the developing social brain, second edition*. New York: W.W. Norton & Co.
- D'Andrea, W., Stolbach, B., Ford, J., Spinazzola, J. & van der Kolk, B. (2012). Understanding why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry*, 82(2), 187-200.
- Duros, P., & Crowley, D. (2014). The body comes to therapy, too. *Clinical Social Work Journal*, 42(3), 1-10.
- Eaton, L., Doherty, K., & Widrick, R. (2007). A review of research and methods used to establish art therapy as an effective treatment method for traumatized children. *The Arts in Psychotherapy*, 34(3), 256-262.
- Eckler-Hart, A. (1987). True and false self in the development of the psychotherapist. *Psychotherapy*, 24(4), 683-692.
- Estep, M. (1995). To soothe oneself: art therapy with a woman recovering from incest. *American Journal of Art Therapy*, 34(1), 9-18.
- False Memory Syndrome Foundation (2006-15) *Frequently Asked Questions*. Retrieved October 16, 2015, from <http://www.fmsfonline.org/?faq=faq>

- Fisher, J. & Ogden, P. (2011). Case study, breaking free: A mind-body approach to retraining the brain, *Psychotherapy Networker*, 35(2).
- Flanagan, L.M. (2011). Object relations theory. In J. Berzoff, L.M. Flanagan, & P. Hertz (Eds.) *Inside out and outside in: psychodynamic clinical theory and psychopathology in contemporary multicultural contexts*, (pp. 118-157). Lanham: Rowman & Littlefield.
- Franklin, M. (2010). Affect regulation, mirror neurons and the third hand: formulating mindful art interventions. *Art Therapy: Journal of American Art Therapy Association*, 27(4), 160-167.
- Freud, S. & Breuer, J. (1895). *Studies on hysteria*. New York: Basic Books.
- Fleshman, B. & Fryrear, J. (1981). *The Arts in Therapy*. Chicago: Nelson-Hall.
- Gantt, L. & Tinnin, L. (2009). Support for a neurobiological view of trauma with implications for art therapy, *The Arts in Psychotherapy*, 36, 148-153.
- Harvey, M. (2007). Towards an ecological understanding of resilience in trauma survivors: Implications for theory, research and practice. *Journal of Aggression, Maltreatment and Trauma*, 14(1), in press. 1-32.
- Hass-Cohen, N. (2006) Art therapy and clinical neuroscience in action. GAINS Community Newsletter,1, 10-12.
- Hass-Cohen, N., Findlay, J.C., Carr, R. & Vanderlan, J. (2014). "Check, change what you need to change and/or keep what you want": An art therapy neurobiological-based trauma protocol. *Art Therapy*, 31(2), 69-78.
- Herman, J. (1992). *Trauma and recovery: The aftermath of violence- from domestic abuse to political terror*. New York: Basic Books.

- Jaycox L.H., Ebener, P., Damesek, L., & Becker, K. (2004). Trauma exposure and retention in adolescent substance abuse treatment. *Journal of Traumatic Stress*, 17, 113-121.
- Johnson, D. (2009). Commentary: Examining underlying paradigms in the creative arts therapies of trauma. *The Arts in Psychotherapy*, 36(2), 114-120.
- Kardiner, A. (1941). *The Traumatic neurosis of war*. Menasha: George Banta Publishing Co.
- Kennedy, H., Reed, K., & Wamboldt, M. (2014) Staff perceptions of complementary and alternative therapy integration into a child and adolescent psychiatry program, *The Arts in Psychotherapy*, 41(4), 21-26.
- Kinniburgh, K., Blaustein, M., Spinazzola, J. (2005). Attachment, self-regulation, and competency: A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals*, 35(5), 424-430.
- Konopka, L. (2014). Where art meets neuroscience: a new horizon of art therapy. *Croatian Medical Journal*, 55(1), 73-74.
- Kramer, E. (1986). The art therapist's third hand: Reflections on art, art therapy, and society at large. *The American Journal of Art Therapy*, 24, 71-86.
- Liebermann, M. (1986). *Art therapy for groups: A handbook of themes and exercises*. Northampton: Brookline Books.
- Luxenberg, T., Spinazzola, J. & Van der Kolk, B. (2001). Complex trauma and disorders of extreme stress (DESNOS) diagnosis, part one: Assessment. *Directions in Psychiatry*, 21(25), pp. 373-394.
- Malchiodi, C. (2003). *Handbook of art therapy*. New York: Guilford Press.

- Malchiodi, C. (2005). *Expressive therapies*. New York: Guilford Press.
- Malchiodi, C. (2006). *Art therapy sourcebook*. New York: McGraw-Hill.
- Malchiodi, C. (2014) Trauma-Informed Art Therapy. Retrieved on November 5, 2015 from <http://www.cathymalchiodi.com/art-therapy-books/trauma-informed-art-therapy/>
- McNamee, C. (2005). Bilateral art: Integrating art therapy, family therapy, and neuroscience. *Contemporary Family Therapy*, 27(4), 545-557.
- Miehls, D. & Applegate, J. (2014). Introduction to neurobiology and clinical work. *Smith College Studies in Social Work*, 84 (2/3), 145-156.
- Miller, J. (2012). *Psychosocial capacity building in response to disasters*. New York: Columbia University Press.
- Mitchell, S.A. & Black, M.J. (1995) *Freud and beyond: A history of modern psychoanalytic thought*. New York: Basic Books.
- National Child Traumatic Stress Network (2015). Complex Trauma. Retrieved on October 10, 2015 from <http://www.nctsn.org/trauma-types/complex-trauma>
- National Institute of Mental Health. Post-Traumatic Stress Disorder. Retrieved from http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml#part_145370
- Ogden, P., Fisher, J., Pane, C. & Minton, K. (2013). Including the body in mainstream psychotherapy for traumatized individuals. Retrieved July 2014, from www.sensorimotorpsychotherapy.org/article%20APA.html

- Rayner, E. (2000). The British independents: A brief history. Retrieved on October 30, 2015 from <http://www.pschoanalysis.org.uk/britind.htm>
- Rivers, W.H.R. (1918). The repression of war experience. *The Lancet*, 1, 173-177.
- Rubin, J. (2010). *Introduction to art therapy: Sources and resources*, New York: Routledge.
- Seigel, D. (2003). An interpersonal neurobiology of psychotherapy: The developing mind and the resolution of trauma. In D. Seigel & M. Solomon (Eds.) *Healing trauma: Attachment, mind, body and brain*, (pp.1-56). New York: W. W. Norton & Company Inc.
- Skeffington, P. & Browne, M. (2014) Art therapy, trauma and substance misuse: Using imagery to explore a difficult past with a complex client. *International Journal of Art Therapy*, 19(3), 114-121.
- Slayton, S. (2012) Building community as social action: an art therapy group with adolescent males. *The Arts in Psychotherapy*, 39(3),179-185.
- Spinazzola, J., Rhodes, A., Emerson, D., Earle, E., & Monroe, K. (2011). Application of yoga in residential treatment of traumatized youth, *Journal of the American Psychiatric Nurses association*, 17(6), 431-444.
- Talwar, S. (2007). Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP). *The Arts in Psychotherapy*, (34) 22-35.
- Trauma. (n.d.) In *Merriam-Webster Online*, Retrieved September 28, 2015, from www.merriam-webster.com/dictionary/trauma.
- U.S. Department of Veterans Affairs (2015) National Center for PTSD. Retrieved on Nov 2, 2015 from <http://www.ptsd.va.gov/index.asp>.

- Van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry*, 1(5), 253-265.
- Van der Kolk, B.A., Pelcovitz, D., Roth, S., Mandel, F., McFarlane, A., & Herman, J.L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry*, 153(7), 83-93.
- Van der Kolk, B., Roth, S., Pelcovitz, D. Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18(5), 389-399.
- Vick, R. (2003). A brief history of art therapy. In C. Malchiodi (Ed.), *Handbook of art therapy*, New York: Guilford Press. Pages. 5-15.
- Winnicott, D.W. (1958). The capacity to be alone. In D.W. Winnicott (Ed.) *The maturational process and the facilitating environment: Studies in the theory of emotional development*, (pp. 29-36), London: The Hogarth Press.
- Winnicott, D.W. (1971). *Playing and reality*. London: Routledge Classics.
- Woody, J.D. & Beldin, K. (2012). The mental health focus in rape crisis services; Tensions and recommendations. *Violence and Victims*, 27(1), 95-108.